Clarification of Nurse Practitioner *Specialty* and *Subspecialty* Clinical Track Titles, Hours, and Credentialing

Report of a Four-Phased Research Project Conducted by the National Organization of Nurse Practitioner Faculties

Monica S. Scheibmeir, PhD, ARNP, FAANP
Principal Investigator

Report prepared by Berlin Sechrist Associates,
Linda E. Berlin, DrPH, RN, WHNP-BC and
Karen R. Sechrist, PhD, RN, FAAN, Principals

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National Organization of Nurse Practitioner Faculties
900 19th Street, NW, Ste. 200B, Washington, DC 20006
Tel. (202) 289-8044 • Fax: (202) 384-1444 • E-mail: nonpf@nonpf.org

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EXECUTIVE SUMMARY

This report provides a summary of the processes and findings of a four-phased research project funded by the National Council of State Boards of Nursing (NCSBN) Center for Regulatory Excellence and undertaken by the National Organization of Nurse Practitioner Faculties (NONPF) during the period of June 2007 through June 2009. The project was based on the shared concerns of the two organizations regarding clinical track titling, credentialing, and hours requirements for increasing numbers of nurse practitioner (NP) programs at the *specialty* and *subspecialty* level.

Study Purpose and Specific Aims. The overall purpose of the study was to amplify and clarify information about current and emerging NP educational pathways leading to *specialty* and *subspecialty* preparation. In order to accomplish the overall objective, the study was conducted in four interrelated phases with each phase building on the findings of the previous phase. The specific aims of the four study phases were to:

Phase I. Identify the range of *specialty* and *subspecialty* NP educational tracks from a review of Web sites of all schools of nursing with master's-level NP programs.

Phase II. Clarify titling, hours, curriculum, and credentialing information with selected faculty from programs with *subspecialties* through regionally stratified focus groups.

Phase III. Validate information emerging from the focus groups through a survey of all schools of nursing with master's-level NP educational programs.

Phase IV. Prioritize future directions for NP education based on project findings with the NONPF membership at a Priority-Setting Forum during the 2009 NONPF annual meeting.

Importance of the Project. The results quantified what is currently in place in NP educational programs nationally providing a baseline for implementation of the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education* (APRN Consensus Work Group and the NCSBN APRN Advisory Committee, 2008).

Project Team. Monica S. Scheibmeir, PhD, ARNP, FAANP, Associate Professor, University of Kansas Medical Center School of Nursing served as Principal Investigator. NONPF subcontracted with researchers Linda E. Berlin, DrPH, RN, WHNP-BC and Karen R. Secrhist, PhD, RN, FAAN. Berlin Sechrist Associates Principals, to conduct all aspects of the study. Kathryn E. Werner, MPA, NONPF Executive Director, provided facilitation and support services for the project through the national NONPF office.

An Advisory Group of NONPF members was appointed to provide input regarding all research related issues. Members of the Advisory Group were: Debra Barksdale, PhD, RN, CFNP, CANP, FAANP, Assistant Professor, University of North Carolina-Chapel Hill School of Nursing; Charlene M. Hanson, EdD, FNP, FAAN, Professor Emerita in Nursing, Georgia

Southern University College of Health and Human Sciences School of Nursing; Doreen C. Harper, PhD, RN, FAAN, Dean and Professor, University of Alabama at Birmingham School of Nursing; Julie Marfell, ND, CS, FNP, Chair, Department of Family Nursing/Course Coordinator, Frontier School of Midwifery and Family Nursing; Ann L. O'Sullivan, PhD, FAAN, CRNP, Professor, Primary Care Nursing-Clinician Educator, University of Pennsylvania School of Nursing; and Joanne M. Pohl, PhD, ANP-BC, FAAN, Professor, University of Michigan School of Nursing.

Phase I Aim, Methods, and Findings. The aim of Phase I was to identify the range of *specialty* and *subspecialty* NP educational tracks from a review of Web sites of all schools of nursing with master's-level NP programs. Identification of schools with *subspecialty* clinical tracks, further, provided the target sample for the Phase II Focus Groups. The secondary purposes of the review were to examine the variety of clinical track titles, as defined by curricula in specific practice areas, and to assess the overall quality of the Web sites.

The purposes were accomplished by a systematic review of Web sites of the schools of interest. A total of 1,037 NP clinical tracks were identified on the Web sites of 328 schools. Major findings were:

- The words, *specialty* and *subspecialty*, were used infrequently on the Web sites to designate NP clinical tracks:
  - A total of 410 clinical tracks (39.5% of 1,037 tracks) in 106 schools (32.3% of 328 schools) were designated by the word specialty.
  - A total of 77 clinical tracks (7.4% of 1,037 tracks) in 20 schools (6.1% of 328 schools) were designated by the word *subspecialty*.
- The Family Nurse Practitioner (FNP) clinical track title as defined by curricula accounted for 254 (24.5%) of the 1,037 clinical track titles. The titles of Adult NP (ANP), Pediatric NP (PNP), Geriatric NP (GNP), Neonatal NP (NNP), Acute Care NP (ACNP), Women's Health NP (WHNP), Psychiatric-Mental Health NP (PMHNP), Adult Acute Care NP (ACNP), ANP/GNP, Adult PMHNP, and Family PMHNP accounted for 414 (39.9%) of the track titles. The remaining 369 (35.6%) of the clinical tracks had other unique titles.
- There was much variation in the organization, type, amount, and consistency of information on the Web sites. Information about certification eligibility, credit hours for graduation and total number of required clinical practice hours was missing from many Web sites:
  - Certification eligibility was not provided on the Web site for 38 (37.2%) of the NP tracks in 123 (37.5%) of the schools.
  - Credit hours required for degree/program completion were not available on the Web site for 130 (12.5%) of the program tracks in 15 (4.6%) of the schools.
  - The total number of supervised clinical practice hours required was not reported for 614 (59.2%) NP tracks in 165 (50.3%) of the schools.

The review validates previous findings that expressed concern about varying clinical track titles that do not necessarily reflect role preparation and certification eligibility (Berlin, Harper, Werner, & Stennett, 2002).

Phase II Aim, Methods, and Findings. The aim of Phase II was to clarify NP program titling, hours, curriculum, and credentialing information with selected NONPF member schools through

regionally stratified focus groups. Schools identified in Phase I as using the clinical track designation, *subspecialty*, in their Web site descriptive material comprised the target population for Phase II. Since only 20 schools used the designation, the list of schools was expanded by two schools to achieve geographic representation. The additional schools offered clinical options that could be construed to be *subspecialties.* Of the 22 schools identified, 21 agreed to identify one faculty member to participate. A list of questions for major focus group discussion areas was developed based on Phase I results and sent to participants prior to convening the focus groups to facilitate preparation for discussion.

Three focus groups were held via Web-enhanced teleconferences during the first two weeks of December 2007, one in each of the following regions: West, Midwest, and East. Responses from the sessions were transcribed verbatim and content analyzed for themes. Participant responses were organized into four categories: 1) *Track Title and Coursework Themes*; 2) *Credentialing and Marketability Themes*; 3) *Clinical Hours Themes*; and 4) *Emerging Subspecialties Themes*.

Major findings related to *Track Title and Coursework Themes* were:

- Across all regions, the primary reason given for avoiding the use of the words *specialty* and *subspecialty* was their association with medical *specialties*.
- Participants from all regions agreed that *specialties* have national NP certification while *subspecialties* usually do not.
- Across all regions, there was significant variation when addressing timing of *subspecialty* coursework (i.e., completion of *subspecialty* coursework during or after completing *specialty* coursework).
- Across all regions, there was also significant variation when addressing enrollment eligibility in *subspecialty* coursework (i.e., enrollment in a specific *specialty*, in any NP *specialty*, or in any advanced practice program).
- In all regions, participants stated that dual clinical tracks lead to dual certifications.
- In all regions, participants stated that program individualization is possible to a limited extent (e.g., elective coursework; election of final clinical hours in an area of interest (60-80 hours was normative); and the addition of hours in an area of interest at the end of the program.

Major findings related *Credentialing and Marketability Themes* were:

- State Board of Nursing limitations on *specialty* and *subspecialty* credentials titling varied across the regions and by state.
- Requirements for specific experiences (e.g., lifespan experiences) for re-certification by some state Boards was an issue primarily in the Midwest.
- The value of broad *specialty* preparation in a “major” area (e.g., ANP, FNP) was identified as enhancing marketability in the West and Midwest.

Major findings related to *Clinical Hours Themes* were:

- Midwest and East focus group participants indicated that the number of clinical hours listed on the Web site reflect the number of precepted clinical hours required for certification.
- Within all three regions, participants indicated that clinical and laboratory hours are embedded within courses for many of the programs.

- Discussion about the value of including clinical simulation hours as precepted hours during the Midwest and East focus group sessions included comments that inclusion of clinical simulation hours as precepted clinical hours was being considered.

Major findings related to *Emerging Subspecialties Themes* were:

- Participants in the West discussed development of *subspecialty* preparation related to underserved populations and palliative care.
- Participants in the West and East discussed development of *subspecialty* preparation related to rural health.

Themes emerging from the focus groups became the organizing framework for the survey conducted in Phase III. Discussion comments were the basis for further inquiry and validation with the survey.

Phase III Aim, Methods, and Findings. The aim of Phase III was to conduct a national survey of all schools with master's-level NP programs in order to validate the major themes that emerged from the Phase II focus groups. A survey blueprint based on the focus group discussion was developed and pre-tested. Survey questions were organized in eight sections: 1) *Use of Terms to Describe NP Clinical Tracks;* 2) *Subspecialty Preparation;* 3) *Dual Tracks;* 4) *Individualization of Programs;* 5) *Clinical Hours;* 6) *Regulation;* 7) *Marketability;* and 8) *Emerging Specialties and Subspecialties.* Contact information was obtained from 332 of the target population of 336 institutions identified as offering master's-level NP programs. Web-based survey data were submitted from 295 schools for a response rate of 88.9 percent. Overall, analysis of the survey data confirm, amplify, and quantify information obtained from the focus groups.

Major findings in the section, *Use of Terms to Describe NP Clinical Tracks*, were:

- Half of the 295 respondents (N=149; 50.5%) indicated use of the word, *specialty*. Among the 146 schools (49.5%) not using the word, most were unsure of the reason why the word was not used (N=59). A wide variety of words were used among schools when the word, *specialty* was not used; the most frequently used was the word, track (N=69).
- A total of 39 schools (13.2%) offered clinical tracks that might be considered *subspecialties* but only nine of these schools used the term, *subspecialty*.
- The number of words used by each school to identify NP clinical tracks was summed. A total of 88 schools (61.5%) used one word, another 27 schools (18.9%) used two words, and 28 schools (19.6%), used between three and six different words.

Major findings in the section, *Subspecialty Preparation*, were:

- In 21 (53.9%) of the 39 schools offering *subspecialty* preparation, the subspecialty tracks are unique to a specific NP *specialty* track.
- In 24 (61.5%) of the 39 schools with *subspecialty* clinical tracks, *subspecialty* coursework is offered concurrently with *specialty* coursework.
- Graduates completing *subspecialty* clinical tracks in 16 (41.0%) of the 39 schools are eligible to sit for NP certification examinations related to their *subspecialty* preparation.

Major findings in the section, *Dual Tracks*, were:

- A total of 78 (26.4%) of the 295 responding schools offer, by curricular design, opportunities for students to enroll in two NP clinical tracks concurrently with eligibility to sit for two NP certification examinations upon graduation.

Major findings in the section, *Individualization of Programs*, were:

- Almost all (N=266; 90.2%) of the 295 responding schools offer students some opportunity for program individualization. The most frequently listed methods were:
  - Election of last required hours in an area of interest (N=179).
  - Taking additional elective coursework to meet individual goals (N=149).
  - Adding clinical hours in an area of interest concurrently with required clinical coursework (N=140).
- Almost a quarter of the schools (N=71; 24.1%) experience some type of pressure from employers for students to have clinical experiences and/or coursework in an area of interest to the employer. Interests are addressed most often by:
  - Allowing students to precept with the employer during their final required clinical hours (N=45).
  - Students have additional elective coursework and/or clinical experiences in the area of interest to the employer (N=26).

Major findings in the section, *Clinical Hours*, were:

- Respondents for half (N=149; 50.5%) of the 295 schools indicated that they use clinical simulations in the education of NPs; another third (32.9%) are planning to do so.
- Among the 149 schools that use clinical simulations, 39 (26.2%) count clinical simulation time as direct care hours; 25 of these schools count 10 hours or fewer as direct care hours.
- When asked if clinical simulation hours should be included in direct clinical care hours in the future, almost two-thirds (N=192; 65.1%) of the 295 respondents answered affirmatively.
- When asked to comment on the components of clinical hours at their school, almost two-thirds of the 295 participants (N=190; 64.4%) responded to this open-ended question by summarizing *components of clinical hour*s as follows:
  - Clinical hours are direct care hours only (n=104).
  - Laboratory and clinical hours are differentiated in various ways (n=40).
  - Some skills laboratory, simulation, or other experiences are included in clinical hours (n=35).
  - Skills laboratory, simulation, and clinical hours are not differentiated (n=11).
- Another 38 (12.9%) of the 295 participants gave clock hours data as either hours per credit (n=24) or total clinical clock hours required (n=14) when asked to comment on the components of clinical hours at their school.
  - The range of clinical hours per credit was wide (2 to 200; median = 4 hrs per credit[n=7]).

- The range of total clinical clock hours was from 540 to 960.

- The remaining 67 (22.7%) participants described the ways clinical hours are tracked, provided other unique responses, or gave no clear response.

Major findings in the section, *Regulation*, were:

- A total of 129 respondents (43.7%) indicated that state Boards of Nursing place limitations on recognition of NP *specialties* in their states. Among these, 30 (23.3%) indicated that the limits create problems.
- Just over a third of the 295respondents (N=110; 37.3%) indicated the Board placed limitations on how *specialty* NP credentials could be displayed in their title.
- State regulatory limitations on the way *subspecialty* preparation is marketed were identified by 28 (9.6%) of 295 participants; half of this group (n=14) indicated that NPs were prohibited from openly marketing their *subspecialty* preparation.
- Nearly half (N=131; 44.4%) of the 295 schools indicated a concern in their states about NPs with initial broad preparation (e.g., FNP) being allowed to continue to practice in narrowly-focused *specialty* areas (e.g., adult acute care, pediatric acute care) now that national certification examinations exist for these *specialties*.

Major findings in the section, *Marketability*, were:

- The majority of respondents (N=246; 83.4%) indicated that NPs with broad preparation were more marketable than those with narrowly-focused preparation. The most frequently given reason(s) were:
  - Graduates have greater employment flexibility (N=223).
  - Graduates can narrow their focus with additional *subspecialty* preparation if their career coals or employment requires it (N=207).
  - Rural communities employ graduates and require NPs who can address health care needs across the lifespan (N=192).
- Just over half (N=166; 56.2%) of the participants indicated that *subspecialty* preparation did not enhance marketability.
- Among the 126 (42.7%) participants who indicated that *subspecialty* preparation enhances marketability, the most frequently identified reason(s) were:
  - Graduates can market themselves in a specific area in which they want to practice (N=115).
  - Employers in our area are looking for NP graduates with specific expertise (N=82).

Major findings in the section, *Emerging Specialties and Subspecialties,* were:

- Most of the 295 participants (N=184; 62.4%) do not have plans to add new NP *specialties* within the next two years, whereas 50 (16.9%) plan to add new NP *specialties* and another 37 (12.9%) would do so if they had the resources.
- Of the 50 schools planning to add *subspecialties,* acute care (N=15) and gerontology (N=12) were the areas most frequently identified. Likewise, these areas were also the areas most frequently identified to be added if resources were available (acute care, N=11; gerontology, N=12).

- The most frequently listed resources lacking among the 37 schools that would like to add *specialties* were faculty (N=34) and/or fiscal resources (N=29).
- The most frequently identified emerging NP *specialty* practice areas over the next 10 years were: hospitalist/ acute care/critical care (N=21); genetics/healthcare genetics (N=13); and gerontology/ geriatrics (N=12).
- Likewise, the majority of schools (N=240; 81.4%) do not have plans to add new NP *subspecialties* within the next two years. A total of 13 (4.4%) plan to add new NP *subspecialties* and another 16 (5.4%) would do so if they had the resources.
- The most frequently identified NP *subspecialties* to be added were palliative care or palliative care in the gerontology track (N=3) and acute care or acute care in the ANP track (N=2). If resources were available four schools would add gerontology or a geriatric focus in the ANP track and three would add a psychiatric-mental health clinical track.
- As was true among schools lacking resources to add *specialties,* faculty (N=14) and fiscal resources (N=13) were the most frequently listed resources lacking among schools that would like to add *subspecialties*.
- Emerging *subspecialties* over the next 10 years listed most frequently were palliative care/hospice (N=8) and oncology (N=5).

