Academic Preparation of a Nurse Practitioner:

Doctor of Nursing Practice versus Master of Science in Nursing

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Doctor of Nursing Practice Program

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Notes from the Author

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I dedicate this DNP dissertation in memoriam of John T. Dawson, whose memory I carry, whose character I strive to embody, and whose Ticklers I often referenced throughout this degree. I have learned you should not expect life's very best if you are not giving it your very best.

Abstract

The Doctor of Nursing Practice (DNP) degree was declared by the American Association of Colleges of Nursing to be the most qualified degree for advanced practice registered nurses (APRN) to enter clinical practice. Despite this recommendation, only 25 percent of schools nationwide have made this transition in their programs due to various barriers posed by programs, including financial constraints, sustainability of the program, and limits on faculty for project implementation. The purpose of this DNP project is to evaluate the differences and similarities between MSN and DNP educational programs in students' preparation for APRN practice and to document gaps in findings. A readiness assessment tool was utilized to identify readiness to practice and program changes for APRN programs. Of the 92 survey responses, 51 responses met the inclusion and exclusion criteria. Only one DNP-prepared nurse practitioner felt overly-prepared when transitioning to practice. Five MSN-prepared nurse practitioners felt their degree did not meet master's degree *Essentials* and were all educated exclusively online or hybrid mostly online. The project's barriers included small sample size, lack of a standardized tool, and nonresponse bias. Based on these findings of this brief, piloted study, the responses suggest increased preparedness of a doctorally prepared NP compared to a masters prepared NP. There are many opportunities for further investigation to warrant possible recommendation of a standardized education degree for NP preparation.

Keywords: academic preparation, masters-prepared NP, doctorally-prepared NP, NP perception, provider readiness to practice

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Section I. Introduction

Background

In 2004, the American Association of Colleges of Nursing (AACN) voted to declare the Doctor of Nursing Practice (DNP) degree as the most qualified degree for advanced practice registered nurses (APRN) to enter clinical practice (Auerbach et al., 2015). AACN recommended that all master's programs transition to the DNP by 2015 (Auerbach et al., 2015). Despite this recommendation, less than 25 percent of schools producing APRNs for clinical practice have entirely met the goal of transitioning from a Master of Science in Nursing (MSN) to a DNP degree (Auerbach et al., 2015). There has been a slow movement for schools to adopt a DNP despite the universal agreeance of the education's value (Auerbach et al., 2015). Barriers to this transition from the MSN to the DNP include financial constraints, limitations on faculty resources to develop capstone projects, and DNP programs' sustainability (Auerbach et al., 2015). When initiated, the DNP degree's essentials were laid out within a 22-page document to educate academic institutions about the DNP's program requirements (American Association of Colleges of Nursing [AACN], 2015). The quintessential difference between the two degrees is the preparedness of the individual to practice. Individuals who are educated at the doctoral level are prepared to advance scientific inquiry and practice within the highest leadership levels to help design quality improvement initiatives that bridge the access to care gap (American Association of Colleges of Nursing [AACN], 2006).

Organizational Needs Statement

Sigma Theta Tau International (STTI), an internationally recognized nursing honor's society, has developed a mission to improve healthcare worldwide through the development of nurse leaders (Sigma Theta Tau International [STTI] Honor Society of Nursing, 2020). Through

this mission, the Beta Nu Chapter of STTI Honor Society of Nursing partnered with a DNP student as a Leadership Intern who identified a need to evaluate differences within the educational construct between a masters-prepared nurse practitioner and a doctorally-prepared nurse practitioner in their readiness to practice. Through the evaluation of curriculums, the leadership intern of the Beta Nu chapter of STTI created a readiness assessment tool to evaluate practitioners. There was little research objectively evaluating APRNs' outcomes and abilities of the different degree pathways and their ability to produce providers who feel ready to practice. With the knowledge obtained from the readiness tool, the findings can be published within the STTI literature repository to offer suggestions to different academic institutions nationwide regarding APRNs preparations.

Educational differences between doctorally-prepared nurse practitioners and masters-prepared nurse practitioners can influence APRNs' readiness to practice upon graduation. However, while AACN (2015) recommends the entry-level practice degree transition to the clinical doctorate; they do not require doctoral preparation. As such, the leadership intern of the Beta Nu Chapter of STTI has deemed the degree ambiguity a problem. East Carolina University is affiliated with Beta Nu, and like many other nurse practitioner programs nationwide, they transitioned to the Doctor of Nursing Practice degree due to AACN's recommendation. The Beta Nu Chapter of STTI leadership intern viewed the educational preparedness differences as problematic due to the diverse curricular offerings preparing APRNs for practice.

An APRN entry to practice's national benchmark includes a current license as a registered nurse in one or more states, a graduate nursing degree, and a passing score on the nationally recognized certification exam for the APRN specialty. Curriculum requirements for APRN education included a didactic encompassing relevant medical, nursing, behavioral, and

biological sciences for an APRN within the specialty role, legal, professional, and ethical APRN responsibilities, and a minimum of 500 supervised, relevant clinical practice hours (Advanced Practice Registered Nurse [APRN] Consensus Work Group & the National Council of State Boards of Nursing [NCSBN] APRN Advisory Committee, 2008).

The need to review educational coursework of differing degrees regarding provider readiness to practice met Healthy People 2020, Healthy People 2030, and North Carolina 2030 goals. Curriculums of academic institutions underwent an evaluation to ensure each student has courses in evidence-based practice, public health, informatics, research, statistics, finance, and leadership before graduating. Evaluation of the curriculum and provider readiness assessed the students' ability to tackle the principles of Healthy People 2030. These principles include: to promote physical, mental, and social health and wellness, encourage healthy, robust social, economic, and physical environments, gain health equity and literacy, eliminate disparities of health, and help the patient reach their utmost health potential (Office of Disease Prevention and Health Promotion [ODPHP], 2020).

Healthy North Carolina 2030 indicators were directly related to nurse practitioners because all providers strive to provide better clinical care, promote health equity and behaviors, increase social and economic influences, and foster a healthier physical environment for each North Carolinian (North Carolina Institute of Medicine [NC IOM], 2020). Overall, this educational analysis hoped to increase the primary care workforce, a direct health indicator target (NC IOM, 2020). Assessment of curriculums from institutions that confer master's or doctoral degrees to nurse practitioners and provider readiness addressed the Quadruple Aim by exploring curriculum content intended to increase students' capacity to provide better population-based healthcare (Bodenheimer & Sinsky, 2014). Both the MSN and DNP degrees intend to increase

the healthcare workforce by preparing students to function as APRNs to provide evidence-based care, improving patients' experiences and facilitate health and wellness (Bodenheimer & Sinsky, 2014). Curriculum assessment considered providers' readiness to lower healthcare costs (Bodenheimer & Sinsky, 2014). Finally, the curriculum assessment looked for content that potentiates providers' capacity for self-care to reduce burnout (Bodenheimer & Sinsky, 2014).

