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DNP Roadmap Task Force Report
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BACKGROUND AND CONTEXT

A number of societal, scientific, and professional developments has stimulated a major paradigm change in graduate education in nursing. One major impetus for this change was the American Association of Colleges of Nursing's (AACN) decision in October 2004 to adopt the goal that preparation for specialization in nursing should occur at the doctoral level by 2015. In addition to that decision, other factors encouraging this change include the preparation by master's degree programs of advanced generalists such as the Clinical Nurse Leader (AACN, 2004b) and recommendations by the National Research Council of the National Academies (2005) for changes in doctoral preparation for those planning for careers with a heavy concentration in research.

Additional movement for the paradigm shift in graduate education in nursing comes from several landmark reports that focus on the nursing shortage, the crisis in the health care system, and proposed strategies for addressing these critical issues. The Institute of Medicine (IOM) report titled *Crossing the Quality Chasm* (2001) stresses that the health care system as currently structured does not, as a whole, make the best use of its resources. The aging population and increased client demand for new services, technologies, and drugs contribute to both the increase in health care expenditure and to the waste of resources. A recommendation in the report calls on all health care organizations and professional groups to promote health care that is safe, effective, client-centered, timely, efficient, and equitable (p. 6).

In a follow-up report titled *Health Professions Education: A Bridge to Quality*, the IOM Committee on the Health Professions Education (2003) states, "All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics" (p. 3).

Other factors that have built momentum for change in nursing education at the graduate level include the rapid expansion of knowledge underlying practice; increased complexity of patient care; national concerns about the quality of care and patient safety; shortages of nursing personnel; demands for a higher level of preparation for nurses who can design and assess care and lead; shortages of prepared nursing faculty, leaders in practice, and nurse researchers; and increasing educational expectations for the preparation of other health professionals. The development of a practice doctorate is supported in the National Research Council's report titled *Advancing the Nation's Health Needs: NIH Research Training Programs* (2005). That report notes the need for the nursing profession to develop a "non-research practice doctorate" to prepare expert practitioners who can also serve as clinical faculty.

In recognition of these developments, several nursing schools began developing plans for new practice doctorates, which created considerable ferment and some confusion in the field. In March 2002, AACN formed a task force “to examine the current status of clinical or practice doctoral programs, compare various models, and make recommendations regarding future development” (AACN, 2004a, p. 1). The task force made 13 recommendations, 4 of the most critical being:

1. The Doctor of Nursing Practice (DNP) is the degree associated with practice-focused doctoral education.
2. The practice doctorate be the graduate degree for advanced nursing practice preparation, including but not limited to the four current advanced practice nursing (APN) roles: clinical nurse specialist, nurse anesthetist, nurse midwife, and nurse practitioner.
3. A transition period should be planned to provide nurses with master’s degrees, who wish to obtain the practice doctoral degree, an efficient mechanism to earn a practice doctorate.
4. Practice-focused doctoral programs will be accredited by a nursing accrediting agency recognized by the U.S. Secretary of Education (i.e., the Commission on Collegiate Nursing Education (CCNE) or the National League for Nursing Accrediting Commission).

At AACN’s Fall 2004 Semiannual Meeting, Elizabeth Lenz, chair of the Task Force on the Practice Doctorate, moved that the *Position Statement on the Practice Doctorate in Nursing* (2004a), including all 13 recommendations, be endorsed by the membership. The membership adopted the position statement by a majority vote, and 2015 was established as the target date for graduate programs leading to advanced nursing practice preparation to transition to the doctoral level. In January 2005, AACN’s Board of Directors appointed two task forces to move the association’s work forward. The DNP Essentials Task Force was charged with developing the curricular content and the competencies for the DNP. The second task force, the DNP Roadmap Task Force, was given the following charge:

- Develop an implementation plan that provides a roadmap for achieving the goals of the AACN position statement by 2015;
- Delineate key institutional and academic issues that must be addressed in academic institutions;
- Assess regulatory and /or legislative frameworks that shape practice authority, reimbursement, and/or academic authority, and identify implications of these frameworks;
- Identify actual and/or potential challenges and opportunities inherent in the assessments and make recommendations;
- Map potential interfaces and/or partnerships that can be created to assist undergraduate and graduate nursing programs to participate in achieving the 2015 goal; and
- Develop recommendations that detail actions and timelines for accomplishment with specific focus on the role of AACN in facilitating the implementation process.

Process of the Task Force

To address the charge, the task force carried out a number of activities. Rogers' Diffusion of Innovations theory (2003), which provides a conceptual framework for understanding the process of the adoption of new practices or technologies and the associated social changes, was used to guide the work. Rogers' work indicates that in facilitating the adoption of an innovation it is important to help the community of potential adopters and other stakeholders participate in the process, clarify their understanding of the innovation, and reduce uncertainty. This translates into developing materials and communication channels that provide information and opportunities for input from various stakeholders. In addition to conducting meetings and conference calls, the task force carried out the following activities:

- Conducted two internet surveys of schools to assess if they were offering or preparing to offer a DNP program.
- Held regional conferences in cooperation with the Essentials Task Force in five locations throughout the country (Boston, St. Louis, Atlanta, Houston, and San Diego) (see Appendix A).
- Held a national stakeholders conference in cooperation with the Essentials Task Force in Washington, DC in October 2005 in which 65 leaders (Executive Directors and/or President) from 44 professional organizations participated. (See Appendix B).
- Made presentations on two national internet/telephone conferences arranged by the American Nurses Association.
- Participated in a variety of conference calls.
- Held two joint meetings with the Essentials Task Force.
- Gave a presentation and conducted a forum at the Fall 2005 AACN Semiannual Meeting in cooperation with the Essentials Task Force.
- The chair presented at the Advisory Council for the National Institute of Nursing Research (NINR) in January 2006.
- The chair presented at the June 2006 Conference of the Association of Community Health Nursing Education.
- The chair gave a presentation with the Chair of the Essentials Task Force and conducted a discussion at the AACN Doctoral Conference in January 2006, at the AACN Master's Conference in February 2006, and at the February 2006 AACN Faculty Practice Conference along with a member of the Clinical Nurse Leader Implementation Task Force.
- Developed the DNP Tool Kit, a Frequently Asked Questions reference and other resources that have been posted on the AACN Web site for review and comment (<http://www.aacn.nche.edu/DNP/dnpfaq.htm>).

National Dialogue and Progress Toward the 2015 Goal

A significant number of organizations and individuals is engaged in the national dialogue on the DNP. The intent is to set in motion processes that achieve the idealized goal of moving to the DNP. At all meetings related to the DNP, a systematic effort has been made to create forums in which those who attend are encouraged to participate actively in the process by providing input to the work of both the Essentials and Road Map Task Forces. As the work progressed, the efforts to provide information, encourage dialogue, and build consensus seemed to be successful and at the fifth regional conference in San Diego and the 2006 AACN Doctoral Conference, task force members and AACN staff collectively sensed that a “tipping point” had been reached and that the issue was no longer whether the DNP initiative would move forward, but how to make it as successful as possible.

