White Paper:
The Doctor of Nursing Practice Degree

January 2013
Mission of the Coordinating Board

The Texas Higher Education Coordinating Board’s mission is to work with the Legislature, Governor, governing boards, higher education institutions and other entities to help Texas meet the goals of the state’s higher education plan, "Closing the Gaps by 2015," and thereby provide the people of Texas the widest access to higher education of the highest quality in the most efficient manner.

Philosophy of the Coordinating Board

The Texas Higher Education Coordinating Board will promote access to quality higher education across the state with the conviction that access without quality is mediocrity and that quality without access is unacceptable. The Board will be open, ethical, responsive, and committed to public service. The Board will approach its work with a sense of purpose and responsibility to the people of Texas and is committed to the best use of public monies. The Coordinating Board will engage in actions that add value to Texas and to higher education. The agency will avoid efforts that do not add value or that are duplicated by other entities.
Executive Summary

The American Association of Colleges of Nursing (AACN) has called for a doctoral-level degree for entry into advanced nursing practice. However, only the National Board of Certification and Recertification of Nurse Anesthetists and the American Association of Nurse Anesthetists have established a deadline for requiring the doctoral degree before a student may take the national certification examination. By 2025, all new nurse anesthetists must complete the Doctor of Nursing Practice (DNP) degree. The current minimum educational requirement for a new advanced practice registered nurse (APRNs) is a Master of Science in Nursing (MSN) degree with a specialty in nurse anesthesia, nurse midwifery, nurse practitioner, or clinical nurse specialist.

Based upon the AACN position paper, institutions in Texas have developed DNP programs. The Board has approved seven DNP programs at public institutions contingent upon the degrees being post-master’s degree programs rather than post-baccalaureate degree programs. The rationale for this was based on the lack of patient outcomes research to support requiring doctoral degrees for all advanced practice nurses, the increased cost and time required to complete the longer DNP, and the dire need to maintain the master’s-level nursing programs from which 75 percent of all nursing faculty at the undergraduate level come.

In December 2011, the Board stated that it would not consider new DNP programs until such time as the staff had conducted a study of the existing programs and the need for additional programs. Based upon a September 2011 survey of the state’s DNP programs, Board staff found that, in Academic Year 2012, 84 percent of all qualified applicants were admitted to a MSN to DNP program, and 80 of 240 first-semester “seats” in these DNP programs were left unfilled. The workforce demand, as evidenced by postings for advanced nursing practice positions in hospitals, physician’s practice offices, and clinics in September and October 2012, showed that none required a DNP, and the majority required only a MSN.

Requiring the DNP in place of the MSN for APRNs has significant cost implications for both the state and students. In Texas, students would have to take on average an additional 39 semester credit hours (SCH) at an average additional cost of between approximately $10,400 and $21,000, depending upon whether the program was at a university or health science center. The state would also pay between approximately $18,750 and $27,500 more in formula funding. Additionally, the time to degree for an APRN would increase.

If the BSN to DNP pathway was substituted for the BSN to MSN to DNP pathway, the institutions have indicated that they will reduce the number of SCH required, thereby reducing the total time to degree for a DNP-educated nurse. The number of SCH that will be saved varies by DNP program and the concentrations in the DNP program. If national certification or accreditation requirements mandate the DNP as the entry to APRN, the elimination of the MSN may result in fewer SCH than current DNP programs require. This may also indicate that institutions are able to reduce the current number of SCH required for the BSN to MSN to DNP.

If all master’s-level APRN programs were eliminated in favor of the DNP, community colleges would face even more significant challenges to their ability to recruit sufficient faculty to sustain their nursing programs which produce approximately 60 percent of all initial licensure nurses.
The Doctor of Nursing Practice degree (DNP) emerged as a unique offering at a few institutions of higher education over the last 10 years, but it has since grown in the number of programs across the nation and in Texas. With that growth and subsequent number of requests for these programs from Texas public institutions, members of the Texas Higher Education Coordinating Board (THECB) sought additional information about the degree and its impact on nursing education and nursing practice. In response to Board members request, the THECB staff prepared this White Paper to address these major questions about the DNP: What is the Doctor of Nursing Practice? How and why has it proliferated nationally and in the state? Should the Board consider additional DNP programs beyond the current number offered at Texas public institutions, and if so, should it consider tracks that allow students to enter the program after completing the bachelor’s degree (a BSN to DNP pathway)?

In preparing this paper, THECB staff reviewed survey data collected from the state’s nursing programs, researched trends on advanced nursing practice, and examined the policy positions of government agencies and professional nursing organizations. Staff also surveyed health care facilities on current and future hiring trends, compared the proposed DNP to previous health degree expansion efforts, calculated the cost of expanding master’s-level nursing education to the doctoral level, and conducted interviews of institutional and agency representatives.

What is the Doctor of Nursing Practice Degree?

Origins and Intent

In 2004, the member institutions of the American Association of Colleges of Nursing (AACN) endorsed a policy statement prepared by an AACN Taskforce, calling for moving the current level of preparation necessary for advanced nursing practice (i.e., nurse anesthetists, nurse midwives, nurse practitioners, clinical nurse specialists, and nurse administrators) from the master’s degree to the doctoral degree by 2015. The effect of the new policy was significant. The Commission on Collegiate Nursing Education, the autonomous accrediting arm of AACN, would expand its process for accreditation to DNP programs. While it would continue to accredit master’s degree programs with advanced practice offerings, AACN stated that “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.” (DNP Roadmap, p.12)

The organization said the need for change was driven by research and trends in health care delivery and health professional education. Major drivers leading to the new policy included:
• Research showing a clear link between higher levels of nursing education and better patient outcomes.
• The increased complexity of patient care and national concerns about the quality of care and patient safety.
• Shortages of doctoral-prepared nursing faculty.
• Increasing educational expectations for the preparation of other health professionals, including Pharmacy (PharmD), Physical Therapy (DPT), and Audiology (AuD), all of which require practice doctorates.

While the new policy signified a major shift in educational requirements in advanced nursing practice, it was not intended to alter the current scope of practice for specialty nurses. The new policy recognized that State Nurse Practice Acts would continue to describe the scope of practice allowed, and that the Acts would differ from state to state.

The position statement was not intended to eliminate all master’s degree programs. The AACN recommended that higher education institutions revise their master’s degree programs in line with The Essentials of Master’s Education in Nursing (2011) to prepare nurses for other non-specialist roles such as the nurse educator and the clinical nurse leader.

Content of the Degree

To standardize the content for this new degree, AACN prepared The Essentials of the Doctoral Education for Advanced Nursing Practice. The curriculum has eight foundational outcome competencies, commonly called the “DNP Essentials,” which apply to all DNP programs regardless of specialty or focus:

1. Scientific underpinnings of practice
2. Organizational and system leadership for quality improvement and systems thinking
3. Clinical scholarship and analytical methods for evidence-based practice
4. Information systems/technology and patient care technology for the improvement and transformation of health care
5. Health care policy for advocacy in health care
6. Inter-professional collaboration for improving patient and population health outcomes
7. Clinical prevention and population health for improving the nation’s health
8. Advanced nursing practice

As part of that curriculum, DNP students also would complete a minimum of 1,000 clinical hours. This adds 500 hours to the minimum of 500 clinical hours required (in Texas) for licensure as an advanced practice nurse (specifically nurse practitioners and clinical nurse specialists) with a master’s degree. Some specialties and individual programs require more than 500 clinical hours at the master’s degree level, and the 1,000 hour minimum requirement would be adjusted accordingly in the DNP program.
Comparison to the PhD in Nursing

One of the early criticisms of the degree was that it would discourage potential students to enter Doctor of Philosophy in Nursing (PhD) programs. In response, AACN members worked to clarify the differences between the PhD and the DNP and other practice doctorates (e.g., the Doctor of Nursing Science) which preceded the DNP. The following descriptions summarize those differences in a national and state context.

The PhD is a research-intensive degree that prepares nurse scientists/scholars to generate and disseminate new knowledge for the nursing discipline. Students are prepared to independently perform research and scholarship. As with PhDs in other disciplines, students are usually required to pass qualifying exams and complete a dissertation. Faculty who teach in these programs in Texas have PhDs in nursing or in related disciplines and are normally tenured or on the tenure track. Seven Texas public institutions offer the degree as a post-master program, and five of those institutions also offer it as a post-baccalaureate or alternate entry program. The average MSN to PhD pathway program in Texas is 65 SCH; the average BSN to PhD pathway program is 80 hours.

