

Editorial

Nurse practitioner education: keeping the academic pipeline open to meet family planning needs in the United States

According to the Centers for Disease Control and Prevention, family planning is one of the greatest public health achievements of the 20th century. Ample research shows that family planning helps women and men maintain reproductive health, allows women to avoid unintended pregnancies and assists families in determining the number, timing and spacing of their children — all of which contribute to the well-being of individuals, families and the broader society as well [1].

There are 66.4 million women in the United States of reproductive age (13–44 years). More than half (36.2 million) of these women are sexually active, not seeking pregnancies and in need of contraceptive services and supplies. Due primarily to poverty or young age, over 17.5 million of these women do not have insurance or financial resources and need publicly funded contraceptive care [2].

Nurse practitioners (NPs) provide the majority of family planning services in public health departments, community health centers and Planned Parenthood affiliates in the United States. For example, 75% of the 1780 clinicians employed nationally by Planned Parenthood affiliates are NPs [3].

Family planning centers are facing many challenges today such as serving a more diverse population with increasingly complex needs, rising costs, a poor economy and new technologies. Many are also facing a shortage of health care providers. Recruitment and retention of clinicians who provide reproductive care — physicians, NPs, certified nurse midwives and physician assistants — are very costly tasks. The provision of family planning services requires unique skills, knowledge and sensitivity to client needs. Policy makers, public health leaders and other stakeholders are concerned that we are not educating enough new clinicians to provide family planning services to future generations.

If NPs are to continue to provide a majority of family planning care, we need to examine the pipeline into NP careers and address issues that could potentially impact future access to care. One of these concerns is that the number of women's health NPs (WHNPs) entering the profession has declined in recent years. As WHNPs retire, the supply will not keep up with the demand. The National

Certification Corporation reports that roughly 350 NPs are certified in women's health in an average year [4]. Given the size of our nation's patient population requiring services of WHNPs, collective action is needed now to encourage more NPs to specialize in women's health.

Amplifying this issue is the fact that the United States is experiencing a shortage of registered nurses, which impacts the population of nurses available to become NPs. Furthermore, the number of RNs with bachelor's degrees is only 34.2% of the current RN population [5]. The current shortage of registered nurses is driven primarily by the increasing demand for professional nurses in multiple areas of health care. In the past, nursing schools also experienced dramatic declines in the interest in a nursing career given the fact that women, who make up the largest portion of the profession, have more career options than in past years. Fortunately, that has changed with growing awareness of the attractive career opportunities available to nurses today, and schools of nursing are now facing the dilemma of expanded demand that outpaces available slots for students.

Nursing school enrollments need to increase by 2–3% each year in order to meet the projected required numbers of nurses for the future. And, as noted above, applications far exceed the acceptance numbers. This results from a lack of nursing faculty and an inability for nursing programs to grow. Nursing faculty members are required to have a master's degree and preferably a doctorate, degrees held by only 13% of all nurses. Additionally, the average age of a graduate level nursing faculty is 57.3 years. The rapidly aging and diminishing supply of nurse faculty must be addressed to ensure a healthy and stable nursing workforce into the future [6].

In addition, educational requirements for this role are changing. Early in the 1970s, WHNPs were prepared in certificate programs funded by the Title X family planning program. Five Title X NP programs, geographically distributed through the United States, educated the majority of the NP workforce from the early 1970s through 2001 when the programs were phased out. Notably, these programs excelled at recruiting and educating nurses who were community based and ethnically diverse. The Title X programs required that the applicant whose tuition was

covered by Title X was an RN sponsored by a Title X provider that guaranteed a position in the sponsoring agency's clinic upon graduation. One Title X NP program boasted a 50% enrollment of minority applicants, far exceeding the number of minorities in other NP programs. The vast majority of students in all of these programs were recruited directly from their local communities (personal correspondence with author, Sharon Schnare, former director, Harbor-UCLA Title X Nurse Practitioner Program). Continuing education (CE) programs have been a foundation of NP training programs since the beginning, and Title X still funds these programs today.

The phase-out of certificate programs was a result of political pressures to house NP programs within schools of nursing and to institute a master's degree requirement to sit for national certification. As disciplines evolve and roles are clarified, educational requirements evolve as well. The move to graduate level preparation for NPs was inevitable.

The majority of states now require NPs to hold a master's of science in nursing as well as national certification in order to be licensed to practice. NPs without master's degrees who were practicing and licensed in the state prior to these requirements are still eligible to practice through grandfather clauses. However, in most cases, they cannot move to another state and become licensed to practice. A new degree, a doctorate nursing practice (DNP), is now being proposed as the entry into advanced specialized nursing practice by 2015 [6]. Should the DNP be required by states, NPs who do not hold this degree would also be grandfathered in. Once again, however, these NPs would not be able to move to another state that requires a DNP unless previously licensed there [7].

