THE INFLUENCE OF DOCTOR OF NURSING PRACTICE EDUCATION ON NURSE PRACTITIONER PRACTICE

by

Paula Christianson-Silva

A DNP Project Submitted to the Faculty of the

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As members of the DNP Project Committee, we certify that we have read the DNP Project prepared by Paula Christianson-Silva entitled "The Influence of Doctor of Nursing Practice Education on Nurse Practitioner Practice" and recommend that it be accepted as fulfilling the DNP Project requirement for the Degree of Doctor of Nursing Practice.

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Final approval and acceptance of this DNP Project is contingent upon the candidate's submission of the final copies of the DNP Project to the Graduate College.

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STATEMENT BY AUTHOR

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DEDICATION

To Dave Silva, my life partner, who inspires, challenges, and supports me daily.

Happy 30th Anniversary!

What Fifty Said
by Robert Frost

When I was young my teachers were the old.
I gave up fire for form till I was cold.
I suffered like a metal being cast.
I went to school to age to learn the past.

Now when I am old my teachers are the young.
What can't be molded must be cracked and sprung.
I strain at lessons fit to start a suture.
I go to school to youth to learn the future.

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ABSTRACT

Nurse practitioners (NPs) have been undergoing a rapid transition in their entry-level degree, from Master of Science in Nursing (MSN) to Doctor of Nursing Practice (DNP). At this time, it is important to establish research evidence on the effects of doctoral education on NP practice. Therefore, a qualitative study of practicing NPs that have returned for the DNP degree was conducted. The purpose was to describe NPs' perceptions of their DNP education, and particularly its influence on their professionalism and patient care. A literature review and evidence synthesis process showed that the available body of research provides little insight into the question of how DNP education affects NP practice; therefore, qualitative description methodology was used to describe this phenomenon. The research questions that guided the study were: 1) What changes do practicing NPs describe about their clinical practice after the experience of completing a DNP?; and, 2) What are the NPs' perceptions of and concerns about the influences of their DNP educational experience on their clinical practice? Two published models and the DNP Essentials (AACN, 2006) informed and guided the data collection and analysis process. Purposive sampling and analyses continued concurrently until data saturation was achieved. Ten DNP prepared NPs were interviewed, and there was wide variation in the sample. The overarching theme *Growth into DNP Practice* summarizes the participants' perceptions of the changes that have occurred as a result of their DNP educational experience. Four major themes that support the overarching theme are: (a) *Broader Thinking and Work Focus*; (b) *New Knowledge and Interests*; (c) *New Opportunities*; and, (d) *"Doctor" Title an Asset*. Conceptual categories under each major theme are described. Participants were overwhelmingly positive about the influences of their DNP education on their practice, but the role of the DNP graduate in knowledge translation has yet to be fully operationalized.

INTRODUCTION

Background

Advanced practice registered nurses (APRNs), including nurse practitioners (NPs), have been undergoing a transition in their entry-level degree, from Master of Science in Nursing (MSN) to Doctor of Nursing Practice (DNP). Precipitated by demands for NPs with greater skill and knowledge, and in response to the increasing length and content of master's degree programs, three innovative universities opened DNP programs in 1999, 2001, and 2005 (Hathaway et al., 2006). The American Association of Colleges of Nursing (AACN) published a position statement making recommendations for the DNP in 2004, followed by *The Essentials of Doctoral Education for Advanced Nursing Practice* (DNP Essentials) in 2006 to guide DNP program development. In 2008, the National Organization of Nurse Practitioner Faculties (NONPF) endorsed an evolution to the DNP as the entry level degree for NP practice. NONPF has also developed core and specialty competencies for nurse practitioners (NONPF, 2012).

Nursing schools nationwide have now initiated the DNP. Currently 243 DNP programs are enrolling students and an additional 59 programs are in the planning stages (AACN, 2014). Most programs also provide the DNP for MSN-prepared NPs seeking this previously unavailable terminal degree, an alternative to the Doctor of Philosophy (PhD) in Nursing. DNP programs are currently available in 48 states and the District of Columbia, including a number of online or mostly online programs (AACN, 2014).

The Problem and Significance to Nursing

The move from MSN to DNP as the recognized degree for NPs has been rapid, but little evidence-based information is available to document the effects of this additional education on nurse practitioner practice, patient outcomes, competencies, professional satisfaction, or

professional activities. Are DNP-prepared NPs better than or different from MSN-prepared NPs? And, if so, how are they different and how are these differences operationalized in their clinical practice?

Answers to these questions may be used to guide nurses interested in becoming nurse practitioners toward the MSN or DNP degree, or masters-prepared NPs in deciding to pursue a DNP. They may assist NP educational leaders in curriculum development and in decisions regarding introduction of DNP programs. Employers may use this knowledge in hiring NPs or in supporting NPs to pursue a DNP. Finally, this evidence may provide support for or against continuing the trend toward DNP level education and the eventual phasing out of master's degree programs.

Purpose and Aims

At this transitional time in the APRN professions, it is important to establish research evidence on the effects of doctoral education on APRN practice. Prior to studying differences between DNP and MSN prepared NPs, it is necessary to describe what NPs perceive to be the influence of their DNP education and what concerns they have regarding this experience. Once themes are described, future studies will be needed to evaluate whether MSN-prepared NPs identify the same or different themes, and comparing DNP to MSN-prepared NPs on a variety of measures.

Therefore, a qualitative descriptive study of practicing nurse practitioners that have returned for the DNP degree was conducted. The purpose was to describe NPs' perceptions of their DNP education, and particularly its influence on their professionalism and patient care. Qualitative description (QD) is a useful methodology for this study because the phenomenon of

interest is in the phase of new knowledge development, and a gap in the literature has been identified (Sandelowski, 2010).

Literature Review

The literature review began with an evaluation of the research evidence on the effects of a DNP degree compared to a MSN degree on NP or APRN practice. It was further expanded to include higher degrees compared to lower degrees in nursing, and to other healthcare fields offering a doctoral degree.

One study was found that specifically looked at perceptions of DNP practice. Stoeckel and Kruschke (2013) conducted phone interviews with 12 practicing DNPs in the western United States in an effort to describe their challenges and role differences since completing the DNP. Five broad categories or themes were identified: *educational preparation, practice settings, role acceptance, challenges, and leadership*. Under educational preparation, sub themes were *acknowledgement of growth through their DNP program*, and *different perceptions of what DNP academic programs should look like*. Challenges were identified as *evolving leadership roles, peer and staff skepticism, and regulatory encumbrances*. The title of doctor was mostly associated with role acceptance by colleagues in other disciplines, but nurse peers were sometimes vocal in their lack of support. The researchers conclude that more study is needed into the "value added" by the DNP (Stoeckel & Kruschke, 2013).

Kleinpell and Goolsby (2012), Dunaway and Running (2009), and Adams and Miller (2001) collected data on NP educational levels but did not report them completely, nor did they compare data on educational levels to the other important study variables: practice areas, mean base salary, career satisfaction (Kleinpell & Goolsby, 2012), professional memberships, job

satisfaction (Dunaway & Running, 2009), or score on an inventory of professional nursing behaviors (Adams & Miller, 2001).

Wu and colleagues (2011) did a case-control study comparing two different educational groups for coping behaviors, intension to quit, and work-related stressors. Their results demonstrated that nurses in the higher educational group reported higher stress levels in the first three years post-graduation compared to nurses in the lower educational group (Wu, Fox, Stokes & Adam, 2011). This study was a well-designed case-control study. However, since it compared Bachelor of Science prepared nurses to Associate Degree prepared nurses, the results may not be generalizable to nurse practitioners.

In a three-group pretest-posttest experimental design study, Stamp (2011) looked at how NPs assess coronary heart disease risks over time, and whether two different interventions would influence the accuracy of their assessment or their insight into the decision-making process. Unfortunately Stamp (2011) did not collect data on the educational level of the NP participants, as it would be interesting to know if NPs of different educational levels varied in their accuracy scores.

A review of qualitative studies looking at APRNs in a variety of settings provides insight into major themes of their professional practice, although none described or compared APRNs by educational level. Nieminen, Marrevaara, and Fagerstrom (2011) found that APRNs possess advanced clinical competence in five areas: assessment of patients' caring needs and nursing care activities, the caring relationship, multi-professional teamwork, development of competence and nursing care, and leadership in a learning and caring culture. Bradway et al. (2011) identified three central themes in APRN care: 1) having the necessary information and knowledge; 2) care coordination; and, 3) caregiver experience, and described the barriers and facilitators to each.

Using a grounded theory approach, Matteliano and Street (2012) studied various primary care health professionals in an effort to document unique ways that NPs contribute to healthcare delivery. NPs were found to play a critical role in bridging both professional and patient cultural divides. Themes that resonated particularly with NPs were their: holistic approach, partnerships with patients, *personalismo*/establishing niches, adherence with professional standards, and culture brokering within healthcare teams. Similar themes were identified in Shiu, Lee, and Chau's (2012) study of good APRN practice in six nurse-led clinics: lack of clarity of the ANP role was found to be a hindering factor.