Overall, the survey responses indicated:

- There is overlap and confusion distinguishing *specialties* and *subspecialties*.
- A wide range of words are used to describe *specialty* and *subspecialty* clinical tracks.
- The nature, scope, and execution of tracks considered *subspecialties* are highly individualized among schools and, at times, among the various clinical tracks within schools.
- NP programs have a wide variance in the number of clinical hours and number of credit hours.
- The ways precepted clinical hours, laboratory hours, and clinical simulation hours are defined and differentiated lacks consistency and clarity.
- Regulatory and credentialing requirements differ among states; these differences impact NP practice, marketing, and recognition of specialty and subspecialty preparation as well as potentially confusing the public.

Phase IV Aim, Methods, and Findings. The aim of Phase IV was to prioritize future directions for NP education based on project findings with the NONPF membership at a Priority-Setting Forum during the 2009 NONPF annual meeting. Priorities were based on the findings from the first three phases of the project and a review of the *Consensus Document*.

The Forum was held during a two-hour plenary session. To set the stage for discussion, the findings from the first three phases of the project were summarized with emphasis on the findings from the Phase III Survey. Key points from the *Consensus Document* were also presented. In addition to providing opportunities for comments and discussion during the forum, a form was provided to participants. Based on the findings from the first three phases of the project and key points from the *Consensus Document*, four topic areas were identified as a starting point for discussion and for priority ranking by participants. Participants were asked to rank the areas on a scale of 1 to 4, with 1 being the highest ranking, based on the priority with which the topic should be

addressed by NONPF. The four topic areas were: 1) *Implementation of the Consensus Document*; 2) *Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours*; 3) *Credentialing*; and 4) *Content and Organization of School of Nursing Web Sites*. Opportunity was provided on the form for participants to write comments related to both the session discussion topics. The estimated attendance at the Plenary Session was 350 participants. Priority topic rankings and written comments were obtained from a total of 209 forms.

The ranking of priority topics showed the following:

- Among the four priority topic areas rated by Forum participants, *Implementation of the Consensus Document* received the largest number of first priority rankings.
- When the numbers of first and second priority rankings were combined for each topic area, *Implementation of the Consensus Document* and *Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours* each received approximately two-thirds of the combined first and second priority rankings.

Major findings related to *Implementation of the Consensus Document* were:

- Participants requested additional clarification of the concept of "population foci" in the APRN Model particularly related to the placement of acute care, psychiatric-mental health, overlapping roles, and programs with multiple population foci.
- Further definition of the terms lifespan and family was requested, particularly as they related to psychiatric-mental health.
- Concern was expressed by some participants that the need to change nurse practice acts in order to implement the *Consensus Document* will result in opportunities for other professionals to attempt insertion of supervisory language.

Major findings related to *Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours* were:

- Interest was expressed in discussing inclusion of simulation hours as clinical hours.
- A majority of attendees expressed, by a show of hands, interest in moving toward a competency-based approach to NP education; comments written by other participants indicated the need to retain clinical hours or create a combined approach of competency-based education/evaluation and minimum clinical hours.
- A need for clarification of the impact on credentialing related to competency-based education was noted.

Major findings related to *Credentialing* were:

- The distinctions and overlap between acute and primary care were issues for many participants in relation to implications for education, credentialing, and scope of practice.

Major findings related to *Content and Organization of School of Nursing Web Sites* were:

- Although this area was generally given a low priority, several participants wrote on their forms that guidelines should be provided to schools.

Summary. In summary, this four-phased research project, based on the shared concerns of the NCSBN Center for Regulatory Excellence and NONPF regarding clinical track titling, credentialing, and hours requirements for increasing numbers of NP programs at the *specialty* and *subspecialty* level, provides a baseline for implementation of the *Consensus Model*. By quantifying the scope of what is currently in place in NP educational programs nationally, the project identified issues germane to implementation of the *Model* as it proceeds. The results of this study with respect to the need for consistency across programs, organizations, and agencies have implications not only for the NCSBN Center for Regulatory Excellence and NONPF leadership but for all organizations concerned with national health policy impacting nursing and nursing education.

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I. Introduction

A. Background

This report provides a summary of the processes and findings of a four-phased research project funded by the National Council of State Boards of Nursing (NCSBN) Center for Regulatory Excellence and undertaken by the National Organization of Nurse Practitioner Faculties (NONPF) during the period of June 2007 through June 2009. The project was based on the shared concerns of the two organizations regarding clinical track titling, credentialing, and hours requirements for increasing numbers of nurse practitioner (NP) programs at the *specialty* and *subspecialty* level.

NONPF has a 30-year history of promoting quality NP preparation at the national and international levels. Representing over 1,300 NP educators, NONPF has assumed the leadership role in all issues central to NP education and preparation. In 2000-2001, NONPF, in collaboration with the American Association of Colleges of Nursing (AACN), conducted a curriculum survey of master's-level NP educational programs to address the issue of the variation in clinical track titling and designated area of primary certification (Berlin, Harper, Werner, & Stennett, 2002). Recommendations for further study emanating from the curriculum survey provided the impetus for undertaking this research project including: the development and evolution of program titles; the relationship of NP role preparation and *subspecialty* roles; and certification eligibility.

The lack of congruence between clinical track titling and NP educational preparation was also noted by NCSBN related to regulation of advanced nursing practice. In the 2002 document, *Position Paper on the Regulation of Advanced Practice,* NCSBN Task Force members expressed concerns regarding the proliferation of NP programs with a *subspecialty* focus (NCSBN, 2002). Concerns focused on two areas. The first related to whether or not satisfactory certification exams existed to evaluate these NP graduates. Because members of state boards of nursing are charged with assuring the public safety provided by nurses in their respective states, the second area related to the concern of Task Force members that the regulatory processes currently in place currently were not adequate to license the *subspecialty* NPs.

NCSBN again noted the challenge in finding areas of clarity related to NP titling and credentialing in the draft of the *Vision Paper: The Future Regulation of Advanced Practice Nursing* (NCSBN, 2006). This paper, and its 2002 predecessor, identified perceived difficulties in regulating NPs at too narrow a focus of practice (e.g., HIV NP) (NCSBN, 2002, 2006). This proposed study, therefore, addressed areas of concern to both organizations related to increasing numbers of NP programs at the *specialty* and *subspecialty* level as well as clinical track titling, credentialing, and hour requirements for these programs.

B. Study Purpose and Specific Aims

The overall purpose of the study was to amplify and clarify information about current and emerging NP educational pathways leading to *specialty* and *subspecialty* preparation. In order to accomplish the overall objective, the study was conducted in four interrelated phases with each phase building on the findings of the previous phase. The specific aims of the four study phases were to:

- Phase I. Identify the range of *specialty* and *subspecialty* NP educational tracks from a review of Web sites of all schools of nursing with master's NP programs.
- Phase II. Clarify titling, hours, curriculum, and credentialing information with selected faculty from programs with *subspecialties* through regionally stratified focus groups.
- Phase III. Validate information emerging from the focus groups through a survey of all schools of nursing with NP educational programs.
- Phase IV. Prioritize future directions based on project findings with the NONPF membership at a Priority-Setting Forum during the 2009 NONPF annual meeting.

C. Importance of the Study in Relation to the Consensus Model for APRN Regulation

In July, 2008, the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education* was released (APRN Consensus Work Group and the NCSBN APRN Advisory Committee, 2008). This document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines *specialty*, describes the emergence of new roles and population foci, and presents strategies for implementation. Therefore, the organizing framework with respect to the meaning of *specialty* and *subspecialty* areas of clinical practice will change.

However, all parties involved believe in the importance of this project because the results quantified what is in place currently in NP educational programs; and these data will provide a baseline for implementation of the *Consensus Model*.

D. Project Team

Monica S. Scheibmeir, RN, MS, PhD, FNP, Associate Professor, University of Kansas Medical Center School of Nursing served as Principal Investigator. NONPF subcontracted with researchers Linda E. Berlin, DrPH, RN, WHNP-BC and Karen R. Secrhist, PhD, RN, FAAN. Berlin Sechrist Associates Principals, to conduct all aspects of the study. Kathryn E. Werner, MPA, NONPF Executive Director, provided facilitation and support services for the project through the national NONPF office.

An Advisory Group of NONPF members was appointed to provide input regarding all research related issues. Members of the Advisory Group were: Debra Barksdale, PhD, RN, CFNP, CANP, Assistant Professor, University of North Carolina-Chapel Hill School of Nursing; Charlene M. Hanson, EdD, FNP, FAAN, Professor Emerita in Nursing, Georgia Southern University College of Health and Human Sciences School of Nursing; Doreen C. Harper, PhD,

RN, FAAN, Dean and Professor, University of Alabama at Birmingham School of Nursing; Julie Marfell, ND, CS, FNP, Chair, Department of Family Nursing/Course Coordinator, Frontier School of Midwifery and Family Nursing; Ann L. O'Sullivan, PhD, FAAN, CRNP, Professor, Primary Care Nursing-Clinician Educator, University of Pennsylvania School of Nursing; and Joanne M. Pohl, PhD, ANP-BC, FAAN, Professor, University of Michigan School of Nursing.

E. PROTECTION OF HUMAN SUBJECTS IN RESEARCH

The study was reviewed by Independent Review Consulting, Inc. (IRC) for compliance with guidelines for the protection of human subjects in research. IRC affirmed that the study met the criteria for exempt status. Certification is on file with NONPF. Each time individuals were asked to provide responses, they were told verbally and in writing that their responses would be summarized for publication and that individuals would not be identified.

II. PROJECT PHASE I: WEB SITE REVIEW

A. AIM OF PHASE I

The aim of Phase I was to identify the range of *specialty* and *subspecialty* NP educational tracks from a review of Web sites of all schools of nursing with master's-level NP programs. Identification of schools with *subspecialty* clinical tracks, further, provided the target sample for the Phase II Focus Groups. The secondary purposes of the review were to examine the variety of clinical track titles, as defined by curricula in specific practice areas, and to assess the overall quality of the Web sites. These purposes were accomplished by a systematic review of Web sites of the schools of interest.

B. METHODS

1. POPULATION OF INTEREST, SOURCES OF DATA, AND DATA COLLECTION

The population of interest for this phase of the study consisted of all schools of nursing that offered master's-level NP programs in academic year 2006-2007. The list of the universe of schools was obtained from AACN and contained 342 schools. After adjusting for changes in program status in the interval between the 2006-2007 AACN/NONPF survey and the Web site review, the universe of schools with NP programs totaled 337. The sources of data were the Web sites of the schools of nursing. A Microsoft excel spread-sheet was developed to record and summarize information gleaned from the review of all NP clinical tracks offered by each school. The period of data collection was from June 15 to September 15, 2007.

2. MAJOR VARIABLES

The major variable of interest was the designation for each clinical track offered by a school. Each track was designated as *specialty* or *subspecialty* if these words were used in the descriptive material on the Web site. If other words were used for the clinical track (e.g., option or concentration), the exact designation was recorded. If a designation for the track was not found, "no designation" was entered on the data collection instrument.

3. ADDITIONAL VARIABLES

Additional variables for each track were collected in order to obtain information about each clinical track and to assess the overall quality of the Web site. These variables included:

- Clinical track titles
- National certification examination that the track prepares graduates to take
- Full-time length of program in months
- Total credits required for graduation (quarters were converted to semester hours)
- Total number of supervised clinical practice hours in which direct clinical care is provided

4. COVERAGE RATE

During the data collection period, Web sites of 328 of the 337 schools were reviewed. The overall coverage rate was 97.3 percent.

C. FINDINGS

1. MAJOR VARIABLE: NP CLINICAL TRACK DESIGNATIONS

A total of 1,037 clinical tracks were identified in 328 schools. Of these, 410 clinical tracks (39.5%) in 106 schools (32.3%) were designated by the word, *specialty*, and 77 clinical tracks (7.4%) in 20 schools (6.1%) were designated by the word, *subspecialty*. Slightly more than one-half of the clinical tracks (51.3%) in 187 schools (57.0%) were identified with other words in the Web site material, and for 37 clinical tracks (1.8%) in 15 schools (4.6%) no word was used to describe the clinical tracks (Figures 1 and 2).

Figure 1. NP Clinical Track Designations on Web Sites Using Total Clinical Tracks as the Denominator (N=1,037)

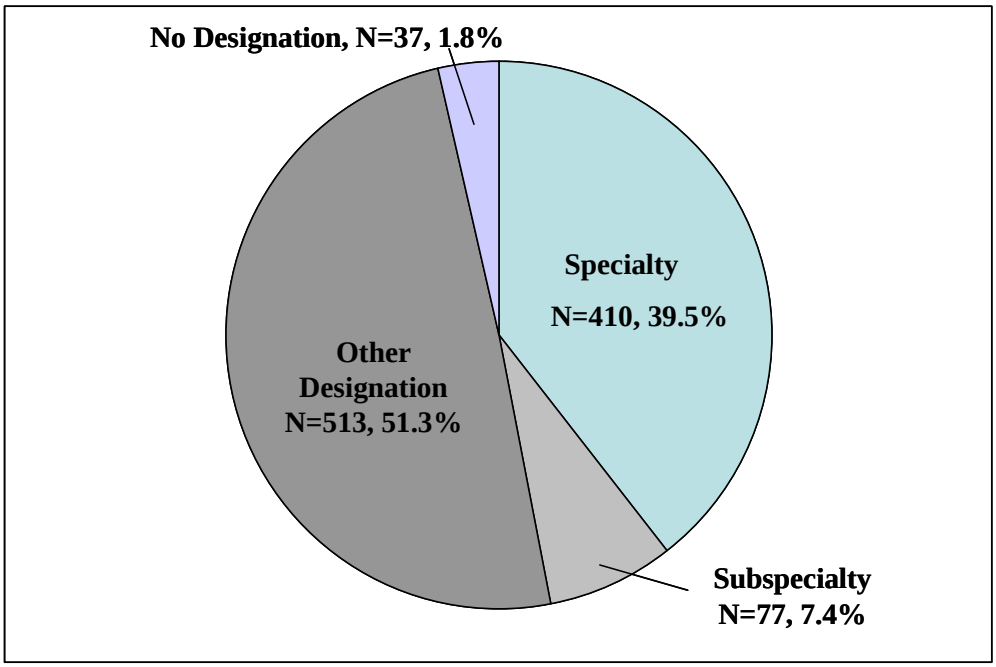
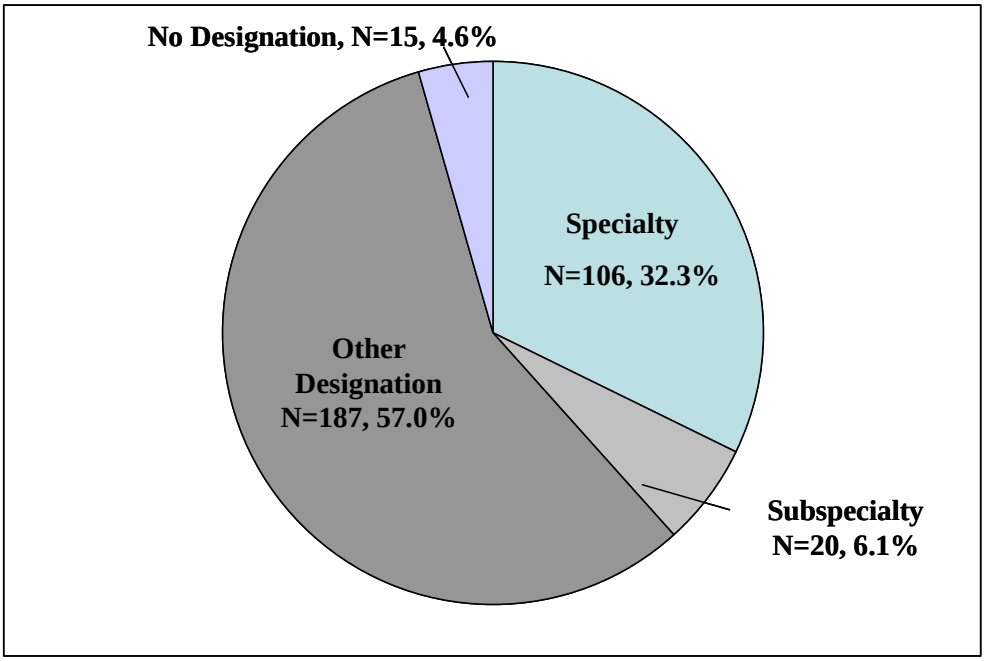


Figure 2. NP Clinical Track Designations on Web Sites Using Total Schools as the Denominator (N=328)



A variety of words or terms were used to describe clinical tracks in the "Other Designation" category. Table 1 lists those used and the number of clinical tracks. In several instances, the designation changed from one area of the Web site to another. For example, "Concentration" in one area may be referred to as "Option" in another area. The designations, further, did not always differentiate between general tracks and more focused tracks, or *specialties* and *subspecialties*. The designation might refer to both types of tracks in a given school.