The sense of positive momentum is mirrored in data collected regarding DNP program planning and development. According to AACN data, in the spring of 2005 there were 8 DNP programs admitting students, and 60 additional schools had DNP programs under consideration. By summer 2005, a total of 80 schools had DNP programs under consideration. In the fall, an email survey of AACN members indicated that 9 institutions had DNP programs in place and 162 schools were at some stage of developing/planning a DNP program. In February 2006, another email survey of member institutions indicated that 11 institutions had DNP programs and were admitting students, 5 had graduated students, and 190 institutions were in the process of developing/planning a DNP program. Of the 190 institutions reporting, 70 reported having a faculty task force in place, 32 had completed a needs assessment, 28 were seeking approval from their university, 18 were seeking approval from their state’s higher education board, and 32 were developing curriculum. It is of particular interest that 29 institutions reported plans to collaborate with another institution while 7 institutions already were collaborating.

A summary of the key issues and challenges was developed after considering the charge given to the task force and analyzing the issues that emerged in the regional conferences, the national stakeholders’ conference, and in the forum held at the fall 2005 AACN Semiannual Meeting. These issues are discussed here as are potential strategies and activities that could be undertaken by AACN and other stakeholders.

ACADEMIC ISSUES

The Link Between the DNP Program and the Institutional Mission

The DNP allows academia and clinical settings to establish new models of affiliation and collaboration, particularly in terms of practice and research. Faculty who practice in the clinical setting and clinical staff who serve as faculty contribute to strong collaborative partnerships that enhance the academic practice mission. Moreover, DNP graduates enhance the academic research mission given their abilities to translate academic research findings and evidence into practice.

The Practice Mission

Schools and departments of nursing have varying opinions regarding the question of whether practice is part of their mission and if so, to what extent. Available data show that relatively few schools of nursing have formalized their practice commitment, either by developing and operating a nursing center (20%; Berlin, Stennett, & Bednash, 2002) or an academic clinical program (15%; Sebastian, personal communication). However, all schools and departments of nursing have important connections to practice settings and many clinical faculty continue to practice on their own time or in some cases are granted time for practice by the school.

As previously noted, schools of nursing with the first DNP programs have active faculty practice programs with long-standing practice commitments as part of their mission. Academic leaders in these institutions suggest that their DNP initiatives are a function of their awareness of changing practice needs. In fact, at one institution, it became evident that to fully tap into the potential for faculty practice in terms of the scholarship of application or practice (particularly developing new innovations in practice and research utilization) doctoral level preparation for practitioners and others was needed. While PhD faculty are supportive of the practice initiative, with few exceptions it has been difficult for research faculty to maintain their funded research programs and teach while also spending significant time in an active clinical practice.

How might the collaboration between academia and practice be positively affected by the DNP? The lines between faculty and clinical staff would blend with each serving the dual role of clinician and academician, resulting in the development of new educational models that test new and emerging nursing roles. This would lead to increased practice innovation and improved health care, and provide a richer clinical learning environment for students who could participate with faculty in their scholarship activities. Faculty practice scholarship activities would accelerate by having more faculty with practice commitments prepared with the competencies of the DNP graduate. Further, the broader range of skills of the DNP-prepared clinician may result in more options for developing contracts and other practice arrangements for faculty-practice partnership. This could expand teaching and research resources and strengthen the credibility and viability of nursing within the community. An important byproduct could be the opportunity for faculty to remain active in the kind of practice for which they are preparing students as well as creating additional fiscal resources to enhance faculty salaries. As evidence of this possibility, medical colleges have found ways to keep a significant component of their faculty in practice and to pay reasonably competitive salaries.

The Research Mission

Maintaining and strengthening the research mission of schools of nursing is imperative to contributing to the knowledge base necessary to support health care in the future. There are a number of ways in which individual graduates and the DNP movement can support the research mission of schools of nursing and the profession.

With regard to research, the academic preparation and predominant focus of DNP graduates is on the use of research findings in making practice decisions. Thus, the development of DNP programs will increase the number of nurses with an appreciation for the importance of research, who can use research in their practice and in their teaching, and who can provide leadership to others, resulting in policies and practices that are informed by the best research evidence possible.

Another positive contribution of the DNP movement is that DNP graduates can alleviate the faculty shortage by assuming more leadership in the clinical education of students at the baccalaureate and graduate levels and in other roles in schools of nursing. Such a development would allow research-intensive faculty more time to target their efforts on the highly competitive arena of federally supported research and the mentoring of PhD students and new researchers. Disturbing data on the projected future needs for nursing faculty, the projected shortfalls due to retirements, and the sluggish production of PhDs despite the growing number of PhD programs (Berlin & Sechrist, 2002) demand that something change. The preparation of DNP graduates can be a part of that change.

Perhaps the greatest potential contribution of the DNP to the research mission will be strengthening the linkages between the practice and research efforts in schools of nursing, and the connection between schools and their practice partners. There are several facets to this: DNPs can serve as practice-focused members of the research team; DNPs can identify practice issues and unresolved practice questions, which can lead to important research questions and the generation of insightful hypotheses; and DNPs can provide leadership in the translation component of health services research. Moving forward, it is critical to have expert nurse clinicians as part of research teams.

Recommendations for Institutions

1. *Evaluate links among the DNP and the research, scholarship, practice, teaching, and service mission of the institution.*
2. *Develop faculty practice arrangements to attract, retain, and adequately compensate faculty actively involved in practice.*
3. *Strengthen links with the practice environment to:*
 - *Enhance the practice mission*
 - *Develop strong collaboration and exchange*
 - *Develop practice opportunities for faculty*
 - *Develop teaching opportunities for clinicians*
4. *Encourage the development of DNP and PhD teams to provide leadership in the translation component of research in the health care setting.*

Recommendations for AACN

1. *Expand the data collected on faculty and students by including information on:*

- a) *the extent to which DNP and PhD/DNSc students are enrolled in the same courses; and*
- b) *faculty funding for research and scholarship by type of terminal degree.*
2. *Include doctoral preparation of school of nursing faculty (e.g., PhD, DNSc DNP, EdD) in the annual survey of schools of nursing.*
3. *Sponsor or cosponsor, with other groups, such as AONE or various practitioner groups, national or regional efforts directed to broaden understanding of scholarship in the practice environment.*
4. *Obtain current national information on how school of nursing practice missions are structured and financed, and their relationship to the educational, service, and research missions of schools of nursing, with and without DNP programs.*
5. *Document the involvement of DNP faculty in practice and clinical staff in teaching to provide information on the “value added” by the DNP.*
6. *Identify ways to collaborate with the faculty practice network to enhance the faculty practice mission.*
7. *Create networks and share best practices in developing research teams.*
8. *Develop joint programming for DNPs/PhDs in the research network. Use AACN’s Research Leadership Network (RLN) and/or offer programming at the Doctoral Conference to encourage the development of teams to evaluate patient-centered care.*

DNP Program Issues

In the DNP regional conferences and in other discussions regarding the development of DNP programs, a number of program issues were raised. In addition to those relating to the essential curricular components and addressed in the *DNP Essentials* document, the three program issues of most interest were: pathways to DNP preparation, maintaining quality and rigor, and program length.