The concept of professionalism is complex and difficult to measure. Studies that attempt to evaluate professionalism in NPs and other healthcare professionals were reviewed in order to gain understanding of the concept and the influence of educational preparation. Adams and Miller (2001) measured professionalism in NPs using the Professionalism in Nursing Behaviors Inventory (PNBI). The PNBI categories include educational preparation, autonomy, theory, maintaining competency, and adherence to the American Nurses' Association (ANA) Code of Ethics, as well as participation in publication, research, professional organizations, and community service. NPs in the Adams and Miller (2001) study were found to have a high degree of professionalism as measured by the PNBI (mean composite score 16.7 out of 27 possible) compared to other groups tested - nurses in various practice settings (10.13), nurse managers (13.4) and nurse executives (14.9). Only a group of nurse educators scored higher (18.7) (Adams & Miller, 2001).

Chisholm, Cobb, Duke, McDuffie, and Kennedy (2006) developed an instrument for measuring professionalism and professional behaviors in pharmacy student that was later cross-validated by Kelley, Stanke, Rabi, Kuba, and Janke (2011). The Professional Assessment Tool

measures six tenets of professionalism-altruism, accountability, excellence, duty, honor and integrity, and respect for others. Aguilar, Stupans, Scutter, and King (2013) used the Delphi technique to obtain consensus on essential professional values and behaviors for occupational therapists. Consensus was achieved for seven of the professional values and behaviors that emerged: 1) continually strives to improve their knowledge, skills and competence; 2) integrates client's priorities, occupations and goals in therapy; 3) maintains staff and client confidentiality; 4) reflects on and improves their own practice; 5) respects the client and their family; 6) empowers clients to make decisions; and, 7) doesn't pass judgment on people's lifestyle, culture or beliefs.

Van de Camp, Vernooij-Dassen, Grol, and Bottema (2004) performed a systematic review and qualitative analysis of the literature in an attempt to conceptualize professionalism in medicine. They group associated elements into three themes: interpersonal, public, and intrapersonal professionalism, and conclude that professionalism is multidimensional in nature. A study by Hershberger, Zryd, Rodes, and Stolfi (2010) identified self-control as a fundamental component of professionalism in medical residents.

Iacobucci, Daly, Lindell and Griffin (2012) measured the strength of professional nursing values among senior baccalaureate nursing students using the Nurses Professional Values Scale (NPVS)-Revised, a scale derived from the ANA Code of Ethics. The mean composite score in their sample was high (101.43 out of 130 possible, SD=12.78), indicating strong professional nursing values. The researchers consider values to be an important indication of the development of professional identity (Iacobucci, Daly, Lindell, & Griffin, 2012).

In order to determine the best time to study DNP-prepared NPs in their educational or career trajectory, the literature was reviewed for studies comparing professionalism or similar

qualities in health professional populations at different time points. LeDuc and Kotzer (2009) compared the NPVS scores of nursing students, new graduates practicing less than one year, and seasoned practitioners practicing at least five years. No statistically significant differences were found among the three groups, suggesting that experience did not influence the development of professional values (LeDuc & Kotzer, 2009).

The profession of physical therapy (PT) has transitioned from the masters to the clinical doctorate as the entry into practice degree. No studies were found comparing the two educational groups. Anderson and Irwin (2013) compared professionalism in a group of doctoral level PT students at three weeks and the final 33 weeks of clinical experience using the American PT Association Professionalism in PT: Core Values Self-Assessment (PPTCVSA). The PPTCVSA measures professional core values of accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. PPTCVSA scores improved significantly between the two time points, indicating that education had a positive effect on professional values development (Anderson & Irwin, 2013). Results of the Anderson and Irwin (2013) study and those of LeDuc and Kotzer (2009) are conflicting in regard to the impact of experience and education on development of professional values.

A large body of research has documented the quality of patient care provided by NP and physician comparison groups. In a systematic review of these studies, NPs were found to provide care equivalent to or better than physicians in the following areas: patient satisfaction, self-reported perceived health, functional status, glucose control, lipid control, blood pressure, emergency department or urgent care visits, hospitalizations, and mortality (Newhouse et al., 2011). However, no studies were found comparing quality of care between NPs of different educational levels.

What rationale do leaders in nurse practitioner education and in other professions provide for the move from MSN to DNP prepared NPs, and how do they predict DNP prepared NPs will be different? A review of practice and educational journal articles was conducted to study this question. In a seminal article, Vincent, Johnson, Velasquez, and Rigney (2011) discuss the value of DNP prepared NPs as practitioner-researchers who can narrow the research to practice gap through translational research. They predict improvements in quality of care, since DNP educated NPs understand how to apply research findings in clinical settings and will generate new knowledge directly from their practice. Vincent, Johnson, Velasquez, and Rigney (2011) further propose that transformations in the healthcare system are possible because DNP prepared NPs are able not only to implement evidence based practice, but also to study and modify evidence based interventions within their clinical settings. In addition, DNPs understand and are able to effect change in complex healthcare systems (Vincent, Johnson, Velasquez, & Rigney, 2011).

The true drivers of the DNP movement are practicing nurses who appreciate the need for additional education to meet their workplace demands. The DNP allows the profession to clearly differentiate between an academic and professional degree common in other fields, and actualizes the theory-research-practice loop advocated for many years (Hathaway et al., 2006; Brown-Benedict, 2008). The AACN (2004) recommends that DNP graduates be prepared to meet the shortage of nurse educators.

Others see the DNP as directly responding to the recommendation of the 2011 Institute of Medicine (IOM) report, The Future of Nursing: Leading Change, Advancing Practice, that nurses must work to their highest potential to meet needs of rural and underserved populations (Rutledge, 2011). NPs are uniquely qualified to work with physicians and others to meet the

severe shortages of primary care providers, and DNP prepared NPs are challenged to take on leadership roles in healthcare organizations (Iglehart, 2013).

In summary, it is clear from the literature review and evidence synthesis process that the available studies provide little insight into the question of how educational level affects the practice or professional activity of nurse practitioners (Table 1). The dearth of research is likely due to the newness of DNP programs and the current lack of large numbers of DNP level NP graduates. The literature review did provide insight into major themes of professionalism and professional practice among NPs and other healthcare providers. It is unclear from the reviewed research studies if or how professionalism and practice are influenced by additional education. Practice and educational leaders predict but have not yet studied major DNP level NP differences.

TABLE 1. *The Influence of DNP Education on NP Practice, Literature Summary*

Content Area	Author	Date
Introduction, History of DNP Movement, Growth of DNP		
• New entry degree for advanced practice nurses, including nurse practitioners	Hathaway, D., Jacob, S., Stegbauer, C., & Graff, C.	2006
• Rapid growth since first program in 1999	AACN	2004
• Supported by professional organizations	AACN	2006
• Currently 243 DNP programs, 59 in planning	NONPF	2012
	AACN	2014
Study Describing Perceptions of DNP level NP Practice		
• Themes – educational preparation, practice settings, role acceptance, challenges, leadership	Stoeckel, P. & Kruschke, C.	2013
• Title doctor associated with role acceptance		
• More study needed into "value added" by DNP		
Comparing MSN to DNP Prepared NPs, Higher to Lower Degree Prepared Nurses		
• Educational level often not reported	Kleinpell, R., & Goolsby, M.	2012
	Dunaway, L., & Running, A.	2009
• BSN prepared nurses have higher stress than ADN prepared nurses in first three years	Adams, D., & Miller, B.	2001
	Wu, T., Fox, D., Stokes, C., & Adam, C.	2011
• No studies comparing MSN to DNP prepared NPs	Stamp, K.	2011
Studies Identifying Themes in NPs' Professional Practice		
• Clinical competence in assessment, caring relationship, multi-professional teamwork, leadership	Nieminen, A., Marrevaara, B., & Fagerstrom, L.	2011
• Bridge cultural divides	Bradway, C., Trotta, R., Bixby, M., McPartland, E., Wollman, M., Kapustka, H….Naylor, M.	2011
• Holistic approach	Matteliano, M., & Street, D.	2012
• Adherence to professional standards	Shiu, A., Lee, D., & Chau, J.	2012
• Role clarity is hindering factor	Adams, D., & Miller, B.	2001
• High professionalism compared to other nursing groups		
Studies Identifying Themes in Other Healthcare Providers' Professional Practice		
• Tenets of professionalism – altruism, accountability, excellence, duty, honor, integrity for others	Chisholm, M., Cobb, H., Duke, L., McDuffie, C., & Kennedy, W.	2006
• Professional behaviors – strive to improve, integrates client's goals, maintains confidentiality, reflects to improve, respects clients, empowers clients, doesn't pass judgment	Kelley, K., Stanke, L., Rabi, S., Kuba, S., & Janke, K.	2011
	Aguilar, A., Stupans, I., Scutter, S., & King, S.	2013
	Van de Camp, K., Vernooij-Dassen, J., Grol, R., & Bottema, B.	2004
• Professionalism is multidimensional	Hershberger, P., Zryd, T., Rodes, M., & Stolfi, A.	2010
• Self-control fundamental	Iacobucci, T., Daly, B., Lindell, D., & Quinn Groffin, M.	2012
• Values important to professional identity		