Table 1. Words Used to Describe NP Clinical Tracks in the "Other Designation" Category (N=513 Clinical Tracks)

Words Used	N
Option, Program Option, NP Option, or Track/Option	125
Program or Program with NP Track as Part of the Title (e.g., GNP Program)	90
Concentration, Area of Concentration, or Concentration Option	87
Track/Track/Major	84
Focus, Area of Focus, Focal Area, Focus Option, Clinical Focus, or Track/Focus	42
Role, Functional Role, Functional Role Focus, Functional Track/Role	26
Major	23
Clinical Emphasis, Emphasis, Emphasis Area	21
Minor	1
Other Words/Terms: Area of Study, Clinical Specialization, Pathway, Specialization, Specialty Courses, Specialty/Specialized Courses, Study Pathway	15

2. ADDITIONAL VARIABLES

a. Clinical Track Titles as Defined by Curricula. The number and percent of clinical track titles that accounted for almost two-thirds (64.4%) of the titles are shown in Table 2; the remaining third (35.6%) of the titles are listed as "other titles" and includes: Emergency NP, Occupational Health NP, Palliative Care NP, PNP for Children with Special Needs, PNP/Latino Health Care, and PMHNP Addiction Focus.

Table 2. Clinical Track Titles, Number and Percent of Total Track Titles

Title	N	Percent	Cumulative Percent
Family Nurse Practitioner (FNP)	254	24.5	24.5
Adult Nurse Practitioner (ANP)	101	9.7	34.2
Pediatric Nurse Practitioner (PNP)	69	6.7	40.9
Geriatric Nurse Practitioner (GNP)	47	4.5	45.4
Neonatal Nurse Practitioner (NNP)	39	3.8	49.2
Acute Care Nurse Practitioner (ACNP)	38	3.7	52.8
Women's Health Nurse Practitioner (WHNP)	38	3.7	56.5
Psychiatric-Mental Health Nurse Practitioner (PMHNP)	32	3.1	59.6
Adult ACNP	18	1.7	61.3
ANP/GNP	17	1.6	63.0
Adult PMHNP	10	1.0	63.9
Family PMHNP	5	0.4	64.4
Other Titles	369	35.6	100.0
Total	1,037	100.0	

b. NP Clinical Tracks by Major Groupings. At the request of the Advisory Group, the 1,037 clinical tracks were also categorized by the major population groupings proposed by the APRN Consensus Work Group in the May 21, 2007 draft document (Table 3). The top three grouping were Across Life Span (28.0%), Adult (19.7%), and Child (11.7%). Fifteen percent of clinical tracks could not be categorized in the major groupings and were included in the category "other." The NP clinical tracks included in each of the major groupings are shown in Figure 3.

Table 3. Number and Percent of Clinical Tracks by Major Focus Groupings Proposed by the APRN Consensus Work Group (May 21, 2007 Draft)

Major Group	N	Percent
Across Life Span	290	28.0
Adult	204	19.7
Child	121	11.7
Psychiatric-Mental Health	106	10.2
Older Adult (Geriatric/Gerontology)	66	6.4
Gender Specific	51	4.9
Neonatal	42	4.1
Other	157	15.0
Total	1,037	100.0

c. National Certification Examination Eligibility. Information about certification eligibility was not provided on the Web site for 38 (37.2%) of the NP tracks in 123 (37.5%) of the schools. When certification information was provided, the exact examination for which graduates would be eligible was not consistently given.

d. Length of Program in Months. The full-time length of the program in months was infrequently given. Often, programs were listed as requiring two or three years of full-time study. Details about the Programs of Study, when available, were reviewed to determine program length in months. For more than half of the clinical tracks (N=553, 53.3%), no information could be found regarding full-time length of the track. Tracks without program length information were present in 160 (48.8%) of the schools.

e. Total Credits Required for Graduation. Attempts were made to locate credit hours for all programs and program tracks by searching all Web site documents, including college/university catalogs. Credit hours required for degree/program completion were not available on the Web site for 130 (12.5%) of the program tracks in 15 (4.6%) of the schools.

f. Total Supervised Clinical Practice Hours. The total number of supervised clinical practice hours required was not reported for 614 (59.2%) NP tracks in 165 (50.3%) of the schools. In several instances, clinical practice hours and/or total credit hours required for a particular program track varied from one location on the Web site to another. Information on Web sites about combined NP/CNS or dual NP track programs with content that might be called "*subspecialty*" was not consistently clear about the number of additional clinical practice and/or credit hours required to accomplish the programs.

Figure 3. NP Tracks Included in Each Major Grouping

Across the Life Span
Family NP, Primary Care Family NP, Acute Care NP across the life span, Family NP with Psych Focus, Rural Family NP, Community-Based Family NP, Family NP with Cardiovascular Care, Family NP with Cardiac Care, Family NP with Diabetes Care, Family NP "with other special areas of practice", Family/Palliative Care NP (dual track), Family NP with Public Health Leadership (dual major)

Adult
Adult NP, Adult Primary Care NP, Adult Acute Care NP, Adult Acute and Critical Care NP, Adult NP-Cardiovascular Care, Adult NP-Oncology, Adult NP-Infection Control, Adult NP/CNS-Cardiopulmonary, Adult NP-HIV/Oncology, Adult NP/CNS, Adult Health NP with Occupational Environmental Health, Adult Health NP with Home Care, Adult Health NP with Palliative Care, Adult NP with Forensic nursing focus, Rural Health Adult NP

Child
Pediatric NP, Pediatric/Neuropsychiatric NP, Pediatric NP/Adolescent Health Care, Pediatric NP-Mind/Spirit/Health Care, Pediatric NP-Latino Health Care, Pediatric NP/CNS, Pediatric /Pediatric Acute Care NP (dual track), Acute Chronic Care Pediatric NP, School NP, Pediatric NP for Children with Special Needs, Pediatric/Oncology NP (dual track), Pediatric/Child & Adolescent Mental Health CNS, Pediatric Acute and Chronic Care NP, Pediatric Acute Care NP, Pediatric Primary Care NP, Pediatric NP and Community/Public Health Leadership, Pediatric NP with Pulmonary *specialty*, Pediatric Acute Care NP/CNS, Pediatric NP/CNS

Psychiatric Mental Health
Psychiatric Mental Health NP (population group not specified), Psychiatric NP/CNS, Rural Psychiatric/Mental Health NP, Adult Psychiatric Mental Health NP/ANP (dual track), Family Psychiatric Mental Health NP, Adult Psychiatric Mental Health NP, Child & Adolescent Psych iatric Mental Health NP, Child & Adolescent Mental Health NP/PNP (dual track), Psychiatric Mental Health NP with Child *subspecialty*, Psychiatric Mental Health NP with adolescent *subspecialty*, Psychiatric Mental Health NP with elderly *subspecialty*, Psychiatric Mental Health NP with family *subspecialty*, Psychiatric Mental Health NP with genetic *subspecialty*, Psychiatric Mental Health NP (group, family, or individual), Primary Care Psychiatric Mental Health NP

Older Adult
Geriatric NP, Geriatric NP/Neuropsychiatric NP, Geriatric NP/CNS, Primary Care Geriatric NP, Geriatric/Oncology NP, Geriatric/Palliative Care NP, Geriatric NP with Community/ Public Health Leadership (dual major)

Gender Specific
Women's Health NP, Women's Health Primary Care NP, Women's Health NP/CNS, Women's Health/Oncology NP (dual track), Women's Health NP/CNM (dual major)

Neonatal
Neonatal NP, Neonatal NP/CNS

Other
Dual tracks crossing population groups-FNP/ANP, ANP/GNP, PNP/NNP, FNP/GNP, FNP/PNP, WHNP/FNP, FNP/School Health. *Subspecialty*-Occupational Health, Occupational Health/Neuropsychiatric NP, Oncology NP, Forensic NP, Holistic Health NP, Emergency NP, Trauma/Critical Care/Emergency NP. Population Group not stated (e.g., adult or pediatric)-Acute Care NP, Acute Care NP with cancer *subspecialty*, Acute & Critical Care NP, Acute Care NP-Flight Nurse, Acute Care NP-Cardiovascular, Acute Care NP-Cardiopulmonary, Acute Care NP with Critical Care, Acute Care NP-Oncology Acute Care NP-Emergency Preparedness, Acute Care NP-Cardiac Surgery Acute Care NP-Orthopedics, Acute Care NP-Trauma, Acute Care NP-Wound, Ostomy, & Incontinence, Acute Care NP-Pulmonary, Acute Care NP-Nephrology, Acute Care NP-Neurology, Acute Care NP-General Surgery, Acute Care NP-Transplant HIV/Aids NP, Palliative Care/End of Life NP, Addictive Behaviors NP, Integrative Therapies in Primary Care.

g. Overall Quality of the School of Nursing Web Sites. The most striking finding was the amount of information that was missing. Fifty-nine percent of the sites made no reference to the number of supervised clinical practice hours required in clinical tracks, and 53 percent did not specify the length of the program. The name of the national certification examination that graduates are eligible to sit for was absent in 37 percent and 12 percent did not list the number of credits required for graduation (Table 4). These findings were surprising considering that a school's Web site is the most powerful recruitment tool. In addition, omission of this critical information may lead to liability issues.

Table 4. Information *Not* Reported on Web Sites (N=1,037 NP Clinical Tracks)

Variable	Percent
Supervised Clinical Practice Hours (Direct Patient Care)	59
Full-Time Length of Program in Months	53
National Certification Examination Eligibility	37
Credits Required for Graduation	12

D. SUMMARY OF PHASE I MAJOR FINDINGS

A total of 1,037 NP clinical tracks were identified on the Web sites of 328 schools. The words, *specialty* and *subspecialty*, were used infrequently on the Web sites to designate NP clinical tracks. A total of 410 clinical tracks (39.5% of 1,037 tracks) in 106 schools (32.3% of 328 schools) were designated by the word specialty. A total of 77 clinical tracks (7.4% of 1,037 tracks) in 20 schools (6.1% of 328 schools) were designated by the word *subspecialty*.

The FNP clinical track title as defined by curricula accounted for 254 (24.5%) of the 1,037 clinical track titles. The titles of ANP, PNP, GNP, NNP, ACNP, WHNP, PMHNP, Adult ACNP, ANP/GNP, Adult PMHNP, and Family PMHNP accounted for 414 (39.9%) of the track titles. The remaining 369 (35.6%) of the clinical tracks had other unique titles.

There was much variation in the organization, type, amount, and consistency of information on the Web sites. Lack of information about certification eligibility, credit hours for graduation and total number of required clinical practice hours was missing from many Web sites:

- Certification eligibility was not provided on the Web site for 38 (37.2%) of the NP tracks in 123 (37.5%) of the schools.
- Credit hours required for degree/program completion were not available on the Web site for 130 (12.5%) of the program tracks in 15 (4.6%) of the schools.
- The total number of supervised clinical practice hours required was not reported for 614 (59.2%) NP tracks in 165 (50.3%) of the schools.

The review validates previous findings that expressed concern about varying clinical track titles that do not necessarily reflect role preparation and certification eligibility (Berlin, Harper, Werner, & Stennett, 2002).

III. PROJECT PHASE II: FOCUS GROUPS

A. AIM OF PHASE II

The aim of Phase II was to clarify NP program titling, hours, curriculum, and credentialing information with selected NONPF members through regionally stratified focus groups.

B. METHODS

1. SAMPLE

Schools identified in Phase I as using the clinical track designation, *subspecialty*, in their Web site descriptive material comprised the target population for Phase II. Since only 20 schools used the designation, the list of schools was expanded by two schools to achieve geographic representation. The additional schools offered clinical options that could be construed to be *subspecialties.*

NONPF staff took responsibility for contacting the schools and identifying a faculty member familiar with the range of NP *specialties* and *subspecialties* offered by the school. Identified faculty members agreeing to participate in the focus groups were asked to sign a consent form agreeing to the taping of the session for the purposes of content analysis. Of the 22 schools, 21 identified a faculty member who agreed to participate in the focus groups.

2. PREPARATION FOR DISCUSSION

A list of questions for the major focus group discussion areas was developed based on Phase I results. The list was sent to participants prior to convening the focus groups to facilitate preparation for discussion and to allow participants to obtain information from others at their school. The questions were:

1. Just a few Schools and Colleges of Nursing use the terms *specialty* and *subspecialty* when referring to NP clinical tracks. Are there reasons why those specific terms are not used more frequently?
2. Are all clinical tracks that might be termed *specialty* and *subspecialty* linked to national certification?
3. What issues are related to *subspecialty* certification?
4. How is your *subspecialty* coursework organized?
5. How do you determine clinical hours for *specialty* and *subspecialty* clinical tracks?
6. How do you differentiate supervised clinical hours from laboratory and simulation hours?
7. Are there emerging *subspecialties* that are being considered?

3. DATA COLLECTION

Three focus groups were held via Web-enhanced teleconference during the first two weeks of December 2007, one in each of the following regions: West, Midwest, and East. A list of schools participating by region is shown in Appendix A.

Berlin Sechrist Associates were the facilitators for the focus groups. Presents Plus, a Web conferencing company, was contracted by NONPF to support the Web and audio portions of the Web-enhanced teleconference-based focus groups. The sessions were taped to permit verbatim transcripts to be generated following the sessions.

Following initial instructions to participants, the purpose of the overall project and the focus groups was summarized by Kathryn Werner, NONPF Executive Director. Key points were shown on the Web site in slide format. General introductions of facilitators were followed by self-introduction by participants which was limited to the role of the participant in NP education at the participating school.

Each of the areas for discussion was first introduced by Dr. Karen Sechrist, who served as the primary facilitator. Follow-up questions and requests for clarification were prompted during discussion. Transcripts of the sessions were reviewed and content analyzed for themes by Berlin Sechrist Associates.

C. FINDINGS

Participant responses were organized by theme into four thematic categories: 1) *Track Title and Coursework Themes*; 2) *Credentialing and Marketability*; 3) *Clinical Hours*; and 4) *Emerging Subspecialties*.

1. TRACK TITLE AND COURSEWORK THEMES

a. Use of the Words, *Specialty* and *Subspecialty*. One of the probes related to titling was directed at clarification as to why the words, *specialty* and *subspecialty*, were not used more frequently. Across all regions, the primary reason given for avoiding the use of the words was their association with medical *specialties*. Two additional avoidance themes were voiced, one in the Midwest and one in the East. A participant from the Midwest indicated that the word, specialist, is included in titling for other master's programs so the word is avoided to decrease confusion. In the East, a participant indicated that the FNP and ANP practice preparations are at the generalist level and the word, specialist, does not seem to fit.

Participants in the West and East focus groups discussed definitions of the terms. In both regions, *specialty* denoted a broad area of practice (FNP or ANP) while *subspecialty* was defined as an area of intensive content within the broad practice area.

Participants from all regions agreed on connectedness to certification: *specialties* have national NP certification while *subspecialties* usually do not. Often the *subspecialty* certification, if available, was identified as appropriate to any advanced practice nurse or to another specific advanced practice, such as nurse-midwife.
A theme of increasingly incorporating the use of the word, *specialty* was expressed by participants in the West and Midwest groups. In both regions, the term is becoming more common as *subspecialties* are added to programs. A Midwest participant indicated that

concerns about regulation related to titles may require the use of the words, *specialty* and *subspecialty,* for clarity.

b. Organization of *Subspecialty* Coursework. Across all regions, there was significant variation when addressing timing of *subspecialty* coursework. The following statements were made:

- Program requires completion of *specialty* before undertaking *subspecialty* coursework.
- *Subspecialty* courses are distinct but offered concurrently with *specialty* coursework.

Across all regions, there was also significant variation when addressing enrollment eligibility in *subspecialty* coursework. The following statements were made:

- Enrollment is required in a specific *specialty* in order to obtain *subspecialty* content.
- Coursework is "stand alone" and available to students in any advanced practice program.

Participants in the West added that *subspecialty* content may be offered as a certificate program either within the program of study or as a post-graduate option.

c. Dual Clinical Tracks. In all regions, participants stated that dual clinical tracks lead to dual certifications. Although most participants agreed that dual clinical tracks would lead to dual NP certifications, other non-NP options constituting a dual track were mentioned within specific programs (e.g., nurse-midwife, some *subspecialties*, and non-clinical options such as nurse educator). During the Midwest focus group, a participant indicated that options for students to add content to a program in a specified area might be perceived as a dual track. Although preparation may lead to qualification for more than one certification, preparation in more than one *specialty* is not referred to as "dual track." Concern was expressed in all of the regions that students electing these options are faced with maintaining dual certification as well as liability insurance for two *specialties*.

d. Individualization of Programs. In all regions, individualization is possible to a limited extent. Individualization options include: elective coursework; election of final clinical hours in an area of interest (60-80 hours was normative); and the addition of hours in an area of interest at the end of the program. Two participants from Midwest and East regions mentioned that final clinical hours gave the student perspective on what happens in a particular area of medical specialization without providing full *subspecialty* preparation.

Participants from all three regions acknowledged the tension in adhering to program standards while addressing individual student requests for specific clinical placements. In all regions, there was consensus that students must meet clinical experience requirements for their particular primary program in order to be eligible for certification.

Employer pressure was addressed by participants in the East region. When employers sponsor or permit employees to obtain advanced degrees, they want particular *specialty* or *subspecialty* preparation as part of the program. Students may be allowed, therefore, to precept with the employer as part of the end-of-program residency. Another participant mentioned that some acute care facilities are limiting preceptor access to ACNP students because they want to hire those graduates.