Problem Statement

Currently, there was no evidence to support whether a difference exists in preparation and readiness to practice for newly graduated nurse practitioners based on masters or doctoral preparation. Further investigation was needed to identify gaps in preparation and readiness to practice.

Purpose Statement

The purpose of this DNP project was to evaluate the differences and similarities between MSN and DNP educational programs in preparing students for APRN practice and documenting gaps in findings.

Section II. Evidence

Literature Review

A comprehensive literature review was conducted to evaluate the different educational programs for DNP and MSN. Critical evaluation of the evidence was orchestrated and ranked based on the quality and levels of evidence. The different curriculums' findings were compared to the National Organization of Nurse Practitioner Faculties (NONPF) Nurse Practitioner Core Competencies, AACN (2011) Master's Essentials, and AACN (2006) Doctoral Essentials. The literature was used to analyze anticipated provider readiness based on educational programs. A literature review was conducted using the Cumulative Index of Nursing and Allied Health (CINAHL), PubMed, and Google Scholar databases. Medical subject headings (MeSH) terms included DNP education, MSN education, and FNP programs. Search terms included nurse practitioner core competencies, core competencies of family nurse practitioners, DNP education, MSN essentials, DNP essentials, FNP readiness, education nursing masters, and education nursing doctorate. Most articles were limited to a period of five years, full-text, and peer review. The sentinel pieces of literature, which encompass NP core competencies, DNP essentials, and MSN essentials, were included despite the five-year time limit. These searches yielded approximately 174 articles. After a thorough review of titles and abstracts, 50 articles were reviewed in detail. Eight of those articles were considered pertinent to the project and were utilized to synthesize the literature. All eight relevant articles offered a variety of levels of evidence, based on Melnyk & Fineout-Overholt's 2011 model, including three clinical practice guidelines, two articles which are level III, one article which is level V, and two articles which are level VII (Melnyk & Fineout-Overholt, 2011).

Current State of Knowledge

At the time of the literature search, the guidelines from the early 2000s remained pertinent. There was little literature that evaluated provider readiness when comparing both degrees. Among AACN, DNP education's value is increased through the added content (Auerbach et al., 2015). Current recommendations for doctoral programs for post-baccalaureate students should be three years, including summers with a minimum of 1,000 hours of supervised practice within the academic program, with graduates meeting all eight DNP Essentials (AACN, 2006). Many master's graduates do not receive the appropriate degree for completing the rigorous curriculum (AACN, 2006). The AACN (2015) currently recommends that the DNP is the preferred preparation pathway for nurses seeking the highest practice abilities. Therefore, it is anticipated that many master's graduates do not receive the most advantageous degree of clinical preparedness (AACN, 2006). Approximately three times the number of students enroll in MSN programs among the schools offering students the choice between MSN and DNP degrees (Auerbach et al., 2015). Despite the AACN recommendations, cost remains a crucial barrier for schools to transition to only DNP programs (Auerbach et al., 2015).

Current Approaches to Solving Population Problems

Optimal degree attainment has not been critically appraised to the point that research has been published**.** The gaps in provider readiness identified among the two degrees exposed a need for increased rigor for clinical education, increased online programs, and inconsistency between nurse practitioner programs' curricula (Hart & Macnee, 2007; Terhaar et al., 2016). When addressing provider readiness, incorporating ethics into a DNP curriculum helps increase leadership (Bowie et al., 2019; Grace, 2018). Institutions that secure clinical sites and preceptors for students likely increase rigor for clinical education, leading to improved student readiness to enter clinical practice (Hart & Macnee, 2007). Although identified as a gap in the specifics

established for how institutional curriculums meet MSN and DNP essentials, a new-graduate provider preparation's adequacy has not been thoroughly studied (Hart & Macnee, 2007). Analysis of the NP core competencies developed by faculty serving on a national committee at NONPF regarding curriculum development led to fundamental courses including evidence-based practice, leadership, policy, research, statistics, finance, informatics, population health, and incorporation of a quality improvement project (NP Core Competencies Content Work Group, 2014). This DNP project used all of these findings to develop a readiness assessment tool for evaluating new graduate practitioners entering the clinical provider workforce.

Evidence to Support the Intervention

The development of a readiness assessment tool to address curriculum gaps required an in-depth analysis of the NP core competencies. There are nine different core competencies of a FNP that the curriculum should meet. An in-depth investigation of 46 academic institution curriculums was conducted to determine provider readiness for new graduates. The first core competency met via the curriculum is maintaining a scientific foundation, which can be accomplished by incorporating evidence-based care (NP Core Competencies Content Work Group, 2014). Out of 17 DNP curriculums evaluated, all 17 incorporated evidence-based practice. Out of the 29 master's curriculums evaluated, all 29 incorporated evidence-based practice. The second and third core competencies, leadership and quality, involve integrating leadership courses into the curriculum to develop change (NP Core Competencies Content Work Group, 2014). Fifteen out of 17 DNP curriculums incorporated leadership, while ten out of 29 master's curriculums offered a leadership course. The fourth competency, practice inquiry, requires clinical investigative strategies to be fostered through a curriculum with evidence-based practice, research, and statistics (NP Core Competencies Content Work Group, 2014). With all

three courses of evidence-based practice, research, and statistics built-in, 12 of the 17 DNP curriculums and nine out of 29 master's curriculums appeared to meet this competency. Technology and information literacy is the fifth competency that can be achieved through offering evidence-based practice guidelines, informatics, and research courses that "integrate appropriate technology for knowledge management to improve care" (NP Core Competencies Content Work Group, 2014, p. 7). The number of DNP curriculums encompassing all three courses was 13 out of 17, whereas master's curriculums encompassing all three were four out of 29 institutions. The sixth competency, healthcare policy, is met through offering courses in finance, informatics, policy, and population health to develop an "understanding of practice [which] is interdependent on policy" (NP Core Competencies Content Work Group, 2014, p. 8). Eleven out of 17 DNP curriculums and zero of the 29 master's curriculums had incorporated into all four courses of the sixth competency. The seventh competency encompasses health delivery systems, including courses in healthcare finance, population health, research, and a quality improvement project (NP Core Competencies Content Work Group, 2014). Although all 17 DNP curriculums required quality improvement projects, only 12 out of the 17 DNP curriculums evaluated appeared to offer all three courses. Only one master's curriculum offered all three courses but did not require a quality improvement project. The eighth competency, ethics, was attained through courses related to population health, policy, and research (NP Core Competencies Content Work Group, 2014). All 17 of the DNP curriculums evaluated included those three courses, whereas only eight out of the 29 master's curriculums evaluated included those three courses. The ninth competency, independent practice competency, required practical applications of pharmacology, physiology, pathophysiology, screening and diagnostic studies, and health promotion (NP Core Competencies Content Work Group, 2014). All DNP and

master's curriculums evaluated met this competency. Finally, these curriculums were evaluated to identify those appearing to meet all the NP competencies. Only eight DNP curriculums of the 17 evaluated and zero of the 29 master's curriculums evaluated met all expectations (NP Core Competencies Content Work Group, 2014). DNP graduates are bridging a care gap by creating a provider capable of translating research, implementing quality improvement measures, leading, collaborating, and educating individuals and populations (Terhaar et al., 2016). A readiness tool for assessing curricula can be developed and will assess which courses students had before graduation and students' perceived readiness, on a Likert-type scale, that each course prepared them to enter the clinical provider workforce.

