Writing DNP Clinical Case Narratives

Demonstrating and Evaluating Competency in Comprehensive Care
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The Doctor of Nursing Practice (DNP) program at the Columbia University School of Nursing (CUSN) is designed to prepare advanced practice nurses to be comprehensive care providers, with the knowledge and skills necessary to provide fully accountable health care for patients across clinical sites and over time. A competency-based approach is used to educate and evaluate DNP student performance in comprehensive care.

The American Association of Colleges of Nursing (AACN) publication *Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006) outlines eight competencies that form the basis for DNP curricula and course objectives. All DNP students are expected to demonstrate achievement of the AACN essentials. The AACN also recommends that all DNP programs include an integrative practicum and terminal scholarly project that represent the culmination and synthesis of the DNP curriculum. DNP students enrolled in tracks that are clinically focused must demonstrate mastery of a variety of clinical competencies that focus on direct patient care, including full accountability and coordination of care across settings and time, translation and evaluation of research for practice, and interdisciplinary collaboration (NONPF, 2006). Schools of nursing are developing mechanisms to measure doctoral-level clinical competencies. At CUSN students demonstrate mastery of comprehensive care competencies through clinical case narrative writing.

CUSN faculty members have been developing and refining the clinical case narrative format for the past seven years. Case narrative writing is an academic exercise that promotes a systematic reflective process for DNP students to apply to all patient care encounters. This format is grounded in clinical and doctoral competency, which is incorporated into students’ approach to patient care.

The clinical case narrative provides a framework wherein students can systematically document clinical encounters with patients, and faculty members can assess DNP students’ performance. The descriptive nature of the narrative provides a basis for understanding the complex cognitive processes employed during the provision of care. The case narrative requires in-depth reflection, high-level analysis and synthesis, and critical appraisal and application of clinical evidence. This iterative process of case narrative thinking and writing is a consistent thread throughout the DNP curriculum and is transformative for students. The process is internalized by DNP students and becomes an enduring method of reflective, evidence-based clinical care.

The purpose of this book is to provide DNP faculty and students with a reliable and detailed guide to use when implementing a format to document the care provided. Case narratives differ from the traditional case study format.
When writing case narratives, students make public the decision-making process, identify the evidence that supports the decision, discuss the robustness of the evidence, analyze the effectiveness of the clinical decision, and critically reflect on the overall case.

Text Organization

This book is divided into six sections. The first section discusses comprehensive patient care, introduces the complexities of clinical competencies and their integration into clinical practice, and discusses case narratives as a template for demonstrating clinical competency. The subsequent sections of the book discuss the DNP approach to specific patient populations. Each section includes DNP case narratives written by CUSN DNP students who have provided direct patient care in ambulatory and inpatient settings. These narratives serve as exemplars of the format and can be critically examined in the classroom setting to promote discussion of the provision of evidence-based comprehensive care. General guidelines for writing specific types of notes in different clinical settings are provided in the appendices.

Case Narrative Organization

Each case narrative is based on an actual patient encounter. Some case narratives depict a single encounter that illustrates several competencies. The majority of case narratives depict complex management over time to demonstrate application of the competencies at the DNP level. All narratives include the reason for selecting the case, assessment, care provided, and outcomes. Evidence is cited throughout the narrative to support each decision-making nexus. With each citation, the evidence is briefly summarized in italics and “lev-eled” according to the Oxford Centre for Evidence-Based Medicine (Centre for Reviews and Dissemination, 2009). After appropriate sections in the narrative, when a component of the competency is demonstrated, it is indicated in bold font. Readers may then make their own determination whether it has been sufficiently met. DNP students have the opportunity to document their critical thinking process at difficult decision points in critical appraisal sections, which are identified by a box format. The narrative concludes with the competency defense, in which DNP students explain how each competency in the narrative was satisfied. Readers are able to reflect and comment on students’ justification and determine if the competency was successfully fulfilled.

Case Narratives as Clinical Tool

Clinical case narratives are important tools that support the education of doctoral nurse clinicians. Their in-depth description and reflection provide a model through which students can demonstrate their ability to employ the complex cognitive processes needed to discern the appropriate provision of care. Narratives provide faculty with a student-generated product that they can
use to analyze and evaluate the level of reflection, analysis, synthesis, critical appraisal, and application of the clinical evidence required of students at this level of practice.

**Case Narratives as Clinical Scholarship**

Clinical case narratives are an example of innovative clinical scholarship. Scholarship in the traditional model of nursing has been defined in terms of scientific inquiry through research. With the paradigm shift in nursing education and the emphasis on evidence-based practice, new forms of scholarship are emerging. Clinical case narratives are an example of scholarship in nursing that “can be defined as those activities that systematically advance the teaching, research, and practice of nursing through rigorous inquiry that 1) is significant to the profession, 2) is creative, 3) can be documented, 4) can be replicated or elaborated, and 5) can be peer-reviewed through various methods” (AACN, 1999).

The book is meant to provide DNP faculty and students with a methodical guide for writing case narratives that can be used as a process evaluation format during the development of clinical expertise and as an outcome assessment to measure the synthesis of knowledge and the attainment of clinical competencies. Writing and presenting case narratives create opportunities for doctoral students to think systematically, critically appraise and individualize the evidence, and engage in clinical scholarship.

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**References**

We are indebted to those who pioneered comprehensive care in advanced practice nursing. We wish to thank Dr. Mary Mundinger of Columbia University School of Nursing for her vision and perseverance. She created the ideal academic environment and universal faculty practice in which this new level of practice was implemented, tested, and validated, and became the foundation for the doctoral clinician. Under Dr. Mundinger's leadership, engagement in comprehensive, evidenced-based practice at the highest level is embedded in the culture of doctoral-level practitioners. We also recognize physician colleagues, Dr. Michael Weisfeld, formerly of Columbia University Medical Center, now at Johns Hopkins, and Dr. William Speck, both of whom showed vision and courage in their support of this expanded nursing role. As a result of their commitment to improving patient outcomes, they facilitated the breakdown of systematic barriers so patients could have access to care by advanced practice nurses at Columbia University Medical Center.

