The Doctor of Nursing Practice and Clinical Nurse Leader
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The Doctor of Nursing Practice and Clinical Nurse Leader

Essentials of Program Development and Implementation for Clinical Practice

JOYCE J. FITZPATRICK, PhD, MBA, RN, FAAN
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Editors

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For almost a decade, the American Association of Colleges of Nursing (AACN) has led a series of strategic discussions and policy formulations related to the dramatically evolving nature of the health care environment and the unique contributions that nursing makes. This national dialogue has included a wide array of stakeholders from education—both nursing and higher education at large—and practice arenas. Representatives of other health professions have also contributed to this conversation.

Out of these important discussions have come two very significant and groundbreaking innovations for nursing, which this book describes: the development of the Clinical Nurse Leader (CNL®) role and the recommendation that education for advanced nursing practice should occur through professional doctoral programs that award the Doctor of Nursing Practice (DNP).

The movement toward these two innovations was framed by an understanding that health care has become increasingly complex, and that despite the sophistication of the interventions used to assure a healthy population, multiple errors and inequalities in care delivery persist. Moreover, the rapid aging of the U.S. population, the growth in diversity among patients, and the enhanced application of technology both for patient care and information management have created a need for an increasingly competent nursing professional.

The need for the CNL emerged from the work of nurse executives to apply positive deviance theory and design a new nursing role that would focus on the clinical microsystem, evidence-based practice, the outcomes of care, and how the interprofessional health care team can collaborate to unify fragmented care. These nurse executives urged AACN to lead in the development of a new model of education to create a highly competent generalist clinician with the ability to address all these issues. The work of two AACN task forces—the Task Force on Education and Regulation for Professional Nursing Practice I and II—responded to this call with the recommendation that AACN support the
creation of master’s degree-educated advanced generalist nurses who would fill the CNL role.

To support this evolution in professional nursing, AACN sought teams of education and practice partners who would lead in this national experiment. The overwhelming response in which more than 100 academic nursing programs and almost 200 clinical partners joined AACN to implement this innovation provides evidence that the role is filling a much needed void in the health care system. The continued expansion and support for this work in multiple arenas including the largest nursing system in the US, the Department of Veteran’s Affairs, gives further evidence that the CNL is needed to fulfill the professional mandate to provide high quality and safe patient care.

The movement to the DNP is focused on the education for advanced nursing practice, including nurse specialists engaged in providing a full array of health care services. The approval of the AACN position statement on the DNP by institutional members in 2004 was the culmination of similar work in which stakeholders from practice, education, other health professions, and policy makers at large discussed and framed the challenges facing nurses functioning at the highest possible level. The challenges being faced by entry level and advanced generalist nursing clinicians are also part of the framework of advanced nursing practice. Further, the educational programs that prepared advanced nursing clinicians had for some time been reformulating curriculum to address the growing need for expanded knowledge and competencies for specialized practice.

The Task Force on the Practice Doctorate in Nursing reviewed the shifting nature of advanced nursing education curricula and noted that these programs carried credit loads that exceeded the norm for master’s degree in other professional fields. Further, both clinicians and employers identified the need for these advanced nursing professionals to have exposure to other content that was not traditionally included in the master’s level programs such as aggregate data management, translational science, analysis of costs and outcomes of care, identification of evidence gaps, and formulations of system level interventions and monitoring. Coincident with the work of the AACN task force, the National Academy of Science released a report on the future research workforce for all health professions and recommended that nursing develop two distinct pathways to the terminal degree, thus allowing nursing professionals to make decisions about whether to pursue a research-focused or practice-focused degree.
Similar to the very positive response to the CNL, AACN has witnessed a dramatic and rapid uptake of the recommendations in the DNP position statement with new programs emerging monthly. The target recommendation to transition to the DNP from the master’s degree for the education of advanced specialized nursing clinicians by 2015 is widely accepted, and work continues in many communities including accreditation, certification, and regulation.

AACN is committed to supporting innovation in nursing education and practice to assure that our nation is served by expert clinicians delivering high quality and safe professional nursing care. We look forward to continued expansion of these two innovations and trust that AACN will continue to lead in these efforts.

