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Abstract

ABSTRACT Objectives: This paper presents thoughts of practice leaders in the community/public health nursing (C/PHN) specialty on advanced nursing practice (ANP) and the necessary educational preparation for such practice.
Design and Sample: Practice leaders were engaged in conversations specifically focused on the Doctor of Nursing Practice (DNP) as preparation for ANP in their specialties, and asked to consider the benefits of, and challenges to, this educational program.
Measures and Results: The resulting remarks were then assessed for themes by the interviewers and these are presented along with thoughts on the future of education for ANP.
Conclusion: Overall, there was much agreement among the practice leaders interviewed about the importance of a broad skill set for ANP in the specialty. However, the practice leaders interviewed here also identified the practical challenges involved in educating nurses at the DNP level in the C/PHN specialty, as well as some concerns about the definitions of ANP for the future.

In 2004, the American Association of Colleges of Nursing (AACN) presented a position paper defining the Doctor of Nursing Practice (DNP) as the appropriate educational preparation for advanced nursing practice (ANP). The rationale for advancing specialty education in nursing to the practice doctorate was that ANP is taking place in increasingly complex care systems and requires an expanding knowledge base/competencies for the roles. In order to appropriately prepare nurses to practice at an advanced level, existing Master's in Nursing (MSN) programs were growing in credit hours. In addition, the AACN contended that a DNP requirement for nurses practicing at an advanced level would help achieve parity with many other health professionals educated at the doctoral level; and that such preparation for specialty nurses could result in more doctorally prepared nurses, thus addressing the faculty shortage (AACN, 2004).

Following the dissemination of the position paper, AACN membership approved *The Essentials of Doctoral Education for Advanced Nursing Practice* in 2006, which recognized graduates of DNP programs as independent practitioners with advanced knowledge and skills across nursing specialties and the enhanced ability to effect change in today's complex health care system (AACN, 2006b). The eight essentials, modeled after the current master's essentials (AACN, 1996), serve as outcome competencies for all DNP graduates. The first seven essentials include the following content and competencies: scientific underpinnings of practice; organizational and systems leadership for quality and systems thinking; clinical scholarship and analytic methods for evidence-based practice; information systems and technology and patient care technology for the improvement and transformation of health care; health care policy and advocacy in health care; interprofessional collaboration for improving patient and population health outcomes; and clinical prevention and population health for improving the nation's health. The eighth essential, ANP, focuses on specialty

practice; AACN specifies that national specialty organizations determine specific content and competencies. This essential includes two foci, indicating two possible curriculum options: advanced practice nursing and aggregate, systems, or organizational focus. The curriculum for the advanced practice nursing option focuses on the requisite knowledge, skills, and competencies for delivery of direct care to individuals and families; AACN mandates the inclusion of three separate courses in advanced health/physical assessment, advanced physiology/pathophysiology, and advanced pharmacology. The Aggregate, Systems, or Organizational option is for those who do not provide direct care, which includes ANP roles in administration, health care policy, informatics, and public health/population-focused care (AACN, 2006b). In a recent somewhat related development, a new consensus model for Advanced Practice Registered Nurse (APRN) licensure and certification has been accepted by many nursing specialty groups, which mandates that APRN preparation be focused on direct care to individuals and families, as presented in the advanced practice nursing option above. The second option addressed in the DNP essentials would thus not lead to the APRN credential (National Council of State Boards of Nursing [NCSBN], 2008).

For the purposes of this paper, we will present a discussion of ANP as presented in the eighth DNP essential as the overall terminology for nurses with advanced education in their specialty and use APRN as the term for those licensed and certified to provide direct care to individuals, including disease diagnosis and prescriptive authority.

The AACN advised that by 2015, entry into advanced practice nursing (APRN) will require a DNP degree (AACN, 2006a). This led to a rapid proliferation of DNP programs within nursing academia. As of June 2009, 92 schools or colleges of nursing offered a DNP, of which the majority are post-master's degree programs. At that time, AACN reported an additional 102 schools were considering granting a DNP degree. DNP programs are now available in 34 states plus the District of Columbia. States with the most programs (five or more) include Florida, Minnesota, New York, Pennsylvania, and Texas. From 2007 to 2008, the number of students enrolled in DNP programs nearly doubled from 1,874 to 3,415. During that same period, the number of DNP graduates increased from 122 to 361. In a review by the authors of programs accepting applicants, numerous programs offer a post-master's DNP with a focus on leadership and approximately 10 (14%) of programs advertised a population or public health option (AACN, 2009).