TABLE 1. - *Continued*

Content Area	Author	Date
Studies Comparing Professionalism in Same Professional Group Over Time or Career Trajectory		
• No difference between nursing students, new graduates, and seasoned practitioners • Improvement in physical therapy students after clinical experience	LeDuc, K., & Kotzer, A. Anderson, D., & Irwin, K.	2009 2013
Systemic Review Comparing Quality of Care in Nurse Practitioners and Physicians		
NP and MD comparison groups equivalent in (High Evidence Grade): • Patient satisfaction • Self-reported perceived health • Functional status • Glucose control • Lipid control • Blood pressure • ED or urgent care visits • Hospitalizations • Mortality	Newhouse, R., Stanik-Hutt, White, K., Johantgen, M., Bass, E., Zangaro, G., …Weiner, J.	2011
Predictions from Nurse Practitioner Leaders and Others on Outcomes of DNP Education		
• Practitioner-researchers • Narrow research to practice gap • Improved quality of care due to application of research findings • Generate new knowledge directly from practice • Effect change in complex healthcare systems • Differentiates academic vs. professional degree • Actualizes theory-research-practice loop • Improves shortage of nurse educators • Allows APRNs to work to full potential • Meets needs of rural and underserved populations • Improves primary care provider shortages • Leaderships roles in healthcare organizations	Vincent, D., Johnson, C., Velasquez, D., & Rigney, T. Hathaway, D., Jacob, S., Stegbauer, C., & Graff, C. Brown-Benedict, D. AACN IOM Rutledge, C. Iglehart, J.	2011 2006 2008 2004 2011 2011 2013

FRAMEWORK

Research Questions

The research questions that guided the study were:

1) What changes do practicing NPs describe about their clinical practice after the experience of completing a DNP?
2) What are the NPs' perceptions of and concerns about the influences of their DNP educational experience on their clinical practice?

Conceptual Framework

This study was guided by the model Organizational Framework for Explicating the Role of the DNP Graduate in Knowledge Translation developed by Vincent, Johnson, Velasquez, and Rigney (2010) (Figure 1). DNP prepared APRNs are identified as practitioner-researchers, primarily contributing to translational science. The scientist-researcher is traditionally the domain of the PhD prepared nurse. The role circles overlap, showing that the domains are not separate and how they work together through the translational research continuum: basic research, efficacy studies, implementation/dissemination studies, quality improvement/program evaluation, and effectiveness studies.

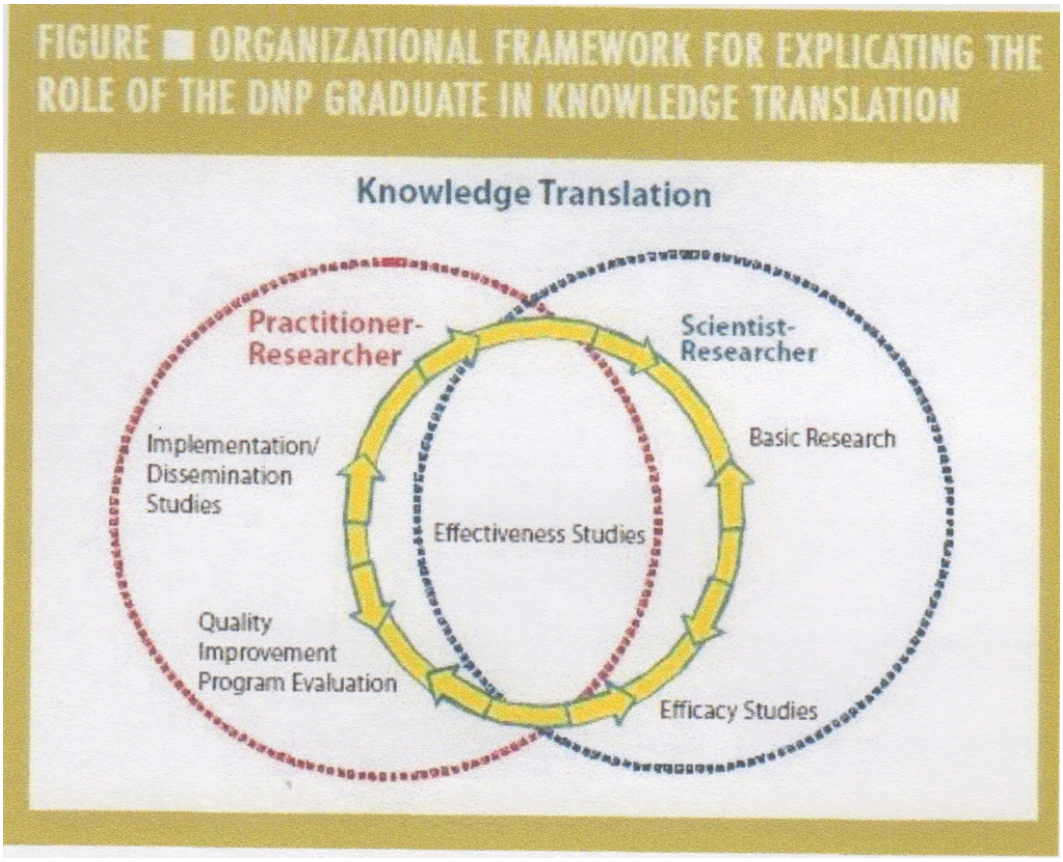

FIGURE 1. Organizational Framework for Explicating the Role of the DNP Graduate in Knowledge Translation. (From: "DNP-prepared nurses as practitioner-researchers: Closing the gap between research and practice," by Vincent, Johnson, Velasquez, & Rigney, 2010, *American Journal for Nurse Practitioners, 14*(11-12), p. 28-34.)

This study sought to describe the degree to which NPs who have returned for a DNP perceive themselves as practitioner-researchers, and how they perceive this role to be operationalized in work with scientist-researchers. The study was a test of the model. Also, it was structured to identify any other themes perceived as explicating DNP-prepared NPs' role in knowledge translation. These additional themes, if identified, could be used to expand upon or supplement the model.

The Strong Model of Advanced Practice (Figure 2) further informed the study. It was developed by a group of APRNs and academic faculty at Strong Memorial Hospital, University

of Rochester Medical Center. The Strong Model defines five domains of the APRN role: direct comprehensive care, support of systems, education, research, and publication and professional leadership (Ackerman, Norsen, Martin, Wiedrich & Kitzman, 1996).

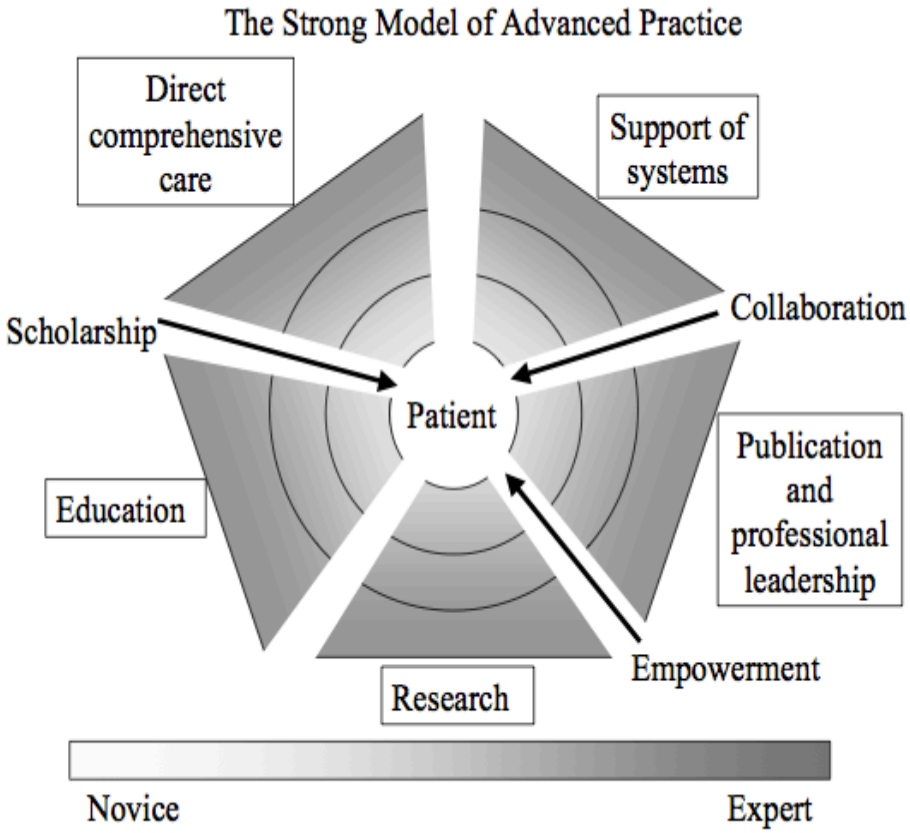

FIGURE 2. The Strong Model of Advanced Practice. (From: "Development of a model of advanced practice," by Ackerman, Norsen, Martin, Wiedrich, & Kitzman, 1996, *American Journal of Critical Care, 5,* p. 68-73).

In the Strong Model, the five domains of the APRN role, that overlap but are not mutually exclusive, are bound by three unifying attributes of practice: collaboration, scholarship, and empowerment. The patient is central (Ackerman, Norsen, Martin, Wiedrich & Kitzman, 1996). The model builds on the work of Patricia Benner to include her five levels of professional advancement or proficiency: novice, advanced beginner, competent, proficient, and expert

(Benner, 1982). This study will use the Strong Model's five domains of the APRN role, three unifying attributes of APRN practice, and five levels of professional advancement to guide data collection and analyses.