C. Fay Raines, PhD, RN
Geraldine “Polly” Bednash, PhD, RN, FAAN

—Dr. Fay Raines, President (2008-2010)
American Association of Colleges of Nursing

Dr. Geraldine Bednash, Executive Director
American Association of Colleges of Nursing
This book is a direct result of the editors’ firm commitment to advanced education for nurses in clinical practice. Throughout my career in nursing education I have supported the professional doctorate. In 1990 with faculty colleagues I implemented the first post-master’s clinical doctoral program at Case Western Reserve University (Case). We were anxious to lead the revolution for nursing education and demonstrate the excellence of our students and graduates. Since that time, and even preceding the Case program implementation, there have been scholarly deliberations at educational conferences and debates in the literature regarding the best approach for nursing education, particularly for those nurses functioning at the highest levels of clinical practice.

When the American Association of Colleges of Nursing (AACN) launched its planning effort for the professional doctorate we at Case were ecstatic, as we considered this a “tipping point” for the movement toward advanced education for nurses in clinical practice. The strength of the Doctor of Nursing Practice (DNP) movement as we know it today is evidence that the nursing education and professional practice communities were ready for the change. Within a short period of time after the introduction of the DNP, AACN also launched the Clinical Nurse Leader (CNL) program initiative.

In this book, my coeditor, Meredith Wallace, and I have profiled these historical changes in nursing education. We have selected contributors who have been involved in the DNP and CNL movements from several perspectives, from architects of the programs to those who are students in selected programs. This book is intended as an introduction to the two programs, prepared as a marker of a point in time, when there have been proposed program designs. Yet, we know that the evolution will continue and that the development of DNP and CNL program objectives, curricula, and expected outcomes are not static.

One of the most important contributions of this book is charting the development of doctoral education in nursing, from its earliest roots at
Teachers College, Columbia University, to the current DNP programs development at several top universities. Chapters 1 through 3 set the foundation for consideration of the current status of DNP programs. Chapters 4 and 5 identify important issues for future DNP program development, including the impact on the clinical environment for the student and the graduate.

Chapters 6 through 9 include particular attention to the historical development of the CNL programs. Authors delineate the core program requirements and the expectations of students and graduates in the clinical and academic arenas. Particularly important is the discussion of the transition of current master’s-level nursing education programs to the CNL program.

There are several other components of this book that are important contributions to the state of the art of nursing education regarding the DNP and CNL. The critical issues of credentialing, certification, and licensure of graduates are addressed in Chapter 10. Chapters 11 and 12 include “voices from the field” of current DNP and CNL students. These voices add a dimension that could not be garnered from the program designers or faculty and thus present a different perspective.

We are particularly indebted to AACN for granting permission for the inclusion of several documents related to the DNP and CNL programs. These inclusions again will serve to mark a “point in time” and will assist those who are in the process of program design to obtain all of the relevant materials in one place.

We are hopeful regarding future developments for graduate education in nursing, particularly for the preparation of nurse clinicians at the same level as colleagues in other health disciplines. It is extremely satisfying to witness the unfolding of a professional dream, that of doctoral education for advanced clinical practice in nursing. It also is most rewarding to share information about the dream unfolding in this book. We, the editors and chapter authors, know that this work will stir continued discussion and debate.

Joyce J. Fitzpatrick, PhD, MBA, RN, FAAN
Editor
Nursing education at all levels has had a multifaceted history, and so it is with graduate education, at both the master’s and doctoral levels. Whereas in many disciplines and professions there are straightforward paths to both academic degrees and professional credentialing, in nursing, both historically and currently, there exist a myriad of educational options. The diversity of entry and exit points in nursing education is confusing to the public and often also difficult for those in other health professions to understand. The focus of this book is on two new educational pathways in nursing, the Doctor of Nursing Practice (DNP) and the Clinical Nurse Leader (CNL®). Yet, it is important to frame this presentation within the context of both the broader educational issues in nursing and the societal context.

**BASIC EDUCATION FOR NURSING**

There are four paths for entering nursing and four for exiting nursing education at the prelicensure level. Students can enter associate degree (AD) programs (offered primarily through community colleges), diploma programs (offered through hospital schools of nursing), baccalaureate programs (offered through colleges and universities) and graduate-level entry programs (offered through colleges and universities, and leading to
either baccalaureate or master’s degrees in nursing). The exit paths enable graduates to sit for the NCLEX-RN licensure exam, and successful passing of this exam means that the individual can practice as a Registered Nurse (RN). There are a wide range of programs and various models for moving from one level of nursing education to another. For example, many schools offer Baccalaureate (BSN) degree programs for applicants who have no previous degrees in nursing (often referred to as accelerated programs for college graduates). These accelerated programs range in length from 12 to 36 months depending on the educational backgrounds of the students. Some schools offer RN completion programs that can range from 1 to 3 years in length depending on the previous educational background of the students. And yet other schools bypass the BSN degree and offer master’s level education for either RNs or for college graduates without previous nursing education. As of 2008 there are approximately 1,800 schools of nursing in the United States that offer basic preparation for nurses (eligibility to practice as an RN) (National League for Nursing [NLN], 2008). Between 2005 and 2006, 150 new prelicensure RN programs in nursing were added, and yet the rate of growth in enrollments was only 3% in 2005 and 1.5% in 2006. BSN enrollments grew by only 4.2% in 2006; enrollments in associate degree programs were effectively unchanged, and diploma enrollments fell by 2.6% in 2006 (NLN, 2008).