The DNP is a practice-intensive degree that prepares clinicians to use knowledge generated by research scholars in the delivery of high quality health care. Students are prepared for using knowledge to deliver services and solve clinical problems. As with other practice doctorates (e.g., the EdD.), students complete a practicum, capstone or evidence-based project, and/or scholarship portfolio rather than a dissertation. Faculty who teach in these programs in Texas have PhDs in Nursing and related disciplines or have DNP degrees. THECB survey results showed that 27 DNP-credentialed faculty had teaching responsibilities in the state’s DNP programs for the current academic year. Of those 27 faculty, 11 percent had a tenure-track appointment. Twelve Texas institutions offer the post-master’s degree program and three offer the DNP as a post-baccalaureate degree program. The average MSN to DNP pathway program at Texas public institutions is 42 SCH; the average BSN to DNP pathway program (based a recent national survey of programs) is 79 SCH.

Responses from a September 2012 THECB survey indicated that the overwhelming reasons why students have chosen a DNP program over a PhD program was to prepare for a leadership role in health care, improve health outcomes in practice settings, and meet the new or anticipated standards for APRN practice. The schools’ responses showed that potential students are knowledgeable about the differences between the two degrees, and many have a clear preference for a degree that would help them translate research into practice rather than prepare them to conduct original research.

Types of Nurses Eligible to Enroll in the Program

Nurses who typically apply to a DNP program are seeking education in “advanced nursing practice.” When the DNP was introduced by the AACN Task Force in 2004, the term “advanced nursing practice” was intended to encompass four highly regulated roles in nursing: the nurse anesthetist, the nurse midwife, the nurse practitioner, and the clinical nurse specialist.
Collectively, these specialist nurses are called advanced practice registered nurses (APRNs). “Advanced nursing practice” also includes nurse administrators or nurse executives. In 2011, students graduating from programs specializing in these four roles, plus nurse administration, represented 91 percent of the state’s 1,263 master’s degree graduates. However, as the academic market for DNP students expands, so have the offerings in DNP programs. Institutions have developed DNP “tracks” or “concentrations” in other areas of nursing specialization, including public health nursing, nurse education, nursing policy, and informatics.

Educational Pathways to the DNP

There are two educational pathways to the DNP. Students who have completed their master’s degree (and are licensed if their master’s degree is in an APRN role) can enter a post-master’s degree program (the MSN to DNP pathway). The curriculum for the MSN to DNP pathway consists of primarily the “DNP Essentials,” approximately 500 hours of clinical practice (depending on APRN role), and a final project or other summative activity for the degree. The second pathway for students is the post-baccalaureate degree program (the BSN to DNP pathway), which combines the academic curriculum needed for APRN certification and licensure (or other requirements for a nursing specialty) with the “DNP Essentials.” The student would complete approximately 1,000 hours of clinical practice (or more depending on APRN role) and a summative project for the degree. A national survey of 152 DNP programs showed that 35.5 percent of DNP programs were BSN to DNP pathways, and 64.5 percent were MSN to DNP pathways. Nursing stakeholders expect that more institutions will transition to the BSN to DNP pathway as the AACN date for full implementation nears.

A depiction of how that AACN policy position would affect educational pathways for Texas students is shown in Appendix A.

How and why has the DNP proliferated nationally and in the state?

The National Environment

Accreditation Bodies

Once the 2004 policy statement was published, the AACN developed resources for transition to the DNP, and the Commission on Collegiate Nursing Education began accrediting new DNP programs. AACN reports on its website that 193 DNP programs are known to exist in the nation, and 106 have been accredited to date.

In contrast to the AACN’s policy, the National League for Nursing (NLN), a second professional nursing organization, has not taken as strong a position on the DNP. In September 2011, it released a statement calling for multiple pathways to advanced nursing practice. “A Vision for Post-Baccalaureate Nursing Education” sited data that showed the quality of master’s-prepared nurse practitioner practice and stated that it is
imperative that we ensure that there is an adequate nursing workforce to meet the needs of American society. . . . In the face of our ongoing nursing shortage and the need for a patient-centered, community-responsive health care system, how can we exclude nurses from a variety of entry points for both pre-licensure and post-licensure programs? Advanced nursing practice must be flexible and adaptable. We cannot meet the public’s needs with just one approach. (September 12, 2011, Press Release, p.1)

As a result, the National League for Nursing Accreditation Commission (NLNAC), the accreditation arm of the NLN, continues to accredit both master’s degree programs and DNP programs. A national survey of DNP programs reported that the NLNAC has accredited seven known DNP programs.

Texas Response

The deans and directors of the state’s baccalaureate and graduate nursing programs support the AACN position on the DNP. Under the Texas Organization of Baccalaureate and Graduate Nursing Education (TOBGNE), the deans and directors approved a plan for transitioning to the DNP for the state’s 23 institutions that currently offer master’s degrees in one or more of the four APRN roles. The plan called for only DNP-APRN programs to be established after 2015. TOBGNE approved the plan at its February 10, 2011, meeting and the plan was reaffirmed at its October 5, 2012 meeting.

Certification Bodies

Certification bodies have a pivotal role in the requirements to practice nursing. Graduates of APRN programs must pass a certification exam to be licensed to practice in Texas, so national certification bodies are important stakeholders in any decision to expand educational requirements for a profession. The national certification bodies for the four APRN roles have been supportive of the move to doctoral education, but only the National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA) and the American Association of Nurse Anesthetists (AANA) have conformed to the AACN expectation for entry-level doctoral-prepared APRNs. To be eligible to take the national certification examination and become a nurse anesthetist, a student must graduate from a program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA). The COA will not consider any new master’s degree programs for accreditation beyond 2015. It has established a timetable of 2025 for new graduates to have practice doctorates to be certified in that specialty. All students enrolled in a nurse anesthesia program in January 2022 and later must graduate with a DNP or DNAP per the COA mandate.

If other certification bodies change their credentialing standards to require the doctoral degree for entry to practice, then the question of whether Texas public institutions should phase out master’s degree programs and offer only the BSN to DNP pathway is, for the most part, decided. A new standard for entry-to-practice would make the master’s degree obsolete for graduates, and the state’s nursing programs would be obligated for the students’ sake to teach to the certification standard. The state could establish its own certifications standards, but that
prospect would likely be viewed as unrealistic and untenable, and graduates from master’s programs would be greatly disadvantaged if they were to move out of state to practice advanced practice nursing.

The influence of COA’s new policy on nurse anesthetist programs would eventually require the THECB to consider lifting a contingency on the approval for The University of Texas Health Science Center’s (UTHSCH) to offer the DNP. UTHSCH is currently restricted to the MSN to DNP pathway. That means that students who enroll in its nurse anesthetist program, the only state-supported program in Texas, would complete the DNP as two degree programs: first, the BSN to MSN pathway; and second, the MSN to DNP pathway. While the two-step process meets the same goals of the BSN to DNP pathway, it appears to be less attractive to potential students who are well aware of emerging professional credentials for the profession. Following the COA’s decision, two of the four BSN to MSN nurse anesthetist programs in the state (Texas Christian University and Baylor College of Medicine) transitioned to the BSN to DNP pathway, and the third program (Texas Wesleyan University) plans to transition to the BSN to DNP pathway in 2013.

Institute of Medicine Report

A recent publication from a Committee of the Institute of Medicine has also shaped national and state views on the future of nursing education and the need for doctoral-prepared nurses. The 2011 report, *The Future of Nursing: Leading Change, Advancing Health*, recommended that “nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.” An additional recommendation of the report was to double the number of nurses with a doctorate by 2020. However, within that context, the report did not advocate for the DNP as the entry to practice, citing the “lack of evidence on outcomes”:

At this point, more evidence is needed to examine the impact DNP nurses will have on patient outcomes, costs, quality of care, and access to clinical settings. It is also difficult to discern how DNP nurses could affect the provision of nursing education and whether they will play a significant role in easing faculty shortages. While the DNP provides a promising opportunity to advance the nursing profession, and some nursing organizations are promoting this degree as the next step for APRNs, the committee cannot comment directly on the potential role of DNP nurses because of the current lack of evidence on outcomes. (Committee, p.195)

National Statistics and Trends for DNP Programs
National statistics show growth in both PhD and DNP programs with DNP programs increasing at a greater rate over the last six years. In 2011, the AACN reported 184 institutions offering the DNP degree.