Following analysis of the first interview transcript, interview questions derived from the DNP Essentials were added to the topic guide. The DNP Essentials form the conceptual foundation of DNP-level NP education and practice. The DNP Essentials are: I) Scientific Underpinnings for Practice; II) Organizational and Systems Leadership for Quality Improvement and Systems Thinking; III) Clinical Scholarship and Analytical Methods for Evidence-Based Practice; IV) Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care; V) Health Care Policy for Advocacy in Health Care; VI) Interprofessional Collaboration for Improving Patient and Population Health Outcomes; VII) Clinical Prevention and Population Health for Improving the Nation's Health; and, VIII) Advanced Nursing Practice (AACN, 2006).

The Organizational Framework for Explicating the Role of the DNP Graduate in Knowledge Translation (Vincent, Johnson, Velasquez, and Rigney, 2010), the Strong Model (Ackerman, Norsen, Martin, Wiedrich & Kitzman, 1996), and the DNP Essentials (AACN, 2006) informed and guided the data collection and analysis process. However, QD methodology allows for an evolution in conceptual thinking as the study progresses, focusing the researcher on truthful description of the phenomenon. According to Sandelowski (2000), an advantage of QD is that it allows description from the informants' perspective without the encumbrance of a preselected, exact theoretical framework.

METHOD

Study Design: Qualitative Description

Qualitative description (QD) was a useful methodology for this study because the phenomenon of interest is in the phase of new knowledge development, and a gap in the literature had been identified. QD is minimally structured, descriptive, and naturalistic, and may include elements of other post-modern qualitative research methods such as ethnography, grounded theory, phenomenology, and case study (Sandelowski, 2000; 2010). Ethnography is concerned with the cultural context of behavior and includes in-depth fieldwork, particularly observation (Prasad, 2005; Spradley, 1980; Wolf, 2012). Grounded theory seeks to develop or add to a theory or model to explain human behavior (Wuest, 2012). When the aim is an understanding of the meaning of human experience, QD may borrow from phenomenology (Crist & Tanner, 2003). Finally, elements of case study may be utilized to describe complex phenomenon in the form of typical and atypical cases (Hentz, 2007; Zucker, 2001).

The intent of qualitative research is to seek an understanding of the phenomenon from the participants' perspective (Wright & Schmelzer, 1997). QD allows researchers to describe a new phenomenon in everyday terms and without being encumbered by a pre-selected and exact theoretical or methodological framework (Melnyk & Fineout-Overholt, 2011; Munhall, 2012; Sandelowski 2000; 2010).

Setting

Interviews were conducted at a private, quiet location of the participants' choice, such as their home or office. They were face-to-face or utilized Blackboard Collaborate, a secure internet audio and video program.

Participants

The participants were practicing NPs who are over 18 years of age, reside in the United States of America, have completed a DNP degree, are certified in at least one NP specialty, and had practiced for at least one year between their MSN and DNP programs. Included were Acute Care, Adult-Gerontology Acute Care and Primary Care, Adult, Family, Gerontology, Pediatric, Psychiatric-Mental Health, and Women's' Health NPs with DNPs (graduation in December 2014 or earlier). Excluded were other Advanced Practice Nurses such as Clinical Nurse Specialists, Certified Nurse Midwives, and Certified Nurse Anesthetists, NPs who have not completed a DNP, and DNP-prepared NPs who did not practice as NPs for at least one year prior to returning for their DNP.

Purposive or network sampling occurred starting with potential participants known to the principal investigator's advisors, faculty, current and former colleagues, and other professional contacts. Potential participants were invited to participate via email (Appendix A).

Maximum variation, choosing a broad range of varied cases, in sampling was attempted. NPs were recruited from different areas of the country, different practice settings and specialties, and were graduates of different DNP programs. At the end of their first interview, NPs were offered a $50 gift card to thank them for their participation.

Procedure for Protection of Human Subjects

The principal investigator and faculty committee members completed training in human subject's protection through the Collaborative Internal Review Board (IRB) Training Initiative program. The College of Nursing Departmental Review Committee and The University of Arizona IRB approved the study prior to beginning data collection. The study was granted exempt status by The University of Arizona IRB (Appendix B). Each participant reviewed the

Disclosure form (Appendix C), and a copy was retained. It was made clear that participants may withdraw from the study at any time without any negative consequences.

During the study, all demographic data collection forms, tapes, transcripts, field notes, data sheets, and related documents were kept in password-protected files or in a locked fire box at the principal investigator's home. Each participant was given a numerical identifier, with names known only to the principal investigator. At the end of the project, the principal investigator transferred all identifying documents to College of Nursing, room 410, where it will be kept for six years.

Data Collection Procedures

Following review of the Disclosure and verbal consent, each participant completed a Demographic Data Collection form (Appendix D). Data collection centered on minimally structured, open-ended interviews of 30-90 minutes with participants at a location and time of their choice (Neergaard, Olsen, Anderson, & Songergaard, 2009). A topic guide with interview questions was prepared in advance, guided by the research questions and conceptual framework, and revised as needed (Crist, n.d.; Seidman, 1991) (Appendix E). However, participants were encouraged to describe their experiences and concerns "in their own ways" (Milne & Oberle, 2005, p. 415). All interviews were recorded on a digital recorder or using Blackboard Collaborate, a secure internet program. Field notes were recorded following each interview, describing body language, inflection, the environment, or other observations. All participants were asked to participate in verification of study findings during analyses, known as member checking (Lincoln & Guba, 1985).

Data Analysis Procedures

All de-identified interviews were professionally transcribed. Each transcribed interview and field notes were read multiple times. Keeping in mind the research questions, all data bits were given open codes, those with similar descriptions and meanings grouped into conceptual categories, and categories further abstracted to develop major themes and an overarching theme. An inductive approach was utilized in the abstraction process, with new codes being constantly compared to the previous (DeSantis & Urgarriza, 2000; Elo & Kyngas, 2007).

Purposive sampling and analyses continued concurrently until saturation was achieved: no further themes emerged with additional data. The goal was thick description, or a rich explanation of the behavior in context (Spradley, 1980) and maximum variation in the sample.

Trustworthiness

As in all qualitative analyses, meeting Lincoln and Guba's (1985) criteria for trustworthiness was necessary. Member checking to improve *credibility* (accuracy of findings), and an audit trail for *transferability* (providing sufficient detail for replication) were especially important (Wolf, 2012). All findings were checked and confirmed by participants. Interview tapes and transcripts will be kept for review as requested.

Dependability (stability or repeatability) was evidenced by use of an audit trail. *Confirmability* (degree of investigator neutrality) was demonstrated by use of a confirmability audit that showed links between assertions, findings, and interpretations with the data distinguishing those as meaningful to the research questions. Data bits were taken directly from the participants' words, and themes induced directly. A faculty committee member regularly reviewed raw and analyzed data and provided critiques on findings and the data abstraction process. The principal investigator performed all analyses with oversight by the faculty

committee member. Since the principal investigator is a practicing NP and DNP student, much attention was paid to *reflexivity* (consideration of personal involvement). These were demonstrated through field notes and regular journaling about any thoughts and biases. (Lincoln & Guba, 1985)

Study Timetable

The timetable for the study is shown in Table 2.

TABLE 2. *Study Timetable*

2014 – 2015	
Proposal Preparation	January-August
Proposal Defense and Approval	September
IRB Application Submission	December
Data Collection	(after IRB approval) January-March
Data Analysis	January-March
DNP Project Defense	April

Study Budget

A Student Research Grant from Sigma Theta Tau International, Beta Mu Chapter, supported this research (Appendix F). The budget is outlined in Table 3.

TABLE 3. *Study Budget*

Expense Item	**Amount (US $)**
Olympus V406 Digital Recorder	114.99
Professional Transcription Services – 25+ hours	1,250.00
Thank You Gifts - $50 Gift Cards for 10 participants	500.00
Printing/Duplication/Misc.	50.00
Total Expenses	1,914.99

FINDINGS

Participant Demographics

The participants were ten practicing NPs with DNP degrees completed between 2009 and 2014 (N=10). At the time of the study, the participants resided in Arizona (3), California (2), Colorado (1), Florida (2), Michigan (1), and Minnesota (1). Nine participants were female and one was male. Participants ranged in age from 33 to 62 years with a mean age of 49. All participants had DNPs from nine different accredited universities across the United States. They ranged in total practice experience from 7 to 41 years with a mean of 24.3 years. Post-DNP, the participants reported having practiced between 1 and 6 years with a mean of 3.3 and a median of 3.5 years.

All participating NPs were nationally certified. There were five Family NPs (FNPs), two Psychiatric-Mental Health NPs (PMHNPs), one Acute Care NP (ACNP), and one Pediatric NP (PNP). One participant was certified as a Woman's Health NP, FNP, and Adult-Gerontology ACNP. Their current practice settings varied broadly and included family practice clinics, adult diabetes, a pediatric clinic, a school-based health center, a prenatal clinic, urgent care settings, community mental health centers, and a large hospital. Six participants had academic appointments or teaching responsibilities at a university in addition to their clinical practice. Six were active in a local, state, or national NP organization. Detailed participant demographics and an alphabetical list of DNP programs they attended are provided separately to minimize the risk of participant identification (Appendix G).