In 1965, the NLN membership adopted a resolution that supported college-based programs of nursing, calling for the movement of nursing education into institutions of higher education. That same year, 1965, the American Nurses Association (ANA) published its first position statement on nursing education, calling for nursing education within the general system of higher education. The ANA vision was for two levels of nursing education, technical (at the AD level) and professional (at the BSN level) (ANA, 1965).

These early position statements on nursing education at the university level were delivered in the context of broader political discussions of health care. While the position statements were issued almost 20 years after the landmark report of Brown (1948), which called for professional nursing education at the university level, with separate autonomous schools of nursing, the content was similar. Brown contended that the nursing education system was inadequate to meet the nation’s health care needs. Until the mid-1960s the professional nursing community did little to implement these changes. But in 1965, the era of the Great Society, there was considerable national debate about health care. Medicare and Medicaid were born, making access to health care available to older
persons and the poor. Importantly, at the time of the 1965 position statements by both ANA and NLN, approximately 72% of all nurses studied in hospital diploma schools (Donley & Flaherty, 2002). With the societal demand for more nurses and the pressure of hospitals to maintain their supply through hospital-based diploma programs, there was a strong negative reaction to the positions to move nursing to the university level and close diploma programs. To this date, 2008, some diploma programs remain.

Perhaps the most dramatic change since the 1965 position papers has been the rise in associate degree education for RNs. As of 2006, graduates of AD programs represented 41% of all prelicensure RN graduates (NLN, 2008). Graduates of AD, diploma, and BSN pre-licensure programs all are eligible for the same RN licensing examination.

GRADUATE EDUCATION PRIOR TO 1965

In 1952, the NLN held a working conference in Chicago in which criteria for nursing education at the graduate level were developed (Campbell, 1964). One of the key recommendations was that specialty preparation should be at the master’s level. According to Fondiller (2001), this conference marked the beginning of a concentrated effort by the NLN Council of Baccalaureate and Higher Degree Programs (CBHDP) to strengthen master’s and doctoral education in nursing in clinical specialties, supervision, administration, teaching, and research (p. 9). Master’s degree programs were expanded during the decade following the working conference. By 1962 there were 47 master’s degree programs in nursing, which enrolled a total of 1,717 full-time students (Campbell, 1964). Many of the early master’s degree programs were not clinically focused, but rather offered what were labeled functional minors, in either nursing education or nursing administration. Clinically based master’s degree programs grew after the introduction of two forms of clinical specialization, the clinical nurse specialist (CNS) programs and the nurse practitioner (NP) programs, both of which were introduced in the mid-1960s.

ADVANCED PRACTICE NURSING EDUCATION

Advanced Practice Nurses (APRNs) include four groups of nurses: clinical nurse specialists (CNSs), nurse anesthetists (CRNAs), nurse
midwives (CNMs), and nurse practitioners (NPs). Currently there are about 140,000 APRNs in the United States, including 88,000 NPs, and 54,000 CNSs, the two largest groups of APRNs (Health Resources and Services Administration [HRSA], 2004). There are a wide variety of practice sites for APRNs, including acute and primary care, managed care, and emergency services. Just as there are differences in places of employment, there are a range of employment options, including self-employment, professional practice groups, hospitals and health systems, and managed care organizations. There continues to be some diversity in the scope of practice of APRNs, as this is determined by state, rather than national, legislation. States also set the minimum educational and certification requirements for APRN practice in their jurisdictions. Core competencies for APRN have been described in specialty areas, including those for adult, family, gerontological, pediatric, and women’s health NPs. The specialty associations for CRNAs, CNMs, NPs, and CNSs have delineated the competencies for those APRN roles. Presently, all CNSs and NPs are prepared in master’s degree or post-master’s programs in schools of nursing. The preparation of CRNAs is at the master’s degree level as of 1998, and the majority of programs for preparation of CNMs, are at the master’s degree level.