2. CREDENTIALING AND MARKETABILITY THEMES

a. State Regulation. Participants in the West and Midwest regions raised issues related to the titling impact of state regulations. In at least one Western region state, the State Board regulates titles to assure they reflect certification. *Subspecialty* credentials, further, may not be used because of titling protections but might be included on a resumé.

State Board limitation of *specialty* recognition was a concern primarily in the Midwest. A participant from that region indicated that the State Board is not recognizing the Emergency NP as a *specialty*. In addition, the Board is requiring lifespan experiences for re-certification which affects NPs working with populations of specific ages (e.g., ANP, GNP, PNP). The participant also expressed concern that NCSBN is interested in all NPs being FNPs first.

A West participant considered the impact of emerging credentialed *specialties* (e.g., ACNP, Psychiatric-Mental Health) on practicing NPs. The participant suggested the possibility that state boards may place limitations on practice in newly credentialed areas in which NPs are not specifically credentialed even though they have practiced in those areas in the past. Limitations would also make it more difficult for NPs to change areas of practice.

b. Marketability of NP Preparation. The value of broad preparation in a "major" area (e.g., ANP or FNP) was expressed by participants in the West and Midwest focus groups to enhance marketability. Even if the student plans to function as a GNP or Women's Health NP, broad preparation was perceived to be better. In the context of rural health care, the FNP was seen as more marketable preparation than a PNP, GNP, or ANP since the NP would be expected to care for patients across the lifespan.

Participants in the Midwest and East discussed marketability of emerging *subspecialties*. Discussion points included the importance of evaluating student demand, need in the community, marketability, and the ability to offer the number of required hours for *subspecialty* preparation within a given geographic area before offering a *subspecialty*.

3. CLINICAL HOURS THEMES

Review of the NP program Web sites produced some confusion regarding the nature of clinical hours listed on Web sites. Focus group participants in all regions were asked to share their views on the nature of posted clinical hours.

a. Differentiating Precepted Clinical Hours and Laboratory Hours. Midwest and East focus group participants indicated that the number of clinical hours listed on the Web sites reflect the number of precepted clinical hours required for certification. Within all three regions, participants indicated that clinical and laboratory hours are embedded within courses for many of the programs. However, in all instances, the participants indicated it was possible to determine the nature of the hours based on the course.

One West participant indicated that at least that program and perhaps others have separate course numbers for lecture, laboratory, and clinical experiences. Another participant in the West indicated that the hours for laboratory, seminar, and clinical experiences were clear in the syllabi but may not be evident on the Web site. Another West participant indicated that careful separation of clinical and laboratory hours may not be universal.

b. Clinical Simulation. Program participants from the Midwest and East discussed inclusion of clinical simulation hours as precepted hours. Participants from the Midwest and some participants from the East indicated that clinical simulation hours were not included as precepted clinical hours. Several of the East participants indicated that clinical simulation hours accounted for between three and ten precepted hours. One East participant indicated that the suture workshop was also counted as precepted time.

Discussion about the value of including clinical simulation hours as precepted hours took place during the Midwest and East focus group sessions. With the increasing sophistication of clinical simulation centers and case presentations, some participants indicated that inclusion of clinical simulation hours as precepted clinical hours was being considered.

c. Dual Track Clinical Hours. The subject of dual track clinical hours was discussed by participants in the East. Two differing methods of handling clinical hours were shared:

- Students fulfill all hours for both *specialties*/tracks.
- Hours may be reduced in the second NP program if the second *specialty*/track is post-graduate and the student can verify work with the type of clients in the second *specialty*/track (e.g., a FNP who adds a GNP).

Concern was expressed in the East focus group about the number of hours required for dual tracks, *specialties*, and *subspecialties* to prevent student burn-out. Although certifications require separate hours, some of the critical decisions overlap. The suggestion was made that there is a need to look at this issue.

4. EMERGING *SUBSPECIALTIES* THEMES

When asked about perceptions of emerging *subspecialties*, participants identified both emerging areas of practice and issues surrounding development of *subspecialties*.

a. Emerging Areas of Practice. Participants in the West discussed development of *subspecialty* preparation related to underserved populations. NP *subspecialty* preparation would place emphasis on cultural and clinical competence for a specific population through an immersion experience and adaptation of practice environments to be responsive to culturally diverse groups.

Content related to high risk and vulnerable populations (homeless, incarcerated, medically marginalized, substance-abusing, individuals with mental health issues) is embedded in the curriculum. Focus group participants in the West suggested it would be interesting to think about this area as a *subspecialty*.

Rural health was viewed as both embedded content and an emerging *subspecialty* in the West and East. All FNP and ANP students in some programs are required to have a rural placement prior to graduation. In these programs, rural health was not viewed as a potential *subspecialty*. In other programs, rural health opportunities were available through advanced study and were more likely to be seen as a potential *subspecialty*.

Palliative Care was identified as an emerging *subspecialty* by West participants. Since the area of practice is often interdisciplinary, it is anticipated that development of a *subspecialty* would have additional challenges. Also, even though there is national certification available (which is not NP-specific) states do not recognize/license this area of practice currently.

West participants suggested several areas as potential *subspecialties* without additional discussion: border health, adolescent health (in conjunction with either a PNP or FNP), international health, corrections nursing, forensics, and wound care. A Midwest participant suggested there are potentially as many NP *subspecialties* as there are medically-based areas of practice (e.g., cardiac, renal).

b. Issues Surrounding Development of *Subspecialties*. Discussion about the area of gerontology took place in the East focus group. Participants mentioned the following in relation to gerontology content as a *subspecialty* or *specialty*:

- Considering whether the GNP should be offered as a *subspecialty* within the FNP and/or ANP or a stand-alone program.
- Now "morphing" the ANP to an ANP with gerontology so that all ANP students take gerontology.
- Including content related to gerontology in all primary care courses.

Participants from two East schools added that they have trouble filling their GNP slots each year.

Preparation of FNPs and ANPs for roles in the emergency department was discussed by East region focus group participants. One of the schools is considering melding acute care with the FNP in some fashion. Issues expressed related to this area of practice were:

- Some FNP and ANP students want broad preparation and also acute care experience.
- Some settings hire FNPs and ANPs but require that they return to school to obtain a post-graduate ACNP and become certified within a given period of time.

Participants from two regions noted the actual and potential influence of outside entities in development of *subspecialties*. In the West, a participant noted that *subspecialty* development has been driven by grant funding, not necessarily student interest. A Midwest participant indicated that their school has been targeted by special interest groups coming to faculty and doing presentations to generate interest in geropsychiatry, forensics, and endocrinology.

West participants addressed issues of inter-relationships among current and potential *subspecialties*. Two examples were given: 1) development of an infectious disease NP and the relationship of the program to the HIV *subspecialty*; and 2) the relationship of a mass casualty *subspecialty*, if developed, to the program in public health.

In the Midwest, participants noted that several areas of practice that were considered narrowly focused or "maverick" have become, over time, certified areas of practice (e.g., ACNP). The question was raised as to whether there will be more narrowly focused *specialties* (e.g., Flight NP, Cardiac NP) or fewer *specialties* and more *subspecialties*.

The Midwest focus group addressed the inability to add *subspecialties*. The following points were made:

- Program is trying to decrease in size and scope so not planning to add *subspecialties*.
- There is a problem of faculty workload.
- Need to accommodate growth in core tracks.

How some types of content should be handled was a discussion point among West participants. They stated that there are frequently questions about whether some types of content should be integrated, a *subspecialty*, or provide dual preparation.

West participants also discussed the need to be clear about the impact of emerging *specialties* and *subspecialties* related to scope of practice, licensure, recognition, and insurance consequences. Midwest participants added that highly specialized NP practice may create certification/recertification issues and may require specialized certification examinations that do not currently exist.

In the Midwest, a participant noted that some of the emerging *specialties*/*subspecialties* may be occurring in response to the need for "physician extenders" because of the medical residency problem. Caution was suggested with regard to this issue so that NPs are not substitutes or extenders for the medical community.

D. Summary of Phase II Major Findings

Participant responses were organized into four categories: 1) *Track Title and Coursework Themes*; 2) *Credentialing and Marketability Themes*; 3) *Clinical Hours Themes*; and 4) *Emerging Subspecialties Themes*.

Major findings related to *Track Title and Coursework Themes* were:

- Across all regions, the primary reason given for avoiding the use of the words *specialty* and *subspecialty* was their association with medical *specialties*.
- Participants from all regions agreed that *specialties* have national NP certification while *subspecialties* usually do not.
- Across all regions, there was significant variation when addressing timing of *subspecialty* coursework (i.e., completion of *subspecialty* coursework during or after completing *specialty* coursework).
- Across all regions, there was also significant variation when addressing enrollment eligibility in *subspecialty* coursework (i.e., enrollment in a specific *specialty*, in any NP *specialty*, or in any advanced practice program).
- In all regions, participants stated that dual clinical tracks lead to dual certifications.
- In all regions, participants stated that program individualization is possible to a limited extent (e.g., elective coursework; election of final clinical hours in an area of interest (60-80 hours was normative); and the addition of hours in an area of interest at the end of the program.

Major findings related *Credentialing and Marketability Themes* were:

- State Board of Nursing limitations on *specialty* and *subspecialty* credentials titling varied across the regions and by state.
- Requirements for specific experiences (e.g., lifespan experiences) for re-certification by some state Boards was an issue primarily in the Midwest.
- The value of broad *specialty* preparation in a "major" area (e.g., ANP, FNP) was identified as enhancing marketability in the West and Midwest.

Major findings related to *Clinical Hours Themes* were:

- Midwest and East focus group participants indicated that the number of clinical hours listed on the Web site reflect the number of precepted clinical hours required for certification.
- Within all three regions, participants indicated that clinical and laboratory hours are embedded within courses for many of the programs.
- Discussion about the value of including clinical simulation hours as precepted hours during the Midwest and East focus group sessions included comments that inclusion of clinical simulation hours as precepted clinical hours was being considered.

Major findings related to *Emerging Subspecialties Themes* were:

- Participants in the West discussed development of *subspecialty* preparation related to underserved populations and palliative care.
- Participants in the West and East discussed development of *subspecialty* preparation related to rural health.

Themes emerging from the focus groups became the organizing framework for the survey conducted in Phase III. Discussion comments were the basis for further inquiry and validation with the survey.

IV. PROJECT PHASE III: SURVEY

A. AIM OF PHASE III

The aim of Phase III was to conduct a national survey of all schools with master's-level NP programs in order to validate the major themes that emerged from Phase II.

B. METHODS

1. SURVEY DEVELOPMENT

The Principal Investigator, NONPF Advisory Group, and Berlin Sechrist Associates met in April 2008 to discuss the findings from the focus group analysis. Building on these findings, the survey blueprint was developed by the Principal Investigator and Berlin Sechrist Associates. Specific content areas included the issues relevant to the titling of NP clinical tracks, organization of *subspecialty* coursework, clinical practice hours, and new and emerging *subspecialties* as they currently existed.

Drafts of the survey questions were distributed for review and comment to the Advisory Group during May and June, with approval of the final instrument in mid-July. The survey and accompanying materials were then forwarded to a Web-based survey firm, IntelliSurvey, Inc. The firm was contracted by NONPF to provide survey access, technical support, and e-mail reminders to the participants, and downloadable survey data to Berlin Sechrist Associates.

2. PRETEST

The Advisory Group and the Principal Investigator agreed to appoint a faculty member in each of their respective institutions who had overall knowledge of all NP clinical tracks to participate in the pretest of the online survey. The major purposes of the pretest were to state opinions about the general layout of the site, ease of navigation, and clarity of the instructions. Five of the seven schools submitted evaluations during the period of August 4 through 11, 2008. Based on the pretest findings, final modifications were made to improve site navigation and responses to selected items.

3. TARGET POPULATION AND SURVEY LOGISTICS

The survey target population was comprised of the 336 institutions identified as offering master's-level NP programs in the NONPF and AACN 2007-2008 database of NP educational programs. Schools with collaborative or joint NP programs with other institutions were counted as one program.

NP educators or administrators overseeing NP education in each of the institutions were contacted via email to obtain agreement for school participation. Those not responding via email were contacted by telephone. By August 20, contact was made with 332 (98.8%) of the universe of schools with master's-level NP programs. Administrators were asked to designate one person who had in-depth institutional knowledge about NP programs to serve as the survey leader (Appendix B). Upon designation of the survey leader, a summary of the project

including a hard copy of the survey was emailed to each survey leader so responses could be considered prior to completing the survey online. Copies of the introductory letter and the survey in hard copy are located in Appendix C.

The survey Web site was activated on August 25, 2008 with a survey submission deadline of September 26. General reminders were sent via e-mail on September 8 and 19 to contact persons at schools who had not yet submitted a survey and a personal e-mail was sent by the NONPF President on September 17. In addition, e-mails were sent by Berlin Sechrist Associates to contact persons at schools with incomplete surveys on the due date to determine intention to complete. Based on the number of positive responses, the deadline was extended until October 10 and then until November 24 in order to maximize the number of responses.

During preliminary examination of the data, it was discovered that during the course of transferring databases between organizations that 12 schools were not notified when the survey Web site was activated. These schools were contacted by telephone and given the opportunity to complete the survey.

4. Response Rate

From the 332 schools for which contact information was obtained, a total of 295 surveys were submitted for an overall response rate of 88.9 percent. The weekly cumulative response rate is shown in Table 5. The list of participating institutions can be found in Appendix D.

Table 5. Weekly Cumulative Survey Response Rates

Week	N of Completed Surveys	Cumulative Percent Response Rate
1	73	22.1
2	23	28.9
3	64	48.2
4	25	55.7
5	70	76.8
6	21	83.1
7+	19	88.9

5. Characteristics of Respondents and Nonrespondents

Table 6 summarizes the institutional characteristics of respondent and nonrespondent schools. Most responding schools were: 1) located in the Southern region; 2) in public institutions; 3) classified as universities; and 4) were not part of an academic health center. There were no statistically significant differences between respondent and nonrespondent groups in region, type of institution, parent institution, or association with an academic health center.

Table 6. Selected Characteristics of Respondent and Nonrespondent Institutions with Master's-Level NP Programs (N=332 Schools); Response Rate, 88.9%.

	Respondents (N=295)		Nonrespondents (N=37)		Differences[a]	
Characteristic	**N**	**%**	**N**	**%**	**χ^2**	***p* value**
Region					2.49	ns
North Atlantic	80	27.1	8	21.6		
Midwest	74	25.1	10	27.0		
South	103	34.9	11	29.7		
West	38	12.9	8	21.6		
Type of Institution					3.31	ns
Public	180	61.0	21	56.8		
Private	115	39.0	16	43.2		
Parent Institution					0.25	ns
University	262	88.8	29	78.4		
Other	33	11.2	8	21.6		
Part of an Academic Health Center					3.47	ns
No	213	72.2	32	86.5		
Yes	82	27.8	5	13.5		

[a] Chi-Square, Yates' Chi-Square, or Fisher's Exact Test.

C. FINDINGS

Survey questions (Q) were organized in eight sections: 1) *Use of Terms to Describe NP Clinical Tracks*; 2) *Subspecialty Preparation*; 3) *Dual Tracks*; 4) *Individualization of Programs*; 5) *Clinical Hours*; 6) *Regulation*; 7) *Marketability*; and 8) *Emerging Specialties and Subspecialties.* Section headings and survey questions precede responses to questions within each section.

1. SECTION I. USE OF TERMS TO DESCRIBE NP CLINICAL TRACKS

Q1. Is the word, *specialty*, used in your school's literature and/or Web site when referring to any of the NP clinical tracks offered by your school?

In response to the first question, half of the respondents (50.5%) indicated use of the word, *specialty,* in school literature and/or on the Web site shown in Table 7.

Table 7. Use of the Word, *Specialty*, in School Literature and/or on the Web Site (N=295 Schools)

Word, *Specialty,* Used	**N**	**%**
Yes	149	50.5
No	146	49.5
Total	295	100.0

Q1-1. What are the reasons that the word, *specialty*, is avoided?

If the word was not used (N=146), respondents were asked to identify the reason or reasons the word, *specialty*, was avoided at their school. Responses are summarized in Table 8. Multiple responses were permitted.

Table 8. Reasons the Word, *Specialty*, Was Not Used (N=146 Schools)[a]

Reasons Word Not Used	N
Unsure of the reason(s) why the word is not used	59
Some NP clinical tracks are at the generalist level, therefore, the use of the word, *specialty*, does not seem to fit	51
The word, *specialist*, is included in the titling for the CNS	18
The word is associated with medical *specialties*	7
Unable to use the word because of state regulations	3
Other reasons ▪ One clinical track, program, or option (n=10) ▪ Use other words or methods of titling (n=10) ▪ University/School preferences, policies, or regulations (n=5) ▪ Historical reasons including program credentialing (n=2) ▪ Offer NP program with two tracks so consider the word redundant (n=1) ▪ The word, *specialty*, suggests there are *subspecialties* (n=1)	29
Reason not Given	2

[a]Multiple responses permitted

Q1-2. What words are used to describe NP *specialty* clinical tracks at your school?