Evidence-Based Practice Framework

Identification of the Framework

This project used the IOWA Model of Research-Based Practice to Promote Quality Care based on its intent to create change (Titler et al., 1994). The problem-focused trigger was identifying differences between the MSN and DNP educational preparations to conclude which degree best prepares APRNs for practice (Titler et al., 1994). The next part of the IOWA Model involved assembling a team to evaluate the relevant research, weighing the consistency and quality of research, to effectively critique the findings (Buckwalter et al., 2017; Titler et al., 1994). This team critiqued the research through the partnership between the leadership intern and the Beta Nu Chapter of STTI. Synthesis of current evidence, including a lack of evidence supporting the preparation to design and implement change, guided the team's next steps (Buckwalter et al., 2017). Thus, a new provider toolkit and evaluation plan was developed that considers resources and constraints that will be used to develop an implementation plan and collect further data (Buckwalter et al., 2017). From this, the project was evaluated to consider if a

change is appropriate for practice adoption (Buckwalter et al., 2017). The key personnel and indicators were utilized to create the sustainability of the change (Buckwalter et al., 2017). Finally, the results were disseminated (Buckwalter et al., 2017).

Ethical Consideration & Protection of Human Subjects

Currently, there are no ethical considerations for this project aimed at new graduate nurse practitioners. The intervention was equal for all new graduates within the target population. There is no potential harm to the target population due to the nature of the surveys. During project implementation, there was no potential that anyone in the target population can be taken advantage of due to the project's use of non-specific identifiers, which cannot be traced back to the subjects.

East Carolina University was affiliated with the project site; therefore, the University and Medical Center Institutional Review Board (IRB) approval requirements remained the same. A letter of approval from the chapter president was provided. Preparation for this project's formal approval process included completion of the Group 2 Course: Social and behavioral research investigators and key personnel, offered through the Collaborative Institutional Training Initiative (CITI) Program Modules. The first step was the completion of the CITI modules. The DNP student utilized the guidance of an IRB quality improvement/program evaluation self-certification tool. The DNP project course faculty and project mentor reviewed the accuracy of the self-certification tool. The responses were entered into East Carolina University Self-Certification Qualtrics survey. It was deemed that the project required IRB approval.

Section III. Project Design

Project Site and Population

The project site was conducted at an academic institution in eastern North Carolina. The target population is MSN and DNP new graduates over a three-month time frame. The population was limited to graduates within the last three years. The project site utilized a variety of social media, including Facebook, Instagram, and Twitter, to collect responses from the target population. The social media posts targeted MSN providers looking to go back to school as well as recent MSN and DNP graduates of either degree. The survey and posts incorporated a header that will ask the responder to share the survey with their classmates, colleagues, and friends. The project site partnered with an outside company and professional groups to increase responses. A barrier to utilizing social media, professional groups, and outside companies is the potential for non-response bias. The convenience sampling of the population may skew the data collected.

Description of the Setting

The project was conducted predominately online, through the use of different websites. One setting of the project will be a variety of social media. Another setting will include a partnership between the DNP student and an outside company for distribution of the survey. The third setting will include utilizing NP professional groups to facilitate distribution of the survey.

Description of the Population

The population included BSN to MSN and DNP prepared nurse practitioners who have graduated within the last three years. The population was limited due to their availability to be informed of the survey. The population included NPs who are either on social media or are members of different professional organizations.

Project Team

The team that conducted the project includes the DNP student, the project site champion, and the student's course faculty. The project site champion provided knowledge and advice throughout creation, by this DNP student, of the survey and analysis of the results. The DNP project faculty mentor helped the DNP student navigate the IRB approval process and help facilitate dispersion of the surveys. She has collaborated with the DNP student to help develop project goals and outcomes to meet project requirements.

Project Goals and Outcome Measures

The goal of this project was to document individuals' self-identified perceptions of preparedness based on their graduate degree. The domains within the Commission on Collegiate Nursing Education (CCNE) will be utilized, as well as the master's and doctorate core competencies established by NONPF to compare to the individuals' survey responses. The responses of new BSN to MSN/DNP NP graduates within the last three years will be compared to the core competencies and domains.

Description of the Methods and Measurement

The methods of disseminating the survey, after IRB approval, including utilization of social media groups and professional organizations list serves. The measurements of the answers to the different questions on the survey will be collected and transferred onto an excel spreadsheet each week. Measurements to questions will be collected through the Likert scale, yes or no answers, and short answer. Based on the number of responses, the survey will be redistributed to the social media groups and professional organizations through the use of a standardized format, outlined in Appendix A. The survey will remain an open link so respondents can disperse the survey to their colleagues, classmates, and friends.

Discussion of the Data Collection Process

The data was collected through the use of a Qualtrics survey. The collected data of individual responses to the surveys was transferred to an excel spreadsheet. The spreadsheet was organized by each week that the survey is open. The data collected was limited to respondents who have less than three years of experience.

Implementation Plan

The project's implementation plan included a variety of steps. After IRB exempt approval, the project implementation initiation included developing a Qualtrics survey with the established questions in Appendix B. The link was then distributed throughout the different websites. Each week, the project responses were analyzed to see how many individuals responded. An algorithm was developed by the DNP student and the project site champion. Based on the number of responses, if there are fewer responses than the algorithm's established number, the link would be redistributed the next week. Whereas, if there more responses than established number of responses, the link would not be redistributed that week. Every week, the DNP student culminated the responses and analyze for comparisons.

Timeline

The project began through formal IRB approval through the academic institution. As seen in Appendix C Project Timeline Table, the Qualtrics survey was developed and disseminated to the variety of settings by September 7th, 2020. The survey was open for at least six weeks. At the end of week two of the survey being open, the DNP student analyzed how many individuals have responded. Based on the number of responses, the DNP student discussed the length of time to keep the survey open with the project site champion. An algorithm was developed based on the number of expected responses to help determine how long the survey will be kept open. Based

on whether the number of responses at the end of week six met the expected number of responses, the value determined whether the survey would close or remain open for two or four more weeks. At the latest, the survey remained open until November 2, 2020.