All of the APRN roles, have historically had some tensions with organized nursing education, although many of the issues have now been resolved. Initially, there was debate as to whether those practicing as NPs and CRNAs, in particular, were practicing within the scope of nursing or medicine. The practice issues were complicated by the placement of many nurse anesthesia educational programs outside of nursing education, and the placement of NP programs at the certificate level, often under the educational tutelage and, at times, control of both physicians and nurses. CNM practice and education also has had its struggle with nursing, both conceptually and educationally. There has been continued discussion within the American College of Nurse Midwives (ACNM) as to whether midwifery is a separate profession from nursing, even though its origins within nursing are strong.

**CRNA Education**

The first organized course in anesthesia for graduate nurses was offered in 1909 (American Association of Nurse Anesthetists [AANA], 2008). AANA has its own accrediting commission, which monitors the more than 80 programs that have developed in the past century. Almost half
of the programs are in schools of nursing, at the master’s degree level. A requirement for master’s degree level education as preparation for nurse anesthesia programs has been in effect since 1998. Graduates of CRNA programs are eligible to take the certification exam through the Council on Certification of Nurse Anesthetists (CCNA) (AANA, 2008).

**CNM Education**

Nurse midwifery education has existed in the United States since 1925 (Varney, Kriebs, & Gegor, 2004). Early in its development, nurse midwifery was viewed as a clinical specialty within nursing (Burst, 2005). The Committee on Organization was formed in 1954; this Committee led to the formation of the ACNM and was organized to set standards for education. ACNM not only accredits nurse-midwifery education programs but also has a component that provides credentialing to nurse-midwives (Burst, 2005). Of the 45 nurse-midwifery programs in place in 2005, 35 are in schools of nursing at the master’s degree level. There are four programs in schools of medicine (Burst, 2005).

**CNS Education**

The first CNS programs in nursing began in the mid-1960s, at the same time that there was much discussion within the profession about the most appropriate degree for entry into professional nursing practice. The primary debate at that time was whether the baccalaureate degree in nursing (BSN) should be required for entry into practice. There also were many societal changes that made health care more available in the United States. The first CNS programs were begun in clinical areas in which there was faculty expertise, such as psychiatric nursing. There also was considerable national funding for development of the specialty of psychiatric nursing in the 1960s. CNSs are prepared as clinical experts in the diagnosis and treatment of illness and the delivery of evidence-based nursing interventions. Presently, there are more than 200 programs preparing CNSs, in a wide range of specialties, including, for example, oncology, cardiovascular, and psychiatric nursing, and specialties that are developmentally focused, such as pediatric and gerontological nursing. The CNS role is focused on the following dimensions: direct clinical practice, expert coaching, collaboration, consultation, research, clinical and professional leadership, and ethical decision making. Historically, the CNS role developed within acute care hospitals but has expanded to other areas (Sparacino, 2005).
NP Education

In 1965, the first NP program was developed at the University of Colorado by Loretta Ford, a nurse, and Henry Silver, a physician. It was a pediatric NP program implemented to meet the need for primary care delivery in underserved areas. Many of the first NP programs were certificate programs, rather than graduate programs. In 1968, Boston College offered one of the first NP programs at the master’s degree level, and the University of Colorado program became a master’s degree program in the early 1970s (Pulcini & Wagner, 2002). The decade of the 1970s was one in which the number of NP specialties rose, and legislative initiatives were introduced in many states to legitimize the role, particularly within primary care. By 1973 there were over 65 NP programs in the United States; some of these programs granted certificates and some granted master’s degrees (Pulcini & Wagner, 2002). The steady growth of NP programs continued for the next 35 years to the present as employment opportunities increased and new NP specialties were introduced. Historically, the NP role began in primary care but has now developed within every component of health care, including acute care hospitals and long-term care facilities.