We wish to express our gratitude to the members of the Council for Comprehensive Care, who provided clarity and focus about comprehensive care competencies and the doctor of nursing practice role in the provision of comprehensive care. Given the changing landscape of health care and health care financing today, the council has kept us cognizant of the context in which the DNP role is evolving, and has encouraged us to proactively define ourselves.

Finally, we acknowledge the work of the faculty and students in the Columbia University Doctor of Nursing Practice program, whose personal insights expanded and transformed the case-narrative format in the DNP residency in order to advance the doctoral role in comprehensive care.

The editors express their appreciation to Margaret Zuccarini of Springer Publishing for her gracious invitation to prepare a book on DNP clinical case narrative writing and Gayle Lee for her support in facilitating the completion of this text.
The DNP, Comprehensive Patient Care, Clinical Competencies, and Clinical Case Narrative Writing
Over the past 40 years, two convergent and interdependent themes have emerged in the health professions; the cascade of new medical knowledge and the corresponding demand from patients for more targeted care have led to the unprecedented development of specialty and subspecialty roles in medicine. As physicians have been increasingly drawn to new, challenging frontiers of practice and well-paid careers, the generalist underpinning for our health care system has eroded. During the same years that new science was flowering in medicine, the seeds of independent comprehensive care were taking root in nursing.

THE EMERGENCE OF THE NURSE PRACTITIONER MODEL

In the early 1960s, community health nurses were the most independent of nurses. Visiting patients in their homes or community centers, they were faced with diagnostic and treatment challenges for which they knew they needed additional knowledge. Their patients—particularly those with chronic illnesses—had health care needs that required new and expanded skills. Lee
Ford, RN, and Henry Silver, MD, at the University of Colorado answered this challenge in 1965 with a unique, new training program that produced the first “nurse practitioners” (NPs) in community health nursing. These NPs were taught to conduct more comprehensive physical and medical assessments and to act on their findings. At the same point in time, national health policy underwent a dramatic change that would prove to be one of the most serendipitous events in the field of advanced practice nursing.

That year (1965), federal law was passed establishing Medicare and Medicaid. These new laws—federal Medicare for the elderly and disabled, and Medicaid, a federal-state partnership for care of the poor—opened access for care to millions who had never had it before. The resources for primary care—the first access point for detection and treatment of illness—were profoundly underdeveloped for the overwhelming new demand. The nurse practitioner model, originally developed for community health nurses, soon became associated with primary care delivery and moved, with the speed of all ideas spawned in a time of need, to rural and inner-city areas, where these newly educated NPs became primary care providers. In only seven years, by 1972, those who completed this nascent training program were authorized to receive direct reimbursement (discounted from MD fees) from Medicare and Medicaid for clinic visits in rural and underserved areas.

NURSES MOVED INTO PRIMARY CARE AS PHYSICIANS MOVED OUT

During the 1970s and 1980s, there was resurgent interest in physician careers in primary care, particularly the new family practice role—a combination of obstetrics, pediatrics, and general medicine. This mission harkened back to the revered and by then mythical family doctor who handled most of an individual’s health care needs. By 1970, however, physicians also had many new career choices, all better paying with fewer demands on their time than primary or family practice often required. There was more prestige in specialty practice, and patients were becoming accustomed to seeing specialists, especially because the major users of specialty care had Medicare and did not need referrals from their generalist physician. Concurrently, nursing was developing formal degree programs for primary care NPs, who were making inroads, state by state, in acquiring prescriptive privileges and independence to see patients without MD supervision.

This progression—nurses moving into primary care as physicians moved out—did not generate significant MD concern other than the desire to control and supervise nurses in their expanded roles. In the late 1980s, however, things began to change. Nursing was in decline as a profession, and schools were struggling to maintain enrollments. During the years when the NP model of care was becoming established, nursing schools, especially in universities and on medical center campuses, were focused on developing research programs. Schools aspired to have research faculty with PhDs who engaged in sponsored research, but these scientists were also expected to educate nurses who required significant clinical mentoring. Research, when done successfully,
is all-encompassing. It is difficult indeed to be a fully engaged and funded researcher, actively publishing and developing new science, and also to be an active up-to-date clinician mentoring novice clinicians. Many schools wanted to have an all-doctoral faculty, in line with other health profession schools, but found that researchers were not best suited (or most willing) to be clinical supervisors, and students could tell if their mentors were not fully engaged or current in the clinical endeavor.

COLUMBIA UNIVERSITY SCHOOL OF NURSING’S MODEL OF CLINICAL EDUCATION

Columbia University School of Nursing (CUSN), not immune to national trends, concluded that a new model of education was needed to remedy this disconnect. Recruiting distinguished researchers was a crucial element of building the configuration needed, but a new academic clinical component was added. Those who taught clinical courses would themselves be immersed in clinical practice at the highest level of their own education. As part of their academic assignment, Columbia nursing faculty with practices in primary care or specialty practices would take students and introduce them to current practice at its very best. The model thrived. Clinicians devoted to caring for patients became faculty members without leaving the patient care roles they valued. Students had enviable clinical experts as their teachers, and researchers were free to pursue their science and share their scholarship with students. Amazingly, nursing had adopted the academic-medical model.

In the early 1990s, nursing faculty practice—expert clinicians and teachers—had taken off at Columbia Presbyterian Medical Center, which was developing a major primary care presence for families in the hospital’s broad neighborhood and was applying for New York State funding to do so. The academic health center physicians had already established a premier clinical presence in every aspect of medicine except primary care, and there were inadequate physician resources in the center to meet the primary care goals of the hospital. William Speck, MD, then president of the hospital, asked the nursing school to provide that resource. With a new and vibrant faculty cohort in the school, the resource that both the hospital and medical center needed was in place. The opportunity to become a recognized primary care entity in a major academic health center, combined with a patient population with a great unmet need for general care, presented a unique opportunity to conduct a rigorous evaluation of primary care delivered by nurses. If NPs were to become a recognized and high-quality resource for patients in a sphere of practice where MDs had set the standard, a randomized clinical trial comparing NPs with primary care MDs would be the most useful and strongest evaluation.