Respondents for the 146 schools not using the word, *specialty*, were asked to identify words used at their schools to describe NP clinical tracks. Three participants did not provide responses. Table 9 lists the words and the number of schools in which each of the words was used for the 143 schools for which responses were provided. Multiple responses were permitted.

The number of terms used by each school to identify NP clinical tracks was summed. A total of 88 schools (61.5%) used one term, another 27 schools (18.9%) used two terms, and 28 schools (19.6%), used between three and six terms.

Additional Comments About the Word, *Specialty*. There were some issues related to the interpretation and use of the word, *specialty.* Five respondents answering "yes" to use of the word, *specialty,* at their schools qualified and broadened the use of the word. Four respondents commented that they used words such as *specialty tracks*, *specialization tracks*, or *specialization sequences* to refer to their NP clinical tracks; and an additional school used *role specialization*. As noted in Table 9, some of these same words were used by respondents answering "no" when asked if they use the word, *specialty.*

Table 9. List of Words Used to Describe NP Clinical Tracks When the Word, *Specialty*, Was Not Used (N=143 Schools)[a]

Words Used	N
Track	69
Area of Concentration	39
Option	26
Area of Study	15
Clinical Focus	14
Area of Focus	14
Role	12
Focus	11
Major	11
Program	8
Focus Area	6
Functional Role	6
Area	5
Emphasis	3
Concentration	2
Program of Study	2
Other Words (n=1 Response Each) Clinical Tracks, Clinical Concentration, Emphasis Area, Functional Area, Minor, Pathway, Specialty Courses, Specialization	8

[a]Multiple responses permitted

Several other school respondents indicated that the word, *specialty*, was not used when referring to the clinical track but was used when referring to coursework (i.e., NP *specialty* courses). Of these, five perceived coursework to be use of the word, *specialty,* while two did not. One respondent identified the word as referring to both the NP clinical track and the coursework.

Six respondents differentiated between the words, *specialty*, *specialization,* and *specialized area*. Two of these respondents indicated their school did not offer *specialties* while four indicated that they did offer *specialties*.

Five additional respondents indicated that the word, *specialty,* as well as another word or words (e.g., option, concentration, program, or track) were used at their schools. Another respondent indicated that the official term used was *area of emphasis* but that the word, *specialty*, was used for recruitment purposes since it was better understood by prospective students. Informal use of the word, *specialty* was noted by one respondent and the lack of consistency in use of the word was mentioned by another.

Q2. Does your school offer NP clinical tracks that might be considered *subspecialties*?

Participants were asked if their schools offered NP clinical tracks that might be considered *subspecialties.* Table 10 shows that 39 schools (13.2%) offered clinical tracks that are considered *subspecialties*.

Table 10. School Offers NP *Subspecialties* (N=295 Schools)

***Subspecialties* Offered**	**N**	**%**
Yes	39	13.2
No	256	86.8
Total	295	100.0

Q2-1. Is the word, *subspecialty*, used in your school's literature and/or Web site when referring to any of the NP clinical tracks?

The majority of the 39 participants responding that their schools offered *subspecialty* NP clinical tracks stated that the word was not used in school literature and/or on the Web site as shown in Table 11.

Table11. Use of the Word, *Subspecialty*, in School Literature and/or on the Website (N=39 Schools)

Word, *Subspecialty*, Used	**N**	**%**
Yes	9	23.1
No	30	76.9
Total	39	100.0

Q2-2. What words are used to describe NP *subspecialty* clinical tracks at your school?

Respondents from the 30 schools that do not use the word, *subspecialty*, were asked to identify the words used to designate NP clinical tracks that might be considered *subspecialties*. Table 12 lists the words and the number of schools in which each of the words was used. Multiple responses were permitted.

Additional Comments About the Word, *Subspecialty*. Several issues surfaced related to the use of the word, *subspecialty*, and interest in or offering *subspecialty* coursework. The respondent for one program indicated that the NP clinical track (e.g., FNP or ANP) is the *subspecialty* based on a state requirement that ARNP is the required title for all NPs. Another respondent, indicating that the school does not offer *subspecialties*, described a scenario where students might add *subspecialty* content (e.g., cardiovascular) to a clinical track. Two respondents indicated that they have *subspecialties* in their program materials but do not offer them either due to lack of students or because of an organizational recommendation. Future interest in or plans for offering *subspecialties* was identified by participants from three schools. One respondent indicated the lack of a definition of the word, *subspecialty,* was confusing.

Table 12. List of Words Used to Describe NP Clinical Tracks the Word, *Subspecialty*, Was Not Used (N=30 Schools)[a]

Term	N
Track	11
Area of Concentration	7
Clinical Focus	7
Focus Area	6
Option	5
Focus	4
Area of Focus	3
Role	3
Concentration	2
Program	2
Other Words (n=1 Response Each): Major, Preparation, Program of Study	3

[a]Multiple responses permitted

2. SECTION II. *SUBSPECIALTY* PREPARATION

Q3. Are the *subspecialty* clinical tracks available only to students enrolled in a specific NP *specialty* track?

Individuals completing the survey for schools with *subspecialties* (N=39) were asked if *subspecialty* clinical tracks were available only to students enrolled in a specific NP clinical track. Respondents could also select an option indicating that some tracks were unique while other were not. As shown in Table 13, more than half of the schools (53.9%) have *subspecialty* clinical tracks unique to a specific NP *specialty* track and seven schools (17.9%) indicated that some tracks are unique while others are not (Table 13).

Table 13. *Subspecialty* Clinical Tracks Unique to Specific NP *Specialty* Tracks (N=39 Schools)

Subspecialty Tracks Unique	N	%
Yes, *subspecialty* clinical tracks are unique to specific NP *specialty* tracks	21	53.9
No, *subspecialty* clinical tracks are not unique to specific NP *specialty* tracks	11	28.2
Some NP *specialty* tracks have unique *subspecialty* options, others do not	7	17.9
Total	39	100.0

Subspecialty options available to more than one NP *specialty* track at the seven schools included: geriatrics, psychiatric-mental health, and oncology. Additionally, several respondents added a comment that *specialty* content for which an NP certification examination is not

available is offered to students in NP clinical tracks as well as to other advanced practice nurses.

Q4. How is the timing of *subspecialty* coursework organized in NP clinical tracks?

School representatives were asked how the timing of *subspecialty* coursework is organized in NP clinical tracks. Responses are shown in Table 14. In the majority of schools (61.5%), *subspecialty* coursework is offered concurrently with *specialty* coursework.

Table 14. Timing of *Subspecialty* Coursework in NP Clinical tracks (N=39 Schools)

Timing	N	%
Subspecialty coursework is offered concurrently with *specialty* coursework	24	61.5
Organization of *subspecialty* coursework varies among NP tracks	9	23.1
Subspecialty coursework is completed only after completion of *specialty* coursework	3	7.7
Other Timing Scenarios (1 response each) ▪ Summer *subspecialty* intensives are followed by additional work in program year 2 ▪ Initial foundation in *specialty* completed before *subspecialty* coursework undertaken ▪ Depends on availability of faculty	3	7.7
Total	39	100.0

Q5. Do *subspecialty* clinical tracks prepare graduates to sit for national certification examinations?

As shown in Table 15, 41.0 percent of the respondents indicated that their schools prepared *subspecialty* clinical track graduates to sit for national NP certification examinations.

Table 15. Preparation of Graduates Taking *Subspecialty* Clinical Tracks to Sit for National Certification Examinations (N=39 Schools)

Prepared to Sit for Certification Examinations	N	%
Yes, for NP certification examinations	16	41.0
Yes, for certification examinations available to any advanced practice nurse	6	15.4
No, they are not prepared for national advanced practice certification examinations	9	23.1
Some *subspecialties* prepare for national advanced practice certification and others do not	8	20.5
Total	39	100.0

Those respondents indicating that some *subspecialties* prepare graduates for national advanced practice certification while others do not clarified their responses. At one school, the *subspecialty* may prepare the student for an examination in another discipline. Respondents for two schools indicated that students may select content in a very defined area of acute care

nursing practice for which there will not be a specific examination other than their *specialty* examination as an acute care NP.

Respondents from three schools addressed palliative care, occupational health, diabetes, and/or holistic health. They indicated that these areas are offered as *subspecialties* and may have examinations but the examinations are not necessarily framed in the context of an NP or other advanced practice role. One respondent stated that additional clinical hours may be necessary to sit for the examinations.

Q6. What criteria does your school use when deciding to offer *subspecialty* content?

Respondents from the 39 schools offering *subspecialties* were asked to identify the criteria used at their school when deciding to offer *subspecialty* content. Table 16 lists the number of schools selecting each of the criteria. Multiple responses were permitted.

Table 16. Criteria Used to Decide to Offer *Subspecialty* Content (N=39Schools)[a]

Criteria	N
Student Demand	35
Need in the Community	31
Faculty Interest	27
Resources Required to Offer Coursework	27
Need in the State	26
Marketability of Graduates	25
Employer Interest	23
Ability to Offer Required Number of Hours	20
Interest of National Organization	9
Importance to APRN Practice	1
Outside Funding	1
Prevalence of the Issue	1

[a]Multiple responses permitted

Additional Comments About *Subspecialty* Preparation. One school participant summarized the evolution of *subspecialty* preparation based on the needs of the community as well as the availability of specific opportunities within a major medical center. Highlighted were the development of clinical tracks for acute care and pediatric acute care as well as an oncology focus with the ANP program.

Another participant discussed the issue of cost-effectiveness in offering clinical tracks. Specifically, *subspecialties* in women's health and geriatrics were discontinued due to low demand and limited numbers of faculty in those areas.

3. SECTION III. DUAL TRACKS

Q7. Do you offer students the opportunity, by curricular design, to take dual NP clinical tracks, that is, students can enroll in two NP clinical tracks (e.g., ANP and GNP) concurrently and are eligible to sit for two NP certification examinations upon graduation?

Participants were asked if students were offered, by curricular design, the opportunity to enroll in two NP clinical tracks concurrently with eligibility to sit for *two* NP certification examinations upon examination. Responses are shown in Table 17. Schools offering only one NP clinical track were placed in the category labeled, *not applicable*. Approximately one quarter of the schools (26.4%) offer dual NP clinical tracks.

Table 17. Students Offered Dual NP Clinical Tracks by Curricular Design (N=295 Schools)

Offer Dual NP Tracks	N	%
Yes	78	26.4
No	111	37.6
Not Applicable[a]	106	35.9
Total	295	100.0

[a]Schools with only one clinical track

Additional Comments Related to Dual Tracks. Although not currently offering a dual track, respondents for five schools wrote that a dual track option is planned either as part of the master's program or as part of a Doctor of Nursing Practice (DNP) program. One school has only dual track options. At another school, students can enroll in dual NP clinical tracks but are encouraged to graduate from one and complete certification before completing the second track. Four schools do not have dual tracks by design but work with students individually and do not prohibit dual tracks. At one school, the curriculum is designed so that students can enroll in dual tracks but none have elected to do so; another school discontinued the option because of lack of interest.

4. SECTION IV. INDIVIDUALIZATION OF PROGRAMS

Q8. Do you offer any opportunities for students in NP clinical tracks to structure any of their clinical experiences or coursework to meet individual interests or goals?

Participants were asked if opportunities were offered for students in NP clinical tracks to structure any of their clinical experiences or coursework to meet individual interests or goals. The vast majority of schools (90.2%) permit some individualization as shown in Table 18.

Table 18. Program Individualization Permitted (N=295 Schools)

Individualization Permitted	N	%
Yes	266	90.2
No	29	9.8
Total	295	100.0

Q8-1. How can an NP program of study be individualized at your school?

Respondents for the 266 schools where individualization is possible were asked to identify the ways in which NP clinical tracks can be individualized. Table 19 lists the number of schools selecting various types of individualization. Multiple responses were permitted.

Table 19. Ways in which NP Clinical Tracks Can be Individualized (N=266 Schools)[a]

Individualization Methods	N
Students can elect their last required clinical hours in an area of interest	179
Students can take additional elective coursework to meet individual goals	149
Students can add clinical hours in an area of interest concurrently with required clinical coursework	140
Students can add clinical hours in an area of interest after completing required clinical coursework	99
Other Ways in Which NP Clinical Tracks Can Be Individualized[a] ▪ Clinical experiences arranged to meet student interests/goals throughout the program (n=15) ▪ A limited number of the total required clinical hours are allowed in an area of interest (n=14) ▪ Opportunities for clinical research, independent/directed study, capstone/special projects, or course papers in area of interest (n=9) ▪ Placement requests are encouraged or considered (n=8) ▪ Offer/encourage international, rural immersion, or underserved population clinical/service learning options (n=4) ▪ One clinical rotation permitted in area of interest (n=4) ▪ Students able to work with faculty to create dual tracks if none exist in area of interest (n=1) ▪ Students can audit *specialty* courses for physician assistants (n=1)	52

[a]Multiple responses were possible

Thirty-one of the 179 respondents (17.3%) indicating that students can elect their last required clinical hours in an area of interest qualified their response. Most indicated that a portion, but not all, of the final clinical hours can be used for areas of special interest. One respondent commented that the hours may not be elected in a future employment location.

Of the 140 respondents indicating that clinical hours in an area of interest can be added concurrently, three (2.1%) qualified their responses. At one school, it is policy that students may add an additional 10 hours during the clinical practicum in an area of interest. At another

school, secondary MD or DO preceptors are included for additional clinical hours in the interest area. The final school has the policy that students can only add hours after they are shown to be solid in their primary care role.

Five of the 149 respondents (3.4%) indicating that students can take additional elective coursework to meet individual goals added remarks about the electives. One school provides summer clinical electives; another offers gross anatomy with dissection. Electives in other disciplines are possible at another school.

Two participants stated that their schools give preference for placement in areas of special interest to students with employment commitments involving those areas. Four respondents commented that students are encouraged to seek special interest clinical activities or placements to build skill sets and/or address areas of perceived weakness.

Additional Comments About Program Individualization and Student Interests. The vast majority of programs permit students to select at a portion of their clinical hours in areas of interest and many work with students to assure that their interests are addressed. An overriding theme from schools limiting individualization was the need to assure that students met requirements, developed skills, and were prepared for their primary NP role within the required clinical hours.

Q9. Is there pressure from employers for NP students to have coursework and/or clinical experiences in the employer's area of interest?

Respondents were asked if there is pressure from employers for NP students to have coursework and/or clinical experiences in the employers' area of interest. Table 20 shows that about a quarter (24.1%) of schools experienced some pressure from employers.

Table 20. Employer Pressure for Clinical Experiences in Employer's Area of Interest (N=295 Schools)

Employer Pressure	N	%
Yes	71	24.1
No	215	72.9
Do Not Know, Unsure	8	2.7
Not Applicable[a]	1	0.3
Total	295	100.0

[a]Federal/military

Although not listed as a choice, eight respondents (2.7%) commented that they do not know or are unsure if there was employer pressure at their school; their responses were recoded to a *do not know/unsure* category. Whether or not other participants would have chosen this option if it had been available is unknown.

Q9-1. How do you address employer interests?

Respondents for the 71 schools experiencing employer pressure were asked how the school addresses employer interests. Table 21 lists the number of schools selecting various ways in which employer interests are addressed. Multiple responses were permitted.

Table 21. Ways in which Employer Interests are Addressed (N=71 Schools)[a]

Interests Addressed	N
Students are allowed to precept with the employer during their final required clinical hours	45
Students have additional elective coursework and/or clinical experiences in the area of interest to the employer	26
Unable to accommodate employer interests at this time	10
Other Ways in Which Employer Interests are Addressed: ▪ Explore other NP options/consider programmatic change (n=2) ▪ Provide a preceptorship/rotation in the area of interest but not with the potential employer (n=2) ▪ Preceptorship with employer by special written agreement to be sure student not being used as an employee (n=1)	5

[a]Multiple responses permitted

Of the 71 respondents, 17 (23.9%) qualified the response that their schools allow students to precept with their employer during their final clinical hours. Three schools limit the number of hours students can be precepted by the employer. Respondents for five schools noted that the basic clinical track requirements must be met first and the goals of the program must be paramount during the preceptorship. Seven schools permit the preceptorship only if there is promise of employment, a strong chance of employment, or the employer has paid for the educational program. One of these schools, further, requires that a clinical rotation has already occurred at the site and that the preceptor is not a current employer. One school permits a service chief to precept rather than the potential employer and one school, although permitting the practice, strongly discourages employer preceptorships since lines blur between the roles of student and employee.

Three of the 26 respondents (11.5%) who chose the response that students have elective coursework and/or clinical experiences in areas of employer interest added qualifying comments. One stated that the elective coursework needs to be in an area of interest to the student. Another commented that students can elect a portion of their required clinical hours in their employer's *specialty* in their final clinical course, if they are doing well. The third respondent stated that the school developed an elective post-graduate course to address a specific area of employer interest.

Among the 10 survey participants indicating that their school is unable to accommodate employer interests at this time, four (40.0%) added additional comments related to their response. The respondent for one school indicated that the inability to accommodate interest was limited to one program track. Two schools have decided against requests for a first assistant program or emergency room experience. One school does not have the resources to add a clinical track in an area of employer interest.