Section IV. Results and Findings

Results

The data measured the number of responses submitted through the developed Qualtrics survey. The data recorded individual responses to the survey, which allowed for identifiable patterns in strengths and academic preparation gaps as noted by respondents. The original expectation was the completion of approximately 50 surveys, with a mix of DNP and MSN respondents. The actual results were 92 responses to the survey. The inclusion criteria survey graduate respondents who had graduated from 2017 through 2020. The exclusion criterion was nurse practitioners with graduation dates before 2017. There were 51 survey responses, consisting of 17 DNP responses and 34 MSN responses when limited by inclusion and exclusion criteria.

Outcomes Data

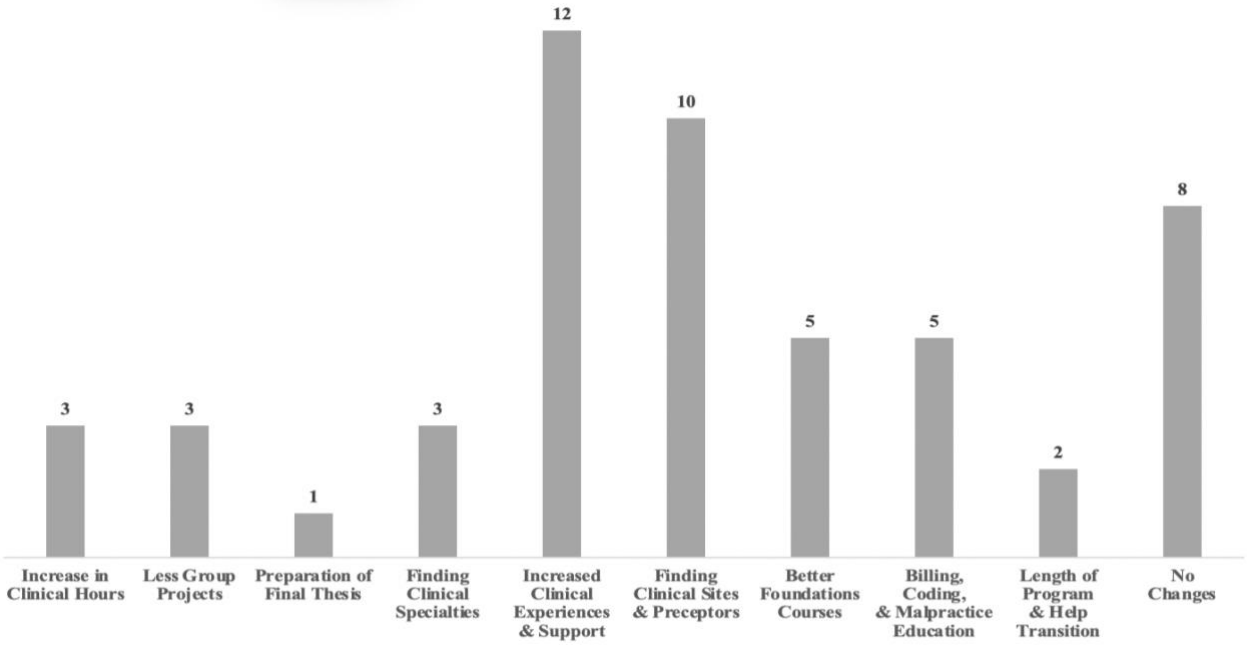
Subjective and objective data were gathered via the Qualtrics survey. Subjective data was obtained through the respondents' opinions regarding what they would have changed regarding their APRN degree program and what would have increased their perceived readiness to practice. Graduation year, years as a registered nurse, degree earned, provider readiness after graduation, degree adequacy to practice, and whether the degree met their respective AACN (2006) *Essentials* were categorized as objective, populations' demographic data. The process outcomes included identifying methods to improve the distribution of the survey. The process measures included increasing responses to the survey and whether the degree obtained impacted the new graduates' perceived level of preparedness. The outcome measure self-identified preparedness based on degree obtained. There were no identified balancing measures that impacted the outcome measure.

Discussion of Major Findings

Initial expectations were that respondents would suggest one to three ideas to change APRN programs and one to three suggestions they feel would have increased their levels of preparedness. The graphic in Figure 1 represents the survey respondents' data and provides insight on identified changes suggested within their nurse practitioner program. The themes that were identified from question one of the Readiness Assessment Survey in Appendix B include requesting increase in clinical hours, less group projects, changes preparation of final thesis, changes to finding clinical specialties, increased clinical experiences and support, finding clinical sites and preceptors, better foundations courses, billing, coding, and malpractice education, changes to length of program and help with transition, and no changes to their NP programs.

Figure 1

Summarized Suggested Changes for NP Programs

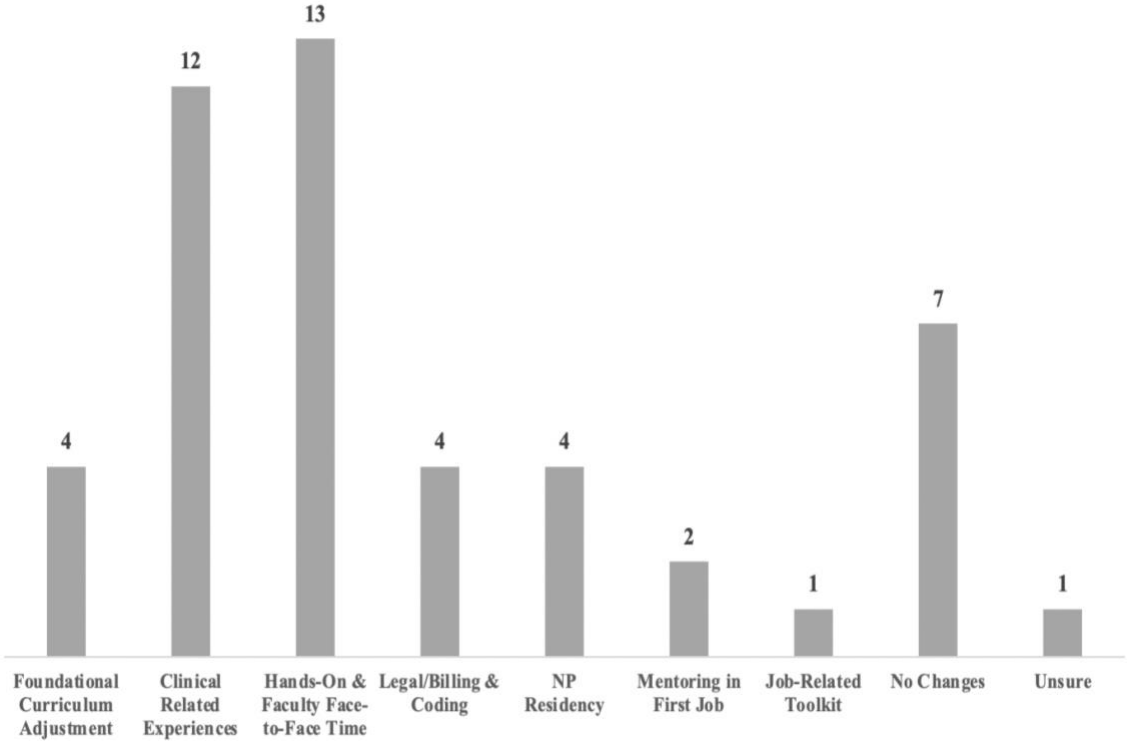


Note. Data represents number of survey respondents per item.