The year 1993—similar to 1965—was an auspicious year for a great leap forward for Columbia nursing; many challenges and opportunities were aligned in a way to foster this advancement. Primary care resources remained deeply inadequate in the community; the hospital needed state funding to construct its new building; medical center physicians were increasingly devoted to specialty—not generalist—practices and were willing to cede primary care to
reliably competent nurses; and the School of Nursing had developed a new but thriving faculty practice model. Even with all of these building blocks in place and with benefits clear to all the players, such a radical change in an academic health center practice environment required visionary, magnanimous physicians and courageous, smart nurses who all agreed to be measured by existing standards. This was the environment that created the opportunity for the randomized controlled trial (RCT) from which the new clinical doctorate could emerge.

PARTICIPATION OF FACULTY NPS IN A RANDOMIZED CONTROLLED TRIAL

It was a transformative time. The chair of Medicine, Myron Weisfeldt, MD, along with Bill Speck, MD, and their joint leadership on the hospital medical board, approved medical participation in the clinical trial and authorized hospital admitting privileges for the faculty NPs in the trial. This authorization was necessary to reduce variables between the trial participants (MDs and NPs) so that the evaluation of outcomes and competencies could be fairly compared. The third extraordinary physician to endorse the trial and NP authority was Herbert Pardes, then dean of the Columbia College of Physicians and Surgeons and vice president of Columbia Presbyterian Medical Center. Without his support and that of Drs. Weisfeldt and Speck, none of the major nursing clinical advancements at Columbia for the last decade could have occurred. These three physicians didn’t just concur; they planned, advocated, informed, and educated and took a lot of political heat.

CUSN faculty NPs signed up for the clinical trial without missing a beat. Of course, they were aware of the potential for failure, of not meeting the bar. But they understood the opportunity to be the first vetted pioneers in the full scope and authority of primary care. They were setting a new standard for the profession, and their courage and confidence were palpable. The school established a group practice for the trial as the Center for Advanced Practice, or CAP.

The RCT evaluated broad aspects of care for over 1,300 (primarily Medicaid) patients for more than a year (Mundinger et al., 2000). No differences were found between MD care and NP care in any category. Although the results have been broadly interpreted as showing that NPs can do what MDs can in primary care, it is critical to understand that the NPs in the trial were educated and experienced beyond traditional NP education. They learned to admit and co-manage critically ill patients; to take a call in a group practice in which the call could be from a patient they had never seen; to perform emergency department evaluations and make judgments about who should treat a patient; to choose a specialist referral and to utilize referral recommendations; to read and interpret x-rays and more complicated lab tests; and to master sophisticated differential diagnostic skills. They learned all of this from their medical colleagues at Columbia, who prepared them for the randomized trial; thus the CAP faculty added crucial medical skills to the strong nursing competencies they had already mastered.
ESTABLISHMENT OF FACULTY PRACTICE: CAPNA

In 1997, with the trial completed and analysis begun, CAP faculty established a new primary care practice, Columbia Advanced Practice Nurse Associates (CAPNA). Admitting privileges at the medical center hospital had become permanent (and also awarded to all faculty NPs who met the same standard). New York State was a welcoming environment for independent nursing practice; full prescriptive privileges were authorized, and only a “collaborative” (consultative) MD relationship was required in order for NPs to establish their own practice. With its seven-year history of successful primary care faculty practice, Columbia nursing succeeded in obtaining agreements from commercial insurers to reimburse CAPNA practitioners directly and at MD rates. With hospital privileges, insurance contracts, and collaborative MD relationships in place, CAPNA opened in midtown Manhattan and began seeing commercially insured patients.

Organized medicine, unmoved by NPs caring for poor or rural underserved patients, was mobilized by the CAPNA practice, which might pose a competitive threat to physicians caring for affluent, insured individuals. The American Medical Association (AMA), the Medical Society of the State of New York (MSSNY), and other inflamed medical groups opposed the NPs. Robert Graham, executive vice president of the American Academy of Family Physicians, stated that what the nurses are doing “comes very close to practicing medicine, which, of course, requires a medical degree and a license” (Lardner, 1998), and the MSSNY executive vice president pledged to work full-time to shut down the CAPNA practice. Unannounced visits by New York State medical officials with accompanying letters and threats to take legal action were common occurrences. There were some amused responses in the media about the differential medical response to NP care for the well insured as compared to the poor and Medicare-insured elderly for whom NPs had provided primary care for over three decades without a whisper of concern from organized medicine. A pharmaceutical firm gave $1 million for a sophisticated ad campaign in support of CAPNA, and 60 Minutes aired a celebratory piece on CAPNA, narrated by Morley Safer. More commercial insurers came on board, and patients signed up for care. The public good had won out, at least for a few years.

THE COLUMBIA DNP MODEL, COLLABORATION ON THE CREATION OF CACC, AND THE AACN ESSENTIALS

In 1999, Columbia nursing set forth the plans for a new degree in nursing—the first clinical doctorate—designed to teach nurses the skills that the CAP nurses first learned informally six years before as preparation for the trial comparing MD and NP practice, and that the CAPNA practice had formalized in 1997. The degree, the doctor of nursing practice (DNP), was approved by the Trustees of Columbia University in 2004. In hopes and confidence that the year’s long university review would be positive, CUSN offered the course of study during the university review to clinical faculty who became the students who would pioneer the new academic degree. To provide a clear firewall between students and faculty, several MD colleagues from the medical school and PhD faculty from CUSN
served as course directors and teachers. The pioneer faculty students formalized and increased their learning as they earned the first DNP degrees in history.