Pathways to DNP Preparation

The Essentials of Doctoral Education for Advanced Nursing Practice or *DNP Essentials* describes various entry points into the DNP curriculum. Regardless of the pathway, in order to graduate the student must attain the end-of-program competencies defined in the Essentials document. The degree-conferring institutions should design the individualized approaches for completion of their DNP curriculum based on a candidate’s prior education and demonstrated competence.

Because of the different entry points, the curriculum can be individualized for candidates based on their prior education, experience and choice of specialization. Early in this transition period, many students entering the DNP programs will have a master's degree built on AACN's *The Essentials of Master's Education for Advanced Practice Nursing* (1996). Graduates of such programs would have already attained many of the competencies defined in the *DNP Essentials*. Therefore, their DNP curriculum would need to be designed to include the higher level and expanded content defined in the *DNP Essentials*. However, consideration must also be given to the variability that exists in master's level nursing programs. Therefore, faculty must assess each candidate's previous educational program to determine the unique learning experiences required to meet the end-of-program competencies of the *DNP Essentials*.

In contrast, the candidate who enters the program with a baccalaureate degree in nursing or another field would require a more comprehensive and longer program of study than a candidate entering the program with a master's degree. These students would require more extensive content and clinical experiences related to all components of the curriculum defined in the *DNP Essentials*, including specialty competencies/content.

Maintaining Quality and Rigor

The adoption of the final *DNP Essentials* will provide faculty of each academic institution with a framework for the DNP curriculum. Faculty should ensure congruence with the following two components of the DNP curriculum model:

1. *DNP Essentials* 1-8 are the foundational outcome competencies deemed essential for graduates of a DNP program regardless of specialty or functional focus.
2. Specialty competencies/content prepare the graduate for those practice and didactic learning experiences focused on preparing the DNP graduate for a particular specialty. Competencies, content, and practica experiences needed for specific roles in specialty areas are delineated by national specialty nursing organizations.

The DNP Essentials document outlines and defines the eight *DNP Essentials* and provides some introductory comments on specialty competencies/content. The specialized content, defined by the specialty organizations, builds on and complements the areas of content defined by the *DNP Essentials* and constitutes the major component of DNP degree programs. DNP curricula should include these two components as appropriate to the specific advanced practice specialist being prepared. Additionally, the faculty of each DNP program has the academic freedom to create innovative and integrated curricula to meet the competencies outlined in the *DNP Essentials* document.

Program Length

Institutional, state, and various accrediting bodies often have policies that dictate minimum or maximum length and/or credit hours needed to award specific academic degrees. Recognizing these constraints, it is recommended that post-baccalaureate DNP programs be three calendar years, or 36 months of full-time study including summers, or four years on a traditional academic calendar.

Post-master programs should be designed based on the DNP candidate's prior education, experience, and choice of specialization. Even though competencies for the DNP build on those attained through master's study, post-master's and post-baccalaureate students must achieve the same end-of-program competencies. Therefore, it is anticipated that a minimum of 12 months of full-time post-master's study will be necessary to acquire the additional doctoral level competencies. The task force recommends that accrediting bodies ensure that post-master's programs validate that students obtain the experiences necessary to acquire all of the required end-of-program competencies. Thus, DNP programs, consistent with the expectations of the *Essentials* document, are efficient and manageable with regard to the number of credit hours required, and avoid unnecessarily long programs of study.

Strategies for Program Development and Implementation

Some leaders of academic nursing programs have recognized two significant obstacles that might challenge the creation of a DNP program: 1) lack of congruence with the mission of their parent institution, and 2) scarce resources, including qualified faculty. Thus, the development of partnerships between those institutions who can not offer the DNP degree and those institutions that have the resources to offer the DNP is an innovative solution to this dilemma. Exemplars of several collaboration models are included in the DNP Tool Kit.

Recommendations for Institutions

1. *Devise DNP curricula and policies responsive to students' backgrounds.*
2. *Ensure the quality of DNP program by creating programs consistent with the components of the DNP curriculum model and have faculty with appropriate preparation.*
3. *Develop high quality doctoral programs that avoid protracted programs of study.*
4. *Seek specialized nursing accreditation for their DNP program.*
5. *Recruit expert clinicians to serve as preceptors and faculty.*

Recommendations for AACN

1. *Develop master's conference programming to explore new models for master's education in nursing that facilitate the link to doctoral education.*
2. *Develop doctoral conference programming to address emerging national policies affecting research and practice missions, such as research priorities, pay for performance, centers for excellence, the NIH roadmap, and practice scholarship.*
3. *Continue to add to the DNP Toolkit other best practice examples of strategies for the development and implementation of DNP programs.*

The Future of the Master's Degree

AACN's (2004a) *Position Statement on the Practice Doctorate in Nursing* represents a vision for the future, and as such, AACN members have endorsed the transition from specialty nursing practice education at the master's level to the DNP by the target goal of 2015. AACN recognizes the importance of maintaining strong interest in roles (e.g., nurse practitioner, clinical nurse specialist, nurse midwife, and nurse anesthetist) to meet existing health care needs.

In response to practice demands and an increasingly complex health care system, programs designed to prepare nurses for advanced practice nursing will begin the transition to the practice doctorate for nurses who initially want to obtain the DNP, as well as for nurses with master's degrees who want to return to obtain the practice doctorate. AACN will assist schools in their transitioning to the DNP and in their efforts to partner with other institutions to provide necessary graduate level course work. Specialty focused master's level programs will be phased out as transition to DNP programs occurs. Master's programs will continue to be offered and will prepare nurses for advanced generalist practice.

Accreditation of Master's Programs

The Commission on Collegiate Nursing Education (CCNE), an autonomous arm of AACN, will continue its mission of ensuring program quality and integrity through the accreditation of baccalaureate and higher degree programs. With the CCNE Board of Commissioners' decision to initiate a process for accreditation of DNP programs, CCNE has expanded rather than limited its scope of operation. This scope includes master's degree programs with advanced practice offerings. In the future, however, programs will need to make decisions regarding advanced practice offerings at the master's level and their viability and ethical standing when the profession has evolved advanced practice education to the doctoral level. Such decisions will be driven by the larger profession, not by accrediting organizations.

Recommendations for Institutions

- 1. Consider reconceptualization of the master's program for advanced generalist practice.*
- 2. Consider evidence from CNL pilot in development of master's programs.*
- 3. Continue dialogue and planning on transition to the DNP.*

Recommendations for AACN

- 1. Provide educational sessions and materials to assist schools in developing master's programs to prepare advanced generalists.*
- 2. Engage in discussion on the future role of the master's degree in nursing.*

Faculty Issues in the Development of a Program

Credentials Required to Teach in a DNP Program

To ensure the scholarship of nursing practice, the faculty ideally should possess a doctoral degree with expertise in the area in which the faculty will be teaching. All of the faculty in DNP programs do not have to have the DNP credential. Rather, schools should recruit faculty with senior leadership experience, a network of leadership influence, and a high level of expertise in an area of clinical practice. Faculty in a DNP program may include pharmacy faculty, public policy faculty, statisticians, medical faculty, informatics faculty, and others. Presently, advanced practice nursing (APN) programs use a variety of faculty including master's prepared APN faculty, faculty without APN preparation, and faculty who do not have a nursing background. These individuals are significant faculty resources, and they will continue to be used in DNP programs. In some instances, highly skilled master's prepared nursing clinicians may assume a role in the preparation of DNP graduates. The most significant issue to be considered is whether the faculty member has the requisite skill and knowledge to teach the particular content or competencies to be acquired in specific courses.