During the last 10 years, both DNP enrollments and graduates have increased dramatically with the growth in new programs.
As of November 15, 2012, AACN’s website lists 193 DNP programs in 42 states. It shows that Pennsylvania leads the nation with 14 institutions offering the degree.

**Number of Institutions Offering the DNP Program**

For the Top-Ten Most Populated States

<table>
<thead>
<tr>
<th>Top-Ten State</th>
<th>Private Institutions</th>
<th>Public Institutions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Florida</td>
<td>3</td>
<td>7</td>
<td>10</td>
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<tr>
<td>Georgia</td>
<td>2</td>
<td>2</td>
<td>4</td>
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<tr>
<td>Illinois</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Michigan</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>New York</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ohio</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>12</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Texas*</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: AACN website.

* The total for Texas does not include DNP/DNAP nurse anesthetist programs at Baylor College of Medicine and Texas Wesleyan University and a recently approved DNP program at The University of Texas Health Science Center at San Antonio.

**The Texas Environment**

**Current Scope of Practice and Regulation of Advanced Practice Nurses**

While national accreditation and certification bodies have a significant influence on nursing education requirements, Texas laws and regulations also play an important role in educational requirements, licensure, and nursing practice. The Texas Board of Nursing (TBON) is the state agency that regulates the profession of nursing, and in that role, licenses initial licensure nurses and the four roles of APRNs (nurse anesthetist, nurse midwives, nurse practitioner, and clinical nurse specialists). To be granted an APRN license, an individual must hold a current license as a registered nurse, complete a graduate degree (a minimum of a master’s degree) in an accredited advanced nursing educational program, and pass a national certification exam within the individual’s educational focus. As of August 2012, Texas had issued 16,429 APRN licenses: 10,701 for nurse practitioners (65%); 3,927 for nurse anesthetists (24%); 1,407 for clinical nurse specialists (9%); and 394 for nurse midwives (2%).

Because a master’s degree is the minimum educational requirement for APRN licensure, TBON does not have a position on the DNP. It does not currently distinguish registered nurses that have the DNP other than noting in a licensure record that a licensee reported voluntarily having a "doctoral degree in nursing" as his/her highest level of educational attainment. As of November 2012, TBON’s licensure data show that 1,153 of the 250,383 registered nurses in Texas have reported obtaining a doctorate in nursing. In discussing the DNP, TBON’s website states:
The Texas Board of Nursing has not discussed [the doctor of nursing practice degree] and does not have a position on the issue at this time. Additionally, although the board would never discourage nurses from furthering their education, nothing in current rules requires that advanced practice nurses be educated at the doctoral level to obtain authorization to practice in an advanced practice role and specialty. (para. 2)

The minimum master’s level requirements would likely change if both of the national nursing organizations stopped accrediting master’s degree programs, or certification bodies were to increase educational standards for APRNs.

Under current laws and regulations, advanced practice nurses work in a variety of settings, such as hospitals, clinics, and physicians’ practices; and, according to their practice specialty and role, they provide a broad range of health care services to a variety of patient populations. Based on an individual’s advanced education and certification, TBON authorizes an APRN to practice only within a particular nursing role. Within that role, an APRN is limited to working within particular patient focus areas: family, adult/gerontological (primary or acute care), pediatrics (primary or acute care), neonatal, women’s health, and psychiatric.

Some APRNs also have authority to write medication prescriptions. Prescribing privileges are limited to APRNs practicing at selective sites such as those serving certain medically underserved populations, physicians’ primary and alternate practice sites, and facility-based practice sites. APRN prescriptive authority is subject to a physicians’ supervision as defined by Texas Medical Board rules.
State Statistics and Trends in DNP Programs

The number of PhD programs has remained constant over the last four years, whereas the number of DNP programs has doubled in the last five years.

The numbers of DNP enrollees and graduates have increased as new programs are created.

In contrast to DNP programs, the number of enrollees and graduates from PhD programs show a different trend. Overall, those numbers have doubled since 2003. But most of that growth has occurred prior to 2008. The numbers of PhD enrollees and graduates have remained stable during the four-year period that institutions reported graduates in the DNP program.
The THECB survey allowed staff to compile a complete list of the 28 total concentrations or tracks offered by the 12 institutions that award the DNP degree.

<table>
<thead>
<tr>
<th>Concentration or Track</th>
<th>Number of Programs</th>
<th>Method of Delivery</th>
<th>Semester Credit Hours</th>
<th>Program Length in Months</th>
<th>Clinical Hours</th>
<th>Enroll PT/FT/Both Students</th>
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<tbody>
<tr>
<td><strong>MSN to DNP Programs</strong></td>
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<tr>
<td>Advanced Practice Nurses</td>
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<tr>
<td>Nurse Anesthetist</td>
<td>5</td>
<td>DE; Hybrid</td>
<td>32-45</td>
<td>24-28 FT; 21-38 PT</td>
<td>0-544</td>
<td>Both</td>
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<tr>
<td>Nurse Practitioner</td>
<td>9</td>
<td>DE; Hybrid</td>
<td>33-46</td>
<td>18-24 FT; 33-36 PT</td>
<td>220-544</td>
<td>Both</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>3</td>
<td>DE; Hybrid</td>
<td>30-43</td>
<td>28-33 PT</td>
<td>500-544</td>
<td>PT</td>
</tr>
<tr>
<td>Nurse Midwife</td>
<td>3</td>
<td>DE; Hybrid</td>
<td>33-46</td>
<td>24-28 FT</td>
<td>500-544</td>
<td>Both</td>
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<tr>
<td><strong>Other Advanced Nursing Practice Specialties</strong></td>
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<tr>
<td>Nurse Administrator</td>
<td>4</td>
<td>DE; Hybrid</td>
<td>30-48</td>
<td>23-24 FT; 30-36 PT</td>
<td>500-1,000</td>
<td>Both</td>
</tr>
<tr>
<td>Public Health Nurses</td>
<td>1</td>
<td>Hybrid</td>
<td>51</td>
<td>36 PT; 29 FT</td>
<td>360+</td>
<td>Both</td>
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<tr>
<td><strong>BSN to DNP/DNAP Programs</strong></td>
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<td></td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td>2</td>
<td>Hybrid</td>
<td>80-129</td>
<td>36 FT</td>
<td>2,500-3,000</td>
<td>FT</td>
</tr>
<tr>
<td>Midwife</td>
<td>1</td>
<td>Face to Face</td>
<td>75</td>
<td>27</td>
<td>1,200</td>
<td>Both</td>
</tr>
</tbody>
</table>

Source: THECB DNP Survey
Note: Schools that reported tracks in “All Advanced Practice Nurse” roles were counted individually under Nurse Anesthetists, Nurse Practitioner, Clinical Nurse Specialist, and Nurse Midwife.

The number of tracks in each specialty is proportional to the number of master’s-prepared students that have graduated in each specialty in recent years. The program information also shows a preference for delivering instruction via distance education.

An itemized list of the state’s DNP programs is in Appendix B.

**Should the Board consider additional DNP programs beyond the current number offered at Texas public institutions, and if so, should it consider tracks that allow students to enter the program after completing the bachelor’s degree (a BSN to DNP pathway)?**

Since 2006, the THECB has approved seven institutions to offer the DNP as a MSN to DNP pathway. Another two such proposals are now pending staff review or consideration by the Board. A map showing the location of approved and pending programs is in Appendix C.

During this six-year period, institutions proposed curriculum plans that represented both the MSN to DNP pathway and BSN to DNP pathway. However, the Board’s eventual approval limited DNP offerings to the MSN to DNP pathway with the intent that such programs continue to preserve the master’s degree as the primary entry-to-practice for APRNs and nurse administrators.
As the number of DNP programs continue to increase at the national and state levels, THECB staff collected data to help determine whether the Board should consider approving additional DNP programs and if the Board should continue to limit program approval to the MSN to DNP pathway.