The recently graduated nurse practitioners' responses data of the second question of the Readiness Assessment Tool in Appendix B isolated trends that would have increased their level of preparedness to practice. The different trends are represented within the graphic in Figure 2. The open-ended questions answered isolated into themes including foundational curriculum adjustment, clinical related experience, hands-on and faculty face-to-face time, legal billing and coding, NP residency, mentoring in first job, job-related toolkit, no changes, and unsure.

Figure 2

Survey Themes to Increase Practice Preparedness for Novice NPs



Note. Data represents number of survey respondents per item.

Data collected from question three yielded ten respondents who graduated in 2017, 11 graduated in 2018, 11 graduated in 2019, and 19 graduates in 2020. Question four of the readiness assessment tool isolated data regarding the new graduates' degree, with 17 DNP responses and 34 MSN responses. The fifth question of the readiness assessment tool identified

of the 17 DNP graduates, 14 were hybrid, mostly online, two were exclusively online, and one was hybrid, face-to-face. Comparatively, of the 34 MSN graduates, three were exclusively in a classroom face-to-face, 13 were exclusively online, four were hybrid mostly face-to-face, and 14 were hybrid, mostly online. Question six of the readiness assessment tool, the years of nursing experience with the DNP graduates ranged from zero to 26 with a mean of 8.4 years and median of 7.5 years. The MSN graduates ranged from one to 35 years with a mean of 9.8 years and a median of 8 years. Within the data collected from questions seven through nine, only one respondent, a doctorally-prepared nurse practitioner, felt overly prepared by their educational programs' adequacy when transitioning to practice. Approximately 10 percent of the 51 respondents, five masters-prepared nurse practitioners, felt their educational program did not meet the required *Essentials.* The individuals who indicated that the program did not meet *Essentials* also noted that they were educated through exclusively online or hybrid mostly online programs.

Further analysis of the data presented regarding questions seven through nine, when controlled for the degree and how the degree was earned. The four MSN graduates who earned their degree exclusively in a classroom, face-to-face, two felt adequately prepared for provider readiness after graduation, of which one felt moderately prepared, and one felt adequately prepared for degree adequacy to practice. One of the exclusively classroom, face-to-face graduates felt moderately prepared provider readiness, yet felt adequately prepared to practice. Two of the graduates of exclusively online earned MSN felt unprepared regarding both provider readiness and degree adequacy to practice, and both felt their degree did not meet *Essentials*. Of exclusively online MSN graduates, seven felt moderately prepared for practice after graduation with five feeling their degree moderately prepared for practice, and four felt adequately prepared

provider readiness after graduation with five graduates reportedly felt their degree adequately prepared the graduate to practice. One of the exclusively online MSN graduates felt moderately prepared to practice yet unprepared of their degree adequacy to practice. The data of the hybrid mostly face-to-face MSN respondents, two graduates felt adequately prepared and two felt moderately prepared regarding both provider readiness and degree adequacy to practice. A graduate of MSN hybrid mostly online program felt severely unprepared concerning both provider readiness and degree adequacy while their program did not meet essentials. One hybrid mostly online graduate felt moderately prepared on both provider readiness and adequacy to practice, yet reported their program did not meet *Essentials*. One hybrid mostly online graduate felt unprepared regarding provider readiness after graduation and degree adequacy to practice. Six new MSN graduates perceived moderately prepared provider readiness after graduation with five of these individuals felt their degree moderately prepared them to practice and one felt adequately prepared by their degrees adequacy to practice. Five graduates reported adequate preparedness for both provider readiness after graduation and with their degree adequacy to practice. Overall, five MSN graduates felt their degree did not meet essentials.

One DNP graduate with three years of RN experience felt overly prepared in both provider readiness and degree adequacy to practice. Regarding the APRN provider readiness level after graduation of the DNP graduates, one graduate, who had zero years of RN experience, felt unprepared yet, felt moderately prepared for their degrees' adequacy to practice. Seven DNP graduates felt moderately prepared for provider readiness for graduation, yet only six felt their degree moderately prepared them for practice, and eight DNP graduates felt adequately prepared for provider readiness for graduation, yet nine felt degree adequately prepared them for practice. All DNP graduates felt their degree met the *Essentials* as recommended by AACN.

Section V. Interpretation and Implications

Cost Benefit Analysis

Cost-benefit of this project must be considered in the context that the project was conducted as a partnership with a single chapter of Sigma Theta Tau International. Associated costs of the project would be people to develop the project, distribute the survey, analyze results, and the financial costs. The employment costs are virtually zero because the project was completely student-led project. For future projects, a partnership between DNP and PhD students could develop a further longitudinal study. The financial costs when funded by a grant, displayed in Appendix D, would include the grants' monetary budget, manpower to distribute the survey, and response-associated costs, which are compared to cost of an in-state master's program. If the investigator decided to incentivize responses, it might be through a monetary gift, such as gift cards to restaurants or retail organization. In comparison, when funded by the university, displayed in Appendix E, the project's financial burdens include the salary of the full-time faculty that was working on the project, the part-time faculty the College of Nursing would need to cover the classes not taught by the full-time faculty member, and the cost of the incentivized responses.

The project would benefit the organization for a variety of reasons. By providing meaningful research regarding perceived provider readiness, the project provides knowledge of educational outcomes to benefit the organization. The knowledge will benefit Sigma's vision of connecting empowered nurse leaders to transform global healthcare, their mission of developing nurse leaders to improve healthcare, and their goals of promoting nursing leadership and advance innovative resources to develop nurse leaders (Sigma Theta Tau International Honor Society of Nursing, 2021; STTI Honor Society of Nursing, 2020). The organization would be allowed to

continue expanding the project, leading to a longitudinal study of at least five years. The project could help to change the narrative and requirements of nurse practitioners' programs nationwide. Increased preparedness to practice will likely increase the quality of healthcare provided by nurse practitioners. Data collected by this project and future extensions of the project can inform nurses seeking graduate degrees for advanced practice, such as NPs, by providing guidance toward educational programs that provide meaningful, rigorous, and evidence-based education to ensure a high level of practice readiness.