From 1999, when the DNP degree plan began at CUSN, until the university approved and granted the first degrees in February 2005, several supporting activities were completed. Knowing that a clinical doctorate in nursing would be highly desirable to nurses and that schools would quickly act to develop such a degree, Columbia invited 20 health policy and nursing leaders to join a new group, the Council for the Advancement of Primary Care, to develop and promulgate standards for this new program of study. Deans from academic health center nursing schools and physicians involved with broad national health policy issues joined the council and have met annually since 2000 to further the standardization mission. In 2003 representatives from eight of the council nursing schools published the competencies that a DNP graduate should achieve (CUSN, 2003). In 2005 the council changed its name to the Council for the Advancement of Comprehensive Care (CACC) to reflect the understanding that DNP clinical education encompassed a broader set of skills and knowledge than primary care alone.

During this same innovative period at Columbia, nursing nationally awoke to the idea of moving advanced practice to the doctoral level; the Columbia model, forged over 20 years of evolution and evaluation, took hold across the country. The American Association of Colleges of Nursing (AACN) voted to phase out MS degree programs in advanced practice nursing by 2015 in favor of the clinical doctorate (AACN, 2005). AACN committees were formed to determine the “essentials” of the new degree, and the resulting document was similar to the 2003 CACC competencies document except in one respect. Whereas CACC focuses on direct patient care as “practice,” the AACN DNP essentials apply to DNP programs developed in other areas of “practice” than the clinical realm. Practice could also be administration, or health policy as conducted by a nurse. Although an inclusive stance by an organization representing all collegiate nursing schools—the great majority of which have no faculty prepared to develop an advanced clinical practice degree program—is understandable, this lack of distinction of DNP direct care competency (practice) has blurred and potentially weakened the public’s understanding of who a DNP is and what this professional can do.

Indeed, as DNP programs proliferate, very few have developed clinical doctoral education at a demonstrably different level than their preceding MS degree programs. Other “essentials” for the new degree are more likely to be clearly doctoral level (informatics, use of evidence, for example), but the “practice” essential is variable. Some DNP programs appear to be clinical research or have a clinical project as the capstone achievement. Some DNP programs clearly have no advanced patient care outcomes (administration or informatics as the “practice” essential) or are offered as online programs.

**COMPREHENSIVE CARE CERTIFICATION EXAM FOR DNP GRADUATES**

The confusion and disparate focus of the DNP degree required action for clarification and standardization. CACC, established to standardize the degree,
changed its mission to standardize the clinical competencies for graduates of DNP programs that focus on comprehensive care. The decision was reached that a national certification examination could become the clarifying competency standard where the degree had failed to do so. The council sought proposals from existing certifying agencies, and in 2007 it selected the National Board of Medical Examiners (NBME).

In 2007 CACC entered into a contract with the NBME to develop an exam utilizing the test pool of questions from the previous Step 3 of the United States Medical Licensing Exams. NBME and CACC representatives developed an exam that was comparable in content and similar in format and that would measure the same set of competencies and apply similar performance standards as Step 3 of the United States Medical Licensing Examination, which is administered to physicians as one component of qualifying for licensure. CACC established a subsidiary group, the American Board of Comprehensive Care (ABCC), which would function as an independent, certifying body for DNP candidates who successfully completed the certification process.

During 2007 and 2008, as over 200 schools of nursing prepared to develop and offer DNP degrees, several conservative medical groups—including the American Academy of Family Practice Physicians, the American College of Physicians, and the American Medical Association—continued to formulate policy and make statements antagonistic to the degree and the certification. They lobbied NBME to withdraw from the partnership with CACC and sought state regulatory change to prohibit DNPs from using their newly earned title of “Doctor.”

To date, these efforts have failed. As the new degrees are established and strengthened and as certification of DNPs expands, the nurses with this new degree, new title, and new competencies are thriving. As in 1935 and 1965, the political context and public need are aligned for radical social advancement. DNPs are qualified and welcomed, by most of the medical profession and increasingly by an informed public, as an answer to critical gaps in the health care system.

Comprehensive care—primary access and broad scope of care—is already in great demand and in great shortage. With health care reform imminent, DNPs are a wise solution to universal coverage with goals of cost-effective, evidence-based care at the core of reform. Medicare and Medicaid fostered the rise of NPs, and universal coverage will open a wide door of access for DNPs.

Primary care has outgrown its early 1970s definition of coordinated, first-contact care. The needs of patients already require more than the most recent definition from a 1996 Institute of Medicine study: “Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (Institute of Medicine, 1996). Primary care, as an encompassing form for generalist care, is outdated. It has never been more necessary to have a wise clinician overseeing the spectrum of generalist and specialist care needed: someone who has authority across sites and over time for patients; someone who can select specialists and communicate a shared strategy for patients; someone whose diagnostic skills are honed to a sharp edge of differential acumen; and someone who understands the distinction...
between strong and not-so-strong evidence and knows how to apply it appropriately for patients.

Comprehensive care is a specialty, but it is one that every individual needs and deserves. DNP education is formulated to develop comprehensive care competencies. Patients, physicians, policymakers, and the broader public are embracing this new role. The doctor of nursing practice with its accompanying clinical certification has arrived and faces a promising and rewarding future.

References


The evolution of clinical competencies at Columbia University School of Nursing’s doctor of nursing practice (CUSN DNP) has been and remains a dynamic, iterative, reflective process. This process has benefited from the critical review and insights of health policy experts, leaders of nursing organizations, deans of schools of nursing, and DNP student residents over the past 10 years. The prevailing guidance has been the vision and understanding that doctorally prepared advanced practice nurses, equipped with expanded knowledge and skills, can improve the access, efficiency, and quality of health care for diverse populations across clinical settings over time.