In light of these developments, several nursing organizations have endorsed the DNP as a *terminal* degree for ANP, including the Association of Community Health Nursing Educators (ACHNE) (Levin et al., 2008). However, public documents reveal limited representation of community/public health nursing (C/PHN) organizations in the early discussions that helped shape the DNP movement. For example, during the development of the *Position Statement* and draft *Essentials* documents (AACN, 2004, 2006b), AACN held invitational meetings that primarily included organizations such as the National Organization of Nurse Practitioner Faculties and 14 organizations within the Alliance for Nursing Accreditation, none of which represent a population-focused specialty (AACN, 2008; Fulton & Lyon, 2005). There was a lack of inclusion of C/PHN specialties before the *Position Statement* was approved by AACN in 2004, and only three C/PHN-based specialty organizations were represented at the regional or national stakeholder meetings held in 2005 before the AACN vote on the *Essentials*

document—the ACHNE, the Hospice and Palliative Nurses' Association, and the American Association of Occupational Health Nurses (AACN, 2006a).

A review of the formative scholarly literature published early in the DNP debate revealed scant mention of the aggregate, systems, or organizational option of the DNP or the effect on the advancement of C/PHN practice. The dialogue included rationale for and critique of the DNP, differentiating between the research and practice doctorates, and effects on entry into advanced practice nursing (APRN) with the predominate focus on the direct care of individuals/families roles (Dracup, Cronenwett, Meleis, & Benner, 2005; Edwardson, 2004; Fulton & Lyon, 2005; Lenz, 2005; Marion et al., 2003; Meleis & Dracup, 2005; Milton, 2005; Mundinger, 2005; O'Sullivan, Carter, Marion, Pohl, & Werner, 2005; Standing & Kramer, 2003; Wall, Novak, & Wilkerson, 2005). Recently, the literature has focused on program curricula and specialty organization positions on the DNP (Avery & Howe, 2007; Brown et al., 2006; Draye, Acker, & Zimmer, 2006; Graff, Russell, & Stegbauer, 2007; Levin et al., 2008; Magyary, Whitney, & Brown, 2006).

In sum, the discussion to date about the DNP has focused on the practice interests of the majority in nursing, that is, those who provide direct care to individuals and families. What is unclear is whether this discussion by the majority represents the educational needs for ANP of those in C/PHN.

Purpose

In light of the recent embrace of the DNP as the degree for ANP, the authors were interested in how this change might be received by the C/PHN community. The focus of the DNP degree is most clearly established for the individual-focused specialties, with the role of APRN. In fact, this has been reaffirmed via recent decisions by a workgroup composed of leadership from a variety of nursing specialty organizations and the NCSBN, who stated in their report that population-focused practice is not defined as an advanced practice nursing specialty (NCSBN, 2008). Thus, we were interested in the opinions of C/PHN practice leaders about the DNP and the knowledge and skills explicated in the DNP essentials and how these related to the knowledge and skills needed in ANP in C/PHN. In addition, we wanted to know what this degree would mean for the C/PHN workforce in terms of required competencies, credentialing and certification needs of agencies, as well as its value as compared with related specialty education preparation, such as the Master's in Public Health (MPH).

Methods

To answer these questions, we conducted a series of focused interviews with leaders in C/PHN to obtain their perspective on the DNP in the C/PHN specialty. C/PHN, defined as population-focused practice, is often considered to encompass several specialty areas (Nursing Counts, 2001). We selected nine nurse leaders we were aware of via their national clinical leadership roles in their specialties, including: occupational health nursing (two leaders); school nursing (two leaders); public health nursing/health departments (three leaders); home health nursing (one leader); and hospice nursing (one leader). We chose nurses with graduate education, who were functioning in an ANP role in the specialty. We defined this as a role requiring a graduate degree, and focused on planning and guiding care to populations, communities, and groups. We focused on nurses in practice, as we believed they would best reflect practice perspectives. The authors worked in pairs to conduct the interviews, and all interviews were tape-recorded and transcribed. The first two authors then reviewed all the transcripts

to look for themes across the responses and any quotes which helped elucidate the points being made. We summarized these themes by interview question and shared this with the remaining authors to review and validate the results. Any discrepancies in interpretations were discussed by the authors until consensus was reached. In addition, we shared our results with the respondents, and allowed them to correct any misinterpretations. University IRB approval was sought and received for these interviews.