There is an unexpected negatively associated cost. The time for researching the evidence to support the project, distributing the survey, analyzing the data, and disseminating the research findings could be seen as an associated negative cost. The costs associated with time could be accrued over weeks to years. Another associated negative cost if project participants receive incentives would be approximately $1,000 to $3,000 depending on the number of respondents and chosen incentive. Overall, the benefits to nursing education and practice outweigh the potential cost burdens. The project has a good return on investment and provide valuable knowledge surrounding academic preparation for advanced practice providers.

Resource Management

The organization has non-monetary resources that add to their successful outcomes. One of those resources is their access to research and information to develop such a project and tool. Another resource the organization possesses includes brilliant, diverse employees who are well versed in academia. Employee experience will allow the project to have a solid foundation to be built. The organization's international group of members can be used as a resource for global development of this project distribution. A potential barrier to successful outcomes is utilizing an IRB for the project, which the organization does not possess. This barrier could lead to a

partnership opportunity with a university IRB. There were no identifiable resources that the organization possessed and not already in use. There is practical feasibility for the organization to reallocate resources to meet successful outcomes within the project due to the low cost associated with the project due to utilization of university students.

Implications of the Findings

The findings of this project have diverse implications yet are the tip of the iceberg. The findings could lead to many different investigational and developmental opportunities to increase the understanding of new-graduate providers' perception of readiness to practice. The findings have implications within academia to further investigate standardization of a recommended degree for practice. Based on these findings of this particular, brief, piloted study the responses suggest there is increased preparedness of doctorally prepared NP when compared to masters prepared NP. The findings have patient, nursing practice, and healthcare system-related implications.

Implications for Patients

The project aimed to identify trends based on new graduate APRN's perceptions of readiness to practice and suggestions for improving formal education to increase their level of preparedness. Therefore, it has substantial implications for the patients they care for and the population as a whole. A new-graduate nurse practitioner who is more prepared to practice will likely lead to evidence-based patient-centered care, increased patient satisfaction, and improved patient outcomes.

Implications for Nursing Practice

The implications for nursing practice could lead to further investigation of nurse practitioners' preparation, including how to change APRN educational programs to improve

providers' practice readiness and facilitate different opportunities to increase the graduates' level of preparedness. One outcome could be the development of a standardized, validated tool to measure new nurse practitioner readiness to practice. Another implication for nursing practice would be developing a tool to motivate or require diverse educational entities to facilitate the transition to a standard degree. These project findings can lead to further investigation of NP education programs' content, delivery methods, and clinical experiences, thereby providing recommendations for changes in the formal education process for NPs. The findings could lead to further research regarding nurse practitioners' educational preparation and isolating the standard degree, which leads to more a dependable and predictable expectation of the abilities of newly-graduated nurse practitioners.

Impact for Healthcare System(s)

An optimally-prepared nurse practitioner will lead to better patient outcomes (American Association of Nurse Practitioners [AANP], 2020). Hiring an optimally-prepared new graduate nurse practitioner will decrease healthcare costs when compared to hiring a physician. Nurse practitioners put patient care at the forefront of their practice (AANP, 2020). Providing a nurse practitioner for all patients to see will lead to increased patient satisfaction, better insurance reimbursement, and a positive return on the healthcare system's investment. There is also the consideration that patients who are happy with their care will recommend the nurse practitioner to others within the community, potentially leading to decreased healthcare costs within the community and increased patient satisfaction scores for the practice (AANP, 2020).

Sustainability

The original organization with whom the project is partnered does not plan to continue the project, but there are ongoing plans of extending this research within the organization. Those

continuing and expanding the research pilot will have some financial costs and dedication of time. The project could continue for years to come, especially as a validated, standardized tool is developed to assess new graduate provider readiness. Additional information necessary to impact sustainability includes updating research and information, adjusting the tool to help lead to sustained reliability and validity, and adjusting the focus within new graduate nurse practitioners.

Dissemination Plan

The data can impact nurse practitioners' academic preparation only when the information is shared. Establishing foundational knowledge based on the data will allow others to build on the foundation. This project hopes to present a knowledge basis through a dissemination plan, including poster presentations at nursing conferences and manuscript submissions in scholarly nursing journals. The events and submissions are listed below:

- East Carolina University College of Nursing Poster Presentation with submission to The Scholarship
- Submission of poster at 2021 Annual NCNA Convention September 23-24, 2021, Charlotte, NC
    - Showcase consideration regarding academic preparation for nurses considering nurse practitioner degree next steps.
- Submission of poster to National League of Nursing (NLN) Education Summit: Leading and Teaching Beyond Resilience September 23-25, 2021, Washington, DC
- Submission of poster to 46th Biennial Convention of Sigma Theta Tau November 6-10, 2021, Indianapolis, IN
- Submission of abstract by April 15, 2021 to 14th National Doctors of Nursing Practice Conference Chicago, IL, August 11-13, 2021

- Submission of abstract within AACN News Watch Weekly Newsletter
    - Due by Monday at 12:00pm to AACN's Editorial Director at boconnor@aacnnursing.org
- Submission of manuscript to *Journal of Professional Nursing*
- Submission of manuscript to *Nursing Education Perspectives:* The NLN Research Journal through Editorial Manager at http://www.editorialmanager/com/nep
- Submission of manuscript to *Journal of Nursing Education* as a Quality Improvement Brief

While this project was initially conducted as student work to meet DNP Essentials, as displayed in Appendix F, the student plans to continue collaborating with ECU faculty to seek formal approval and appropriate methodology to expand this project to a national survey of recent graduates. The student and faculty project partners will stay in touch to share the work, establish roles, and continue to collaborate. The documents will be shared within a shared cloud-based system accessible by all parties involved in conducting the research. The project partners will conduct monthly check-ins to maintain meeting project goals and initiatives. Potentially, the project partners will meet in person once a year to ensure a thorough, in-depth analysis of the project and data, revise goals and objectives, expand implementation, analyze findings, and evaluate the need for continuation of the initiative.

Section VI. Conclusion

Limitations

The biggest limitation to the project included an absence of a standardized tool. This limitation impacted the planning, implementation, and evaluation of the project. During the planning phase, the research had to be geared towards tool development. Without a standardized, valid tool, the results of the study can be called into question.

A limitation with the wording within the IRB paragraph was discovered through the planning process and created a barrier to the project's implementation (seen in Appendix B). The initial paragraph includes the wording: 'goal is to survey *50* individuals in/at *East Carolina University College of Nursing*'. Due to this wording, there was a limitation to whom responded to the survey. Some individual respondents were confused by the wording because they interpreted the wording as an ECU CON student, which was not the case. This limitation could have led to non-response bias.