In some instances, individuals who acquire the DNP will seek to fill roles as educators. As in other disciplines (e.g., biology, business, law), the educational preparation focuses on the area of specialization within the discipline to be taught, not the process of teaching. Therefore, preparation for nursing faculty roles should focus on practice, not education. However, individuals who desire a role as an educator - whether that role is operationalized in a practice environment or the academy - should have additional preparation in the science of pedagogy to augment their ability to transmit the science of the profession they practice and teach. This additional preparation may occur in formal course work during the DNP program or through continuing education. This preparation for the faculty/educator role is in addition to

the preparation necessary for the area of specialized nursing practice. Schools of nursing should not create graduate nursing programs that have education as their major.

Development of Faculty for a New DNP Program

Approaches exist that will assist a program in developing faculty prepared with the DNP. For example, a college planning to offer a DNP, while waiting for approval, may use an avenue in another college with authority to offer doctoral level courses. Using the Special Topics designation, the college could offer DNP courses over several semesters to their current nursing faculty. Once the DNP is approved, the credits earned by the faculty will be transferred into the DNP program. Another strategy to develop DNP faculty would be to share faculty (joint appointments) with another university that has qualified DNP faculty, while faculty proposing a DNP program attended classes in an established DNP program.

Preparation of Preceptors

Clinical preceptors can present with a variety of skills, educational credentials, and expertise. Preceptors could be selected from a variety of disciplines, thereby building the students' interdisciplinary experiences (Sebastian, 2006). An advanced practice nurse with a master's degree or PhD, or a DNSc-prepared nurse who is a leader in establishing clinical excellence, would be an appropriate preceptor. The decision on what constitutes an appropriate preceptor will depend on the route and area of specialization to the DNP. DNP programs might have a variety of preceptors with different knowledge and skills depending on the outcomes of the educational portion of the curriculum. Currently master's-prepared preceptors in APN programs are effective in supervising students for the tremendous amount of time required in the clinical component of the program. In some instances, a portion of these preceptors will choose to obtain the DNP post-master's, thus being further prepared to guide the DNP student in the acquisition of the highest educational level for practice.

Academic Career Path for Faculty in a DNP Program

Integrated Scholarship. In 1999, AACN membership approved the *Position Statement on Defining Scholarship for the Discipline of Nursing*. This statement is very appropriate to address the concerns regarding the scholarship expectations for a faculty member prepared with the DNP. Nursing, along with many other academic disciplines (e.g., engineering, social work, business, education) has proposed faculty reward systems that recognize that "rigorous scholarly inquiry must be applied in the realities and demands of practice." The work by Boyer (1996) provides a useful framework for defining scholarship for a faculty prepared with a DNP and committed to advancing nursing knowledge: (1) *discovery*, where new and unique knowledge is generated; (2) *teaching*, where the teacher creatively builds bridges between his or her understanding and the students' learning; (3) *application*, where the emphasis is

on the use of new knowledge in solving society's problems; and (4) *integration*, where new relationships among disciplines are discovered. These four aspects of scholarship support the values of nursing, which is committed to social relevance and scientific advancement—also essential characteristics of the DNP role.

The first schools to develop the DNP program have had active faculty practice programs with long-standing practice commitments as part of their mission. These early adopters believe that their DNP initiatives grew from an awareness of what needed to happen in practice and a vision of what could be. Important to this issue is the definition of practice, which has been conceptualized to include “any form of nursing intervention that influences health care outcomes for individuals or populations, including the direct care of individual patients, management of care, administration of nursing and health care organizations, and the development and implementation of health policy” (AACN, 2004a, p. 2). At one of the DNP-pioneer institutions, it became evident that the potential for faculty practice in terms of the scholarship of application or practice, particularly to develop new innovations in practice and research utilization, would be realized when the practitioners were doctorally prepared. By having more faculty with practice commitments prepared with the competencies of the DNP, practice scholarship activities should accelerate. This will lead to more practice innovations, better patient care, and a richer clinical learning environment for students who could participate with faculty in some of their scholarship activities. Maintaining a practice as a faculty member has the potential to expand teaching and research resources and strengthen the credibility and visibility of nursing within the community.

Academic Appointment and Progression Options. Faculty in DNP programs may have different appointment options, for example, multi-year contracts, faculty in residence, clinical educator track, or practice-education track. These routes are designed to provide flexibility for faculty roles and practice.

The awarding of and criteria for tenure are the prerogative of the parent academic institution. An institution offering a DNP should review its policies for awarding tenure and, if the institution presently tenures faculty with other practice professional degrees (such as education, medicine, pharmacy, law and audiology), then faculty with the DNP practice doctorate also should be eligible for tenure. In such cases, the standard for tenure should include a broad definition of scholarship consistent with Boyer (1990). Tenure policies should not dictate the educational preparation for advanced nursing practice.

Recommendations for Institutions

1. *Require faculty teaching in the DNP program to maintain an active connection to practice in their area of expertise.*
2. *Support individuals with a wide array of degrees and credentials as appropriate DNP faculty if they possess the needed knowledge and expertise.*

3. *Consider an exchange of faculty or faculty sharing between an established DNP program and a developing program as an approach to faculty development.*
4. *Engage faculty from other disciplines.*
5. *Recognize integrated scholarship as evidence for scholarship for the awarding of appointment, promotion, and/or tenure.*
6. *Support faculty with the DNP degree as eligible for appointment, promotion, and tenure if the institution tenures faculty with other professional doctorates.*
7. *Consider a range of appointment options to offer the greatest flexibility for employment and utilization of DNP faculty.*
8. *Develop education skills of DNP faculty.*

Recommendation for AACN

1. *Develop strategies for sharing “best practices” in the development of DNP faculty.*

COSTS AND BENEFITS OF DNP EDUCATION

A variety of costs will be incurred in considering, planning for, and implementing a DNP program. These costs can be categorized into those incurred by the educational institution, those incurred by the potential student, and those incurred by the society that desires the services of nurses prepared for specialized and sophisticated practice.

Costs and Benefits to Students

Any professional desiring to advance their ability to practice in their particular discipline or profession will incur expenses beyond those expended to gain basic entry-level skills or expertise. These include the cost of tuition or other educational expenses, the loss of income as the individual either delays entry into the profession or decreases their work hours to engage in the education, and any costs associated with supporting their own personal expenses. Nurses who seek to acquire the DNP, similar to other types of professionals, also will incur these same kinds of expenses. Moreover, despite concerns raised by some that nursing professionals will not be willing to incur the costs associated with a DNP program, there is no evidence to support this idea. Additionally, the growing presence of a second-degree nursing student population provides evidence that, increasingly, the potential nursing student is willing to incur significant costs provided a clear benefit is visualized in terms of career opportunities and earning potential.