The CUSN DNP competencies are inexorably linked to the CUSN DNP program, which is based on empirical evidence from outcome studies that utilized the medical model to demonstrate parity between care provided by physicians and nurse practitioners (NPs) (Brown & Grimes, 1995; Carroll & Fay, 1997; Jones & Clark, 1997; Kleinpell-Nowell & Weiner, 1999; Safriet, 1992; Spitzer, Sackett, & Sibley, 1974; U.S. Congress, Office of Technology Assessment, 1986), culminating in a randomized controlled trial (RCT) that demonstrated that primary care faculty physicians and faculty NPs provide the same quality of care, achieve the same patient satisfaction, and utilize resources at the same cost (Mundinger...
et al., 2000). The faculty NPs in the RCT were indistinguishable from the physician group in terms of accountability to patients. Both groups had admitting privileges and followed patients across settings and over time. The faculty NP role with expanded responsibility and accountability provided the model upon which the comprehensive care competencies and CUSN DNP program were built (Smolowitz & Honig, 2008).

**FIRST PHASE OF COMPETENCY DEVELOPMENT**

Prior to the RCT, the scope of practice as provided by the CUSN faculty NPs had not been explored in the literature. This was a new concept for NPs. Following publication of the RCT, CUSN faculty NPs examined their clinical practices to delineate the broadened role and added skills required to provide comprehensive primary care. A detailed examination of the skill sets of these NPs was conducted. Interviews and focus groups were held to identify, clarify, and validate the expanded scope of knowledge and practice competencies required. Expanded knowledge enabled the faculty NPs to provide diagnostically complex care across settings and over time, utilize sophisticated informatics and decision-making technology, and assimilate in-depth knowledge of biophysical, psychosocial, and behavioral sciences. This in-depth study established the need to formalize the educational process and provided the first draft of the CUSN DNP competencies.

**SECOND PHASE OF COMPETENCY DEVELOPMENT**

During the second phase of competency development, CUSN faculty reviewed the newly developed competencies and compared them with established competencies, including the National Organization of Nurse Practitioner Faculties (NONPF) domains and core competencies (NONPF, 2000), *Graduate Education in Internal Medicine: A Resource Guide to Curriculum Development* (1997), and the primary care competencies outlined in *Primary Care: America’s Health in a New Era* (IOM, 1996) to determine consistency and the need for incorporation into CUSN doctoral-level competencies.

This first version of the CUSN competencies utilized the structure and format of the NONPF domains and competencies of nurse practitioner practice (2000) as a foundation. Individual NONPF competencies were expanded or enhanced, and new domains were developed to reflect clinical practice at the doctoral level. Specific competencies developed by physician boards to reflect this level of clinical practice were integrated into the CUSN competencies. The first draft of the clinical doctorate competencies was approved by CUSN faculty in 2001.

**THIRD PHASE OF COMPETENCY DEVELOPMENT**

This draft was brought to the Council for the Advancement of Comprehensive Care (CACC) for review. CACC, spearheaded by Dr. Mary Mundinger, is a consortium of school of nursing deans, health policy experts, and nursing leaders
who are committed to ensuring high standards of comprehensive care and doctoral nursing practice.

CACC members who had been discussing the provision of comprehensive care utilized the Institute of Medicine (IOM) (1996, p. 1) definition: "provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." This definition emphasizes prevention, risk assessment, cultural competence, and coordination of services for a diverse population of patients. Advances in science and technology, including genomics, had created new preventive, diagnostic, and treatment options for patients. In addition, the site of care delivery had shifted away from the hospital to multiple alternative settings.

CACC members conceptualized the doctor of nursing practice (DNP) as a clinician with the necessary skills, education, and competencies, as identified in the IOM definition of primary care, to provide comprehensive care to maintain and improve the health status of patients over time and across sites. They envisioned the DNP as an expert clinician, educated to address the health care challenges created by an increasing number of complex and chronic health care conditions, the growth of information and biomedical technology, the aging and increasingly diverse population, and identified disparities in care.

CACC involvement in the competencies began the third phase of competency development. Deans of nursing schools who were members of CACC and leaders in the national movement to launch the clinical doctorate, who were committed to standardization without prescription, nominated one of their faculty members to serve on the Consensus Committee for DNP Competencies. This committee, chaired by Dr. J. Honig, was charged with the task of discussing and revising the competencies drafted by CUSN faculty. The seven members of the committee included program directors and experienced and practicing advanced practice nurses (APNs) with research doctorates. As a result of the review process, the Consensus Committee agreed that the competencies represented core competencies for doctoral-level advanced nursing practice. This committee of experts, with multiple-specialty APN perspectives, agreed that the core competencies for doctoral-level advanced nursing transcended differences and explicated the commonalities across populations and specialties.

FOURTH PHASE OF COMPETENCY DEVELOPMENT

During the fourth phase, the Consensus Committee report on the competencies was presented at a national meeting of CACC. The competencies were examined, critiqued, revised, and published (CACC, 2003). The 2003 competencies provided the foundation for the educational and content standards for the clinical doctorate at CUSN.

FIFTH PHASE OF COMPETENCY DEVELOPMENT

The first CUSN DNP class graduated in 2005. The experience of these graduates was presented at a national meeting of CACC, initiating the fifth
phase of competency development. A new CACC subcommittee, chaired by Dr. J. Smolowitz, was charged with reexamining the 2003 competencies in light of the experiences of CUSN DNP graduates and examples of health care professionals’ competencies, including the Outcome Project of the Accreditation Council Graduate Medical Education (ACGME, 2007), the Royal College of General Practitioners guide (RCGP, 2009), and the draft of the American Association of Colleges of Nursing Essentials (AACN, 2006). The subcommittee revised the 2003 competencies. A draft was presented to CACC and was approved by CACC members. These competencies were published in the Competencies of a Clinical Nursing Doctorate (CACC, 2006).

