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Doctor of nursing practice by 2015: An examination of nursing schools' decisions to offer a doctor of nursing practice degree

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ABSTRACT

Objectives: The American Association of Colleges of Nursing recommends that nursing schools transition their advanced practice registered nurse (APRN) programs to doctor of nursing practice (DNP) programs by 2015. However, most schools have not yet made this full transition. The purpose of this study was to understand schools' decisions regarding the full transition to the DNP.

Methods: Key informant interviews and an online survey of nursing school deans and program directors were performed.

Discussion: The vast majority of schools value the DNP in preparing APRNs for the future of the health care system. However, other important factors influence many schools to fully transition or not to the postbaccalaureate DNP, including perceived student and employer demand, issues concerning accreditation and certification, and resource constraints.

Conclusion: Multiple pathways to becoming an APRN are likely to remain until various factors (e.g., student and employer demand, certification and accreditation issues, and resource constraints) yield a more favorable environment for a full transition to the DNP.

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Introduction

In 2004, the membership of the American Association of Colleges of Nursing (AACN) approved a position statement supporting the adoption of the doctor of nursing practice (DNP) as the most appropriate level of education for advanced practice registered nurses (APRNs) and recommended that schools transition their current masters of science (MSN) programs to DNP programs by 2015 (AACN, 2004). This position statement has been controversial among nursing school faculty and leadership. Proponents of the DNP degree as a replacement for the MSN argue that this transition will address a number of important societal, educational, and professional issues (Udlis & Mancuso,

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2012). Particularly, with the adoption of the Affordable Care Act, the health care system will require more and better educated APRNs to manage patient care, develop, and execute quality improvement programs and participate in the health care policy making process. A recent Institute of Medicine report titled *The Future of Nursing* (2011) called for a doubling of the number of doctoral-prepared nurses to help meet the future demands of increasingly integrated health care delivery systems, new payment methods that promote care coordination and reward quality, and the impending retirements of nursing faculty. Many advocates of the DNP as the entry-level education for APRNs also point to other health professions that have transitioned to doctoral-level entry, such as pharmacy (Accreditation Council for Pharmacy Education, 2007) and physical therapy (American Physical Therapy Association, 2013).

Those more critical of establishing the DNP as the entry-level degree for APRNs have expressed concern that moving toward the DNP would impose significant costs and faculty burden on schools and worry that such a move will further limit the supply of APRNs at a time when they are in high demand (Cronenwett et al., 2011). Furthermore, these critics argue that there is not yet evidence of added value in terms of outcomes of care provided by DNP-prepared APRNs compared with MSN-prepared APRNs.

Since the AACN's position statement, many schools have developed DNP programs for APRNs, including both postbaccalaureate DNP and postmasters DNP programs (bachelor of science in nursing [BSN] to DNP and MSN to DNP, respectively). According to a recent report of the schools offering graduate education in 2013, nearly half offer a DNP program (Auerbach et al., 2015). Likewise, many schools are offering the DNP as the entry-level degree for APRN education. Roughly 30% of schools that offer APRN education currently offer the BSN to DNP; that percentage could approach 50% in the next several years based on reported plans to adopt BSN to DNP programs in the future. However, schools have moved toward replacing their MSN APRN programs with the BSN to DNP at a much slower rate. Less than 15% of schools that offer some APRN education provide only the BSN to DNP and do not offer MSN-level APRN education. Furthermore, only 27% of schools that had an MSN and offered or planned to offer a BSN to DNP planned to discontinue the MSN (Auerbach et al., 2015). This suggests that many schools are deciding to retain the MSN as an educational option for APRNs.

Little is known about how and why schools decide to offer various combinations of APRN education options. The purpose of this study is to understand schools' decisions related to adopting DNP programs and transitioning toward the BSN to DNP as the sole entry-level option for APRNs in accordance with the AACN position statement. To do this, we use a mixed-methods approach based on key informant interviews and data from a structured online survey of nursing school deans and program directors.

Methods

This study uses a mixed-methods approach to describe the views of representatives from nursing schools with varying levels of adoption of the DNP. The study relies on two novel sources of data: (a) qualitative key informant interviews and (b) an online survey. This section describes the data sources and the methods.

Data Sources

Key Informant Interviews

Key informant interviews were conducted with deans and chairs in nursing schools. In a small number of circumstances, the dean or chair asked other representatives (i.e., concentration directors) to also participate in the interview to provide concentration-specific information. The interview participants were selected to obtain a sample of schools representing varying entry-level APRN program offerings. The schools included those with no graduate-level APRN education, only MSN-level APRN education, a mix of MSN- and DNP-level APRN education, and only DNP-level APRN education. The sampling frame for the study was 550 schools that reported to the 2012 AACN Annual Survey of Nursing Schools and had at least one graduate program. To select the sample, we first placed the schools into eight strata, defined by both their current or planned offering status and their Carnegie Classification codes. Schools were randomly selected within each stratum; if a school refused to participate or did not respond, we replaced it with another school in the same stratum. We conducted interviews with 29 schools.

The interviews lasted approximately 1 hour and were conducted over the telephone by a trained interviewer. The interviews were guided by a semi-structured interview protocol, which was developed iteratively by the authors; a panel of nursing school deans (who did not participate in the interviews) provided expert feedback on the content and organization of the protocol. The main topics discussed during the interviews were (a) the school's background and history of program offerings, (b) its status of program development, (c) arguments in favor of offering a DNP program, (d) arguments against offering a DNP program, (e) facilitators and barriers to offering a DNP program, (f) reasons for retaining or closing a master's degree APRN program, and (g) reasons for adopting the BSN to DNP specifically.

Online Survey Data

The second data source was an online survey of nursing schools developed by the authors and fielded