Any of these costs must be contrasted with the long-term benefits of acquiring a more sophisticated skill set and acquiring specialized expertise, which is highly desirable and presents a larger range of opportunities for employment or enhanced earning potential. Clearly, the growing recognition that nurses with advanced specialized skills are in high demand will mitigate a good deal of the cost concerns associated with this career trajectory. Further, as in any profession, earning potential will be directly related to the clinician's ability to make significant contributions to the mission or strategic goals of the employing organization. The acquisition of enhanced skills for translation of evidence, development of population-focused care models, or intervention in significant policy initiatives will add value to the employment setting. Moreover, current efforts to facilitate rapid movement to the DNP upon completion of basic entry-level education will elongate the nurse's career with these enhanced skills, thus also increasing long-term earning potential.

Nonetheless, resources to support the DNP student should be sought and enhanced. Currently, federal-supported traineeships for advanced practice nursing students are only minimally available to students seeking the doctoral degree. This policy, which restricts the availability of this support source for the DNP student should be modified and efforts must be taken to review and revise this restriction. Currently, teaching assistantships and support through these are traditionally reserved for students in research-focused doctoral programs. Teaching assistantship support should also be available for the DNP student who potentially will serve as a major resource for both didactic and clinical teaching in academic nursing programs. Efforts to find student support for teaching assistantships or scholarships should include collaboration with employers and federal and state agencies. Academic program administrators should advocate for development of student support in the form of scholarships or paid internships that will support the student during their educational program. These efforts could also include advocating for support through the armed services for student scholarships and educational study deferments or support from potential future employing agencies or organizations, which will benefit greatly from the enhanced skills of the DNP graduate. Additionally, students in the DNP program potentially can serve as support staff in nurse-managed clinics or other clinical settings with the potential to generate support funding through this service.

Support for student-incurred expenses is not an issue unique to the design and implementation of the DNP program of study. Currently, approximately two-thirds of all master's level nursing students are in part-time studies while they remain employed to complete their studies (AACN, 2005-2006, p. 19). The preponderance of part-time students is an outcome as new graduates of entry-level nursing studies historically have been discouraged from immediate progression to the specialized and advanced program of study. More rapid access to graduate studies, a growing and highly important trend, could additionally benefit the student by providing a longer term of significantly improved earning potential and could overcome concerns about expanded costs associated with a longer term of full-time study to acquire the DNP.

Costs and Benefits to the Educational Institution

Institutional costs include the array of personnel and support service expenses associated with the implementation of a graduate-level program of study. Faculty salaries represent the largest portion of the institutional costs associated with the academic program. For the DNP program, the potential to incur additional faculty-salary-related expenses will vary depending on the size and skill mix of the faculty already present in the academic program. As is currently a norm in medical schools across the nation, strong relationships with the practice community provides a rich source for faculty who serve as mentors. A long-term benefit to the academic program will be strong connections to a cadre of DNP graduates who will serve not only as sophisticated clinicians but also be identified for service as faculty and mentors to other DNP students, potentially serving to overcome current concerns regarding the growing shortage of nursing faculty.

DNP programs, by virtue of their focus on preparing highly specialized nursing professionals, must also either employ or have collaborative arrangements with a similarly sophisticated group of professionals able to serve as faculty and mentors for the DNP students. The value of developing strong faculty-practice initiatives will enhance opportunities to attract a strong base of clinicians willing to serve as faculty and can provide the potential for additional revenue resources for faculty support.

A current, albeit limited, source of support for the academic unit is the Department of Health and Human Services Title VIII program for advanced nursing education. As discussed previously, the limits placed on the use of these funds for the development and support for doctoral education is an artifact of previous models for advanced nursing education, and efforts should be undertaken to lift the limits placed on support for both doctoral students and doctoral programs.

Clearly, additional revenues will be generated through the added credit hours associated with the DNP program. However, the academic leadership in the nursing program must advocate for adequate resources to mount any graduate program and the DNP program will require a clear base or support from the entire academic institution's leadership. This advocacy should include collaborative support from community partners desiring to employ the DNP graduate and able to influence the academic institution's decisions regarding support and resources.

Costs and Benefits to Society

The growing recognition that nurses prepared with graduate degrees are important resources for health care delivery and access to needed services will require a focused approach to ensure that the number of nurses prepared for this level does not diminish. As academic programs begin transitioning to the DNP, efforts to assist master's degree nurses in acquiring the DNP could delay the production of new advanced nursing clinicians. Schools must focus on ensuring the production of additional nurses prepared at the advanced level and maintaining a robust production capacity that maintains the current graduation level.

Recommendations for the Institutions

1. *Encourage academic program administrators to collaborate with employers and federal and state agencies to find support for scholarships, teaching assistantships, and paid internships for students during their educational program.*
2. *Support academic program administrators as advocates for financial support through the armed services for student scholarships and educational study deferments.*
3. *Develop strong faculty practice initiatives that attract expert clinicians willing to serve as faculty and provide additional revenue.*
4. *Seek collaborative partnerships for creative models and for the sharing of resources.*

Recommendations for AACN

1. *Lead lobbying efforts among organizations to increase support for nursing doctoral education through the Department of Health and Human Services Title VIII program.*
2. *Provide programming on managing faculty resources and faculty development to address faculty issues.*
3. *Work with members and practice partners to remove barriers to graduate education, e.g., requiring practice experience for entry.*

REGULATORY ISSUES

The move from master's education to the DNP for all specialty nursing education will require changes in language in some state and federal statutes, and in accreditation and certification criteria. Nonetheless, the basic premise that underlies regulation licensure, certification, and accreditation, particularly in relation to APNs, remains unchanged. The move to doctoral education for specialty nursing education presents an ideal opportunity for licensing, certifying, and accrediting bodies to enhance collaborative processes, particularly as they relate to advanced practice nursing.

Licensure

Licensure, a form of external regulation, is a publicly controlled operation in which the state or governing authority sets minimum standards for safe practice. Licensure is a public function that has been delegated to the states and territories by the

constitution (American Nurses Association, 1995). Standards of practice are determined by the profession. Professional self-regulation provides accountability to the community served by the profession and acknowledges that the profession will engage in efforts to protect the public from unsafe practice (Bednash, Gibbs, & Honig, 2005). The *DNP Essentials* establishes the standards for education programs and the expectations of DNP graduates. The *Essentials*, a national, consensus-based document, delineates the eight essential competencies that must be attained by all DNP graduates.