Additional Comments About Employer Interests. A common theme expressed in comments was that the pairing of students and employers who were mutually interested was positive for both parties. One respondent added that there is an attempt to put the students with as many potential employers as possible over the course of the program, a practice which faculty find beneficial to students and employers.

Another theme related to the interest of specialists and employers from specific settings, such as *specialty* clinics or rural sites, is having students experience the *specialty* or practice site. Inquiries regarding the lack of a particular option were also mentioned. One respondent indicated that they were able to develop a clinical track based on the needs of the medical center with which they are affiliated.

In some of the schools, employers have increased their expressions of programmatic interest, or pressure, while others indicate pressure has decreased. Congruence with NP clinical track goals was mentioned as a means of diffusing employer pressure.

5. SECTION V. CLINICAL HOURS

Q10. Do you use clinical simulations in the education of NPs at your school?

As shown in Table 22, respondents for half (50.5%) of the schools indicated that they use clinical simulations in the education of NPs. Another third (32.9%) are planning to use clinical simulations.

Table 22. Use of Clinical Simulations in the Education of NPs (N=295 Schools)

Clinical Simulations	N	%
Yes	149	50.5
No	49	16.6
No, but use is planned	97	32.9
Total	295	100.0

Among those answering affirmatively (N=149), 33 respondents (22.1%) added comments related to their responses. Eight of these participants stated that their schools are just beginning to use clinical simulation or use it sporadically. Differences in use among NP clinical tracks were noted by three participants.

Two participants indicated that the nature of the simulation was unclear in the question which may have contributed to the need for respondents to clarify the use of clinical simulation at their schools. Participants from 11 schools stated that they use standardized patients as part of the NP education; Objective Structured Clinical Examinations (OSCE) were listed by two additional respondents and one participant stated that students role-play while gaining interviewing skills. Technology-based clinical simulators (including SIM man), targeted examination patient simulators, and suture arms are used at 10 schools, primarily in health assessment courses. Computer-based, online, or DVD/ hi-fidelity clinical simulations were noted on three surveys. Two respondents indicated that the medical school controls the simulation laboratory and that NP students either do not have access or the nursing school is charged for access.

Nine of the 49 participants stating that the school does not use clinical simulation (18.4%) added comments. Of these, two schools have distance programs. Respondents for two other schools indicated that their programs prefer to have students work with patients. One respondent differentiated between simulated and standardized patients indicating they do use standardized patients; another indicated that they do not have OSCEs but do include patients as part of health assessment skill learning. Another mentioned that they use the medical school's OSCE laboratory. Two participants wrote that their schools do not use clinical simulation but they are interested in exploring possibilities.

Respondents for four of the 97 schools planning to use clinical simulation added comments (4.1%). Their comments were related to the difficulty in finding NP-appropriate simulation materials, ability to provide simulation because of recently-acquired laboratory space, and perceived differences in the importance of clinical simulation for specific NP clinical tracks. One participant noted that planned use of clinical simulation would be limited.

Q10-1. Are clinical simulation hours counted as direct clinical care hours?

Among the schools that use clinical simulations in NP education (N=149), just over a quarter (26.2%) count clinical simulation hours as direct clinical care hours (Table 23).

Six of the respondents answering "yes" to the question qualified their answer by stating that some but not all of the simulation time was counted. Some NP clinical tracks in two schools count simulation hours while others do not.

Table 23. Counting Clinical Simulation Hours as Direct Clinical Care Hours (N=149 Schools)

Clinical Simulation as Direct Care Hours	N	%
Yes	39	26.2
No	110	73.8
Total	149	100.0

Five respondents answering "no" have an interest in counting simulations as clinical hours, and are are pursuing the idea with their state Board of Nursing. One respondent is concerned that simulations violate the requirement of *direct care*.

Q10-2. On average, how many clinical simulation hours are counted as supervised clinical practice hours?

If participants gave an affirmative answer to counting clinical simulation hours as direct care hours (N=39 schools), they were asked to provide the average number of hours that are counted as supervised clinical hours. Responses are shown in Table 24. Almost two-thirds of the schools (64.1%) count 10 or fewer hours as supervised clinical practice hours. One respondent discussed a larger number of simulation hours by including the nature of the simulation experiences which are preparatory for emergencies that cannot easily be duplicated with actual patients.

Table 24. Average Number of Simulation Hours Counted as Supervised Clinical Practice Hours(N=39 Schools)

Average Number of Hours	N	%
Five (5) or fewer	12	30.8
Six (6) to 10	13	33.3
11 to 15	4	10.3
16 to 20	6	15.4
More than 20	4	10.3
Total	39	100.0

Q11. Upon review of published curricular/plan of study materials, it is not always possible to determine the components of clinical hours. How does your school distinguish the number of clock hours that students provide direct clinical care to patients from other experiences such as skill laboratory hours and clinical simulation hours?

Almost two-thirds of the participants (N=190; 64.4%) responded to this open-ended question by summarizing *components of clinical hour*s. Answers in this major category were summarized under one of four themes, as shown in Table 25. Other respondents provided *clock hours data* for clinical hours as hours per credit or total clock hours, described *ways hours are tracked*, discussed *other* ways in which hours as distinguished or gave *no clear response* (see Table 25). Although several participants included content in more than one category, responses were listed under the primary manner in which the question was answered.

Q11-a. Comments About Components of Clinical Hours

Clinical Hours as Direct Care Only. Approximately a third of respondents overall (N=104; 35.3%) answered the question by stating that clinical hours are direct care hours only. Several respondents added information on how the hours were documented, the number of clinical hours required and/or the ratio of credits to clock hours. Others noted that conference, documentation, and consultation time might be included or that lab and simulation time were part of the didactic course. One respondent stated that students must meet demographic percentage requirements and that clinical time may be increased if needed to meet requirements. Another would like to see clinical hours replaced with a competency-based approach.

Table 25. Distinguishing Direct Clinical Care Clock Hours from Other Experiences such as Skill, Laboratory, and Clinical Simulation Hours (N=295 Schools)

Response Categories	N	%
Components of Clinical Hours	190	64.4
Clinical Hours are Direct Care Only (n=104)		
Laboratory and clinical hours differentiated in various ways (n=40)		
Some skills laboratory, simulation, or other experiences included in clinical hours (n=35)		
Skills laboratory, simulation and clinical hours not differentiated (n=11)		
Clock Hours Data	38	12.9
Hours per credit (n=24)		
Total clock hours required (n=14)		
Ways Hours Tracked	30	10.2
Other Responses	19	6.4
No Clear Response Given	18	6.1
Total	295	100.0

Laboratory and Clinical Hours Differentiated in Various Ways. The primary response in this category was that clinical and laboratory hours have different course numbers (n=10). This approach was also noted secondarily in other comments across categories. Another nine respondents stated that clinical hours or management course hours were direct care hours and that lab hours were not included or were part of the didactic course. Other responses focused on the fact that direct and indirect clinical as well as laboratory and simulation hours were specified for each course in syllabi, master files, or listed in some unspecified manner. At one school, differentiation is formal for one track and delineated less formally for others. The nature of the educational experience influences differentiation at one school and at another the faculty coordinator has authority to differentiate.

Some Skills Laboratory, Simulation, or Other Experiences Included in Clinical Hours. The majority of respondents in this category (n=21) chose to provide the number of clinical hours given to lab, simulation, or other experiences at their schools. The range was from four (4) to 70 hours. Among these, respondents stated that hours include simulation but not lab, standardized patient interactions or OSCEs, hours in health assessment with preceptors/patients, skills lab, post-clinical seminars, NP-related CE/CME, conference, role-playing, diagnostics, and/or some observation. Variations by track were noted by three respondents. Five respondents indicated hours were included but gave no details.

Skills Laboratory, Simulation and Clinical Hours not Differentiated. Eleven schools do not distinguish between laboratory, simulation, and clinical hours, although one of the schools has variation by clinical track. One respondent stated that academic credit is given for all learning. Another noted that there are more hours than required by the Board so the skill lab hours are not included for credentialing purposes.

Q11-b. Comments About Clock Hours Data

Hours Per Credit. As noted, 24 participants responded to the question with the number of clinical hours required per credit hour, clock hour, class hour, or academic unit. The range of clinical hours per credit was wide (2 to 200; median = 4 hrs/credit[n=7]). One respondent noted that the large number of hours per credit was a financial benefit to the students. Another noted constraints from a Board of Nursing to increase hours per credit adding that increasing units is too costly for students.

Total Clinical Clock Hours Required. Fourteen participants chose to list clinical clock hours required adding that the hours were in addition to laboratory and/or simulation in four cases. The range of total clinical clock hours was from 540 to 960. One respondent added that time other than direct care is not encouraged. Another added that the hours vary by track and may include an occasional seminar.

Q11-c. Comments About Ways Hours are Tracked

Responses in this category did not provide information on ways hours were differentiated. The responses instead focused on the ways clinical hours were recorded or tracked and included clinical logs (n=13), e-logs (n=7), use of proprietary software or programs (n=6), or general comments about students documenting hours (n=4). Tracking was used to assure not only hours but the total number of patients and meeting of course objectives.

Q11-d. Other Responses

Primarily, responses focused on the location of information related to hours differentiation including course materials such as syllabi and objectives or in a handbook. One respondent discussed faculty responsibility in designating the number of patients students must see and three respondents made comments about the relationship of laboratory and clinical hours.

Q12. With the increasing sophistication of clinical simulation models, do you think that some clinical simulation hours should be included as supervised clinical practice hours in the future?

All participants were asked if clinical simulation hours should be included as supervised clinical practice hours in the future based on the increased sophistication of clinical simulation models. Responses are shown in Table 26. Almost two-thirds (65.1%) of respondents answered affirmatively. Of note, five respondents indicated in comments that they do not know or are unsure. These responses were recoded to a *do not know/unsure* category. Others may have selected the category if it had been available as a response.

Table 26. Counting Clinical Simulation Hours as Direct Clinical Care Hours in the Future (N=295 Schools)

Clinical Simulation as Direct Care Hours	N	%
Yes	192	65.1
No	98	33.2
Do Not Know/Unsure	5	1.7
Total	295	100.0

Additional Comments About Clinical Simulation Models and/or Standardized Patient Simulations. Respondents added comments related to incorporation of simulation hours in the curriculum. The controlled nature of the standardized clinical experience allowing students to develop skills and clinical decision making in a safe environment was addressed. Participants also identified the value of simulation for procedures students are not often able to do in clinical settings, such as procedures in high risk obstetrics. Others added that simulated situations are preparation for real-life encounters. The value of standardized clinical simulations in evaluating students' clinical performance was addressed by several respondents.

Several survey participants also indicated that clinical simulation was viewed at their schools as an additional learning tool but not as a replacement for clinical hours. One respondent stated that simulation hours should be included but schools with online programs may be hampered if students must come to campus. Other survey participants indicated that they were uneasy with simulation hours included as clinical hours, that the issue would need further discussion, or that they needed convincing. One of these noted the value of simulation but raised concern with translation to practice in the actual setting. Another identified the multiple health issue scenarios seen in clinical practice that cannot be easily simulated.

The practice value, limitations, and evolving sophistication of simulation models were also expressed. One respondent noted that SimMan does not have the capacity for eye and ear exams which are areas where students need more practice. Another stated that simulation models are becoming more life-like but are not as real as desired.

Additional Comments About Clinical Hours. As clinical sites become more scarce and/or clinical hours requirements increase, simulation is seen in two schools as a potential clinical hours learning option. The concept of clinical hours was challenged by one participant who indicated that a competency-based approach makes more sense, whether simulation is used or not.

6. SECTION VI. REGULATION

Q13. Does the Board of Nursing in your state limit the NP *specialties* that it recognizes?

Participants were asked if state Boards of Nursing limited the NP *specialties* that were recognized. Responses are shown in Table 27. Almost 44 percent of respondents indicated that Boards of Nursing limited the NP *specialties* that were recognized, whereas almost 47 percent did not impose limitations. This question was dichotomous, as the assumption was made that respondents would be aware of state Board of Nursing regulations regarding NPs. However, 26 respondents indicated in comments that they do not know or are unsure. These responses were recoded to a *do not know* category. Others may have selected the category if it had been available as a response.

Table 27. State Boards of Nursing Place Limitations on Recognition of NP *Specialties* (N=295 Schools)

State Board Places Limitations	N	%
Yes	129	43.7
No	139	47.2
Do Not Know/Unsure	26	8.8
Not Applicable[a]	1	0.3
Total	295	100.0

[a]Federal/military

Several participants clarified their responses regarding limitations. Five participants stated recognition is limited by being linked to national certification examinations. Five additional participants stated that *specialty* recognition is limited to certification by specific organizations or certifying bodies. Another participant stated that the Board follows NCSBN guidelines.

In one state, a participant noted that the Board does not limit *specialties* within the broad advanced practice categories, including the NP category. Participants from two states added that, while the Board limits *specialty* recognition, numerous *specialties* are recognized.

One participant stated that recognition is limited for some clinical areas. Palliative care was mentioned by two other respondents as an area of practice not recognized by their respective boards as a *specialty*. In one state, only population-based *specialties* are recognized.

Titling was mentioned by participants from five states. In these states, NPs are limited to one title regardless of *specialty*.

One respondent stated that the Board in the school's state does not identify *specialties* whereas information shared by three participants identifies that the state specifically limits the *specialty* areas that are available for recognition to those listed in regulations. One respondent noted that the Board lists *specialties* it recognizes and the examination required for the *specialty*. In one of these latter states, the regulations are under review. Two participants stated that their respective Boards either have not looked into the issue or are currently evaluating limitations on *specialty* recognition. An additional participant indicated that the Board historically had not limited *specialty* recognition but might be doing so now.

Q13-1. Has the limitation created problems in recognition of specific *specialties*?

Participants from the 129 schools who indicated there were limits on the NP *specialties* recognized by their respective state Boards of Nursing were asked if the limitation created problems in recognition of specific NP *specialties.* As shown in Table 28, more than two-thirds of the participants (69.0%) indicated that the limits did not create a problem. Although not listed as a choice, 10 respondents (7.7%) indicated in comments that they do not know or are unsure if limits imposed by Boards of Nursing created problems; their responses were recoded

Table 28. Limits Imposed by State Boards of Nursing About Recognition of Specific NP *Specialties* Create Problems (N=129 Schools)

Limitations Create Problems	N	%
Yes	30	23.3
No	89	69.0
Do Not Know/Unsure	10	7.7
Total	129	100.0

to a *do not know/unsure* category. Others may have selected this category if it had been available as a response.

Q13-2. Please list the specific *specialties* that have not been recognized.

Participants from the 30 schools who indicated problems created by the limitations imposed by state Boards of Nursing had created problems in the recognition of specific NP *specialties* were asked to list the *specialties* that were not recognized by the Boards (Table 29). Multiple responses were permitted.

Table 29. List of Specific *Specialties* Not Recognized by Various State Boards of Nursing (N=30 Schools)[a]

***Specialties* Not Recognized**	**N**
Oncology	10
Palliative Care	5
Cardiology	4
Community or Family/Community	3
Diabetes	3
Emergency	3
Acute Care	2
Forensics	2
Interventional Radiology/Radiology	2
Occupational Health	2
Other *specialties* (n=1 response each) Acute Care Cardiology, Child Psychiatric-Mental Health, Dermatology, Disaster Preparedness, Emergency, Gastrointestinal, Genetics, Gerontology, Hospice, Holistic, Orthopedics, Pediatrics, Pediatric Acute Care, Psychiatric-Mental Health, and Pulmonology	15
No Response or Do Not Know	5

[a]Multiple responses permitted

Additional Comments About Limitation of NP *Specialties* Recognized by State Boards of Nursing. A few participants added comments related to practice limitations. The *specialties* of palliative care and home health care were mentioned as problematic for NPs who relocate since they are recognized in some but not all states. One participant raised the issue of liability when NPs market themselves broadly to meet specific states' criteria rather than by a more narrowly focused *specialty* in which they were prepared (e.g., ANP or FNP "with special training").

Prescriptive authority issues were raised by two participants. In one state, practice standards and licensing conflicts needed to be resolved since all advanced practice roles were credentialed under the NP umbrella.

In another state, the Board requires collaborative agreements with primary care providers to obtain prescriptive authority limiting *specialty* practice (e.g., an NP in a cardiology clinic in a collaborative agreement with a cardiologist).

Q14. Does the Board of Nursing in your state limit the way in which NPs can display their *specialty* NP credential in their title?

Survey participants were asked if state Boards of Nursing limited the way in which NPs could display their *specialty* NP credential in their title. Just over a third of the respondents (37.3%) indicated limitations on how *specialty* NP credentials could be displayed in their title, while 59.0 percent stated that Boards of Nursing did not limit the way in which the NP credential was displayed in titles (Table 30). Ten respondents indicated in comments that they do not know or are unsure. These responses were recoded to a *do not know/unsure* category. Others may have selected the category if it had been available as a response.