1. The move to the Doctor of Nursing Practice

The rapid transformation of health care in this nation, and the increased complexity of care provided by nurses with advanced specialized education, has been accompanied by a concurrent transformation of the education for this type of practice. Beginning early in the 21st century, nursing clinicians and educators began experimentation with new types of education that resulted in a professional or clinical doctorate focused on the highest level of practice. The American Association of Colleges of Nursing (AACN) brought together a wide array of clinicians, policy makers, educators and employers to study this evolution of both practice and education and created out of this 2-year consensus-building process a recommendation that all nurses educated for the highest level of practice be required to study in a program that would grant a professional doctorate — the Doctor of Nursing Practice (DNP) [8].

This recommendation came out of the clear recognition that as care had become increasingly complex, the programs educating nurses for advanced practice had expanded requirements far beyond those normally required for a master's degree. Unlike master's programs in other fields

which require 36–40 credits, most advanced nursing programs were requiring far in excess of 60 semester credits. For nurse anesthesia, the required credits were closer to 80. Obviously, learners were not being granted a degree that reflected the time, effort and resources invested to achieve the degree. Moreover, other significant areas of learning were not addressed in the traditional master's degree programs, and expansion of the content to include an exposure to system management, data aggregation and evidence translation could not be included without significant further expansion of the program of study, which would further misalign the degree acquired with the requirements for that degree.

The recommendation to move to the DNP was approved at the membership business meeting of the AACN in October 2004. Coincidentally, in September 2005, the National Academy of Science issued its report titled "Advancing the Nation's Health Needs: NIH Research Training Programs," the 12th in a series of congressionally mandated reports monitoring changing needs for biomedical and behavioral research personnel in the United States [9]. The chapter on nursing examines the career trajectory for nurse scientists and includes recommendations for responding to the shortage of nurse investigators. Though focused on preparing researchers, the report noted that "the need for doctorally prepared practitioners and clinical faculty would be met if nursing could develop a new non-research clinical doctorate, similar to the MD and PharmD in medicine and dentistry" [9].

The response in academia has been a clear indication of the acceptance of this recommendation. Currently, almost 100 DNP programs have begun enrolling and graduating students. Additionally, almost 100 additional programs are in planning phases [10]. Moreover, student interest continues to grow.

For the discipline, several challenges remain. Critique of this transition has emerged from physician groups concerned that the granting of a doctoral degree will allow advanced practice registered nurses (APRNs) to misrepresent themselves as physicians, not nurses, given the common use of the title "doctor" [11]. APRNs have been very clear that they are not physicians but instead nurses with a separate and distinct profession, with a clearly differentiated knowledge base. Moreover, APRNs and multiple other health professionals hold doctoral degrees, and physicians do not own this degree designation. More importantly, however, is the expressed concern that the move to the DNP could elongate or make more costly the preparation of APRNs — a vitally important clinician group for women and others. And, as health care reform policy analysts pay attention to the potential for APRNs to serve as key access points in a revised or expanded health care system, there is concern that this transition could decrease the number of individuals who are prepared for advanced nursing practice.

Clearly, the profession must stay aware of these concerns and not allow the transition to the DNP to either diminish

interest in specialty nursing practice or the supply of APRNs needed to fill vitally important primary care roles. The strong interest from students in these programs seems to indicate that this trend is on the move. The strongest argument for the DNP is providing a degree commensurate with the number of credit hours required in many NP programs. Arguments against the DNP as entry into practice include lack of evidence that DNP programs will improve the clinical skills of NPs; additional tuition burden that may deter NPs from seeking lower paying positions in publicly funded programs; rapid changing health care technology in which formal education soon becomes outdated and where educational needs can only be met through CE and other postgraduate mechanisms; lack of data about how the DNP requirement might attract or deter community-based, ethnically diverse students; and lack of faculty to expand to DNP programs in many parts of the country resulting in fewer programs closer to potential students with family and financial obligations at home.

Regardless, the move to the DNP is the future. Family planning providers who have depended on NPs to provide services must be aware of this move. NPs who currently have a master's or other degree should be aware that while their ability to continue to practice in their state will not be challenged, their ability to move to other states may well be challenged if the DNP requirement is instituted by the 2015 target date.

2. Recommendations

- (1) Convene a task force made up of key opinion leaders in the US to make recommendations on who will care for family planning clients in 2020 to include educators, administrators, potential funders, etc.
- (2) Assure that the entry into practice requirement for NPs is preceded by robust support to maintain and expand the pipeline of nurses in the workforce who can deliver the necessary care services.
- (3) Encourage individuals to become registered nurses and nurse practitioners.
- (4) Encourage the continued availability of programs that are sensitive to the life issues of the students such as programs that can be accessed remotely and require only short periods of time away from home.
- (5) Support funding for scholarships for NPs who will practice in family planning clinics and other publicly funded programs.
- (6) Develop a national marketing campaign that features the benefits of working in family planning settings to RNs, NPs and other providers.

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