The DNP degree represents the attainment of the highest level of preparation in specialty nursing practice, and graduates should hold the appropriate professional nursing license. The DNP, in contrast to many other health professions' practice doctorates, is not an entry-level degree. Recognition of authority or licensure to practice beyond the entry-level Registered Nurse (RN) license currently is only relevant to the four APN roles. There is much discussion within professional nursing regarding the disparate processes among states for recognizing advanced practice nurses authority to practice. In March 2004, the Alliance for APRN Credentialing, formerly known as the Alliance for Nursing Accreditation¹, convened the APN Consensus Process to establish a consensus statement on the regulation of advanced practice nurses. This meeting was called to in response to the many issues surrounding APN regulation, including the definition of advanced practice nursing, specialization, and sub-specialization. A representative panel of advanced practice education, practice, certification, and regulatory organizations comprise the APN Consensus Work Group charged with the development of the consensus statement by the larger consensus group. This statement is still under development, but will address the issue of licensure for DNP graduates.

The *DNP Essentials* document mirrors the format used in AACN's *The Essentials of Master's Education for Advanced Practice Nurses* (1996). The *DNP Essentials* are inclusive of and expand on the competencies included in the *Master's Essentials*. Therefore, graduates of DNP programs will have attained not only those competencies considered essential for master's degree nursing graduates but also will have a broader, and in many knowledge areas, a more in-depth level of competence in these essential areas of nursing practice. In addition, to address the concern of licensure and credentialing bodies, the AACN *Master's Essentials* Advanced Practice Nursing Core (advanced health assessment, advanced pharmacology, and advanced

¹ The Alliance for Nursing Accreditation, created in 1997, was convened by AACN to regularly discuss issues related to nursing education, practice, and credentialing. Organizational members of the Alliance include American Academy of Nurse Practitioners Certificate Program, American Association of Colleges of Nursing, American Association of Critical-Care Nurses Certification Corporation, Council on Accreditation of Nurse Anesthesia Educational Programs, American College of Nurse-Midwives, American Nurses Credentialing Center, Association of Faculties of Pediatric Nurse Practitioners, Inc., Commission on Collegiate Nursing Education, National Association of Clinical Nurse Specialists, National Association of Nurse Practitioners in Women's Health, Council on Accreditation, Pediatric Nursing Certification Board, The National Certification Corporation for the Obstetric Gynecologic and Neonatal Nursing Specialties, National Council of State Boards of Nursing, and the National Organization of Nurse Practitioner Faculties.

physiology/pathophysiology) are deemed essential for all DNP graduates prepared to provide patient care to individuals and families.

In the immediate future, many DNP programs will be designed for individuals already holding a master’s degree in nursing. Beyond that, however, DNP curricula will evolve to include programs designed for a variety of entry options including:

- Post-master’s for individuals with APN master’s degree education
- Post-master’s for individuals with advanced generalist preparation or preparation in a non-APN specialty at the master’s degree level
- Post-baccalaureate nursing education
- Post-baccalaureate direct entry for non-nurses in another field

All DNP programs must ensure that graduates, including those wishing to practice in one of the four APN roles, have attained the necessary competencies and have met the appropriate practice experiences necessary to sit for national certification and practice in the identified specialty nursing role.

Based on a survey of individual state boards of nursing and examination of on-line materials, 20 states require a master’s degree for nurses to practice in an APN role (Table 1) (Phillips, 2005, p. 14). Twenty-three state regulations/laws use language stating that a graduate degree or a minimum of a master’s degree is required for APN authorization to practice (Table 2). Eight states have no language in their state laws regarding educational requirements for practicing in the APN role (Table 3). State and national regulatory boards are encouraged to review all statutes and regulations governing advanced or specialty nursing practice and clarify language to require a graduate level degree as minimum preparation for practice as an APN.

Table 1: States requiring a master’s degree for nurses to practice in an APN role:

Arkansas	Kentucky	Rhode Island
California	Maine	South Carolina
Connecticut	Montana	Washington
Delaware	Nevada	West Virginia
Florida	New Jersey	Wisconsin
Hawaii	Oklahoma	Wyoming
Iowa	Oregon	

Table 2: States using language that a graduate degree or a minimum of a master’s degree is required for APN authorization to practice:

Alabama	Maryland	Ohio
Arizona	Michigan	South Dakota
Colorado	Mississippi	Tennessee
District of Columbia	Missouri	Texas
Georgia	Nebraska	Utah
Illinois	New Hampshire	Vermont

Indiana	New Mexico	Virginia
Louisiana	North Carolina	

Table 3: States with no language around educational degree required to practice in an APN role:

Alaska
Idaho
Kansas
Massachusetts
Minnesota
New York
North Dakota
Pennsylvania

Certification

Graduates of a DNP program should be eligible and prepared for national, advanced specialty certification when available. Criteria to sit for national certification should include graduation from a nationally accredited program. DNP programs should include the eight Essentials, which is foundational for all DNP graduates, plus the appropriate specialty criteria and competencies delineated by the specialty area of practice.

For APNs, public regulation and professional certification have become almost synonymous. In many states, professional certification is used as a proxy by regulators for APN/APRN licensure (see Table 4). A majority of state boards of nursing require national certification for APN authorization to practice. Certification mechanisms exist for all four APN roles: nurse anesthetist (CRNA), nurse midwife (CNM), nurse practitioner (NP), and clinical nurse specialist (CNS). However, certification mechanisms do not exist for all APN specialties within those four APN roles, particularly for CNS specialties. A national, consensus-based model for the recognition of APN roles and specialties is being developed through the APN Consensus Process described previously.

Table 4: Number of State Boards of Nursing that Requires National Certification for Authorization to Practice in One of the APN Roles (Crawford & White, 2003)
N = 54

APN Role	# State Boards that Require National Certification
CNM	44
CRNA	48
CNS	29
NP	38

Since 1998, AACN has endorsed the position that all APNs should be nationally certified. Certification organizations are encouraged to clarify language delineating criteria for APN certification to include graduation from an accredited, graduate-level program. This language is consistent with that used in the National Task Force Criteria for Quality Nurse Practitioner Programs (2002), which has been endorsed by all national NP certifying organizations. In addition, certification organizations are urged to incorporate the expanded DNP essential competencies into the certification assessment mechanism.

Accreditation

The AACN *Position Statement on the Doctor of Nursing Practice* (2004a) recommends that all DNP programs be accredited by a nursing accrediting agency recognized by the U.S. Secretary of Education. The quality of research-focused doctoral programs is ensured through ongoing review and quality assessment, which are generally carried out by the graduate school (or comparable entity) of the offering institution. Practice-focused doctoral programs, like master's programs, prepare graduates for specialized professional practice that is regulated by agencies charged with protecting the safety of the public. The quality of practice-focused doctoral programs, their ability to produce graduates with the requisite competencies for advanced nursing practice, and their adherence to high standards of professional education must be scrutinized and ensured by professional nursing accrediting bodies.

In October 2004, the CCNE Board of Commissioners agreed to initiate an accreditation process for DNP programs, which will entail a review and revision of the CCNE accreditation standards and procedures. With representation on the AACN task force charged to draft the professional education standards for DNP programs, CCNE has actively participated in the development of the *DNP Essentials*. CCNE is expected to consider incorporation of the resulting *DNP Essentials* document during its standards revision process.