Student Demand

To gauge student demand for new DNP programs, THECB staff conducted a survey of nursing programs at 95 community colleges, universities, and health science centers to determine the interest and trends in graduate nursing education among the nursing programs’ faculty and staff. By surveying institutions about their faculty and staff, the THECB provides an incomplete picture of trends in graduate nursing education, particularly since interest in obtaining a DNP may be stronger among practicing nurses outside of academia. The THECB staff surveyed the programs fully aware of that limitation but also restricted by time in seeking practice-based input.

The following bar chart summarizes data for 318 nursing faculty and staff who are enrolled in graduate nursing education.
Survey results show that the master’s degree is still viable among faculty and staff at community colleges. Approximately 44 percent of the 126 community college faculty and staff who are enrolled in graduate nursing education, are pursuing a master’s degree. While 13 community college faculty and staff (4%) are enrolled in DNP programs, none are pursuing the BSN to DNP. Approximately 29 percent of community college faculty and staff are enrolled in MSN to PhD programs.

Among universities and health science centers with and without doctoral degrees, 40 percent of faculty and staff are enrolled in MSN to PhD programs, and 22 percent are enrolled in MSN-DNP programs. BSN to DNP pathway students represent 7 percent of faculty and staff enrolled in graduate nursing education from universities and health science centers.

THECB staff also surveyed the programs about where faculty and staff were enrolled in DNP and DNAP programs.

<table>
<thead>
<tr>
<th>Faculty &amp; Staff at Texas Institutions Pursuing the DNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community &amp; Technical Colleges</td>
</tr>
<tr>
<td>Proprietary</td>
</tr>
<tr>
<td>Out of State Universities/HRI</td>
</tr>
<tr>
<td>In-State Universities/HRI (Independent)</td>
</tr>
<tr>
<td>In-State Universities/HRI (Public)</td>
</tr>
</tbody>
</table>

Findings show that 68 faculty and staff, representing all sectors of higher education, are enrolled in DNP programs. Seventeen of those programs are offered at out-of-state institutions. The majority of faculty and staff at community colleges and at universities without doctoral programs are enrolled in out-of-state programs. Approximately 58 percent of faculty and staff at institutions with doctoral nursing programs are enrolled at independent in-state DNP programs.
THECB also collected matriculation data from the seven public and four independent institutions that offer the MSN to DNP pathway.

<table>
<thead>
<tr>
<th>Academic Year</th>
<th>Qualified Applicants</th>
<th>Admission Capacity</th>
<th>Admitted</th>
<th>New Enrollees</th>
<th>Total Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/1/2008-8/31/2009</td>
<td>189</td>
<td>105</td>
<td>103</td>
<td>91</td>
<td>202</td>
</tr>
<tr>
<td>9/1/2009-8/31/2010</td>
<td>226</td>
<td>135</td>
<td>120</td>
<td>105</td>
<td>262</td>
</tr>
<tr>
<td>9/1/2010-8/31/2011</td>
<td>211</td>
<td>175</td>
<td>150</td>
<td>122</td>
<td>309</td>
</tr>
<tr>
<td>9/1/2011-8/31/2012</td>
<td>285</td>
<td>240</td>
<td>189</td>
<td>160</td>
<td>381</td>
</tr>
</tbody>
</table>

The combined results show that qualified applicants increased by 71 percent, while admission capacity increased by 120 percent during a five-year period. In Academic Year 2012, admission capacity represented 84 percent of qualified applicants, and new enrollees represented 67 percent of admission capacity. That latter statistic represents 80 of 240 positions or “seats” left unfilled in the state’s DNP programs.

To gauge student demand for the BSN to DNP pathway, THECB staff collected matriculation data from the three independent institutions that offer the BSN to DNP pathway.

<table>
<thead>
<tr>
<th>Academic Year</th>
<th>Qualified Applicants</th>
<th>Admission Capacity</th>
<th>Admitted</th>
<th>New Enrollees</th>
<th>Total Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/1/2007-8/31/2008</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>9/1/2009-8/31/2010</td>
<td>112</td>
<td>28</td>
<td>21</td>
<td>21</td>
<td>47</td>
</tr>
<tr>
<td>9/1/2010-8/31/2011</td>
<td>184</td>
<td>53</td>
<td>49</td>
<td>48</td>
<td>92</td>
</tr>
<tr>
<td>9/1/2011-8/31/2012</td>
<td>160</td>
<td>70</td>
<td>60</td>
<td>59</td>
<td>107</td>
</tr>
</tbody>
</table>

The combined data for three programs show that a smaller number of applicants applied for a larger number of available positions over a five-year period. However, there are still more than two applicants for every available position, which indicates a continuing high demand for these programs. Two of the three programs represent nurse anesthetist tracks, which are traditionally highly competitive for admission and have small enrollments. In Academic Year 2012, Texas Christian University had 104 applicants for 45 positions, and Baylor College of Medicine had 49 applicants for 15 positions. A midwifery program at Baylor University was the third BSN to DNP pathway program. It had seven qualified applicants for 10 positions for this same period.

**Workforce Demand**

Along with student interest, THECB staff attempted to measure workforce demand when determining whether more degree programs are needed in the state. Since the DNP is a relatively new nursing degree, it was difficult for staff to gauge the demand for graduates with traditional sources. However, within that limited context, federal and state workforce agencies have documented a high demand for all levels of nurses without specifically identifying doctoral-prepared nurses.
To find evidence of workforce demand, THECB staff reviewed job advertisements and surveyed health care facilities about their current and future hiring practices for nurses with DNP degrees. In September and early October 2012, THECB staff examined a sampling of 135 postings for nursing practice positions in hospitals, physicians’ practice offices, and clinics in both metropolitan and rural locations in Texas. The minimum educational requirements were either a MSN or doctoral degree, depending on the specifics of the position. None of the postings stated a specific requirement or preference for the DNP degree. Staff noted that job standards in the U.S. Veterans Administration preferred a doctoral degree in nursing or a related field for the Nurse V position. THECB staff also reviewed 63 postings for nursing faculty positions across the U.S. The DNP degree was not listed as required or preferred for any of these positions. However, some of the positions were for faculty for the institutions’ DNP programs.

THECB staff also surveyed APRN employers in the Houston–Galveston area about their hiring preferences. The employers, each of which employed between zero and nine DNP-prepared nurses at their facilities, included private/nonprofit healthcare systems with multiple facilities, a public hospital/health science center, a private clinic, and local government agencies. Eight responses were received. Seven respondents indicated that the DNP was not included in any job announcements for APRNs at their facilities, and one indicated that the DNP was a preferred credential in job announcements. One facility expected the educational requirement for APRNs to change over the next five years; and one facility stated that a current position at the facility, a clinical effectiveness position, required a DNP degree. Positions currently held by DNP-prepared nurses included Director of Advanced Practice, Acute Care Nurse Practitioner, System Clinical Nurse Specialist, and Palliative Care Nurse Practitioner.

THECB staff also asked the institutions with DNP graduates to identify the primary position and sector of employment of graduates before and after obtaining their DNP. In most cases, the graduate retained the same or a similar job, although some graduates also accepted teaching positions. While the current data suggest limited upward mobility in obtaining the degree, it is consistent with national statistics showing that among 244 recent DNP graduates surveyed, 20 percent reported a salary increase with an existing employer and 17 percent reported a salary increase with a new employer.

A BSN to DNP Pathway

To answer the more specific question as to whether the state should consider tracks that allow students to enter the program after completing the bachelor’s degree (the BSN to DNP pathway), THECB staff collected current and historical information that could help weigh both the “value” and the “cost” of approving a BSN to DNP pathway. This approach is consistent with the Board’s current position on the DNP which recognizes that a BSN to DNP pathway would affectively minimize the viability of the master’s degree.

THECB staff compiled a list of many of the advantages and disadvantages of the BSN to DNP pathway:

**Advantages:**

- Responds to national accreditation endorsement of the American Association of Colleges of Nursing.
• Provides professional parity with other similarly prepared health care professionals such as pharmacists (PharmD), physical therapists (DPT), and audiologists (AuD).
• Responds to new certification standards for nurse anesthetists [Doctoral degree will be required by 2025].
• Will likely eliminate content duplication in the BSN to MSN to DNP pathway curriculum and thereby reduce the number of semester credit hours leading to the DNP.
• Will likely condense the curriculum and reduce time to the DNP as opposed to the existing BSN to MSN to DNP pathway.
• Provides a more logical sequence of curriculum content. Much of the DNP curriculum can be considered foundation courses for advanced nursing practice: evidence-based practice; information systems; health care policy; inter-professional collaboration; prevention and population health; organizational and system leadership; science-based theory. Parts of this content, as well as other core courses in the existing master’s curriculum, would likely be taken earlier in the program, and advanced practice specialty courses and the practicum would likely be taken later in the program.
• Will maintain the state’s competitiveness for students, if the majority of programs in other states convert to the BSN to DNP pathway.
• Will attract graduates to faculty positions at an earlier age, thus extending their careers in higher education.
• Allows schools to compete for any student aid targeting BSN to DNP students.
• Responds to calls for a better prepared health care workforce and greater inter-professional collaboration.