Results

The first question we asked of the C/PHN nurse leaders was about the role of ANP in their specialty area. Overall, our respondents viewed nurses working at the advanced level as direct care providers, who often had master's degree preparation and were licensed and credentialed in their role. These respondents did not view nurse administrators and program managers as APRNs, even though an estimated one third of public health officers across the nation are C/PHNs (J. Reed, personal conversation, November 5, 2006). Our respondents said that in their practice areas, master's prepared nurses were usually in leadership/management roles, but they did not view these nurses as in the role of APRN. The C/PHN leaders had differing views on the ANP role in their specialty, either not defining it as an APRN role or describing it as a role seldom seen in practice. The one exception to this discussion of the APRN role was school nurses. Our respondents in this area said that some school nurses are master's prepared (depending on the state) and functioned, at least partially, in direct care, but were not considered APRNs.

We next asked the respondents about the appropriate educational background for ANP in their specialty areas. Again, consistent with the earlier question, our respondents did not equate the master's degree with APRN. However, in their specialties, nurses were prepared for ANP with a variety of degrees at the graduate level, including the MSN with a focus on public health, school health, or occupational health, the MPH, the Master's in Business Administration (MBA), master's degrees in other disciplines (such as education, health administration), and the Doctorate of Public Health (DrPH). These degrees were viewed as appropriate preparation depending on the nursing role.

We asked each respondent to review the DNP essentials (AACN, 2006b) and provide us with their perspective on these, and whether the essentials were appropriate for ANP in their specialty area. Overall, the respondents saw the DNP essential content as appropriate for ANP roles in their clinical areas. They did comment on the missing content, particularly in the area of their public health specialty, which would be in the eighth essential. The C/PHN nurse leaders corroborated the need for educational preparation in their areas in health policy, outcomes management, organizational analysis, systems and quality improvement. In addition, the interviewees felt the section on interdisciplinary collaboration was not as strong as what was needed in their practice and spoke to public health being, by nature, an interdisciplinary endeavor. Several respondents, most notably those in the area of occupational health nursing, remarked that the skill set a nurse brought with him or her to the job was more important than the particular degree; that is, in their setting the focus is on what a nurse can do for the organizational goals/outcomes, as opposed to a specific degree/credential.

We asked these C/PHN leaders whether there was a role for the DNP in the C/PHN specialty areas, and were nurses aware of the DNP in their practice communities. The respondents replied that there was

no specific role requiring a DNP in their settings, and there was little awareness of the DNP among their practice colleagues. Because our respondents were nurse leaders in their clinical areas, several had been to national meetings where the DNP degree was discussed, but this awareness did not translate to their worksite.

The respondents further stated that they saw few advantages to the DNP degree in their work setting. Again, they emphasized that the critical element was the skill set a nurse brought and what she or he could do for the organization, rather than a specific educational degree. They agreed the skill set outlined in the DNP essentials would be useful for nurse leaders in their area of practice. Only in school settings did the nurse leaders identify that a doctoral degree would increase salaries for the nurses who achieved it, if the nurses are paid on the teacher salary scale. Also, the school nurse leaders we interviewed said that in schools, some of the professionals that nurses worked with were doctorally prepared, thus having a doctoral degree could put the nurses on parity with these other team members.

We asked our respondents to tell us if they foresaw any challenges to the use of the DNP for ANP in their setting. They identified, as already discussed, that, with the exception of some school districts, the DNP degree would not provide the nurse with a salary differential from current nurses practicing at an advanced level in their clinical area. They also identified that returning to school was a challenge for nurses in their settings due to multiple job and home responsibilities and an overall lack of adequate tuition reimbursement through the workplace. In addition, several respondents asked how the DNP would have any additional value over a DrPH, which was a more recognized doctorate in their setting.

We did ask respondents if they had any additional comments on the DNP, and some comments arose throughout the course of the interviews. One common remark was the concern that those in academia demonstrated too much attention on ANP and not enough upon entry into practice. One of our C/PHN leaders stated this as “This degree (DNP) sounds fine, but what I really want is BSN prepared nurses.” The respondents saw this as a reflection of a “disconnect” between the needs of practice in their area and academic priorities.

Another common comment was that ANP outcomes were currently good, so why did ANP preparation need to change? The respondents felt that current educational programs seemed to be doing a good job of preparing nurses in ANP roles, and thus did not need revision or new degree programs. Additionally, our respondents were concerned about how such changes in educational preparation related to their specialties and what would happen to existing specialty programs at the master's level. They also had questions about who defines nursing specialties and ANP, and expressed concern about their specialty being “left out.” In addition, school nurse leaders said that the school nurse role is in transition from a largely population-based role to including more direct care in their practice, and this development might change educational preparation needs for school nurses.