SIXTH PHASE OF COMPETENCY DEVELOPMENT

The competencies underwent further revisions as a result of DNP faculty and student input. As part of routine outcome evaluations, the competencies were reexamined, and it was determined that further refinement was warranted. The competencies were reconceptualized into complex sets of behaviors. They were collapsed into eleven behavioral competencies, which were essentially the same as the multiple competencies within the nine domains initially used. This iteration of the competencies was published in Case Studies: The Doctor of Nursing Practice, Setting the Standard in Health Care (CUSN, 2005). This change occurred during the period when the NONPF competency structure was being reviewed and revised and stand-alone DNP competencies were being developed for NP faculty (NONPF, 2006). These competencies were subsequently benchmarked against the NONPF doctoral competencies (2006) and found to be consistent in content with a detailed focus on provision of direct, comprehensive patient care.

SEVENTH PHASE OF COMPETENCY DEVELOPMENT

In 2006 the American Association of Colleges of Nursing (AACN) published the Essentials of Doctoral Education for Advanced Nursing Practice. The CUSN DNP Competency Committee benchmarked the CUSN DNP competencies against the AACN essentials and found them to be consistent and in some cases to exceed the competencies outlined in the AACN document. In particular, the CUSN DNP competencies provided much more depth and breadth for Essential VIII that emphasized comprehensive care. See Table 2.1.

EIGHTH PHASE OF COMPETENCY DEVELOPMENT

A natural continuous process of reevaluation of the competencies occurred as CUSN DNP residents and faculty utilized the competencies to discuss case narratives and assess and evaluate direct patient care provided in multispecialty settings. These discussions resulted in the most current version of the DNP competencies, which were developed and piloted at CUSN in 2009 and adopted by CACC in 2010.
## 2.1 DNP Comprehensive Care Competencies

Comparison of Columbia University School of Nursing DNP Competencies in Comprehensive Care, AACN Essentials, and NONPF Practice Doctorate Nurse Practitioner Entry-Level Competencies.

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<td>DNP graduates will demonstrate expertise in the provision, coordination, and direction of comprehensive care to patients, including those who present in healthy states and those who present with complex, chronic, and/or co-morbid conditions, across clinical sites and over time.</td>
<td>The following DNP Essentials outline the curricular elements and competencies that must be present in programs conferring the Doctor of Nursing Practice degree [. . .] The DNP Essentials delineated here address the foundational competencies that are core to all advanced nursing practice roles.</td>
<td>At completion of the program, the NP graduate of the nursing practice doctorate will possess the existing NONPF NP core competencies and the following competencies.</td>
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<td><strong>DOMAIN 1. COMPREHENSIVE CLINICAL CARE</strong></td>
<td><strong>Competency 1. Evaluate patient needs based on age, developmental stage, family history, ethnicity, individual risk, including genetic profile to formulate plans for health promotion, anticipatory guidance, counseling, and disease prevention services for healthy or sick patients and their families in any clinical setting.</strong></td>
<td><strong>Independent Practice</strong></td>
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<tr>
<td><strong>Essential I: Scientific Underpinnings for Practice</strong></td>
<td><strong>Essential VII: Clinical Prevention and Population Health for Improving the Nation’s Health</strong></td>
<td><strong>(1) Practices independently by assessing, diagnosing, treating, and managing undifferentiated patients.</strong></td>
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<tr>
<td><strong>Essential VIII: Advanced Nursing Practice</strong></td>
<td></td>
<td><strong>(2) Assumes full accountability for actions as a licensed independent practitioner.</strong></td>
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<tr>
<td><strong>Scientific Foundation</strong></td>
<td></td>
<td><strong>(1) Critically analyzes data for practice by integrating knowledge from arts and sciences within the context of nursing’s philosophical framework and scientific foundation.</strong></td>
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<td><strong>DOMAIN 1. COMPREHENSIVE CLINICAL CARE</strong></td>
<td>Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking</td>
<td>Practice Inquiry</td>
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<tr>
<td>Competency 2. Evaluate population or geographically-based health risk utilizing principles of epidemiology, clinical prevention, environmental health, and biostatistics.</td>
<td>Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health</td>
<td>(1) Applies clinical investigative skills for evaluation of health outcomes at the patient, family, population, clinical unit, systems, and/or community levels.</td>
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<td></td>
<td>Essential VIII: Advanced Nursing Practice</td>
<td>Health Delivery System</td>
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<td></td>
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<td>(3) Manages risks to individuals, families, populations, and health care systems.</td>
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<tr>
<td><strong>DOMAIN 1. COMPREHENSIVE CLINICAL CARE</strong></td>
<td>Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice</td>
<td>Independent Practice</td>
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<tr>
<td>Competency 3. Formulate differential diagnoses, and diagnostic strategies and therapeutic interventions with attention to scientific evidence, safety, cost, invasiveness, simplicity, acceptability, adherence, and efficacy for patients who present with new conditions and those with ambiguous or incomplete data, complex illnesses, comorbid conditions, and multiple diagnoses in all clinical settings.</td>
<td>Essential VIII: Advanced Nursing Practice</td>
<td>(1) Practices independently by assessing, diagnosing, treating, and managing undifferentiated patients.</td>
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<td>(2) Assumes full accountability for actions as a licensed independent practitioner.</td>
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<td>Scientific Foundation</td>
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<td>(1) Critically analyzes data for practice by integrating knowledge from arts and sciences within the context of nursing’s philosophical framework and scientific foundation.</td>
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<td>(2) Translates research and data to anticipate, predict, and explain variations in practice.</td>
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<td>Quality</td>
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<td></td>
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<td>(1) Uses best available evidence to enhance quality in clinical practice.</td>
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DOMAIN 1. COMPREHENSIVE CLINICAL CARE

Competency 4. Appraise acuity of patient condition, determine need to transfer patient to higher acuity setting, coordinate, and manage transfer to optimize patient outcomes.

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

Essential VIII: Advanced Nursing Practice

Independent practice
(1) Practices independently by assessing, diagnosing, treating, and managing undifferentiated patients.
(2) Assumes full accountability for actions as a licensed independent practitioner.

Scientific foundation
(1) Critically analyzes data for practice by integrating knowledge from arts and sciences within the context of nursing's philosophical framework and scientific foundation.