Overarching Theme: *Growth of the NP and their Practice*

The overarching theme *Growth into DNP Practice* describes and summarizes the participants' perceptions of the changes that have occurred as a result of their DNP educational

experience. Their growth was both internal and external. That is, they reported feeling more prepared and confident about themselves, and describe changes in their thinking. The participants also describe influences on their practice and professional life, and in ways others perceive them. This internal-external dichotomy is well represented by an NP participant, who stated, "Well, I think getting my doctorate, I did meet different people, and then I did start networking differently, and people picked up on that. … I suppose once I had my doctorate… maybe you seek out opportunities, and other people kind of seek you out."

Four major themes support the overarching theme. The major themes are: a) *Broader Thinking and Work Focus*; b) *New Knowledge and Interests*; c) *New Opportunities*; and, d) *"Doctor" Title an Asset*. A conceptual schema of the study findings is shown in Figure 3.

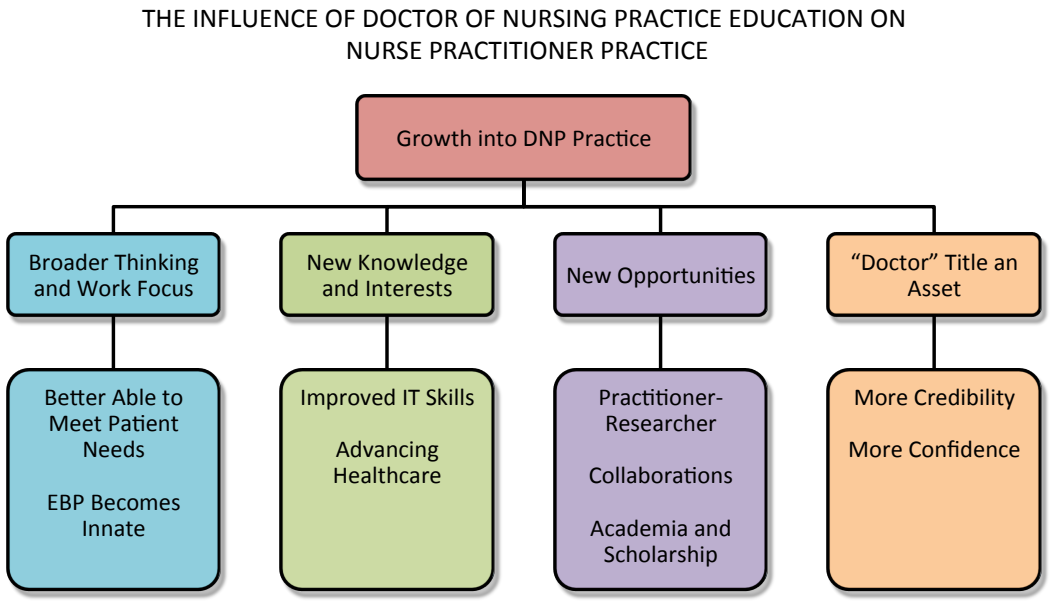

FIGURE 3. Conceptual Schema of Findings.

Major Theme: Broader Thinking and Work Focus

Participants stated repeatedly that they were thinking more broadly since completing their DNP. Phrases such as "systems thinking," "critical thinking," "population health, not just the individual," "increased spirit of inquiry," and "more scholarly" were common. For many, broader thinking led them to pursue a broader work focus. The major theme *Broader Thinking and Work Focus* is supported by the conceptual categories: (a) *Better Able to Meet Patient Needs* and (b) *Evidence Based Practice (EBP) Becomes Innate.*

Conceptual Category: Better Able to Meet Patient Needs

Quality patient care remained the primary goal for all of the NPs in the study, and many described how their DNP experience led to improvements in their care. A PMHNP expressed this goal by stating, "If there's one person that I can help because I'm Dr. A., that would be worth it." Several NPs who remained in the same practice before and after their DNP said that their relationship with patients had *not* changed. However, they went on to describe how they had become a better patient advocate, had become more of a clinical expert, or had developed practice innovations as a result of their DNP.

A PNP stated "I look at like the population of kids with complex medical needs and all that they have to go through getting care and the struggles that they go through as a family, and maybe because I'm an advocate for things beyond just treating their medical concerns, I think maybe that is something that's readily apparent to my families and I think that … has changed the way that I take care of them."

One participant, a primary care FNP in Florida, became a clinical expert in a specialty area. She describes her experience as follows: "I was very interested in preventive cardiology and they had a track in preventive cardiology, so I just became an expert. I took the board certification for

clinical lipidology. My DNP Project was opening a lipid clinic in my office, and looking at clinical outcomes with patients that had more focused cholesterol management."

Another participant NP described developing a practice innovation: "That's one thing I'm passionate about in regards to population health in diabetes management and diabetes prevention. So I got my DNP and I actually implemented a pre-diabetes education program in my large practice group and the DNP helped me to understand all the systems and get that implemented. … I've had podiatrists, diabetes educators, and a pharmaceutical company that's working with me. And one of the grocery store chains in the area is working with me, so it's a really huge project."

An NP in Michigan described her ability to meet patient needs in the following way: "I think I look at my patients differently now in terms of it's not just the one individual patient that I'm working with at any given point in time. It's more the system and the environment in which the patients are functioning. … I work at an alternative high school, so there are LGBT youth there and the school has some knowledge deficits for how to use the right language and how to be supportive of LGBT youth. And I think since having my doctorate, it's definitely changed my ability to understand that I have knowledge and tools to impact that. So I have actually been working with looking into grant funding and providing educational programs for training the school staff and the student body in how to be an ally and supportive of LGBT youth. And I don't know that, before my DNP, I would have even seen that I could have a role in that."

Conceptual Category: Evidence-Based Practice (EBP) Becomes Innate

Although the NPs valued EBP before pursuing a DNP, many described how they were now more critically able to evaluate research evidence and translate it into their clinical practice. They had an improved understanding of the research process, and were therefore better able to

evaluate research articles. More importantly, they *without thinking about it* knew how research results could be applied to their real world patient population and then actively led changes in those patients' care.

A good example of this conceptual category is provided by this quote from an ACNP: "I think when I first started practicing as an NP, it was a little bit more technical. Like, it was doing my job and doing what I just would do. But once I got my DNP, I started thinking about, well, yeah, I can bring up this information about the new blood pressure management guidelines and why we – and helping support why we don't do intensive insulin therapy in ICUs. So rather than kind of following – be more of a follower, you can kind of *lead* some of those changes in care. So I think your focus becomes not just taking care of that patient. I think you get more of a sense of how do you manage that population of patients across a system or across a – I think I just was broader viewed and just more academic about things, I think."

The title for this conceptual category is best evidenced by the following quote: "I practice according to guidelines and that was something I really learned more heavily in the DNP program. So, yeah, I utilized research in my daily practice; but, you know, I do it almost subconsciously now. … the term "evidence based practice" is like seared into you in DNP school. So I think it just becomes part, innate."

Major Theme: New Knowledge and Interests

As might be expected through any educational program, the NPs in the study developed new knowledge and skills, and renewed or developed interest in new areas. The new knowledge and interests most commonly described as a result of their DNP educational experience were conceptualized into two categories. These are (a) *Improved Information Technology (IT) Skills* and (b) *Advancing Healthcare.*

Conceptual Category: Improved Information Technology (IT) Skills

Most of the participants attended an online or partially online DNP Program, which they describe as boosting their comfort level and skills in using the related technology. Several said that their DNP experience was the first time they had worked remotely with others. And they have carried that knowledge into the workplace.

One FNP stated, "Because the program was predominantly online, I developed expertise in being able to work effectively remotely. … So that was extremely helpful in, for example, the international study that I participated in with the age-related macular degeneration. My statistician was in Switzerland. We would have conference calls – they were international conference calls. So we were able to do an entire clinical study report… remotely internationally. So – and I think that is absolutely the way everything is moving. So I think it was a strength that the majority of the work that I did for the doctoral program was remote because it – how do you work effectively remotely? Which has its own set of challenges, but you still need a high quality product at the end. So that experience was excellent preparation." She also discussed using her IT skills in telehealth, in teaching, and in planning a large conference. Living and working in a rural area, the effective use of IT allowed her to do many things.

Several participants described how their informatics course helped them to better utilize IT and to appreciate broader issues related to IT. As an example, one stated, "I didn't understand how networks work and how information systems and EMRs worked, and … how to collect and gather data in a certain way to provide useful information. And then also the issues of information security. So, I mean, I definitely think that my DNP has helped me a lot with that."

She also described using her knowledge: "… an example would be in clinic, you know, when we're trying to look at our outcomes and are checking like the number of patients we have

with certain conditions and then following them and tracking them, looking at their outcomes and then trying to improve the practice based on certain things like that. It makes it a lot easier to pull the charts and to review and make sure we're meeting standards and exceeding standards."

Under the category *Improved IT Skills* there were two negative cases among the participants. One NP stated that although she "can appreciate technology more" she did not learn new skills in IT as a result of her doctoral program. The other said that her DNP Program did not have an informatics course and that "… back in 2007 that [DNP] Essential wasn't really out there too well." Both of these NP participants were early DNP program attenders, with graduations in 2010 and 2009 respectively.