Table 30. Limitations on Display of NP Credentials in Title Imposed by State Boards of Nursing (N=295 Schools)

NP Credential Display Limitations	N	%
Yes	110	37.3
No	174	59.0
Do Not Know	10	3.4
Not Applicable[a]	1	0.3
Total	295	100.0

[a]Federal/military

Several participants qualified their answers regarding credentials display. Two who indicated that their states do not limit the display of *specialty* credentials indicated that discussion on the issue is underway; in one state, the recommendations regarding titling were expected to be forthcoming from the legislature. Three participants stated that there is no limitation but the Board must approve use of a *specialty* designation on an individual basis. One respondent indicating that there were no limitations, added information from the state regulations that advanced practice nurses must verbally indicate that they are an advanced practice nurse and include their *specialty* certification with each patient. Another participant expressed some concern that the state in which the program resides had no oversight of how credentials were displayed or marketed.

Q14-1. How have NPs been limited in the way in which they can display their NP credential?

The 110 school participants who indicated that limitations were imposed by Boards of Nursing in the ways in which NPs could display *specialty* NP credentials in their titles were asked the nature of the limitations. Responses are shown in Table 31.

Table 31. Limitations in the Way in Which NPs Can Display Their NP Credentials (N=110)

Limitation	N	%
NPs are limited to displaying titles and credentials, but these titles and credentials can represent any national NP *specialty* certifications	36	32.7
NPs are limited to displaying titles and credentials representing only a few national *specialty* certifications (e.g., FNP, ANP)	21	19.1
NPs may use only the title APRN and not the NP role designation	9	8.2
Titles and credentials displayed by NPs are regulated, but in another way: ▪ State Boards require that NPs use: - ARNP (n=11) - CRNP (n=9) - CNP[a] or CNP-BC (n=6) - APN[b] or APN-C (N=4) - RN and *specialty*[b] (e.g., RN, FNP) (n=4) - ANP[a] or ANP-BC (n=3) - ANP, CNP (n=1) - LNP (n=1) - NP in title (n=1) ▪ Other comment summarized below (n=2) ▪ No response (n=2)	44	40.0
Total	110	100.0

[a] *Specialty* area optional (e.g., CPNP; ACNP)
[b] Degree optional (e.g., APN, MSN; RN, FNP, MSN)

Additional Comments Related to Limitation on Ways NPs Display Credentials. A survey participant summarized a major issue apparent from the responses in Table 31. Among those states where there is a specific credential requirement, there is marked variation in required credential titles which can result in consumer confusion. NP programs spanning multiple states, additionally, may need to interface with several state Boards with differing requirements.

Q15. In your state, are there regulatory limitations on the way NPS can market their *subspecialty* preparation?

Survey participants from each of the schools were asked if state regulatory limited the way NPs can market *subspecialty* preparation. The majority (77.9%) indicated no limitations as shown in Table 32. A total of 37 respondents (12.5%) indicated in comments that they do not know or are unsure. These responses were recoded to a *do not know/unsure* category. Others may have selected the category if it had been available as a response.

Table 32. State Regulatory Limitations on Marketing NP *Subspecialty* Preparation (N=295 Schools)

State Regulatory Limitations	N	%
Yes	28	9.6
No	229	77.6
Do Not Know/Unsure	37	12.5
Not Applicable[a]	1	0.3
Total	295	100.0

[a]Federal/military

Two respondents answering affirmatively indicated that only *specialties* were recognized in their states and could be marketed. Marketing was linked to certification by two respondents who indicated that recognized certifications in their states were in *specialty* areas. Similarly, two respondents indicated that no *subspecialties* were recognized in their states. Two additional respondents added that the only *specialties* that were recognized in their states were population-focused. Another participant commented that the State Board recognizes the program *specialty* from which the individual graduated but does not formally recognize additional *specialty* or *subspecialty* preparation. The participant added that a practice restriction has occurred with at least one program graduate as a result.

A respondent answering that state regulations limit marketing qualified the answer by stating that the limitation was only related to the need for documentation if the NP was challenged to show appropriate educational background for a *specialty* or *subspecialty*. A participant from a school with a DNP program provided additional information from the state regulations showing that an NP with a doctorate must clarify for the patient what they *are not* (e.g., an MD), as well as provide information about their *specialties* and *subspecialties*. Lack of a definition for the word, *subspecialty*, was confusing for two respondents.

Q15_1. How do these regulatory limitations influence the way NPs market their *subspecialty* preparation?

The 28 respondents who indicated that marketing limitations existed in their states were asked how regulations impacted the ability of NPs to market *subspecialty* preparation (Table 33). Multiple responses could be checked.

Table 33. Ways Regulations Impact the Ability of NPs to Market *Subspecialty* Preparation (N=28 Schools)

Interests Addressed	N
State titling and credentialing protections prohibit the NP from openly marketing *subspecialty* preparation	14
Regulations impact the ability of the NP to market their *subspecialty* in other ways: ▪ *Subspecialties* are not recognized (n=2) ▪ Certification in the *subspecialty* is a requirement (n=2) ▪ Appropriate didactic education and documentation of *subspecialty* preparation are required (n=2) ▪ Only *specialty* certification is recognized and must use *specialty* title (n=2) ▪ All NPs have the same title regardless of *specialty* or *subspecialty* preparation (n=1) ▪ Broad preparation in a *specialty* area is required first (n=1) ▪ *Specialties* and *subspecialties* are not listed on the license (n=1) ▪ Can only market *specialties* and *subspecialties* recognized by the Board (n=1) ▪ The NP role in a given *specialty* is narrowly and restrictively interpreted (n=1) ▪ Rather that state regulation, lack of insurance reimbursement for *subspecialty* preparation inhibits marketing (n=1) ▪ Unsure (n=1)	14

[a]Multiple responses permitted; no participant provided more than one response.

Q16. Is there concern in your state that NPs who have practiced broadly will be prohibited from continuing to practice in *specialty* areas that now have their own certification examination (e.g., FNPs in acute care)?

Respondents were asked to indicate if there was concern in their respective states about NPs with initial broad preparation (e.g., FNP) being allowed to continue to practice in narrowly-focused *specialty* areas (e.g., adult acute care, pediatric acute care) now that national certification examinations exist for these *specialties*. Almost half (44.4%) of the sample had a concern about this issue (Table 34). Seventeen respondents indicated in comments that they do not know or are unsure. These responses were recoded to a *do not know/unsure* category. Others may have selected the category if it had been available as a response.

Additional Comments About Concern That NPs Who Have Practice Broadly Will be Prohibited from Continuing to Practice in *Specialty* Areas With Certification Examinations. Respondents included comments to clarify their answers to this question. Among those answering affirmatively that there were concerns, three indicated that the concern was minimal. One respondent stated the concern was among educators rather than NPs but another stated that the nurses were concerned. Others stated that it was becoming more of an issue or that some were deeply concerned while others were not. Another noted that the concern was with new regulations that may be coming.

The area of acute/critical care was noted by several respondents as an arena in which there is concern. One participant noted that the restriction is under discussion in the state. Another

Table 34. Concern in Respective States About Broadly Prepared NPs Continuing to Practice in *Specialty* Areas That Now Have *Specialty* Certification Examinations (N=295 Schools)

State Regulatory Limitations	N	%
Yes	131	44.4
No	146	49.5
Do Not Know/Unsure	17	5.8
Not Applicable[a]	1	0.3
Total	295	100.0

[a]Federal/military

indicated that some trauma centers are limiting practice. At one school with a medical center, the respondent noted that FNPs are no longer hired for acute care now that there are sufficient numbers of ACNPs graduating. Another participant stated that the FNPs graduating from the school are no longer able to go back to critical care areas even if they worked there prior to obtaining NP education. Four respondents stated that FNPs are still being hired by hospitals, although one added that hospital credentialing was becoming an issue. One noted that PNPs were not hired for acute care but positions were still available for FNPs. Two respondents stated that NPs were either returning to school or adding coursework in acute care. One participant noted that there is confusion about preparation for acute care. One respondent stated that the faculty do not expect FNPs to enter acute care and do not prepare them for it but neither do they prepare the FNPs to enter *specialties* although many choose that route.

Another area in which there were comments was the area of psychiatric-mental health. Three respondents noted issues related to FNPs managing patients in psychiatric-mental health.

The eventuality of prohibitions was noted by one participant. Another foresees new age/population and acute vs. primary care limits. Three respondents indicated that appropriate didactic and practice requirements are needed to extend roles to areas such as critical care and that *specialty* and/or *subspecialty* certification is the recognized way to document scope of practice. Alternately, one respondent stated that there is a need to "fight" this change.

Among survey respondents answering that there were no concerns, six stated that the issue was not a major concern but that change may be coming. Five respondents indicated that there was only concern if the NP was practicing outside of their area of preparation or scope of practice, such as an ANP or FNP working as an ACNP or a PNP working in acute care. Another participant noted that credentials already in place are not in jeopardy.

The issue of certification was addressed by several of those answering that there were no concerns. One participant stated that dual certification should be required. Others noted that individualized standard procedures are used to assure competence regardless of practice setting, NPs practice across the health care continuum, certification is not required for specific practices, NPs do not have a separate scope of practice based on *specialty*, or that practice is population and not site-based.

Q16-1. Comment on the impact of regulatory limitations.

Respondents who indicated concern about this issue (N=131) were asked to elaborate on the impact of regulatory limitations or potential regulatory limitations in their respective states. Of those asked to comment, three respondents indicated that the impact was minimal or that the impact had not changed, two stated that regulation conversations were just beginning, and another 12 gave no comment or were unsure. Comments from the remaining 114 participants were summarized under the themes of: *clinical practice; experience, education, and scope of practice; and regulations and regulatory language.* It is clear from the comments that there are multiple issues and a wide range of opinion related to regulatory limitations.

Clinical Practice. One of the main issues related to the impact of regulatory limitations was related to primary care NPs (FNPs, ANPs, and PNPs) working in acute care practice, psychiatric-mental health, and/or other *specialty* or *subspecialty* areas. Comments in addition to those included as clarifying responses to Table 34 are included here.

Five survey respondents stated that the dialogue about FNPs in acute care is underway in their states; another expressed concern that regulations could significantly impact FNPs and ANPs working in acute care. Another respondent stated that there was significant ambiguity over the issue in the state; an additional participant indicated that the issue of FNPs in acute care has not been resolved in that state and will be a contentious issue.

Eleven participants from schools in other states indicated that primary care NPs are not able to work in acute care and/or emergency care, or that they need acute care credentials. Two added that FNPs with long histories in acute care were no longer able to continue without the appropriate certification. One added that they are not able to see high risk pregnancy patients either but are aware of the limitations when entering the FNP clinical track. A participant stated that ANPs are limited to non-acute care unless specifically certified for acute care.

Job availability was addressed by three participants noting that acute care offers more job opportunities at greater pay for FNPs than does primary care. Further, changing regulations will limit FNP employment possibilities, according to one of the respondents. Another participant, however, stated that FNPs in acute care limits ACNP job opportunities especially since ACNP's are not allowed to practice in primary care.

The relationship of FNPs working in acute care and educational opportunity was discussed by two participants. Lack of an ACNP program in the state was a contributor to FNPs working in acute/critical care for one participant. Another respondent stated that the school was being asked to start an ACNP clinical track.

Employers in hospitals in some states want to hire only ACNPs and other employers preferentially seek individuals with an appropriate credential. Two participants stated that the hospital was credentialing NPs, not the regulators, and limiting FNPs from working in acute care in the region, adding that some employers were more restrictive than regulators. One respondent noted that there is a liability issue for NPs practicing in acute care when prepared for primary care.

One participant acknowledged that primary care NPs working in acute care was problematic but moving into *specialty* or *subspecialty* medical practice areas was not, with adequate preparation. A participant acknowledged that primary care graduates were seeking jobs in medical *specialties*/*subspecialties* even though advised to have the appropriate credential.

Three respondents addressed the need to assure that the FNP generalist working in a *specialty* area is not disenfranchised and another added that it is not in the best interests of one NP group to limit practice of another. A concern that a deficit will occur in *subspecialty* areas if NPs are required to practice solely in their area of certification was stated by two participants.

Conversely, two participants indicated that reimbursement in their states is limited to FNPs and PNPs so there is no incentive to practice in other *specialties* or *subspecialties;* one indicated that this was a waste of talent. Cardiology, an area that is more lucrative, was listed by one participant as an area of practice denied to FNPs in the participant's state.

Several participants discussed issues related to primary care practitioners and psychiatric-mental health clients. Six participants stated that primary care NPs either are already limited or may be limited in the near future from seeing these patients or will require additional *specialty* certification. Another participant stated that reimbursement for care of clients with psychiatric-mental health problems was an issue if the NPs do not have the *subspecialty* designation.

One respondent stated that the medical community does not limit the ability to follow patients by virtue of their location (acute care, outpatient, nursing home, etc.). The respondent goes on to say that the approach nursing is taking is very complicated and restrictive, limiting NPs from meeting the needs of their clients.

Experience, Education, and Scope of Practice. Eight respondents addressed the issue of experience indicating it is not recognized in credentialing but should be considered. Two respondents stated that post-graduate training should be considered since *subspecialty* practice is often gained by experience. Another added that knowledge and skills evolve over time. One participant was concerned that lack of recognition for experience may limit the ability of the NP to obtain *specialty* preparation and limit the NP's scope of practice. The lack of credit for experience was perceived by two participants to decrease autonomy in rural areas.

Five participants addressed the issue of NPs practicing outside their area of expertise and beyond their scope of practice indicating in two instances that practice has not been heavily monitored. One of the participants added that this keeps the profession from moving forward to autonomy and reimbursement and another stated that the NP advanced practice status is jeopardized. Three additional survey respondents stated that the practice area is not a problem in their state as long as it fits within the scope of practice, which is broadly defined. One participant stated that regulatory limitations in the state tend to be individual and based on application for prescriptive authority in an area outside the scope of education. Another respondent perceived a lack of consistency in requiring FNPs to have additional preparation in areas such as immunology and allergy when this is not required for MDs.

One participant noted that potential employers became confused about experience and the value of the educational credential when educational sites were shared with primary and acute care students. The participant suggested a unified educational base with setting and *specialty* layered later to make the preparation clear. Another participant indicated that there will be a need for clinical hours restructuring to meet requirements.

Lack of available academic instruction has resulted in NPs being unable to always demonstrate competency in specialized areas, according to three participants. Another added that graduates must rely on job training. The challenge of providing post-graduate education was mentioned by two participants. One of these added the comment that that the school is

unable to accommodate the primary care NPs interested in returning to school to qualify for the ACNP credential. Another participant stated that limited education opportunities will result in compromised graduate enrollments and employability if a specific area of expertise is needed. Three participants addressed the lack of resources for schools to meet new regulations by supporting multiple *specialties* and/or *subspecialties*. One participant stated that funding was needed from Medicare or elsewhere for post-graduate supervised preparation in a variety of areas.

Two survey participants stated that it was reasonable to limit scope of practice by educational preparation. Six respondents stated that NPs need to obtain required credentials; three of these specified that they need to return to school to meet requirements for certification in *specialty* areas. One participant stated that experience is required in a *subspecialty* area and is closely monitored. However, it was unclear if the experience was post-graduate or during the academic program.

Regulations and Regulatory Language. Six respondents acknowledged the need for better regulation and the role of regulation in consumer protection to assure appropriate preparation for a general practice area but stated that the results need to be reasonable and fair to all parties. Two respondents added that micromanagement through regulation is problematic if it targets specific clients.

Inconsistency in application of regulations across clinical tracks was described as confusing by two respondent who also stated there are more restrictions with pediatric than adult populations. Another participant raised concerns about rigid interpretations of age limits for the GNP.

Three participants expressed concern about regulations in general. One stated that regulatory limitations are considered an unnecessary roadblock for patients and providers. The second stated that regulations are punitive to practitioners and limiting to practice sites. A third respondent indicated that regulations are very restrictive and imply that NPs cannot expand their practice scope without additional education and credentialing.

One participant noted that changes in prescriptive authority and development of governing standards between medicine and nursing were raising issues of credentials and credentialing. Concerns also were expressed about the term, *supervisory*, and medical supervisory language in regulations by five participants One of these stated that the change from collaborative to supervisory practice language is becoming prohibitive for practice. An additional participant stated that language required physician colleagues to be a *specialty* match making it difficult for NPs to practice in some medical *specialty* and *subspecialty* areas.

Concern from two respondent centered on the need for multiple *specialty* exams and certifications and the impact on primary care delivery especially in rural and underserved areas. Another participant suggested that the supply of generalist NPs will be impacted with rigid restrictions and still another expressed concern that regulations will limit the number of NPs available to meet population needs. One additional participant indicated that regulations will limit access and expertise.

The impact of additional education and certification requirements on practice restrictions and the need for job changes was noted by one participant. Another survey respondent discussed the impact of regulations on NP faculty stating that the Board required the specific certification for a faculty member to teach in a clinical track. Increased faculty and support system administrative loads also were linked to increased regulations by one participant.

Four participants chose to identify current regulatory directions in the state in which the school is located. Their comments were: 1) regulators are limiting the list of approved NP credential; 2) regulatory redesign is underway; and 3) regulations are improving in favor of NP practice.