Leadership
(1) Assumes increasingly complex leadership roles.
(2) Provides leadership to foster interprofessional collaboration.
(3) Demonstrates a leadership style that uses critical and reflective thinking.

Quality
(1) Uses best available evidence to enhance quality in clinical practice.

Health Delivery System
(1) Applies knowledge of organizational behavior and systems.
(2) Demonstrates skills in negotiating, consensus building, and partnering.

(continued)
|-------------|-------------|--------------|
| **DOMAIN 1. COMPREHENSIVE CLINICAL CARE**  
Competency 5. Evaluate and direct care during hospitalization, and design a comprehensive discharge plan for patients from an acute care setting. | Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes  
Essential VIII: Advanced Nursing Practice | Independent practice  
(1) Practices independently by assessing, diagnosing, treating, and managing undifferentiated patients.  
(2) Assumes full accountability for actions as a licensed independent practitioner.  
**Leadership**  
(1) Assumes increasingly complex leadership roles.  
(2) Provides leadership to foster interprofessional collaboration.  
(3) Demonstrates a leadership style that uses critical and reflective thinking.  
**Quality**  
(1) Uses best available evidence to enhance quality in clinical practice.  
**Health Delivery System**  
(1) Applies knowledge of organizational behavior and systems.  
(2) Demonstrates skills in negotiating, consensus building, and partnering.  
**Practice Inquiry**  
(1) Applies clinical investigative skills for evaluation of health outcomes at the patient, family, population, clinical unit systems, and/or community health. |
COMPETENCY 6. Direct comprehensive care for patient in a subacute setting to maximize quality of life and functional status.

COMPETENCY 7. Facilitate and guide the process of palliative care and/or planning end of life care by discussing diagnoses and prognosis, clarifying and validating patient desires and priorities, and promoting informed choices and shared decision making by patient, family, and members of the health care team.

COMPETENCY 1. Assemble a collaborative interdisciplinary network, refer and consult appropriately while maintaining primary responsibility for comprehensive patient care.


Health Delivery System
(2) Demonstrates skills in negotiating, consensus building, and partnering.

(3) Manages risks to individuals, families, populations, and healthcare systems.

Independent Practice
(2) Assumes full accountability for actions as a licensed independent practitioner.

Ethics
(1) Applies ethically sound solutions to complex issues.

Policy
(1) Analyzes ethical, legal, and social factors in policy development.

Quality
(2) Evaluates how organizational, structural, financial, marketing, and policy decisions impact cost, quality, and accessibility of health care.

(3) Demonstrates skills in peer review that promote a culture of excellence.

Health Delivery System
(1) Applies knowledge of organizational behavior and systems.

(2) Demonstrates skills in negotiating, consensus building, and partnering.

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<td><strong>DOMAIN 2. INTERDISCIPLINARY AND PATIENT-CENTERED COMMUNICATION</strong>&lt;br&gt;Competency 2. Coordinate and manage the care of patients with chronic illness utilizing specialists, other disciplines, community resources, and family, while maintaining primary responsibility for direction of patient care and ensuring the seamless flow of information among providers as the focus of care transitions across ambulatory to acute, sub acute settings, and community settings.</td>
<td><strong>Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking</strong>&lt;br&gt;<strong>Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes</strong>&lt;br&gt;<strong>Essential VIII: Advanced Nursing Practice</strong></td>
<td><strong>Quality</strong>&lt;br&gt;(1) Uses best available evidence to enhance quality in clinical practice.&lt;br&gt;(2) Evaluates how organizational, structural, financial, marketing, and policy decisions impact cost, quality, and accessibility of health care.</td>
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<tr>
<td><strong>DOMAIN 3. SYSTEMS AND CONTEXT OF CARE</strong>&lt;br&gt;Competency 1. Construct and evaluate outcomes of a culturally sensitive, individualized intervention that incorporates shared decision-making and addresses the specific needs of a patient in context of family and community.</td>
<td><strong>Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking</strong>&lt;br&gt;<strong>Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice</strong>&lt;br&gt;<strong>Essential VIII: Advanced Nursing Practice</strong></td>
<td><strong>Health Delivery System</strong>&lt;br&gt;(4) Facilitates development of culturally relevant health care systems.</td>
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<td><strong>Independent Practice</strong>&lt;br&gt;(1) Practices independently by assessing, diagnosing, treating, and managing undifferentiated patients.</td>
<td></td>
<td><strong>Health Delivery System</strong>&lt;br&gt;(1) Applies knowledge of organizational behavior and systems.&lt;br&gt;(2) Demonstrates skills in negotiating, consensus building, and partnering.</td>
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DOMAIN 3. SYSTEMS AND CONTEXT OF CARE

Competency 2. Evaluate gaps in health care access that compromise optimal patient outcomes, and apply current knowledge of the organization and financing of health care systems to advocate for the patient and to ameliorate negative impact.

Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking

Essential V: Health Care Policy for Advocacy in Health Care

Essential VIII: Advanced Nursing Practice

Leadership
(1) Assumes increasingly complex leadership roles.
(3) Demonstrates a leadership style that uses critical and reflective thinking.

Quality
(1) Uses best available evidence to enhance quality in clinical practice.

Practice Inquiry
(1) Applies clinical investigative skills for evaluation of health outcomes at the patient, family, population, clinical unit, systems, and/or community levels.

Health Delivery System
(1) Applies knowledge of organizational behavior and systems.
(2) Demonstrates skills in negotiating, consensus building, and partnering.
(3) Manages risks to individuals, families, populations, and health care systems.

(2) Assumes full accountability for actions as a licensed independent practitioner.

Quality
(1) Uses best available evidence to enhance quality in clinical practice.

(2) Evaluates how organizational, structural, financial, marketing, and policy decisions impact cost, quality, and accessibility of health care.