Disadvantages/Costs:

• Increases time-to-degree for students to enter practice.
• Increases semester credit hour requirements to enter practice by as much as 85 percent for a nurse practitioner.
• Increases costs to Texas residents to enter practice.
• Increases clinical requirements from 500 hours to 1,000, thereby exacerbating a lack of clinical space that is restricting admission capacity in most master’s degree programs.
• Increases “costs” to the State’s formula funding.
• May discourage potential doctoral students from considering the PhD. Most students enter PhD programs after completing the MSN.
• Exceeds educational requirements set by certification bodies (exception: nurse anesthetists).
• Exceeds licensing requirements of the Texas Board of Nursing, which requires the master’s degree for all advanced practice nurses.
• Ignores body of research that shows master’s-prepared advanced nurse practitioners are effective primary care providers.
• Potentially increases nursing schools’ general operating costs by requiring higher salaries to recruit doctoral-prepared faculty as opposed to master’s-prepared faculty for initial licensure programs.
• Potentially exacerbates the nursing faculty shortage and, thereby, negatively impacts the supply of entry-level registered nurses. Approximately 75 percent of all faculty teaching in undergraduate programs in the state have master’s degrees rather than doctoral degrees.
• Potentially reduces educational outcomes of DNP graduates. Previous MSN to DNP pathway graduates had positive educational outcomes because they had extensive clinical experience to effectively translate and apply context to new DNP content in practice settings.
• Potentially exacerbates the shortage of practitioners and consequently could drive up practitioner salaries and health care costs. The Kaiser Foundation reports that Texas ranks 47th among the 50 states in the number of nurse practitioners per 100,000 persons.

THECB staff expands on a number of these core issues in the remainder of this paper.

**Nature of Previous Degree Expansion Efforts and Costs to the State and Potential Students**

In the last 10 years, the Board has approved degree programs that represented an expansion of educational requirements in health disciplines. Most notably were degree expansion efforts in pharmacy education (where entry-level requirements to the profession advanced from the Bachelor of Science in Pharmacy to the Doctor of Pharmacy) and in physical therapy education (where entry-level requirements advanced from the Master’s in Physical Therapy to the Doctor of Physical Therapy).

In comparing these degree expansion efforts with the proposed BSN to DNP pathway, THECB staff found that the DNP would have a significantly higher percentage increase in semester credit hours with that expansion as compared to the two other previous degree expansion efforts. The Doctor of Pharmacy degree represented a 19 percent increase in semester credit hours, from an average of 125 hours to 149 hours. The Doctor of Physical Therapy degree represented a 26 percent increase in semester credit hours, from an average of 78 hours to 98 hours. The DNP for a nurse practitioner would represent a 72 percent to 85 percent increase, from an average of 46 hours to between an estimated 79 and 85 hours. However, the total number of semester credit hours of academic preparation for these practice-focused doctorates were comparable (Column E in the following table) when measured only in semester credit hours.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Degree Expansion</th>
<th>A: Typical Undergraduate Education Requirements</th>
<th>B: Previous Avg. Entry-to-Practice Requirements</th>
<th>C: Current Avg. Graduate Education Requirements</th>
<th>D: Percent Increase in SCHs (C-B)/B</th>
<th>E: Total Education Requirements (A+C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td>BS to PharmD</td>
<td>72 SCH</td>
<td>BS = 125 SCH</td>
<td>PharmD = 149 SCH</td>
<td>19%</td>
<td>221 SCH</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>MPT to DPT</td>
<td>120 SCH</td>
<td>MPT = 78 SCH</td>
<td>DPT = 98 SCH</td>
<td>26%</td>
<td>218 SCH</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>MSN to DNP</td>
<td>120 SCH</td>
<td>MSN = 46 SCH</td>
<td>DNP = 79-85 SCH</td>
<td>72-85%</td>
<td>199-205 SCH</td>
</tr>
</tbody>
</table>

Expansion degree efforts also increase the number of hours of instruction at clinical sites. Nursing has always had well-publicized shortages in clinical placements that have restricted the number of students that can be admitted to a program. Most of those limitations are at the undergraduate level, but programs in the state also face challenges in clinical placement at the
graduate level. In a 2011 survey conducted by the Texas Center for Nursing Workforce Studies, 11 of 18 institutions reported that the lack of clinical space for APRN students was the “most important” or an “important” reason for not admitting more qualified applicants to their programs. That capacity issue would likely worsen for these institutions, if they transitioned to the DNP, which requires an accredited program to have a minimum of 1,000 clinical hours (as opposed to 500 hours currently required for licensure of many master’s degree graduates in Texas).

In reviewing the implications of a degree expansion effort that would require a student to complete a doctoral degree rather than a master’s degree, THECB staff compared the “cost” of that transition in state formula funding and to the student:

<table>
<thead>
<tr>
<th></th>
<th>BSN to MSN</th>
<th>MSN to DNP</th>
<th>BSN to MSN to DNP</th>
<th>BSN to DNP**</th>
<th>BSN to DNP**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Credit Hours</td>
<td>46</td>
<td>42</td>
<td>88</td>
<td>79***</td>
<td>85****</td>
</tr>
<tr>
<td>University</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formula Funding</td>
<td>$10,389</td>
<td>$23,765</td>
<td>$34,154*</td>
<td>$34,501</td>
<td>$37,896</td>
</tr>
<tr>
<td>Tuition and Fees</td>
<td>$14,480</td>
<td>$13,221</td>
<td>$27,701</td>
<td>$24,868</td>
<td>$26,756</td>
</tr>
<tr>
<td>Total</td>
<td>$24,869</td>
<td>$36,985</td>
<td>$61,854</td>
<td>$59,368</td>
<td>$64,652</td>
</tr>
<tr>
<td>Health Science Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formula Funding</td>
<td>$17,482</td>
<td>$21,282</td>
<td>$38,764</td>
<td>$36,230</td>
<td>$39,270</td>
</tr>
<tr>
<td>Tuition and Fees</td>
<td>$24,793</td>
<td>$22,637</td>
<td>$47,430</td>
<td>$42,579</td>
<td>$45,813</td>
</tr>
<tr>
<td>Total</td>
<td>$42,275</td>
<td>$43,919</td>
<td>$92,201</td>
<td>$78,809</td>
<td>$85,083</td>
</tr>
</tbody>
</table>

Source: State Formula Funding estimates are the product of Fiscal Year (FY) 2011 graduate nursing weights, rates, and DNP hours calculated by the THECB staff. Tuition and Fees estimates use FY 2011 graduate-level THECB Integrated Fiscal Reporting System (IFRS) tuition charges and Semester Credit Hours (SCH) reported by institutions offering a DNP. Tuition rates are nursing tuition divided by the nursing SCH. One institution did not report graduate-level tuition specific to nursing. Its rate was estimated on graduate-level tuition for all graduate-level programs divided by all graduate-level SCH. Fee rates are based on all graduate-level program fee charges divided by all graduate-level SCH, as discipline specific fees are not reported in IFRS. Note: Because THECB staff used all graduate-level fees (and all graduate-level tuition for one institution), actual student charges may be less than what is estimated in the table.

(*) The state’s cost for the two-step BSN to MSN to DNP pathway is less than the BSN to DNP pathway because although the number of hours is more, fewer hours are funded at the doctoral level.

(**) In calculating the BSN to DNP pathway, the first 30 hours are calculated at the master’s funding level/master’s FTE level.

(***) Represents the adjusted average of semester credit hours required for a BSN to DNP program.

(****) Represents the national average of semester credit hours required for a BSN to DNP program in Texas. The state’s public institutions have a higher average number of hours in their MSN to DNP program than the national average and that difference is represented in this second calculation.