Recommendations for Others

Planning

This authors' suggestion for an extension of this project or a similar project would include up-to-date research to adjust the readiness assessment survey. Further recommendations within the planning phase include IRB approval and changing the wording to reduce confusion of respondents, thus increasing the diversity of the respondent pool. This authors' suggestion for planning this project further would be to consider partnering with a Doctor of Philosophy in Nursing professor or student to provide a unique perspective regarding future research and development. This authors' other suggestion for those looking to continue the project includes brainstorming a wider variety of ways to distribute the survey. Another area of planning to

consider for further projects would include possibly working to apply for a grant to increase participation and responses.

Implementation

This authors' suggestion for the project implementation would include the possibility of reaching out to other locations and academic institutions to reach a wider variety of individuals. A subsequent project should consider using a national organization such as American Association of Nurse Practitioners (AANP) or American Nurses Association (ANA) to reach a larger group of nurse practitioners. A cost-associated consideration for implementation is to incentivize the respondents with a gift card for their responses. A final implementation consideration is to broaden the respondents to include a broader range of years since graduation.

Evaluation

Regarding the evaluation of the project, further projects should utilize priorly discerned key identifiers to group respondents, allowing for trends to be easily isolated. When looking wholly at this project, there was a definite limitation in the verbiage of the presurvey disclosure within the readiness assessment tool in Appendix B. Consider continuing to publish the results to allow other students, faculties, and academic institutions to continue to grow the research as able.

Recommendations Further Study

Many other concepts need further investigation. Further investigation is needed to eventually make a recommendation towards standardization of a single degree. One concept that needs more analysis includes standardization of academic preparation of nurse practitioners. The further research is necessary to aptly determine if a single degree pathway leads to increased provider readiness, which could lead to adjustments within the nurse practitioners program curriculums. Another concept to investigate includes developing a better understanding of ways

to increase provider preparedness as a new graduate NP. A third concept includes the development of a valid, standardized tool to assess new graduate providers' readiness to practice. A final recommendation for further study includes an examination of each isolated trends' impact on new graduate providers' readiness to practice.

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Appendix A

Standardized Email

Hello Everyone!

I am a Doctor of Nursing Practice student at East Carolina University. My doctoral project involves a research study, in which I am collecting data as to how your academic preparation impacted your perceptions of readiness to practice, as a recently graduated nurse practitioner. I was hoping to take a couple minutes of your time to answer the short survey in the link below. Thank you for your response!

https://ecu.az1.qualtrics.com/jfe/form/SV_ddrhRaP7MT7EqrP

Thank you,

Sydney Howard

Appendix B

Readiness Assessment Tool

You are being invited to participate in a **research** study titled *"Academic Preparation of a Nurse Practitioner: Doctor of Nursing Practice versus Master's of Science in Nursing"* being conducted by *Sydney Howard*, a *student* at East Carolina University in the *College of Nursing* department. The goal is to survey *50* individuals in/at *East Carolina University College of Nursing*. The survey will take approximately *10* minutes to complete. It is hoped that this information will assist us to better understand *graduates perceived readiness to practice regarding differences in academic preparations*. Your responses will be kept confidential and no data will be released or used with your identification attached. Your participation in the research is **voluntary**. You may choose not to answer any or all questions, and you may stop at any time. We ***will not*** be able to pay you for the time you volunteer while being in this study. There is **no penalty for not taking part** in this research study. Please call *Dr. Janet Tillman or Dr. Gina Woody* at *(252)-744-6416 or (252)-744-6399* for any research related questions or the University & Medical Center Institutional Review Board (UMCIRB) at 252-744-2914 for questions about your rights as a research participant.

<u>Questions for DNP Survey:</u>

1. What would you have changed to your APRN program? Please provide a short answer.
2. What would have assisted with increasing your level of preparedness to practice after graduation? Please provide a short answer.
3. What year did you graduate from your graduate program?
4. What degree did you obtain?
    a. MSN
    b. DNP
5. How did you earn your graduate degree?
    a. Exclusively online
    b. Exclusively in a seated classroom, face-to-face
    c. Hybrid, mostly face to face
    d. Hybrid, mostly online

6. How many years of RN experience did you have before you went back to graduate school? __ Years
7. What was your perceived advance practice registered nurse (APRN) provider readiness level after graduation?
    1. Severely Unprepared
    2. Unprepared
    3. Moderately Prepared
    4. Adequately Prepared
    5. Overly prepared
8. How likely did you feel your degree adequately prepared you to practice?
    1 Severely Unprepared
    2 Unprepared
    3 Moderately Prepared
    4 Adequately Prepared
    5 Overly prepared
9. Do you feel your particular degree met the *Essentials* of your specific degree as recommended by the AACN?
    Referenced DNP
    Essentials (https://www.aacnnursing.org/Portals/42/Publications/DNPEssentials.pdf)
    Referenced Masters
    Essentials (http://www.aacnnursing.org/portals/42/publications/mastersessentials11.pdf
    1 Yes
    2 No

Appendix C

Table 1

DNP Project Timeline

ACTIVITY	START	END	NOTES
Project Start	9/1/20	9/6/20	Finalize the survey and analyze different platforms to place the survey on. Disseminate survey to online format. Meet with site champion for finalizing project implementation tool.
Week 1	9/7/20	9/13/20	First week for possible responses to the survey.
Week 2	9/14/20	9/20/20	Second week for responses. Analysis of the first week of responses. Aim to identify trends. Meet with site champion.
Week 3	9/21/20	9/27/20	Third week open for responses. Will put survey on other platforms. Analysis of second week responses.
Week 4	9/28/20	10/4/20	Fourth week for responses. Will analysis third week responses. Meet with site champion. Meet with faculty.
Week 5	10/5/20	10/11/20	Fifth week for responses. Will analyze the fourth week responses. Will refresh trends based on responses.
Week 6	10/12/20	10/18/20	Sixth week survey open for responses. Will analyze the fifth week responses. Meet with site champion.
Week 7	10/19/20	10/25/20	Analysis of sixth week responses.
Week 8	10/26/20	11/1/20	Will further isolate trends and responses to help facilitate results writeups. Meet with faculty. Meet with site champion.
Week 9	11/2/20	11/8/20	Meet with faculty. Meet with site champion. Compile results from prior weeks to isolate trends.
Week 10	11/9/20	11/15/20	Survey closes. Meet with faculty. Meet with site champion. Reevaluate results.
Project End	11/22/20		Compile responses to disseminate results and propose, if possible, a sustainable change for practice adoption.