Conceptual Category: Advancing Healthcare

Most of the study participants (N=9) discussed how their DNP educational experience had expanded their interest, knowledge, and involvement in health policy and advocacy. One described this evolution as follows: "I think that with the DNP program, that I gained a better appreciation of the importance of trying to effect change within our system all through those levels, effecting change within my organization, effecting change on a local/state level, and effecting change on a national level. And I think this is one of the areas that was really crucial in my DNP education because prior to doing the DNP, I simply operated within the system that I worked in and didn't get terribly involved in any of the local, state, and national organizations. Once I started my DNP program, I began to understand that we all talk about needing change in our healthcare system, that change… requires that we be active and involved and that we take responsibility for making changes rather than just lamenting that they need to be done."

As previously stated, many of the participants (N=6) held an office in a local, state, or national NP organization at the time of the study. One, a state representative for the American

Academy of NPs (AANP), described her work as: "I attend hearings, I meet with legislators, I contact them by email, by phone, try to meet with them in the district. I also utilize that for AANP in going to their federal national health policy conference in two weeks to meet with federal legislators on federal issues related to practice. So I definitely think it has helped me feeling more comfortable, more knowledgeable in advocating for our profession and for healthcare and patient outcomes."

One NP said that she had always had a "passion for policy," but that having a DNP had likely helped her get a recent appointment by her state governor. Another summed up her evolution to a role in advancing healthcare as follows: "I definitely think that the DNP influenced my work because I'm very involved in health policy and actually became vice-president of legislative affairs of nurse practitioners in the state. So it [the DNP] definitely had a huge impact on that."

Major Theme: New Opportunities

All participants described new opportunities that had come their way as a direct result of their DNP educational experience or of their having a doctoral degree. Phrases such as "new possibilities," "got busier," and "asked to do this or that" were common throughout the interviews. One FNP fully captured this major theme in the statement "A lot of doors opened to me at the doctoral level." The major theme *New Opportunities* is supported by the conceptual categories: (a) *Practitioner-Researcher*, (b) *Collaborations*, and (c) *Academia and Scholarship*. There was significant overlap among these categories.

Conceptual Category: Practitioner-Researcher

Of all the conceptual categories, *Practitioner-Researcher* had the most variation in participant descriptions. One participant described actively leading research projects, doing data

analysis, and serving as the clinical lead on large research efforts. One participant has been involved in a diabetes management research project in her work place. Three NPs discussed serving on doctoral student research committees through academic positions. One of the participants holding an academic position described being able to "bring that NP practice piece" to academia and how "from my standpoint who implements the guidelines already and seeing in practice, we came up with different research questions based on, well, reality in practice."

All of the participants expressed that they were now a better consumer of research, and had an improved understanding of the research process since completing their DNP. The majority of participants (N=9) expressed a desire to be more active in research activities. One NP stated, "So I guess I wouldn't say I feel like I'm a researcher or I'm looked to as a researcher, but I think my *capabilities* to do research-type work is very different, much better." She also described the difficulties of pursuing research without outside funding and with the time constraints of full time clinical responsibilities.

Another stated "I do see the DNP as a professional clinical doctorate as well as a clinical research doctorate, but I don't think we have come far enough with that yet, with the clinical research part of it." In the only negative case for the *practitioner-researcher* category, one FNP stated, "Actually, in my program, they stress that we were not researchers, that we applied research into practice and then evaluated the outcome of applying that research." A minority of participants (N=2) mentioned any involvement in quality improvement or program evaluation activities.

Conceptual Category: Collaborations

Many of the participants (N=9) described how their DNP experience led them to place greater emphasis on interdisciplinary collaborations, giving them a "seat at the table" with

members of other professions. Most (N=9) mentioned physicians, pharmacists, other NPs, and/or nurses seeking their advice more often. One PMHNP stated, "I find the response I get from other people, whether it's my direct colleagues or other professionals and roles within my work environment, seem to regard me a little differently. They come to me asking for a little bit more than they would have in the past."

In one interview, the NP working in a prenatal clinic described the influence of her having a DNP degree on collaboration as follows: "I think it made me just more fully aware of how all of us as part of a healthcare team, people in the laboratory to physicians, nurse practitioners, everybody that interacts with patients, how much better we could fully make the healthcare system in this country if there was full collaboration." One participant has been asked to start a new practice with a physician, and another was "the first and only nurse practitioner ever to be able to serve on that board" of a new practice group.

Participants were asked about any experience working with PhD prepared nurses and how the DNP and PhD roles work together. The common response was "complementary," with half stating they were working in any capacity with a PhD prepared nurse. Several (N=5) expressed hope about the collaborative role. As stated by one NP, "So I think it needs to create partnerships because you have PhDs in a silo and practitioners in a silo and the communication isn't open, then you're not really learning and growing from one another. So I think ultimately we should be working in sync." Another participant with an academic appointment said, "We could do a much better job in teaming together, PhD-DNP, to do phenomenal research."

The NP participant actively leading research projects describes the DNP-PhD collaborations as follows: "we all have different areas of expertise that I think are equally important and equally valued. … I do have experience with, for example, the statistical analysis,

but there are things that I'll be the first to ask my PhD colleagues about, the design. Is there a better way to do this, you know, or certain methods?"

One participant made a point of discussing how she felt strongly that in a DNP level practitioner program, it is important to have both PhD and DNP prepared faculty working collaboratively. She stated, "It is critical to have both, to have clinically focused folks and to have research and academically focused faculty because we need that balance for our nurse practitioners."

Several NPs (N=4) described the need for a "different definition of scholarship" for DNP prepared faculty compared to PhDs who are not currently practicing. As an example, one participant with a full time practice and an academic appointment stated, "In [my clinical practice] I am a clinician and I do teaching and education. … it's a big part of my annual evaluation and my promotion. Whereas at the college of nursing they're not looking for what I do as a clinician. …that really doesn't count at all as far as promotion criteria."

Conceptual Category: Academia and Scholarship

A majority of participants (N=6) in the study had academic appointments or teaching responsibilities at a university in addition to their clinical practice. In all of these cases, they were sought out for the position because of their DNP degree, or a doctorate was a minimum requirement for their roles. One NP with five years' experience post-DNP had recently been selected for an academic leadership position. Another acknowledged that the rapid growth of DNP-NP programs and the shortage of suitable faculty had opened up many new academic opportunities.

One described how she "became an educator" after her DNP and was surprised how much she enjoyed it. Another participant said that, "DNPs are very popular as preceptors." An

NP in California differentiated between her "clinical world" where she had long ago achieved respect, and her "academic world" where "I achieved some recognition for having completed the doctorate because it's important in that world."

Most discussed other new post-DNP opportunities that can be defined loosely as scholarship. Those not previously mentioned include "writing a book," "guest lecturer," "creating practice resources," "presenting at a conference," "committee chair," "develop a special interest group," "selected for a fellowship," "supervisory role," "speak at a seminar," "president of an organization," "asked to speak to prospective students," "grant writing," "program director," "published," and "new job." One described being "drawn to do a little bit more once you have your DNP, whether it's – I think you're just kind of into that mode of you're doing and you're trying to advance the practice, your own or others … I suppose once I had my doctorate, not a lot of people do in the whole scheme of things, so I think people do seek you out some."

Major Theme: "Doctor" Title an Asset

The fourth major theme *"Doctor" Title an Asset* brings together participants' statements about how having a doctoral degree empowered them and led to others seeing or treating them differently. Several participants (N=4) mentioned a strange adjustment to the "doctor" title and joked about patients finally being correct in calling them that. This theme is best described by a participant's statement, "But you know, they can call me "doctor" or whatever they want to and that will be fine, you know, and that will be great. And I think it'll just be kind of an asset." The major theme *"Doctor" Title an Asset* is supported by the conceptual categories: (a) *More Credibility* and (b) *More Confidence.*

Conceptual Category: More Credibility

In interprofessional settings, having a doctoral degree meant that participants had more credibility and respect. In the case of one NP "having the title of doctor before my name … is very powerful because there's a certain expectation that comes with having someone that's doctorally-prepared … They know there's a certain level that that person is bringing to the table."

Participants described varied, through mostly positive, responses from their employers and from other professional colleagues. Some employers had to be educated about the DNP. One participant stated "I think the DNP has enabled me to maybe function at a little bit different level as a professional in my field overall and within my organization. And some of that, I think, is as much perception from others for the degree as it is for me as a practicing individual. I think it gives a different credibility partially just because of the title, the credentials." Another NP described how "a lot of the physicians that I work with seem to take me more seriously, see me more as a colleague than a lower level practitioner."

One ACNP said, "As a hospitalist, the nurses and doctors and other providers, they loved it. … They thought it was a real validation of my knowledge and expertise." Other participants described how the "doctor" credential helped or may help in specific professional activities such as giving a talk or getting a book published. One NP outlined mixed impressions in the following statement: "Some people are really in awe and impressed with it and they think that it's something to be proud of. Other people, I think, are threatened by it. I don't know how to say it other than that. And then in academia, there's a sense of, "Good for you, you have your doctorate, but it's still not as good as a PhD."