The calculations show that if the BSN to DNP pathway were to replace the master’s degree as the entry-to-practice, the increased cost to the state and to student would be significant. Institutions would receive $34,501 to $39,270 in state formula funding to produce a DNP graduate, as opposed to $10,389 to $17,482 in state formula funding to produce a master’s degree graduate. Student tuition and fees would range between $24,868 and $45,813 for a BSN to DNP pathway graduate, as opposed to a range between $14,480 and $24,793 for a master’s degree graduate. Total formula funding and student costs would increase up to 160 percent in producing a DNP graduate (as opposed to a MSN graduate) from a state university, and increase up to 101 percent in producing a DNP from a health science center. (Note that these calculations represent semester credit hours for a nurse practitioner track but would vary by specialty.)
If the choice is between the two-step BSN to MSN to DNP pathway and the consolidated BSN to DNP pathway, the institutions would contend that it is less expensive for the state and the student to complete the BSN to DNP pathway. However, it may also be possible for the institutions to make the two-step BSN to MSN to DNP pathway the same number of hours as the BSN to DNP pathway, which would equalize some of the costs.

**Added Value to Health Care**

Data collected about workforce mobility for DNP graduates do not take into account the added value of the DNP graduate to the nursing workforce. That added value has not been measured in any research literature because the degree is too new. However, nurse researchers acknowledge that measuring those outcomes is important to the development of the degree, and stakeholders at the national and state levels have discussed the importance of that research. A recent presentation at a national DNP conference posed important questions: “How do achieved (DNP) competencies translate to improved patient outcomes?” “How are DNPs manifesting change in their respective practice?” “Do DNP program outcomes correlate with improved patient outcomes?”

At the state level, the September THECB survey asked institutions with DNP programs “What quantitative measures are used to determine the competencies of your DNP graduates?” and “What do the outcomes of those measures reveal about the competencies of the DNP graduate as compared to the master’s degree practitioner?” In response, the institutions refer to the DNP degree requirements and specifically the cumulative final exams in outcomes measurement, informatics, epidemiology, and genetics, along with the completion and presentations of capstone projects and portfolios. That instruction, the institutions said, provides the DNP graduate with a more in-depth understanding of the complex health care system and information on how to care for populations of patients, not just individuals. The DNP graduate is typically more qualified to translate research into practice and measure outcomes and is more focused on team collaboration.

One institution provided abstracts of scholarly inquiry projects that represent the culmination of the degree program. The titles of some of those projects are included here as examples of the scope and depth of a DNP student’s work:

- *Implementation of a Diabetes Self-Management Education Program in Primary Care for Adults Using Shared Medical Appointments*
- *Trauma Patient Safety: Handoffs to High Acuity Areas*
- *Implementing a Sepsis Program in a Community Setting Hospital*
- *Induced Hypothermia Protocol for Neuroprotection Following Cardiac Arrest in a Community Hospital.*

**Existing Research on the Master’s-Prepared Nurse**

In the absence of research that shows the impact of the DNP graduate on health care outcomes, THECB staff found a body of research on the efficacy of the master’s-prepared APRN.

A 2011 article in *Nursing Economics* provided a review of that research. The aim of *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review* was to answer the following question: “Compared to other providers (physicians or teams without APRNs), are APRN patient outcomes of care similar?” The researchers ultimately used 69 published articles between 1990
and 2008 on care provided by APRNs, and they reported that patient outcomes of care provided by nurse practitioners and certified nurse midwives in collaboration with physicians are similar to, and in some ways better than, care provided by physicians alone. The researchers also found that the use of clinical nurse specialists in acute care settings can reduce length of stay and cost of care for hospitals. The researchers concluded by saying that the results indicate APRNs provide effective and high-quality patient care, have an important role in improving the quality of patient care, and could help to address concerns about whether care provided by APRNs can safely augment the physician supply to support reform efforts aimed at expanding access to care.

In Texas, the Perryman Group recently published a study that estimated substantial economic benefits to the state when APRNs are fully utilized to provide health care. The Economic Benefits of More Fully Utilizing Advanced Practice Registered Nurses in the Provision of Health Care in Texas: An Analysis of Local and Statewide Effects on Business Activity (2012) estimated that by 2020, the total annual impact of using APRNs in the state would result in $24 billion in total spending activity, and $12 billion in output (or "real gross product"), which is production of goods and services that will occur in Texas as a result of the activity. Another benefit would be 122,735 permanent jobs. The study referenced empirical evidence that demonstrates that the use of APRNs does not compromise patient outcomes.

Both studies made no mention of the educational preparation of APRNs at the master’s or doctoral level. However, given the timeframe of the reports, it is likely that the vast majority of the APRNs were master’s-prepared nurses with only a very small minority likely having doctoral degrees. With those positive results, is it fair to ask whether it is necessary that every APRN have a DNP degree?

Value to Nursing Education

One of the original reasons for establishing the DNP was the possibility that DNP graduates would help relieve the shortage of doctoral-prepared nursing faculty. The recent data collected by THECB staff confirm that DNP graduates are teaching in nursing. Since 2009, 92 of the state's 296 DNP graduates (31 percent) have accepted full-time (50 percent) or part-time (50 percent) positions at nursing programs. Approximately 75 percent of the new faculty accepted positions at universities, 21 percent at health science centers, and 4 percent at community colleges. The institutions reported that 87 percent taught in graduate nursing programs and 13 percent taught in undergraduate programs.

While those graduates are helping to relieve any current and projected shortage of doctoral faculty, the data ignore hiring patterns that point to the state’s reliance on master’s-prepared nurses to teach in both undergraduate programs and advanced practice programs. Faculty data collected by the Texas Center for Nursing Workforce Studies for 2011 showed that master’s-prepared faculty represented 75 percent of all faculty teaching in undergraduate nursing programs and 36 percent of all faculty teaching in APRN programs. The current data suggest that if more institutions move to the DNP, community colleges, which produce approximately 60 percent of the state’s initial RN licensure nurses, could be cut out of the existing pipeline for new master’s-prepared faculty. The trend would also likely increase the cost of nursing education at both the undergraduate and graduate levels, since a doctoral-prepared faculty member would require a higher salary than a master’s-prepared faculty member.
Conclusion

The DNP is a practice-intensive terminal degree for nurses who aspire to address the problems in health care and improve health outcomes in practice settings. The American Association of Colleges of Nursing, one of two national organizations for nursing education, views the DNP as the future entry-level credential for advanced nursing practice, and its membership has endorsed the position that all programs should transition from the master’s degree to the DNP by 2015.

In Texas, the 23 institutions that offer advanced practice nursing degrees have endorsed the AACN’s position, and within a six-year period, the Board has approved seven MSN to DNP pathways programs at public institutions for a total of 12 DNP programs in the state. Another two programs will likely be considered by the Board for public institutions in early 2013. The programs at public institutions were approved as MSN to DNP pathways in an effort to preserve the master’s degree as a viable entry to advanced nursing practice.

With the growth in DNP programs, the Board needs to be informed of a movement toward the BSN to DNP pathway, which would eliminate most master’s degrees in nursing, and the implications of this degree expansion effort. At a time when Texas is seeking to reduce degree completion time, the BSN to DNP pathway will likely increase degree requirements for advanced practice nurses by 72 to 85 percent (from 46 SCH for the master’s degree to 79-85 SCH for the DNP). That represents a significantly greater increase in educational requirements than any other major degree expansion effort of the recent past. It would also affect more students. Using 2011 graduation numbers, THECB staff determined that the transition to the DNP would increase educational requirements for 91 percent of the state’s 1,263 master’s degree graduates in nursing.

At a time when Texas is seeking to be more efficient in producing graduates and making education affordable for students, the DNP will likely increase the state’s formula funding for APRN education by as much as 265 percent (an increase of $27,500 per graduate), and tuition and fees by as much as 85 percent (an increase of $21,000 per graduate).