The National Task Force Criteria (NTFC) is a consensus-based document developed by key stakeholders in the nurse practitioner community, including educators, certifiers, and accreditors. In 2002, AACN endorsed the National Task Force Criteria on Quality Nurse Practitioner Education (NTFC) (2002) which delineates criteria for quality nurse practitioner (NP) graduate programs. The move of NP education from the master's to the DNP level does not negate this endorsement. In addition, CCNE has endorsed and adopted the NTFC. As a result, beginning in 2005, all NP programs in CCNE-accredited programs are required to document that the program complies with the NTFC. To ensure currency of the NTFC, in 2006 AACN and the National Organization of Nurse Practitioner Faculties (NONPF) co-reconvened the National Task Force.

The move to doctoral level education for specialty nursing practice presents an ideal opportunity for accrediting, licensing, and certifying bodies to increase the dialogue regarding program review processes. Collaboration among schools, licensing bodies,

certifiers, and accreditors around program review decreases the resources expended on duplicative review processes.

Quasi-Regulatory Function of CMS

The Centers for Medicare and Medicaid Systems (CMS), in regulations adopted in 1998, authorize reimbursement for services provided by NPs and CNSs. Language in CMS regulations state that nurse practitioners must possess a master's degree in nursing and be a registered professional nurse authorized by the state in which the services are furnished in order to practice as an NP in accordance with state law, and/or be certified as an NP by the American Nurses Credentialing Center (ANCC) or other recognized national certifying bodies with established standards for NPs. NPs without a master's degree had until January 2000 to obtain a Medicare UPIN in order to be reimbursed. The use of this language creates a situation which places CMS in a quasi-regulatory role for APN practice, but particularly for NP practice, because the regulations specifically state that the NP must have a master's degree in nursing in order to receive reimbursement. As stated previously, DNP education programs preparing graduates for APN practice expand upon AACN's *Essentials of Master's Education for Advanced Practice Nursing (1996)*. Dialogue with CMS is ongoing. Changes in this regulatory language to require graduate-level education for reimbursement eligibility is being sought.

Recommendations for Institutions

- 1. Prepare all DNP graduate to be eligible for national, advanced specialty certification, when available.*
- 2. Prepare DNP graduates of the four APN roles (nurse practitioner, clinical nurse specialist, nurse anesthetist, and nurse midwife) to be eligible for national certification in one of the nationally recognized APN roles/specialties.*
- 3. Develop strong collaborative relationships between member institutions and state boards of nursing, to dialogue on issues related to transition to the DNP, credentialing of APNs and recognition of DNPs.*
- 4. Focus efforts on changing language to graduate education in states where regulatory language specifies that a "master's degree" is required for practice in any of the four APN roles.*

Recommendations for AACN

- 1. Work with regulatory and certifying bodies through the Alliance on APRN Credentialing to:*
 - develop a congruent approach to the regulation of APNs*

- *seek consensus from the Alliance to adopt language that “graduate education”, rather than only master’s education, is the appropriate preparation for APNs; and*
 - *address the transition to the DNP for APN entry into practice.*
2. *Convene a group of deans/directors and faculty active in state board activities to discuss issues surrounding regulation and credentialing of APNs.*
 3. *Continue to disseminate to the National Council of State Boards of Nursing and individual state boards of nursing information regarding educational standards for nursing education programs, including APN education programs.*
 4. *Recommend to the CCNE Board that CCNE adopt the Essentials of Doctoral Education for Advanced Nursing Practice as a framework for accreditation of DNP programs.*
 5. *Develop educational initiatives for AACN members focused on issues related to the transition to the DNP, including licensure, credentialing, and accreditation issues.*
 6. *Work with ANA and CMS staff to revise language in federal regulations authorizing Medicare/Medicaid reimbursement of APNs to require graduate-level education, rather than master’s only, as the eligibility criteria.*

Recommendations for Regulatory Bodies

1. *Require national certification for practice in each of the four APN specialties. Graduation from a nationally accredited DNP education program and national certification together serve as a safeguard for quality practice.*
2. *Support the transition from master’s education to doctoral education (DNP) for all APN specialties. Regulatory bodies should allow individuals credentialed to practice in one of the four APN specialties to continue to practice within the full scope of practice for that specialty.*
3. *Establish unified program review processes and agreed upon criteria for nursing program review at all levels of licensing, certifying, and accrediting.*

EVALUATION

At the national level, it will be important to document that the supply of APNs has not suffered due to this movement, that programs are admitting and graduating in a timely way a sufficient number of students, that graduates are being employed in nursing at an advanced level, and that DNP graduates continue to make a measurable

difference in the quality of health care. These factors will help the profession predict the sustainability of DNP programs and direct strategic planning to ensure outcomes as intended.

Data need to be in a consistent format across schools so that determinations can be made regarding the number, location, and focus of DNP programs, sustainability of these programs over time, the number of students enrolled in the programs by area of concentration, the number of graduates by area of concentration, the number of faculty teaching in DNP programs and their preparation, graduate and employer perception of value added by the DNP program, career mobility of DNP graduates, and practice patterns.

Recommendations for Institutions

- 1. Adopt standardized data collection tools related to the DNP so that data can be aggregated at the national level.*
- 2. Participate in the collection of standardized data.*

Recommendations for AACN

- 1. Revise and standardize annual data gathering tools related to DNP programs and share with members.*
- 2. Aggregate and analyze the data related to the DNP.*
- 3. Document the trends and patterns of doctoral education in nursing.*
- 4. Evaluate impact of the DNP on patient outcomes/advanced practice.*
- 5. Serve as a resource for CCNE as policies and procedures for accreditation are developed.*
- 6. Assist DNP programs in designing data collection tools and techniques and with benchmarking.*

Appendix A

Institutions Represented at the Five DNP Regional Meetings in 2005

Total number of academic institutions at the five DNP Regional Meetings: 231

Institutions with Academic Health Centers: 71

Case Western Reserve University	University of Alabama at Birmingham
Creighton University	University of Arkansas for Medical Sciences
Duke University	University of California- Irvine
East Tennessee State University	University of California-Los Angeles
Emory University	University of California-San Francisco
Georgetown University	University of Colorado at Denver Health Sciences Center
Indiana University- Purdue University (Indianapolis)	University of Florida
Johns Hopkins University	University of Illinois at Chicago
Loma Linda University	University of Iowa
Loyola University Chicago	University of Kansas
Medical College of Georgia	University of Kentucky
Medical University of Ohio	University of Louisville
Medical University of South Carolina	University of Maryland
MGH Institute of Health Professions	University of Massachusetts-Worcester
Michigan State University	University of Medicine & Dentistry of New Jersey
Oregon Health and Science University	University of Michigan
Pennsylvania State University	University of Minnesota
Rush University Medical Center	University of Mississippi Medical Center
Saint Louis University	University of Missouri-Columbia
State University of New York, Stony Brook	University of Missouri-Kansas City
Temple University	University of Nebraska Medical Center
Texas Tech University Health Sciences Center	University of New Mexico
The George Washington University	University of North Dakota
The Ohio State University	University of Oklahoma
The University of North Carolina, Chapel Hill	University of Pittsburgh
Thomas Jefferson University	
University at Buffalo	
University of Rochester	
University of South Alabama	
University of South Carolina	
University of South Florida	
University of Southern California	
University of Tennessee Health Science Center	
University of Texas Health Science Center - Houston	
University of Texas Health Sciences Center-San Antonio	