Appendix D

Table 2

Project Budget Funded by a Grant

Item	Unit Cost	Quantity	Total
DNP PhD Student Partnership	$0.00	1	$0.00
ECU CON Faculty Advisor Grant Funding Endowed	$20,000	1	-$20,000.00
Difference in Cost of ECU DNP Verses In-State Masters	$30,000.00 - $90,062.00	N/A	-$60,062.00
Gift Card Incentive to Respondent	$5.00	600	$5,000.00
Time to Develop Survey	$0.00	Months	$0.00
Total			-$75,062.00

Appendix E

Table 3

Project Budget Funded by ECU

Item	Unit Cost	Quantity	Total
DNP PhD Student Partnership	$0.00	1	$0.00
ECU CON Full-Time Faculty 25% of Salary	$24,351.25	1	$24,351.25
Cost of Part-Time CON Faculty to Cover A Section Each Semester	$6,500.00	3	$19,500.00
Gift Card Incentive to Respondent	$5.00	600	$5,000.00
Time to Develop Survey	$0.00	Months	$0.00
Total			$48,851.25

Appendix F

DNP Essentials Mapping

	Description	Demonstration of Knowledge
Essential I ***Scientific Underpinning for Practice***	**Competency** – Analyzes and uses information to develop practice **Competency** -Integrates knowledge from humanities and science into context of nursing **Competency** -Translates research to improve practice **Competency** -Integrates research, theory, and practice to develop new approaches toward improved practice and outcomes	1. Conducted literature research to support need for investigation of differences in academic preparations. 2. Analyzed NP Core Curriculums. 3. Worked through DNP Case Scenarios.
Essential II ***Organizational & Systems Leadership for Quality Improvement & Systems Thinking***	**Competency** –Develops and evaluates practice based on science and integrates policy and humanities **Competency** –Assumes and ensures accountability for quality care and patient safety **Competency** -Demonstrates critical and reflective thinking **Competency** -Advocates for improved quality, access, and cost of health care; monitors costs and budgets **Competency** -Develops and implements innovations incorporating principles of change **Competency** - Effectively communicates practice knowledge in writing and orally to improve quality **Competency** - Develops and evaluates strategies to manage ethical dilemmas in patient care and within health care delivery systems	1. Development of a readiness assessment tool and distributed 2. Applied for IRB exemption. 3. Attended KIPL Future Clinician Leadership College webinars to better understand quality care, patient safety, and advocacy for improved quality, access, and cost of health care. 4. Written DNP paper submission to The Scholarship. Oral presentation of DNP poster at ECU CON Poster Presentations.
Essential III ***Clinical Scholarship & Analytical Methods for Evidence-Based Practice***	**Competency** - Critically analyzes literature to determine best practices **Competency** - Implements evaluation processes to measure process and patient outcomes **Competency** - Designs and implements quality improvement strategies to promote safety, efficiency, and equitable quality care for patients	1. Analyzed 46 different academic institutions curriculums to determine curriculum requirements and NONPF NP Core Competencies. 2. Critically analyzed research within the project regarding

	Competency - Applies knowledge to develop practice guidelines **Competency** - Uses informatics to identify, analyze, and predict best practice and patient outcomes **Competency** - Collaborate in research and disseminate findings	recommendations of academic preparations of NPs. 3. Identification of a framework for the project and utilized framework for implementation and evaluation of the project. 4. Collaborate with College of Nursing faculty to disseminate findings and further investigation of the project.
Essential IV ***Information Systems – Technology & Patient Care Technology for the Improvement & Transformation of Health Care***	**Competency** - Design/select and utilize software to analyze practice and consumer information systems that can improve the delivery & quality of care **Competency** - Analyze and operationalize patient care technologies **Competency** - Evaluate technology regarding ethics, efficiency and accuracy **Competency** - Evaluates systems of care using health information technologies	1. Attended Vimersion to gather information regarding DNP. 2. Completed CITI Modules prior to apply for IRB approval for the project. 3. Uploaded Readiness Assessment Tool, approved thru the IRB, to Qualtrics to allow for the survey to be distributed through a QR code and email.
Essential V ***Health Care Policy of Advocacy in Health Care***	**Competency**- Analyzes health policy from the perspective of patients, nursing and other stakeholders **Competency** – Provides leadership in developing and implementing health policy **Competency** –Influences policymakers, formally and informally, in local and global settings **Competency** – Educates stakeholders regarding policy **Competency** – Advocates for nursing within the policy arena **Competency**- Participates in policy agendas that assist with finance, regulation and health care delivery **Competency** – Advocates for equitable and ethical health care	1. Analyzed health policy regarding academic preparations of NPs. 2. Reviewed NONPF guidelines regarding preparations of NPs. 3. Created dissemination plan which includes allowing information to be distributed to advocate for possible policy change. 4. Advocated for policy change and increased practice rights for NPs to overcome provider shortage with KIPL FCLC at NCMS.
Essential VI ***Interprofessional Collaboration***	**Competency**- Uses effective collaboration and communication to develop and	1. Attended KIPL programs for collaboration with the NCMS.

for Improving Patient & Population Health Outcomes	implement practice, policy, standards of care, and scholarship **Competency** – Provide leadership to interprofessional care teams **Competency** – Consult intraprofessionally and interprofessionally to develop systems of care in complex settings	2. Peer reviewed fellow DNP students' papers. 3. Collaborated with DNP students for poster feedback.
Essential VII ***Clinical Prevention & Population Health for Improving the Nation's Health***	**Competency**- Integrates epidemiology, biostatistics, and data to facilitate individual and population health care delivery **Competency** – Synthesizes information & cultural competency to develop & use health promotion/disease prevention strategies to address gaps in care **Competency** – Evaluates and implements change strategies of models of health care delivery to improve quality and address diversity	1. Addressed health promotion and disease prevention regarding nurse practitioner's readiness to practice. 2. Aimed to address gaps in care by analyzing how the project can incorporate into Healthy People 2020, Healthy People 2030, and Healthy NC 2030.
Essential VIII ***Advanced Nursing Practice***	**Competency**- Melds diversity & cultural sensitivity to conduct systematic assessment of health parameters in varied settings **Competency** – Design, implement & evaluate nursing interventions to promote quality **Competency** – Develop & maintain patient relationships **Competency** –Demonstrate advanced clinical judgment and systematic thoughts to improve patient outcomes **Competency** – Mentor and support fellow nurses **Competency**- Provide support for individuals and systems experiencing change and transitions **Competency** –Use systems analysis to evaluate practice efficiency, care delivery, fiscal responsibility, ethical responsibility, and quality outcomes measures	1. Designed, implemented, and evaluated DNP project utilizing the readiness assessment tool to evaluate academic preparation of nurse practitioners. 2. Met with DNP Project Partner and Faculty regarding evaluation and dissemination of results. 3. Mentored and supported fellow DNP classmates by peer-reviewing their papers, posters, and analyzing their presentations.