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<td><strong>DOMAIN 3. SYSTEMS AND CONTEXT OF CARE</strong></td>
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<tr>
<td>Competency 3. Synthesize the principles of legal and ethical decision-making and analyze dilemmas that arise in patient care, interprofessional relationships, research, or practice management to improve outcomes.</td>
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<tr>
<td>Essential I: Scientific Underpinnings for Practice</td>
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<td>Essential VIII: Advanced Nursing Practice</td>
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<td><strong>DOMAIN 3. SYSTEMS AND CONTEXT OF CARE</strong></td>
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<td>Competency 4. Integrate principles of business, finance, economics, and/or health policy to design an initiative that benefits a group of patients, practice, community, and/or population.</td>
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<tr>
<td>Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking</td>
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<tr>
<td>Essential V: Health Care Policy for Advocacy in Health Care</td>
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<td><strong>Practice Inquiry</strong></td>
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<tr>
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<tr>
<td>2. Provides leadership in the translation of new knowledge into practice.</td>
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<tr>
<td><strong>Quality</strong></td>
</tr>
<tr>
<td>1. Uses best available evidence to enhance quality in clinical practice.</td>
</tr>
<tr>
<td>2. Evaluates how organizational, structural, financial, marketing, and policy decisions impact cost, quality, and accessibility of health care.</td>
</tr>
<tr>
<td>3. Demonstrates skills in peer review that promote a culture of excellence.</td>
</tr>
<tr>
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<tr>
<td>1. Analyzes ethical, legal, and social factors in policy development.</td>
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<td>2. Influences health policy.</td>
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Practice Inquiry
(1) Applies clinical investigative skills for evaluation of health outcomes at the patient, family, population, clinical unit, systems, and/or community levels.
(2) Provides leadership in the translation of new knowledge into practice.
(4) Disseminates evidence from inquiry to diverse audiences using multiple methods.

DOMAI N 4. BUILDING AND USING EVIDENCE FOR BEST CLINICAL PRACTICES AND SCHOLARSHIP
Competency 1. Synthesize and analyze evidence from practice, clinical information systems, and patient databases using informatics tools to identify deficits and improve delivery of care.

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice
Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care
Essential VIII: Advanced Nursing Practice

Quality
(1) Uses best available evidence to enhance quality in clinical practice.
(2) Evaluates how organizational, structural, financial, marketing, and policy decisions impact cost, quality, and accessibility of health care.
(3) Demonstrates skills in peer review that promote a culture of excellence.

Health Delivery System
(1) Applies knowledge of organizational behavior and systems.
(2) Demonstrates skills in negotiating, consensus building, and partnering.
(3) Manages risks to individuals, families, populations, and health care systems.
(4) Facilitates development of culturally relevant health care systems.

(continued)
## 2.1 DNP Comprehensive Care Competencies (Continued)

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<td>(1) Demonstrates information literacy in complex decision making.</td>
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<tr>
<td>(2) Translates technical and scientific health information appropriate for user need.</td>
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<td>(3) Participates in the development of clinical information system.</td>
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### Domain 4: Building and Using Evidence for Best Clinical Practices and Scholarship

**Competency 2. Evaluate quality of care against standards using reliable and valid methods and measures and propose innovative, interdisciplinary models that enhance outcomes.**

**Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice**

**Essential V: Health Care Policy for Advocacy in Health Care**

**Policy**

(1) Analyzes ethical, legal, and social factors in policy development.

(2) Influences health policy.

(3) Evaluates the impact of globalization on health care policy development.
Competency 3. Critically appraise and synthesize research findings and other evidence using a systematic methodology and interdisciplinary models to inform practice and policy for optimal patient outcomes.

Essential I: Scientific Underpinnings for Practice
Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice
Essential V: Health Care Policy for Advocacy in Health Care
Essential VIII: Advanced Nursing Practice

Quality
(1) Uses best available evidence to enhance quality in clinical practice.
(2) Evaluates how organizational, structural, financial, marketing, and policy decisions impact cost, quality, and accessibility of health care.
(3) Demonstrates skills in peer review that promote a culture of excellence.

Practice Inquiry
(1) Applies clinical investigative skills for evaluation of health outcomes at the patient, family, population, clinical unit systems, and/or community health.
(2) Provides leadership in the translation of new knowledge into practice.
(4) Disseminates evidence from inquiry to diverse audiences using multiple methods.

Competency 4. Assess and critically appraise clinical scholarship through participation in the peer review process for the purpose of disseminating knowledge to the professional community.

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice
Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

Quality
(3) Demonstrates skills in peer review that promote a culture of excellence.

Practice Inquiry
(1) Applies clinical investigative skills for evaluation of health outcomes at the patient, family, population, clinical unit systems, and/or community health.
(2) Provides leadership in the translation of new knowledge into practice.

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Technology and Information Literacy
(1) Demonstrates information literacy in complex decision making.

(2) Translates technical and scientific health information appropriate for user need.

(3) Participates in the development of clinical information system.
Competencies will continue to be reviewed and revised. The dynamic state of health care technology and scientific discovery requires constant surveillance of the relevance and adequacy of the outcome competencies. The CUSN DNP competencies provide a blueprint for educational content and graduate certification of a clinical nursing doctorate. The establishment of this doctoral level of education, with well-defined and distinctive competencies, will contribute to quality and access to comprehensive care.

The development of the competencies of a clinical nursing doctorate was made possible by funding from the Teagle Foundation, the W.K. Kellogg Foundation, the Robert Wood Johnson Foundation, and Pfizer Inc.

**Acknowledgments 2003**
Columbia University School of Nursing
University of Illinois at Chicago College of Nursing
University of Iowa College of Nursing
Rush University College of Nursing
University of Texas Health Sciences Center at Houston School of Nursing
Yale University School of Nursing
University of Washington School of Nursing

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Columbia University School of Nursing
University of California School of Nursing
University of Tennessee School of Nursing
Vanderbilt University School of Nursing
Rand Corporation

**References**
Internal Medicine Task Force on Internal Medicine Residency Curriculum. FCIM, Inc. Philadelphia, PA.