HISTORY OF DOCTORAL EDUCATION

Doctoral education in nursing began in the first half of the 20th century. The first doctoral degree offered in nursing was in nursing education, offered first at Teachers College, Columbia University in 1933, followed shortly by the EdD offered at New York University (NYU) in 1934 (this program later became the first PhD program in nursing). There was a 20-year hiatus in the opening of new doctoral programs in nursing. The second PhD program in nursing opened in 1954 at the University of Pittsburgh. Then, in the 1960s three Doctor of Nursing Science programs were started, at Boston University (now closed); Catholic University of America in 1968 (now phased into a PhD program as of 2006); and the University of California San Francisco (UCSF) (opened in 1965, closed in the 1990s, but replaced with a PhD program that was opened at UCSF in 1984). The UCSF program was the first doctoral program opened in the West. In early 1970s, there were only seven doctoral programs in nursing: the EdD at Columbia; the PhD programs at NYU, the University of Pittsburgh, and Case Western Reserve University (opened
in 1972); and the Doctor of Nursing Science (DNS, also called DNSc) programs at Boston University, Catholic University, and UCSF. The expansion of doctoral programs in nursing occurred in the mid- and late 1970s, with the majority of these opened as PhD programs. There were, however, some universities that would not approve PhD programs in nursing, so the DNS programs, which mimicked PhD programs, were started. By the end of the 1970s there were a total of 17 doctoral programs in nursing (AllNursingSchools Web site; Gortner, 1991; Grace, 1989). The research-oriented doctoral programs in nursing grew more rapidly in the decades of the 1980s and 1990s. By the year 2000 there were 73 research-oriented doctoral programs in nursing (64 PhD and 9 DNS/DNSc/DSN programs) (Fitzpatrick & Stevenson, 2003), and by 2005 there were more than 100 research-oriented doctoral programs (American Association of Colleges of Nursing [AACN], 2005a).

**CURRENT STATUS OF GRADUATE PROGRAMS**

**Master’s Degree Programs**

Currently there are approximately 400 master’s degree programs in nursing, which prepare clinicians, educators, and administrators. According to a report prepared by Walker and colleagues in 2003, there were at least 157 separate CNS programs in 139 schools of nursing (Walker et al., 2003). There are a wide range of CNS specialties, including those that follow the disease status of the recipient of care (oncology or cardiovascular CNS programs) and those that are based on the developmental stage of the recipient of care (pediatric CNS programs). The American Academy of Nurse Practitioners (AANP) identified 850 NP specialty tracks available in over 300 institutions as of 2008 (AANP, 2008). Further noted was the fact that currently only a few NP programs are certificate only, that is, they do not offer any graduate degrees (AANP, 2008). The program tracks for NP preparation include those based on developmental stage, for example, pediatric, adult, geriatric; those based on site of services provision, for example, acute care, emergency room; and those based on groups, for example, family, women (AANP, 2008). The distinctions between CNS and NP programs were historically greater than what currently exists in curricula, with the NP programs more focused on direct care and the CNS programs more focused on indirect care components such as patient and staff education, and consultation with
staff. In the recent past, since 2000, there has been a greater emphasis on blended programs (NP plus CNS). Overall, enrollments in master's degree programs rose 18.1% from 2006 to 2007 (AACN, 2007c).

**Doctoral Programs**

There are approximately 113 research-oriented doctoral programs and 74 practice-oriented doctoral programs. There also are 63 schools of nursing planning clinical doctoral programs at the Doctor of Nursing Practice (DNP) degree level (AACN, 2008a). Research-oriented doctoral programs prepare graduates for careers in academe or in research positions in clinical facilities, whereas the DNP programs prepare graduates for clinical practice positions.

**NEW PROGRAMS INTRODUCED BY AACN:**
**THE DOCTOR OF NURSING PRACTICE (DNP) AND THE CLINICAL NURSE LEADER (CNL)**

**DNP Description**

AACN has been deliberating the practice-level doctorate since 2001, which culminated in a vote in support of DNP level education as an entry-level requirement for APRNs by 2015. Formal endorsement of the DNP Position Statement was approved by the AACN membership in 2004 (AACN, 2008b). The AACN “Essentials” document details the history of DNP program development through AACN, essential curricular requirements for DNP graduates, and the plan for future development and implementation (AACN, 2008b).

**CNL Description**

AACN proposed the CNL as the advanced generalist in nursing (AACN, 2007b). The CNL was conceived as a provider of care for individuals and cohorts, and the role is expected to be implemented across a variety of settings. In its white paper on the CNL, AACN has delineated fundamental aspects of the role, educational requirements, professional values, and core competencies (AACN, 2007b). The CNL is prepared at the master’s degree level. The relationship of the CNL (advanced generalist) and CNS (specialist) programs have been delineated in the AACN Working Statement (AACN, 2004).
NUMBER OF NURSES WITH GRADUATE DEGREES