Discussion

Several points arose from these interviews that are worth considering—not only in terms of the DNP, but in terms of educational preparation for nursing practice overall. The C/PHN leaders we interviewed did not believe that their clinical areas were ready for the DNP. The DNP was not a priority issue for these leaders, either because they were not clear that the preparation was equivalent or better to

what was currently available, or because their key practice needs were focused on generalist RN preparation and supply. This raises several issues for educators to consider including the need to continue strengthening the bridge between academia and clinical practice in *all* areas of nursing, to ensure that educators are preparing nurses across levels for the practice challenges of today, and of the future. This would require more frequent meaningful dialogues with nurse leaders in practice across a wide variety of settings. Without this dialogue, the risk is that nurses in practice see the advent of such things as the DNP as meeting the needs of educators but not those of practitioners or the public.

Additionally, nurse educators and researchers need to develop a vigorous plan for research to demonstrate the "value added" to the nursing profession and the public's health of new educational programs/degrees. As the occupational health nursing leaders we interviewed pointed out, it is not the degree a nurse brings, but rather their value added to the organization's outcomes—and overall to improved health outcomes—that is significant. While we strongly support provider education as one mechanism for improving health outcomes, this education needs to be related to the skills and competencies demonstrated to have value in improving these outcomes.

For those in practice, education and research in the area of C/PHN, these interviews also raise several key issues. For example, do the specialties we included here continue to have a common element of population focus? If so, this role also requires further study to demonstrate its value. The population-focused specialties are uniquely different from most of nursing, which is primarily focused on individual/direct patient care. Despite nursing's long history in public health, there is a need to demonstrate that a population-focused nurse is of value—both to the nursing profession and to the field of public health. This role, with its different focus, does not fit into the current nursing definitions of APRN, with the focus on diagnosis and prescriptive authority. Thus, what is ANP in this specialty? Does the ANP role work with a population focus and a background in public health, as well as nursing (Ervin, 2007; Robertson & Baldwin, 2007)? Perhaps a new title and definition, which fits within both nursing and public health, is overdue. The recent ACHNE's white paper on Advanced Practice in C/PHN (Levin et al., 2008) recommends the title Advanced Practice Public Health Nurse (APPHN); however, the ANCC is recommending the title Advanced Public Health Nurse-Board Certified (APHN-BC) for those passing the specialty certification exam. Of note however, is that across the areas within C/PHN, varying titles are used for those certified as specialists. For example, the American Board for Occupational Health Nursing (2008) credentials nurses at the specialist level as COHN-S and the National Board for Certification of Hospice and Palliative Care Nurses (2008) uses the credential of Advanced Certified Hospice and Palliative Care Nurse (ACHPN). Eligibility requirements for these specialty certification exams vary relative to advanced education requirements.

What does nursing's emphasis on the DNP and APRN roles mean for specialties and health needs that cut across clinical areas, such as school health nursing, or home health care? Does the current APRN/DNP designation have implications for creating "silos of practice" such as those often found in medicine? What would be the appropriate educational preparation for nurses who work primarily in multiple settings or with patients who cross settings, such as case management, quality improvement, health policy, or administration? Will nursing education at the graduate level be appropriate background for these nurses or will they need to look to other fields for the appropriate educational

background for their practice? The respondents in this paper illustrated the value of the ANP role, as well as its limitations. These specialties demonstrate a need and a role for nurses at an advanced level of practice that does not include diagnosis or pharmaceutical prescription skills.

Most importantly to these authors, these interviews reminded us that educators need to design educational programs to prepare professionals to meet the health needs of the public overall. Often the debate in higher education focuses on the needs of the nursing profession for status, recognition, or credentialing to support an expanded scope of practice. While these are critical professional issues, we need to always ground our professional practice, educational preparation, and research in preparing nurses for practice that meets the health needs of the American public. At this moment in time, the health care needs of the public call for educating professionals who can work across settings, with an increase in those focused on primary care and public health, because those areas have the greatest demonstrated impact on health outcomes. In addition, the health of the public requires nurses who can work with complex human beings across the life cycle and care settings, in a holistic manner, referring as needed, but always keeping the patient and his or her needs at the center of practice, whether that patient is an individual, family, or population.

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