These costs of degree expansion could be balanced by the benefits of satisfying an increase in workforce demand, student interest, and the value added to health care delivery and nursing education. However, the THECB survey data show that employers are not requiring or preferring the DNP in job postings and, in the last five years, the number of qualified applicants to DNP programs has not kept pace with the number of available positions in both MSN to DNP pathway programs and BSN to DNP pathway programs. No research has been published yet that supports the added value of the DNP practitioner, but there is a body of research literature that shows the value of the master’s-prepared APRN. Finally, the THECB survey results show that 31 percent of the DNP graduates since 2009 (92 DNP graduates) have taken either full- or part-time nursing faculty positions at primarily universities and health science centers. That would be a substantial contribution, if the state did not rely so heavily on master’s-prepared faculty to teach in both undergraduate and master’s level nursing programs. The BSN to DNP pathway would eventually eliminate a pipeline for master’s prepared faculty, and community colleges, which produce approximately 60 percent of the state’s initial RN licensure nurses, could be cut out of the existing pipeline for new faculty.
Appendix A: Texas Public Institutions Current Pathway to Graduate Education and the DNP

Registered Nurse (BSN)

→ = Conventional Pathway
→→ = Unconventional Pathway
(APRN certification likely to be required)

- Number of Programs
- Percent of Graduates from all MSN Programs

Nursing Practice (DNP)

Source: THECB Profile Reports, 2011
AACN’s Proposed Pathway to Graduate Education and the DNP by 2015

Registered Nurse (BSN)

MSN Degrees
- Nurse Educator
- Clinical Nurse Leader

Nursing Practice (DNP)
- Nurse Administration
- Nurse Anesthetist
- Nurse Practitioner
- Nurse Midwife
- Clinical Nurse Specialist

Nursing Practice (DNP)
- Nurse Educator
- Public Health Nurse
- Other Specialties

→ = Conventional Pathway
→ = Unconventional Pathway
(APRN certification likely to be required)
## Appendix B: Texas Institutions Offering DNP Programs

### Doctor of Nursing Practice Degree Programs Offered by Texas Institutions

<table>
<thead>
<tr>
<th>Institution</th>
<th>Concentration or Track</th>
<th>Start Date</th>
<th>Method of Delivery</th>
<th>Semester Credit Hours</th>
<th>Program Length in months</th>
<th>Clinical Hours</th>
<th>Enroll PT/FT/Both Students</th>
<th>Special Requirements of the Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Existing MSN-DNP/DNAP Programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baylor College of Medicine (independent)</td>
<td>Nurse Anesthesia</td>
<td>Jan-11</td>
<td>DE</td>
<td>39</td>
<td>24 FT</td>
<td>0</td>
<td>FT</td>
<td>Capstone Project</td>
</tr>
<tr>
<td>Texas Christian University (independent)</td>
<td>Advanced Practice Nurse (All)</td>
<td>Aug-07</td>
<td>DE</td>
<td>30</td>
<td>24 FT</td>
<td>1000</td>
<td>Both</td>
<td>Practicum; Capstone Project</td>
</tr>
<tr>
<td></td>
<td>Nurse Administrator</td>
<td>Aug-09</td>
<td>DE</td>
<td>30</td>
<td>24 FT</td>
<td>1000</td>
<td>Both</td>
<td>Practicum; Capstone Project</td>
</tr>
<tr>
<td>Texas Tech University of Health Science Center</td>
<td>Nurse Practitioner</td>
<td>Jun-08</td>
<td>Hybrid</td>
<td>45</td>
<td>24 FT; 36 PT</td>
<td>500</td>
<td>FT</td>
<td>Capstone</td>
</tr>
<tr>
<td></td>
<td>Executive Leadership</td>
<td>Jun-08</td>
<td>Hybrid</td>
<td>45</td>
<td>24 FT; 36 PT</td>
<td>500</td>
<td>FT</td>
<td>Capstone</td>
</tr>
<tr>
<td>Texas Woman's University</td>
<td>Nurse Practitioner</td>
<td>no data</td>
<td>Hybrid</td>
<td>46</td>
<td>24 FT</td>
<td>500</td>
<td>Both</td>
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<td>500</td>
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<td>Aug-07</td>
<td>DE</td>
<td>38-45</td>
<td>26 FT; 38 PT</td>
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<td>Both</td>
<td>Evidence-Based Research Project</td>
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<td>Aug-07</td>
<td>DE</td>
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<td>26 FT; 38 PT</td>
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<td>Evidence-Based Research Project</td>
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<td>33</td>
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<td>18 FT</td>
<td>540</td>
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<td>Practicum; Scholarly Project</td>
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<td>Hybrid</td>
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<td>21 FT</td>
<td>540</td>
<td>FT</td>
<td>Practicum; Capstone Project</td>
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<td>Nurse Executive</td>
<td>Aug-12</td>
<td>Hybrid</td>
<td>42</td>
<td>33 PT</td>
<td>500</td>
<td>PT</td>
<td>Clinical Scholarship Portfolio</td>
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<td>Nurse Anesthesia</td>
<td>Aug-11</td>
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<td>41</td>
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<td>Practicum; Inquiry Project</td>
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<td>DE</td>
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<td>32 PT</td>
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<td>PT</td>
<td>Scholarly Project</td>
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<td><strong>Proposed MSN-DNP Programs (Pending THECB staff review and Board consideration)</strong></td>
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<td>Family Nurse Practitioner</td>
<td>Aug-13</td>
<td>Hybrid</td>
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<td>28 PT; 21 FT</td>
<td>120-1000</td>
<td>Both</td>
<td>Practicum; Capstone Project</td>
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<td>Nurse Anesthesia</td>
<td>Jan-11</td>
<td>Hybrid</td>
<td>129</td>
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<td>3000+</td>
<td>FT</td>
<td>Capstone Project</td>
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<td>Midwifery</td>
<td>Sep-07</td>
<td>Face to Face</td>
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<td>Hybrid</td>
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<td>2,500+</td>
<td>FT</td>
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Appendix C: Location of DNP/DNAP Programs

Location of Texas Institutions with Existing or Pending DNP/DNAP Programs

- TX Tech University HSC
- UT at El Paso
- UT at Arlington
- Baylor University (Dallas)
- UT at Tyler
- UTHSC at Houston
- UTMB at Galveston
- Baylor College of Medicine
- Prairie View A&M University (Houston)

● Existing Program
▲ Proposed Program Pending THECB consideration
Appendix D: Letters received in response to draft report
January 22, 2013

Raymond Paredes, Commissioner
Texas Higher Education Coordinating Board
P.O. Box 12788
Austin, Texas 78711

Mr. Fred Heldenfels, Chair
Texas Higher Education Coordinating Board
P.O. Box 12788
Austin, Texas 78711

Gentlemen:

I appreciate the work the Texas Higher Education Coordinating Board (THECB) staff has done to highlight issues related to the Doctor of Nursing Practice (DNP) degree. The “White Paper: The Doctor of Nursing Practice Degree” provides useful information to frame discussions but I have concerns with how the white paper addresses the following issues:

1. Overemphasis on the importance of research on patient outcomes and minimal attention on what the degree program means for nursing professionals;
2. Focus on workforce demand by reviewing job postings;
3. Flawed data on additional student and state funding costs related to DNP programs; and
4. Unclear language related to the “advantages/disadvantages”

1. As I stated in my October 20, 2011 letter to the THECB:

   Although there is no reason to believe that care rendered by a DNP would be any less effective than that offered by a Master’s trained nurse and may very well be improved, that is not the relevant issue. Much more important is whether the degree prepares an individual for careers for which a Master’s degree does not prepare them. In this case the DNP prepares individuals for careers in which they may study, monitor, and improve quality of care and clinical effectiveness. DNP educated nurses may take major administrative and supervisory responsibilities and otherwise provide leadership in nursing, in hospitals and more broadly in health care. It is preparation for this broader set of responsibilities which make the DNP a different and particularly relevant degree as we see major changes occurring in the health care environment. Measuring a DNP degree solely on the
outcomes of patient care provided is a very limited view of the importance of this degree.

2. DNP programs are relatively new with a small number of graduates each year. Many hospitals have acknowledged interest in DNP nurses but rarely include such a requirement in job postings because so few would meet the qualifications. Again, as I addressed in October 2011:

"...Students completing this program have a much better understanding of issues related to measurement of quality, patient safety and clinical effectiveness. They have experience with budgeting, business plans, and the administration and organization of health care, which is a great value wherever they work. The scope of their knowledge is expanded significantly beyond that of the Master’s degree. Therefore the degree prepares them for a wide variety of careers..."