All participants expressed that patients were either neutral or positive about their "doctor" title. Some long-term patients expressed pride when one NP graduated with a DNP. One participant said that her few more educated clients understood the value of the credential. Another stated, "I get a different reception from patients sometimes because of having a doctorate degree. I think it makes some of them feel better about seeing me."

Conceptual Category: More Confidence

Their DNP degree and experience was frequently described as confidence boosting to the NP participants. One participant stated, "I just feel better educated, better prepared." Another said, "I can't tell you if it's because I felt more confident or because you have the degree, people treat you a little differently and they listen to you differently." Several mentioned things they never would have done before their DNP, ranging from collaborating with a colleague to giving a talk to running for a national office in an NP organization.

An FNP described how "I've become a lot more effective in the work that I do. I have a lot more tools to be able to do my work. … I've moved into an even greater leadership role." The word "empowerment" to one participant "may sum up the whole – the change that I underwent as a result of my DNP education because I gained confidence and skills and understanding that allowed me to feel more empowered to do the things that I currently do. … My program empowered me to take a stronger role in leadership, empowered me to have the confidence to move into areas where previously I wasn't perhaps comfortable. And it is absolutely one of the goals in our NP and DNP education is to empower our students to start effecting change within the field of nursing. And it certainly worked well for me."

DISCUSSION

The Organizational Framework for Explicating the Role of the DNP Graduate in Knowledge Translation (Vincent, Johnson, Velasquez, & Rigney, 2010), the Strong Model (Ackerman, Norsen, Martin, Wiedrich & Kitzman, 1996), and the DNP Essentials (AACN, 2006) informed and guided the data collection and analysis process. As a test of the Vincent, Johnson, Velasquez, and Rigney (2010) model (Figure 1), this study sought to describe the degree to which NPs who have returned for a DNP perceive themselves as practitioner-researchers, and how they see this role operationalized in work with PhDs in Nursing, described as scientist-researchers.

One important result was that most of the DNP level NPs (N=6) wanted to be more actively involved in the research process than they were, and felt they were capable of doing so. A few (N=3) expressed that DNPs and PhD nurses needed to work together more collaboratively. Those with appointments in academic settings while also managing a clinical practice described the importance of DNPs being evaluated by standards distinct from their PhD colleagues. It was noted that none of the participants used the terms “translational research,” “knowledge translation,” “implementation/dissemination studies,” or “effectiveness studies” in describing their work. In many of the clinical settings the NPs were expected to provide patient care full time. A minority of the participants (N=2) were involved in quality improvement or program evaluation activities. These results indicate that the role of the DNP graduate in knowledge translation has not yet been operationalized as described in the Vincent, Johnson, Velasquez, and Rigney (2010) model. The model cannot be revised or supplemented until it is first actualized.

Participants in this study were overwhelming positive about their DNP educational experience and the internal personal growth and external opportunities it had afforded them. There were no expressed regrets over getting a DNP. All participants support the transition to the DNP as the entry into practice degree for NPs. Some, however, maintained that provider shortages would slow this evolution and expressed regret that we were creating another two-tiered system in nursing.

Strengths and Limitations

A major strength of this study was maximum variation in the sample. Participants varied widely by location, DNP program, certification, and practice setting. There were no major limitations. It is recommended that future studies use a phone and recording device and not Blackboard Collaborate to record long distance interviews. The Collaborate recordings had some inaudible sections, most of which were recoverable with additional listening by the principal investigator. The Collaborate recordings were also not compatible with transcription software, leading to extra work in transcription.

Trustworthiness

Member checking to improve *credibility,* thick description for *transferability*, an audit trail for *dependability*, and field notes, regular journaling, and faculty review for *reflexivity* and *confirmability* enhanced trustworthiness (Lincoln & Guba, 1985). Interview tapes and transcripts have been kept for review as requested. Data bits were taken directly from the participants' words, coded, and conceptual categories and themes induced directly. A faculty committee member well versed in conducting qualitative studies regularly reviewed raw de-identified data transcripts and the abstracted data bits, then provided direction and critiques during the iterative

process to collate findings. The principal investigator performed all data analyses with oversight from the faculty committee member. All ten participants confirmed agreement with all findings.

Implications for Nursing

Findings of this study may be used to guide nurses interested in becoming NPs toward the DNP degree, or to encourage master's-prepared NPs to pursue a DNP. Educational leaders may use these results in curriculum development, in decisions regarding introduction of DNP programs, and in the hiring and evaluating of DNP prepared faculty. The expansion of part time faculty practice opportunities within academic positions will allow DNP level faculty to maintain clinical effectiveness while better managing patient care, teaching, and research responsibilities. Healthcare employers may use this knowledge when hiring and evaluating NPs, to support nurses and NPs to get DNP degrees, and to more fully appreciate the expanded capabilities of DNP prepared NPs.

Future studies are needed to see if Bachelors of Science in Nursing (BSN) to DNP graduates identify the same or different themes as those outlined above. This study and the BSN to DNP cohort study could be repeated serially to evaluate for differences in themes as DNP programs continue to grow and more DNP level NPs are in practice. Additional research is needed to further explicate differences between MSN and DNP prepared NPs on more objective measures such as professional satisfaction and patient outcomes. Finally, as more DNP prepared nurses earn leadership positions in healthcare systems and in universities, studies will be needed to evaluate their impact – especially on the evolution of the practitioner-researcher role for DNPs.

Conclusion

A qualitative descriptive study of ten practicing nurse practitioners that have returned for further education to complete the DNP degree was accomplished. The purpose of the study was to describe NPs' perceptions of their DNP education, and particularly its influence on their professionalism and patient care. The research questions that guided the study were:

1) What changes do practicing NPs describe about their clinical practice after the experience of completing a DNP?
2) What are the NPs' perceptions of and concerns about the influences of their DNP educational experience on their clinical practice?

Evidence generated by this study generally supports the trend toward DNP level education and the eventual phasing out of master's degree programs. Findings indicate that DNP prepared NPs think and work more broadly, are better able to meet patient needs, use EBP innately, have expanded knowledge and interests, have improved IT skills, advance healthcare through advocacy, collaborate well, are sought out for academic positions and other scholarship activities, and exhibit more credibility and confidence that they did before their DNP. Participants were overwhelmingly positive about the influences of their DNP education on their practice, but the role of the DNP graduate in knowledge translation has yet to be actualized.

APPENDIX A:

PARTICIPANT EMAIL

EMAIL TO RECRUIT POTENTIAL PARTICIPANTS

Dear XXXXX,

You were referred to me by XXXXX. For my Doctor of Nursing Practice (DNP) Project at the University of Arizona College of Nursing, I am conducting a qualitative descriptive study of practicing nurse practitioners (NPs) that have returned for and completed a DNP degree. The purpose is to describe NPs' perceptions of their DNP education, and particularly its influence on their professionalism and patient care.

The study participants must be practicing NPs who have completed a DNP degree, are nationally certified, and are licensed in the state in which they practice. Adult, Family, Geriatric, Psychiatric-Mental Health, and/or Women's' Health NPs with DNPs (graduation in December 2014 or earlier) from around the country will be included. Participants must have practiced as NPs for at least one year prior to returning for their DNP.

If you meet these criteria and are interested, I will send you a Disclosure form with complete information. You will then be asked to complete a demographic questionnaire and participate in an interview of 60 to 90 minutes. The interviews will be conducted at a time and place of your convenience, either face to face or via a secure internet program. After the interview, you will receive a $50 gift card to thank you for your participation.

The University of Arizona Institutional Review Board (IRB), in accordance with federal regulations, has approved this study. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 520-626-6721 or vpr-irb@email.arizoan.edu.

Please reply to me at pchristiansonsil@email.arizona.edu.

Thank you and kind regards,

Paula Christianson-Silva MS, ANP-BC, FNP-BC
Doctor of Nursing Practice Student
The University of Arizona

APPENDIX B:

IRB APPROVAL FORM

THE UNIVERSITY OF ARIZONA

Human Subjects
Protection Program

1618 E. Helen St.
P.O.Box 245137
Tucson, AZ 85724-5137
Tel: (520) 626-6721
http://orcr.arizona.edu/hspp

Date:	February 03, 2015
Principal Investigator:	Paula Frances Christianson-Silva
Protocol Number:	1501650996
Protocol Title:	The Influence of Doctor of Nursing Practice Education on Nurse Practitioner Practice
Level of Review:	Exempt
Determination:	Approved
Documents Reviewed Concurrently:	**Data Collection Tools:** *DEMOGRAPHIC DATA-2.docx* **Data Collection Tools:** *INTERVIEW GUIDE.docx* **Grant/Contracts:** *Beta Mu Chapter Research Grant.docx* **Grant/Contracts:** *STT Student Research Grant Application_PCS.docx* **HSPP Forms/Correspondence:** *Christianson-Silva IRB Ap FINAL with Revisions-2.doc* **HSPP Forms/Correspondence:** *F107 VOTF Christianson-Silva-2.doc* **HSPP Forms/Correspondence:** *Signature page.pdf* **Informed Consent/PHI Forms:** *DISCLOSURE-2.Admin fixed.pdf*

This submission meets the criteria for exemption under 45 CFR 46.101(b).