University of Texas Medical Branch
University of Utah
University of Virginia
University of Washington
University of Wisconsin-Madison
Vanderbilt University
Virginia Commonwealth University
Wayne State University
West Virginia University
Wright State University
Yale University

Private Institutions without an Academic Health Center: 72

Albany Medical College	La Salle University
Barnes-Jewish Hospital College of Nursing and Allied Health	Long Island University
Barry University	Marquette University
Baylor University	Maryville University-St. Louis
Belmont University	Mayo Clinic College of Medicine
Boston College	MedCentral College of Nursing
Boston University	Mercer University
Bradley University	Monmouth University
Brenau University	National University
Brigham Young University	Newman University
Carlow University	Northeastern University
College of St. Catherine	Otterbein College
Concordia University Wisconsin	Pace University
DePaul University	Quinnipiac University
DeSales University	Regis College
Dominican College of Blauvelt	Research College of Nursing
D'Youville College	Robert Morris University
Edgewood College	Rocky Mountain University of Health Professions
Elmhurst College	Saint Joseph College
Evanston Northwestern Healthcare School of Anesthesia	Samford University
Fairfield University	Samuel Merritt College
Frontier School of Midwifery & Family Nursing	Seattle Pacific University
Georgia Baptist College of Nursing of Mercer University	Seattle University
Gonzaga University	Simmons College
Graceland University	St. John Fisher College
Hawaii Pacific University	Tennessee Wesleyan College
Indiana Wesleyan University	Texas Christian University
Kaiser Permanente School of Anesthesia	The Catholic University of America
	The College of St. Scholastica
	University of Delaware
	University of Detroit Mercy
	University of Portland

University of Saint Francis- Indiana
University of San Diego
University of Scranton
Valparaiso University
Villanova University
Viterbo University

Waynesburg College
Webster University
Wheeling Jesuit University
Widener University
Wilmington College
Wolford College

Public Institutions without an Academic Health Center: 88

Albany State University
Arizona State University
Arkansas State University
Armstrong Atlantic State University
Auburn University
Binghamton University
California State University-
Dominguez Hills
California State University-Fullerton
California State University-Long
Beach
Clayton State University
Florida A&M University
Florida International University
Fort Hays State University
George Mason University
Georgia College & State University
Georgia Southern University
Georgia State University
Governors State University
Grand Valley State University
Hunter College of the City University
of New York
Idaho State University
Illinois State University
Indiana State University
Indiana University-South Bend
James Madison University
Kent State University
McNeese State University
Middle Tennessee State University
Midwestern State University
Minnesota State University -
Moorhead
Minnesota State University, Mankato
Mississippi University for Women
Mountain State University
Murray State University

New Mexico State University
Northern Arizona University
Northern Illinois University
Northern Kentucky University
Northern Michigan University
Northwestern State University of
Louisiana
Oakland University
Oklahoma University
Prairie View A & M University
Rutgers, The State University of New
Jersey
Salem State College
San Diego State University
San Jose State University
Southeast Missouri State University
Southern Illinois University
Edwardsville
Texas A&M University - Texarkana
Texas A&M University-Corpus Christi
Texas Woman's University
The University of Akron
The University of Louisiana at
Lafayette
Towson University
Troy State University
University of Alaska Anchorage
University of Central Arkansas
University of Central Florida
University of Colorado at Colorado
Springs
University of Connecticut
University of Kansas
University of Massachusetts-Amherst
University of Massachusetts-Boston
University of Massachusetts-Lowell
University of Michigan-Flint
University of Missouri-St. Louis

University of Nevada-Las Vegas
University of New Hampshire
University of North Carolina at Greensboro
University of North Carolina-Charlotte
University of North Florida
University of Rhode Island
University of Southern Maine
University of Southern Mississippi
University of Tennessee - Knoxville
University of Tennessee-Chattanooga
University of Texas-Arlington
University of Texas-Pan American

University of Texas-Tyler
University of Wisconsin-Eau Claire
University of Wisconsin-Milwaukee
Valdosta State University
Washington State University
West Texas A&M University
Western Carolina University
Wichita State University
Winona State University

Other Organizations Represented: 21

Alexander's Children Services
American Academy of Nurse Practitioners
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
Coalition for Nurses in Advanced Practice
Community Health Network
Department of Veteran Affairs, Office of Nursing Services
Department of Veteran Affairs of Greater Los Angeles
Navy Nurse Corps Anesthesia Program
Nurse First Family Health Center
Oncology Nursing Certification Corporation
Oregon State Board of Nursing
Paldmar Powerado Health
The Queen's Medical Center
Saint Francis Medical Center
Texas Board of Nurse Examiners
Texas Nurse Practitioners
Texas Nurses Association
United Health Group
US Army Medical Department, Academy of Health Sciences
William Beaumont Hospital

APPENDIX B

Institutions Represented at the National Stakeholders' Meeting in October 2005: 44 Institutions

American Academy of Ambulatory Care Nursing (AAACN)
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Critical-Care Nurses (AACN)
American Association of Nurse Anesthetists (AANA)
American College of Nurse Practitioners (ACNP)
American College of Nurse-Midwives
American College of Nurse-Midwives Division of Accreditation
American Nurses Association (ANA)
American Nurses Credentialing Center
American Organization of Nurse Executives (AONE)
Association of Community Health Nursing Educators (ACHNE)
Association of Faculties of Pediatric Nurse Practitioners, Inc.
Association of Nurses in AIDS Care (ANAC)
Association of periOperative Registered Nurses (AORN)
Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)
Commission on Collegiate Nursing Education
Commission on Graduates of Foreign Nursing Schools (CGFNS)
Competency Credentialing Institute
Council on Accreditation of Nurse Anesthesia Educational Programs
Council on Graduate Education for Administration in Nursing
Dermatology Nurses Association (DNA)
Emergency Nurses Association (ENA)
Hospice and Palliative Nurses Association (HPNA)
HRSA Division of Nursing
International Nurses Society on Addictions (IntNSA)
International Society of Nurses in Genetics, Inc. (ISONG)
National Association of Clinical Nurse Specialists (NACNS)
National Association of Nurse Practitioners in Women's Health (NPWH)
National Association of Pediatric Nurses Associates and Practitioners (NAPNAP)
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties
National Council of State Boards of Nursing (NCSBN)
National League for Nursing (NLN)
National Nursing Staff Development Organization (NNSDO)
National Organization of Nurse Practitioner Faculties (NONPF)
Nurses Christian Fellowship
Oncology Nursing Certification Corporation
Oncology Nursing Society (ONS)

DRAFT

Pediatric Nursing Certification Board
Sigma Theta Tau, International (STTI)
University of Tennessee Health Science Center
University of Virginia
University of Washington

Appendix C

Members of the Roadmap to the DNP Task Force:

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