"...Does the degree in fact expand an individual's education, knowledge, and learning so that they can make additional contributions either in teaching, administration, health care delivery or administration, including health policy? The clear answer to this question is that the DNP does in fact do this. Is there a demand for the students who are graduates of the program? Unequivocally this is the case. We have a substantial nursing shortage and we also rank 45th among the states in the number of physicians available. Hospitals have been increasingly hiring nurses with higher levels of education and training. The need for all kinds of well-prepared nurses will continue to grow."

3. The data on page 1 and a table on page 20 of the report attempt to indicate the additional costs to the State and student to complete a doctoral level rather than masters' level nursing degree. Unfortunately the estimate of State costs is overstated relative to current funding because it uses FY 2011 as the basis. The formula funding rate in FY 2011 was higher than current funding levels for both general academic and health related institutions and the nursing weights for general academic institutions were also higher in FY 2011 than they are now.

Regarding the tuition and fee estimate, while I appreciate the language in the report that says, "...actual student charges may be less than what is estimated in the table" the flaw in the described methodology produces estimates which have little relation to what an actual nursing student would pay and result in information which is potentially counterproductive.
4. At the bottom of page 16 is a section of the report titled, "A BSN to DNP Pathway" that attempts to address the advantages and disadvantages of the BSN to DNP Pathway. I believe this section is inappropriately titled because the "advantages" and "disadvantages" included speak to the differences between a masters' level degree and doctor's level degree, not the BSN to DNP Pathway. In fact, the BSN to DNP Pathway is more efficient than the BSN to MSN to DNP Pathway currently required of public DNP programs in Texas.

Thank you for the willingness to work with our Institutions

Best Wishes,

Kenneth I. Shine, M.D.
Executive Vice Chancellor for Health Affairs,
The University of Texas System

cc: Chancellor Francisco Cigarroa

KIS/rjb
Response to “White Paper: The Doctor of Nursing Practice Degree, January 2013”

January 22, 2013

Janelle Shepard, RN-BC, BSN
Chair, Committee on Academic and Workforce Success
Texas Higher Education Coordinating Board
P.O. Box 12788
Austin, TX 78711

Dear Ms. Shepard:

The staff of the Texas Higher Education Coordinating Board (THECB) has prepared a white paper to answer the following questions posed by the Board:

1. What is the Doctor of Nursing Practice Degree?
2. How and why has the DNP proliferated nationally and in the state?
3. Should the Board consider additional DNP programs beyond the current number offered at Texas public institutions, and if so, should it consider tracks that allow students to enter the program after completing the bachelor's degree (a BSN to DNP pathway)?

The report is very comprehensive in its answers to the questions posed, but I/we fear the negativity expressed toward the DNP degree and potential obstacles placed on institutions for the cost effective and timely delivery of the degree would place Texas students and nursing programs at a great disadvantage in years to come as other states move forward with goals set by national professional and accreditation organizations and endorsed by the Texas Organization of Baccalaureate and Graduate Nursing Education.

Limiting access to doctoral education or making it more onerous by requiring three educational steps/degrees instead of two is in conflict with the stated mission of the THECB: “...provide the people of Texas the widest access to higher education of the highest quality in the most efficient manner.”

Although the report is full of statistics, it is missing a very important one. Nationally and in Texas only one-half of one percent (.005%) of all nurses hold a doctoral degree. No wonder, as the White Paper states, “75% of faculty have only the masters degree” – but this is not the preferred preparation. Do we accept less than the doctoral degree in other undergraduate disciplines? The Future of Nursing report by the
Institute of Medicine and the Robert Wood Johnson Foundation calls for a doubling of the number of nurses with a doctoral degree. Do we have any hope of reaching that meager goal if we limit access in Texas?

While it may be accurate that job advertisements don’t specify doctorate required for the reason of their scarcity, most ads state it thusly “doctorate preferred; masters required.”

As to the pipeline for community college faculty it should be reiterated that masters degree programs would not be discontinued. The BSN to DNP pathway would only be for Advanced Practice roles – other masters programs would remain. Furthermore, according to the Texas Board of Nursing (BON) and the Texas Center for Nursing Workforce Studies (TCNWS) at the Texas Department of Health and Human Services (DHHS), and using 2010 data, there were only 60 APRNs out of 956 faculty in community college who reported being APRNs. Of these 60, 49 were full time, but this could mean they work full time in practice and teach part time. It is further complicated by the fact that when nurses renew their licenses, they can only select if they are an APRN or a faculty/educator, but not both. If we took the figure of 60 out of 956 faculty, it would only be 7% of community college faculty are APRNs. The conclusion is that this is not the pool from which community colleges get their faculty.

It should be noted that the only request for the BSN to DNP before the THECB is for one program in Texas with the nurse anesthesia program. Anesthesia is a special case because of its national deadlines and the fact that private institutions in Texas have moved to the BSN to DNP, and student enrollment in the state BSN to MSN to DNP program has dropped.

In conclusion, recommendations should be based on future needs, not on maintaining a stagnant past. Texas deserves no less. Health care challenges in the foreseeable future have been described as a coming Tsunami. We must be prepared.

cc:

Fred W. Heldenfels IV
Chair
Texas Higher Education Coordinating Board

MacGregor M. Stephenson, JD, PhD
Assistant Commissioner
Academic Affairs and Research Division
Texas Higher Education Coordinating Board
Michael L. Evans, PhD, RN, FAAN  
Dean, Texas Tech University Health Sciences Center

Joan Creasia, PhD, RN  
Dean, Texas Woman's University

Elizabeth Poster, PhD, RN  
Dean, University of Texas-Arlington

Elias Provencio-Vasquez, PhD, RN, FAAN, FAANP, RN  
Dean, University of Texas-El Paso

Patricia L. Starck  
Patricia L. Starck, DSN, RN, FAAN  
Dean, University of Texas Health Science Center at Houston

Eileen Breslin, PhD, RN, FAAN  
Dean, University of Texas Health Science Center San Antonio

Pamela Watson, RN, ScD  
Dean, University of Texas Medical Branch-Galveston
Other TOBGNE Members

Carolina Huerta, EdD, RN, FAAN
University of Texas-Pan American
President, TOBGNE

Pam Martin, PhD, RN
University of Texas at Tyler

Paulette Burns, PhD, RN
Texas Christian University

Time did not permit the gathering of other signatures
January 18, 2013

Texas Higher Education Coordinating Board
P.O. Box 12788
Austin, Texas 78711

Re: “White Paper: The Doctor of Nursing Practice Degree, January 2013”

Honorable Board Members:

We are writing on behalf of the more than 240 member organizations of the Texas Team Advancing Health through Nursing, which is a coalition of diverse stakeholder organizations committed to achieving the recommendations established by the Institute of Medicine in their 2010 landmark report entitled “The Future of Nursing: Leading Change, Advancing Health”. With the implementation of healthcare reform looming, our state cannot afford to be left behind due to unfounded apprehensions that a streamlined educational trajectory for preparation of Advanced Practice Registered Nurses would imperil the future faculty workforce.

We specifically would like to express our concern about the White Paper: The Doctor of Nursing Practice Degree, January, 2013 which is to come before the Texas Higher Education Coordinating Board, Item X-B on January 24, 2013 and specifically the conclusion which discourages Texas from moving ahead with the national agenda of preparation of Advanced Practice Registered Nurses at the doctoral level. Health care is changing rapidly; more will be expected of individual practitioners in the future as science advances, as new models of delivery of care are designed, as quality and safety concerns become more focused, and as quality for cost values are emphasized. We do not believe the assertion that a streamlined BSN to DNP would "cut out the existing pipeline for new faculty". Rather we believe better prepared clinicians will result in better prepared faculty equipped to teach entry-level nurses to meet the challenges that Texas will face.

We urge you to approve the proposal submitted by the University of Texas Health Sciences Center Houston, not basing your decisions on what we believe to be unfounded data contained in the aforementioned White Paper, but to look to the “future needs of Texans” and support approval for the streamlined BSN to DNP degree as you have done for other professions in the past.

Sincerely,

Joyce Batcheller RN, DNP
Sr. V.P. Seton Health Care System
Co-Leader of the Texas Team

Cole Edmonson RN, DNP, FACHE, NEA-BC, RWJF - ENF
Chief Nursing Officer Texas Health Dallas
Co-Leader of the Texas Team
Reference List


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