As of 2004, of the total number of registered nurses (N = 2,909,357) living and working in the United States, approximately 376,901 (13%) held a graduate degree (master’s or doctorate), according to the national database report (HRSA, 2004). Over the period from 1980 to 2004 there was a 339% increase (from 85,860 to 376,901) in this number (HRSA, 2004). As of 2004, there were 240,460 RNs prepared as Advanced Practice Registered Nurses (APRNs), or 8.3% of the RN population. This estimate represents a 22.5% increase from the estimate in 2000. The majority of those who completed APRN programs were prepared as nurse practitioners (141,209 RNs) followed by CNS-prepared RNs (72,521 RNs). These two groups together account for 82.8% of all APRNs. Nurse anesthetists comprised the third largest group of APRNs, with 32,523 CRNAs in 2004. There were 13,684 nurse midwives (CNMs) as of 2004 (HRSA, 2004).

FACTORS RELATED TO APRN ISSUES

In addition to the changing demographics in the United States, which have increased the overall demand and need for health care, there are other factors directly related to the preparation of APRNs at all levels. These include workforce, education, and practice needs. No one of these dimensions can be addressed independently, and all affect the new educational programs proposed, specifically the DNP and CNL.

Workforce Needs

The current nursing shortage, begun in the middle of this decade, has been identified as the worst ever, with projections varying regarding the numbers of nurses needed by 2020, from 340,000 to earlier projections of 800,000 (AACN, 2007a). Projections of workforce needs are almost always based on the need for basic RNs to fill hospital positions in acute care institutions and do not take into account the needs for APRNs. Yet, it is clear that without the base supply of RNs the enrollment in APRN educational programs will not continue to expand. In times of shortages of RNs, graduate-level enrollments often decline, as nurses have extensive opportunities for employment and often higher levels of compensation. The RN shortage of the current decade has been attributed to the following
factors: enrollment in schools of nursing not growing fast enough to meet demand; a shortage of faculty, thus making it impossible to expand programs; the increasing age of the workforce, with projections about large numbers of retirements in the next 10 years; changing demographics, thus increasing the demand for nursing services; job burnout and dissatisfaction and high nurse turnover and vacancy rates (AACN, 2007a).

**Education Needs**

There is a critical shortage of nurse faculty, one that is predicted to increase as the aging faculty workforce retires. This shortage of faculty is affecting the overall nursing shortage by limiting the number of students who can be accommodated in basic nursing programs. According to the AACN Report on 2007–2008 enrollments, there were 40,285 qualified applicants turned away from baccalaureate and graduate programs primarily due to the faculty shortage (AACN, 2008c). During 2006–2007, AACN reported that 3,306 qualified applicants were turned away from master’s degree programs and 299 qualified applicants were turned away from doctoral programs, primarily due to the shortage of faculty (AACN, 2007c). A complicating factor affecting the faculty shortage is that for 307 (78%) of the doctoral graduates who reported their employment plans in the AACN 2004–2005 survey, 22.5% reported that they planned to work in settings other than academe (AACN, 2005b).

**Practice Needs**

Both NP- and CNS-prepared nurses provide high quality care and make a significant contribution to the overall health care delivery system in a range of practice settings. Outcomes have been linked to safe, high-quality, cost-effective care. Fulton and Baldwin (2004) delineated the outcomes of CNS practice as reduced length of hospital stays, reduced costs, increased patient satisfaction, improved pain management, and fewer complications in hospitalized patients. The positive outcomes of NP practice also have been substantiated (Feldman, Ventura, & Crosby, 1987; Hooker, Cipher, & Skescenski, 2005; Mundinger, Kane, Lenz, Totten, & Tsai, 2002).

**SUMMARY**

Nursing education has had a complex history, one that has been inextricably linked to the development and delivery of health care services in
the United States. There has not been a direct or smooth path in either the educational preparation of APRNs or in the design of the U.S. health care system. The future path also is not clear, and for nursing education and practice, there continue to be several entry and exit points, and a lack of consensus regarding the best road forward.

Currently, there are major issues surrounding nursing education and practice at the advanced levels, including programs to prepare nurses at the DNP and CNL levels. These issues include regulatory and licensure concerns, accreditation of academic programs and credentialing of individual practitioners, and the nature of the educational programs for APRN preparation. AACN has led a 3-year process to develop consensus on these issues and has reported extensively on the developments (AACN, 2007b, 2008b). Each of these issues is complex and will require continued deliberations by key stakeholders in order to chart the future course that is most advantageous to delivery of high-quality nursing and health care.

REFERENCES