- The University of Arizona maintains a Federalwide Assurance with the Office for Human Research Protections (FWA #00004218).
- All research procedures should be conducted in full accordance with all applicable sections of the Investigator Manual.
- Exempt projects do not have a continuing review requirement.
- Amendments to exempt projects that change the nature of the project should be submitted to the Human Subjects Protection Program (HSPP) for a new determination. See the Investigator Manual, 'Appendix C Exemptions,' for more information on changes that affect the determination of exemption. Please contact the HSPP to consult on whether the proposed changes need further review.
- All documents referenced in this submission have been reviewed and approved. Documents are filed with the HSPP Office. If subjects will be consented the approved consent(s) are attached to the approval notification from the HSPP Office.

Your proposal is in compliance with Federalwide Assurance 00004218. This project should be conducted in full accordance with all applicable sections of the IRB Investigators Manual and you should notify the IRB immediately of any proposed changes that affect the protocol. You should report any unanticipated problems involving risks to the participants or others to the IRB.

APPENDIX C:

DISCLOSURE FORM

DISCLOSURE

THE INFLUENCE OF DOCTOR OF NURSING PRACTICE EDUCATION ON NURSE PRACTITIONER PRACTICE

Doctor of Nursing Practice (DNP) Project
Paula Christianson-Silva MS, ANP-BC, FNP-BC

You are being asked to take part in a research study being conducted by Ms. Christianson-Silva, a student at The University of Arizona College of Nursing. The information on this form is provided to help you decide whether or not to participate. If you decide you do not want to participate, there will be no penalty to you. And you may withdraw from the study at any time without penalty.

As you know, in recent years nurse practitioners (NPs) have been undergoing a transition in their entry-level degree, from Master of Science in Nursing (MSN) to Doctor of Nursing Practice (DNP). The move from MSN to DNP as the recognized degree for NPs has been rapid, but little evidence-based information is available to document the effects of this additional education on nurse practitioner practice, patient outcomes, competencies, professional satisfaction, or professional activities. Are DNP-prepared NPs better than or different from MSN-prepared NPs? And, if so, how are they different, and how are these differences operationalized in their clinical practice?

This study will use qualitative description to study practicing NPs that have returned for and completed a DNP degree. The purpose is to describe NPs' perceptions of their DNP education, and particularly its influence on their professionalism and patient care.

The research questions that guide this study are:

1) What changes do practicing nurse practitioners describe about their clinical practice after the experience of completing a DNP?
2) What are the NPs' perceptions of and concerns about the influences of their DNP educational experience on their clinical practice?

Benefits of this study are that the information may be used to guide nurses interested in becoming nurse practitioners toward the MSN or DNP degree, or masters-prepared NPs in deciding to pursue a DNP. Results may assist NP educational leaders in curriculum development and in decisions regarding introduction of DNP programs. Employers may use this knowledge in hiring NPs or in supporting NPs to pursue a DNP. Finally, this evidence may provide support for or against continuing the trend toward DNP level education and the eventual phasing out of master's degree programs. There are no direct benefits to you.

If you choose to take part, you will be asked to complete a demographic questionnaire and to participate in an interview of approximately 60-90 minutes. I will also be taking notes of my observations during the interviews. Interviews will be conducted face-to-face at a private

location of your choice, or via WebEx, a secure internet program. Interviews will be audio recorded.

Some NPs may be asked to participate in a second or third interview of 30-60 minutes, to gather additional information or to verify findings. Again, your participation will be voluntary and you may decline at any time.

Aside from your time, there are no costs or risks associated with your participation. You will not be paid for your participation. However, after the first interview you will receive a $50 gift card to thank you for your participation. All information related to this study will be kept confidential, either in a locked cabinet or password-protected file. Results of this study will be sent to you if desired.

Questions regarding this study should be directed to Paula Christianson-Silva at pchristiansonsil@email.arizona.edu. The University of Arizona Institutional Review Board (IRB), in accordance with federal regulations, has approved this study. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 520-626-6721 or vpr-irb@email.arizona.edu.

Please retain this disclosure form for your records.

APPENDIX D:

DEMOGRAPHIC DATA FORM

DEMOGRAPHIC DATA FORM

Participant Number

Name

Age

Gender

Education History (Year, School Name)

- ADN / Diploma
- BSN
- MSN/NP
- DNP
- Other
- Other

Certification(s)

Specialty

Practice Setting

Years of Practice Experience

- Prior to BSN
- Prior to MSN/NP
- Prior to DNP
- Post-DNP
- Other

APPENDIX E:

TOPIC GUIDE WITH POTENTIAL INTERVIEW QUESTIONS

TOPIC GUIDE WITH POTENTIAL INTERVIEW QUESTIONS Revised 3/9/15

Life Review

Tell me a bit, briefly, about your career as a nurse and nurse practitioner.

What led to your decision to return to school for a DNP?

Since completing your DNP, how has your work life and practice changed?

Details of the Experience

Do you perceive any changes in the way you are treated by others since completing your DNP? If so, how?

Some have described DNP-prepared NPs as practitioner-researchers. Do you see yourself as a practitioner-researcher? If so, how is this role operationalized in your practice?

Have you worked with PhD-prepared nurses since completing your DNP? If so, how did these roles work together?

The translational research continuum is usually described as the following: basic research, efficacy studies, implementation/dissemination studies, quality improvement/program evaluations, and effectiveness studies. Where do you see the work of DNP-prepared NPs falling on this continuum?

A group of Advanced Practice Registered Nurses (APRNS) developed a model that defines five domains of the APRN role. Please speak to how your DNP education may have changed your work in each of these domains:

1. direct comprehensive care
2. support of systems
3. education
4. research

5. publication and professional leadership

The same model describes these domains as being bound by three unifying attributes of APRN practice. Please discuss how your DNP educational experience may have influenced your work in each of these attributes:

1. collaboration
2. scholarship
3. empowerment

Has your relationship with patients changed? If so, how?

You may be familiar with the AACN "DNP Essentials." Please address how your DNP education has influenced you work in each of the following areas:

1. scientific underpinnings for practice
2. organizational and systems leadership for quality improvement and systems thinking
3. clinical scholarship and analytical methods for evidence-based practice
4. information systems/technology and patient care technology for the improvement and transformation of health care
5. health care policy for advocacy in health care
6. interprofessional collaboration for improving patient and population health outcomes
7. clinical prevention and population health for improving the nation's health
8. advanced nursing practice

Please discuss any other aspects of your work as a DNP-prepared nurse that we have not addressed.

What concerns do you have about the DNP educational experience and its influence on clinical practice?

Additional Details of the Experience and Reflection

You mentioned XXX (experience) was/meant XXX (interpretation) to you. Is that close to how you interpret it?

Debriefing

How has this interview been for you?

Is there anything else you would like to say?

APPENDIX F:

GRANT AWARD LETTER

Sigma Theta Tau International
Honor Society of Nursing®

Beta Mu Chapter

Research Grant Award

March 14, 2014

Paula Christianson-Silva

I am very pleased to inform you that you have been awarded the DNP Student Research Grant Award for your application to accomplish the study entitled, "A Study of the Influence of Doctor of Nursing Practice Education on Nurse Practitioner Practice". I will also inform your faculty advisor, Dr. Janet DuBois regarding your receiving this honor.

You will be awarded a grant of $1000 at the Annual Beta Mu Chapter Banquet on April 30, 2014 that is being held at The University of Arizona, Student Union, North Ballroom, Tucson, AZ. As a member of Beta Mu you will soon receive an invitation to this event.

Again, congratulations on your award!

Sincerely,

Audrey Russell-Kibble, DNP, FNP-C
STTI Beta Mu Chapter, Research Counselor

APPENDIX G:

PARTICIPANT DEMOGRAPHICS AND LIST OF DNP PROGRAMS

Participant Demographics

Number	Residence	Gender	Age	Practice Experience	Post DNP	Certification	Practice Setting	Academic Position?
01	AZ	F	62	41	1	PMHNP	CMHC	No
02	MN	M	41	19	3	ACNP	Hospital	Yes
03	FL	F	54	31	2	FNP	Diabetes	No
04	CA	F	45	18	1	WHNP FNP AGACNP	Prenatal WH	Yes
05	AZ	F	43	18	3	FNP	Rural CHC	Yes
06	AZ	F	52	28	5	PMHNP	CMHC	No
07	MI	F	33	7	1	FNP	School-based HC	Yes
08	FL	F	54	31	5	FNP	IM Lipid	Yes
09	CO	F	49	27	6	PNP	Peds	Yes
10	CA	F	57	23	6	FNP	Urgent Care	No
Mean			**49**	**24.3**	**3.3**			**N = 6**

Note. PMHNP = Psychiatric Mental Health NP, ACNP = Acute Care NP, FNP = Family NP, WHNP = Women's Health NP, AGACNP = Adult-Gerontology Acute Care NP, PNP = Pediatric NP; CMHC = Community Mental Health Center, WH = Women's Health, CHC = Community Health Center, HC = Health Center, IM Lipid = Internal Medicine & Lipidology, Peds = Pediatrics

List of DNP Programs Attended by Participants

The University of Arizona (2)

Florida Atlantic University

University of Massachusetts, Amherst

University of Minnesota

University of South Alabama

University of South Florida

Texas Christian University

Wayne State University (Michigan)

Western University of Health Sciences (California)

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