Eight participants identified perceived needs related to regulation. They were:

- National licensure of RNs
- Elimination of mandatory collaboration
- Agreement on a way to credential nurses not related to tasks but populations
- Phasing in of regulations to allow practice, practitioners, and education to adapt
- Reasonable and consistent use of titles which helps maintain a positive advanced practice reputation
- Proactive advanced practice action
- A broad, rather than narrow, interpretation of regulations.

Section VII. Marketability

Q17. In your experience, is the NP's marketability enhanced by initial broad preparation in a *specialty* area (e.g., FNP) rather than in a more narrowly-focused *specialty* area?

This question dealt with whether or not the NP's marketability was enhanced by initial broad preparation in a *specialty* area (e.g., FNP) rather than a more narrowly-focused *specialty* area. The majority of respondents (83.4%) indicated that NPs with broad preparation were more marketable than those with narrowly-focused preparation (Table 35). One respondent commented that the answer was not known. This response was recoded to a *do not know/unsure* category. Others may have selected the category if it had been available as a response.

Table 35. NP's Marketability is Enhanced by Broad Preparation (N=295 Schools)

Broad Preparation Increases NP Marketability	N	%
Yes	246	83.4
No	48	16.3
Do Not Know/Unsure	1	0.3
Total	295	100.0

Q17-1. From your perspective, what are the reasons broader preparation is more marketable?

The 246 respondents who agreed that the NP's marketability was enhanced by initial broad preparation in a *specialty* area enhanced marketability rather than in a more narrowly-focused *specialty* area were asked to indicate perceived reasons for increased marketability. Table 36 lists the number of respondents selecting each reason. Multiple responses were permitted.

Table 36. Reasons Why Broad Initial NP Educational NP Preparation is More Marketable (N=246 Schools)[a]

Reasons	N
Graduates have greater employment flexibility	223
Graduates can always narrow their focus with additional *subspecialty* preparation if their career goals or employment requires it	207
Rural communities employ our graduates and require NPs who can address health care needs across the lifespan	192
It is easier to move from one state to another	115
Other reasons (n=1 each per response) ▪ More flexible to adapt to the health care need of an aging population ▪ Meet needs of underserved populations ▪ General public is familiar with FNPs and therefore ask for them ▪ Growing demand for and shortage of primary care providers ▪ Broad preparation is desirable for international work ▪ Career goals and life plan change; the flexibility of broad preparation allows them to change and grow	6

[a]Multiple responses permitted

Additional Comments About Marketability Based on Broad *Specialty* Preparation. The majority of comments related to the marketability enhancement because of broad *specialty* preparation addressed three themes: the merits of broad-based preparation prior to narrow-focused preparation, the preference for broad-based preparation for rural and underserved populations.

Seven participants reinforced the importance of broad-based preparation prior to narrow-focused preparation. One of the participants summed it up by saying that broad-based education ensures greater overall competence and safety for the public. Another respondent stated that NPs with narrow role preparation practicing in broader area is not a service to health care consumers or our profession. A third respondent affirmed that changing health care needs requires broad education; and a fourth participant stated that broader knowledge enhances patient care even in a more narrowly-focused *specialty* area.

Four participants commented that some narrowly-focused *specialty* graduates express regret that they did not obtain broad-based education first primarily because of increased marketability and because NPs in a narrow *specialty* practice do more general primary care even within the context of *specialty* diagnosis.

Eight participants alluded to the heavy reliance on NPs with broad preparation in rural areas who can provide care across the lifespan. Other participants reinforced that some employers, including retail clinics prefer NPs with broad preparation.

Q18. In your experience, is the NPs marketability enhanced by *subspecialty* preparation?

Survey participants were asked if NP marketability was enhanced by *subspecialty* preparation. Just over half (56.2%) felt that *subspecialty* did not enhance marketability (Table 37). Although not listed as a choice, three respondents commented that they do not know the answer to this question. These responses were recoded to a *do not know/unsure* category. Others may have selected this category if it had been available as a response.

Table 37. NP's Marketability is Enhanced by *Subspecialty* Preparation (N=295 Schools)

***Subspecialty* Preparation Increases NP Marketability**	**N**	**%**
Yes	126	42.7
No	166	56.2
Do Not Know/Unsure	3	1.1
Total	295	100.0

Q18-1. In what ways is the NPs marketability enhanced by *subspecialty* preparation?

Respondents from the 126 schools that answered affirmatively to Q18 were asked to state the ways in which marketability was enhanced by *subspecialty* preparation. Results are shown in Table 38. Multiple responses were permitted.

Table 38. Ways in Which NP Marketability is Enhanced by *Subspecialty* Preparation (N=126 Schools)[a]

Ways Marketability is Enhanced	**N**
Graduates can market themselves in a specific area in which they want to practice	115
Employers in our area are looking for NP graduates with specific expertise	82
Other Ways Marketability is Enhanced: ▪ Enables networking via preceptors who want NPs with *subspecialty* preparation (n=2) ▪ Better prepared to deal with complexity of health care (n=1) ▪ Additional clinical time is usually added (n=1) ▪ Quality outcomes because of increased knowledge (n=1) ▪ Job market is expanded (n=1)	6

[a]Multiple responses permitted; total N of responses exceeds 126

Added Comments About Marketability. Of the 126 participants answering affirmatively, many made general comments or qualified their answers. Five participants addressed *subspecialty* education in general. Three stated that any additional preparation in any area beyond broad-based NP education would only augment their skills; and the fourth respondent stated that *subspecialty* preparation within educational programs assures an adequate knowledge base (not just clinical experience) and integration of theory and clinical within supervised clinical

practicums. The fifth respondent commented that *subspecialty* preparation was advantageous only after completion of a broad population focus education followed by *subspecialty* preparation at the post-master's level. It was of interest to note that of the 166 respondents who indicated that the NPs marketability was not enhanced by *subspecialty* preparation, six made comments about how *subspecialty* education was accomplished. Two respondents commented that students and employers seemed to be dealing with *subspecialty* preparation by primarily using an "on the job" approach; and four participants noted that most employers who want NPs with *subspecialty* training are willing to employ a generalist and prefer or expect to provide the *subspecialty* training themselves.

Two respondents specifically addressed community needs, stating that *subspecialty* preparation was beneficial only it helps to meet the needs of the community and the diversity of health care services in that community. A third participant added that *subspecialty* preparation is a way to address areas where there is a shortage of expertise in the traditional health care systems, i.e., needs of patients were not being met by current providers/health care systems, such as under-recognition of occupation health problems and a shortage of psychiatrists.

Nine participants stated that *subspecialty* preparation was desirable "sometimes," "may be," or "could be," but gave no further explanation. However, others limited their affirmative answers to select areas of preparation, such as palliative care (n=1); acute care, (n=1); genetics and geriatric psychiatric-mental health (n=1); cardiovascular disease (prevention and rehabilitation) (n=1); family practice, internal medicine, and endocrinology (n=1); and diabetes, and women's health (n=1). Two respondents commented that they were not clear about the meaning of the word, *subspecialty*.

Two participants noted that *subspecialty* marketability is only enhanced if the clinical sites are appropriate, such as a hospital *specialty* practice (n=1), large major teaching facilities (n=1). an area of practice that does not have a national certification examination, One respondent remarked that *subspecialty* preparation was enhanced only within the specific *subspecialty*, however general marketability is limited by *subspecialty* preparation. An additional participant stated that *subspecialty* preparation was positive, but marketability was more often enhanced by general preparation like family. Another respondent stated that *subspecialty* preparation helps marketability when NPs are in areas where there is strong competition with other NPs and PAs, especially in urban areas.

Section VIII. Emerging *Specialties* and *Subspecialties*

Q19. Is your school planning to add any new NP *specialties* within the next two years?

Participants were asked if their school plans to add new NP *specialties* within the next two years. As shown in Table 39, most schools (62.4%) do not have plans to add *specialties*. Eight percent (8.1%) of respondents reported they do not know about plans to add new *specialties*. Note that *do not know/unsure* was available as a response category in this question.

Table 39. Plans to Add New NP *Specialties* Within the Next Two Years (N=295 Schools)

Plans to Add New *Specialties*	N	%
Yes	50	16.9
No	184	62.4
We would like to add an NP *specialty* but do not have the resources	37	12.6
Do Not Know	24	8.1
Total	295	100.0

Q19-1. Please list the NP *specialties* your school is planning to add; and
Q19-2. Please list the NP *specialties* your school would add if you had the resources.

Respondents for the 50 schools planning to add NP *specialties* in the next two years and the 37 schools that would like to add an NP *specialty* if they had resources were asked to list those *specialties*. The alphabetical listing is shown in Table 40. Acute care, gerontology, pediatrics, and psychiatric-mental health are the *specialties* identified most often. Multiple responses were permitted.

Q19-3. What types of resources are you lacking?

Survey participants answering for the 37 schools that would add NP programs if the school had resources were asked to identify the types of resources that were lacking. Their responses are in Table 41. Multiple responses were permitted.

Almost all of the 37 schools lack adequate numbers of faculty (N=34; 91.9%). One respondent added a comment that a lack of fiscal resources was the primary problem and that faculty could be hired if finances were available. Another respondent commented that faculty are the critical resource and that the clinical sites and preceptors could be developed if faculty were available. This respondent also commented that administrative support to add faculty is lacking since NP education is perceived to be expensive.

Table 40. List of NP *Specialties* Planned for the Next Two Years (N=50 Schools) and Those That Would be Added if Resources Were Available (N=37 Schools)

Specialties	**Planning to Add in Next Two Years N[a]**	**Would Add if Had Resources N[a]**
Acute Care	15	11
Acute Care/Family		1
Acute Care Hospitalist		1
Adult	3	4
Adult/Chronic		1
Adult/Gerontology	2	
Adult/Gerontology Acute/Primary	1	
Cardiology		1
Environmental Health	1	
Family	2	1
Genetics		1
Gerontology	12	12
Gynecology		1
Neonatal	2	2
Oncology	2	1
Palliative Care	1	
Palliative/Acute Care		1
Pediatrics	4	7
Pediatric Acute Care	2	1
Psychiatric-Mental Health	9	2
Psychiatric-Mental Health, Child		1
Psychiatric-Mental Health, Family	2	
Psychiatric-Mental Health/Gerontology	2	1
Women's Health	2	4

[a]Multiple responses permitted

Table 41. Types of Resources Lacking (N=37 Schools)[a]

Resources Lacking	**N**
Faculty	34
Fiscal	29
Clinical Sites	19
Clinical Preceptors	19
Classroom/Educational Space	11
Student Pool	6
Other Resources Equipment	1

[a]Multiple responses permitted

Q20. From a *national* perspective, please list any new *specialties* that you see emerging within the next 10 years.

Survey participants from all of the 295 participating schools were asked to list, from a national perspective, newly emerging *specialties* that are likely within the next 10 years. More than half of the respondents (N=159; 53.9%) stated that there were none and another nine (3.1%) were unsure. A total of 97 respondents (32.9%) listed one or more emerging *specialties*; the remaining respondents included perspectives in comment (N=30; 10.1%).

The 97 respondents who listed *specialties* included both current *specialties* that are gaining impetus as well as new *specialties* or *specialty* areas. *Specialties* identified by three or more respondents are listed in Table 42 with emergence of a hospitalist/acute care/critical care practitioner identified most frequently. Emerging *specialties* identified by two participants included: aesthetics, child and adolescent mental health, community health, environmental health, home care, informatics, interventional radiology, and perioperative management. Those listed by one school participant included: adolescent health, bariatrics, college health, developmental pediatrics, cultural groups with special health needs, holistic health, international primary care, long-term care, occupational health, ophthalmology, pediatric health, and women's health.

Table 42. NP *Specialty* Practice Areas Gaining Impetus or Expected to Emerge Over the Next Ten Years (N=97 Schools)[a]

***Specialty* Practice Areas**	**N**
Hospitalist/Acute Care/Critical Care	21
Genetics, Healthcare Genetics	13
Gerontology/Geriatrics	12
Cardiology, Cardiovascular	9
Oncology	9
Palliative Care, Hospice	9
Emergency	8
Forensics	6
Pediatric Acute Care	6
Disaster Preparedness and Bioterrorism	5
Orthopedics	5
Dermatology	4
Psychiatric-Mental Health	4
Urgent Care	4
Chronic Care, Chronic Care and Aging	3
Endocrinology, Diabetes	3
Pain Management	3
Psychiatric-Mental Health, Seniors/Gerontology	3

[a]Multiple responses permitted

Added Comments About Emerging *Specialties*. Three of the respondents identifying geriatric health stated they included the *specialty* because of the expected surge in need and demand for the *specialty*. One noted changes in certification options related to the *specialty* were also cited as a reason for the expected increase. Two of the individuals suggested the emergence of geriatric-specific roles, such as rehabilitation, chronicity, and dementia will contribute to the increased demand.

Regulatory issues affecting emerging *specialties* were noted by several participants. One acknowledged the importance of geriatrics but noted issues for long-term care when NPs with this certification are restricted from seeing patients younger than 65 years. Two respondents addressed inhibition of emerging *specialties* due to restrictions by a state nursing board on titling and requiring double clinical hours if a graduate has more than one certification.

Emergence of the DNP was noted by 11 respondents. Comments included the need to focus on the DNP, providing opportunities for specialization following the DNP, or development of DNP *specialties* that mirror MD *specialties/subspecialties*.
In addition to those survey participants who indicated that there were no emerging *specialties*, one respondent stated a hope that there would be consolidation rather than proliferation and another indicated that the situation was already too fragmented. One respondent stated the hope that there would be no additional *specialties* at the master's level and another respondent suggests looking at ways to identify foci rather than developing new *specialties*. Two participants indicated that the new titling initiative has reduced the likelihood of emerging *specialties*.

Q21. Is your school planning to add any new NP *subspecialties* within the next two years?

Participants were asked if their school plans to add new NP *subspecialties* within the next two years. As shown in Table 43, only 13 (4.4%) have plans to add *subspecialties*. Almost nine percent (8.8%) of respondents reported they do not know about plans to add new *subspecialties*. Note that *do not know/unsure* was available as a response category for this question.

Table 43. Plans to Add New NP *Subspecialties* Within the Next Two Years (N=295 Schools)

Plans to Add New *Subspecialties*	N	%
Yes	13	4.4
No	240	81.4
We would like to add an NP *subspecialty* but do not have the resources	16	5.4
Do Not Know/Unsure	26	8.8
Total	295	100.0

Q21-1. Please list the NP *subspecialties* your school is planning to add; and
Q21-2. Please list the NP *subspecialties* your school would add if you had the resources.

Respondents for the 13 schools planning to add NP *subspecialties* in the next two years and the 16 schools that would like to add *subspecialties* if they had resources were asked to list those *subspecialties*. Some respondents included the clinical track in which the *subspecialty* will or would occur as shown in the alphabetical listing in Table 44.

Table 44. List of NP *Subspecialties* Planned for the Next Two Years (N=13 Schools) and Those That Would be Added if Resources Were Available (N=16 Schools)

Subspecialties	**Planning to Add in Next Two Years N[a]**	**Would Add if Had Resources N[a]**
Acute Care/Acute Care in ANP Track	2	2
Adult	1	
Cardiology		2
Complimentary Therapies	1	
Dermatology		1
Diabetes	1	
Emergency/Critical Care		1
Environmental Health	1	
Genetics	1	
Gerontology/Geriatrics/Gerontology Focus in ANP Track	1	4
Gynecology		1
Hospitalist		1
Mental Health/Mental Health in FNP Track	1	1
Palliative Care/ Palliative Care in Gerontology Track	3	
Pediatrics		1
Pediatric Acute/Critical Care	1	1
Psychiatric-Mental Health	1	3
Rural		1
Women's Health/Women's Health in FNP or ANP Track	1	2

[a]Multiple responses were possible

Several responses related to the addition of *subspecialties* were not included in the table. One school plans to provide *subspecialty* preparation based on student preference in the Acute Care NP clinical track within the next two years. Three respondents listed the DNP degree rather than specific NP *subspecialties*.

Development of or focus on the DNP was also commented on by three individuals who were unsure and five who gave a negative answer when asked if their school plans to add *subspecialties.* Other comments related to the directions for potential *subspecialty* content. For example, one school received a grant to incorporate gerontology content in the curriculum which may influence *subspecialty* directions at the graduate level. Another respondent indicated that the school conducted a needs assessment to determine future *subspecialty* requirements. An additional participant wrote that, although their school had no plans, they are always open to possibilities.

Q21-3. What types of resources are you lacking?

Survey participants answering for the 16 schools that would add NP *subspecialties* if the school had resources were asked to identify the types of resources that were lacking. Their responses are in Table 45. Almost all of the respondents (87.5%) indicated that the resource that was lacking to add *subspecialties* was faculty.

Table 45. Types of Resources Lacking (N=16 Schools)[a]

Resources Lacking	N
Faculty	14
Fiscal	13
Clinical Preceptors	10
Clinical Sites	8
Classroom/Educational Space	7
Student Pool	3

[a]Multiple responses were possible

Q22. From a *national* perspective, please list any new *subspecialties* that you see emerging within the next 10 years.

Survey participants from the 295 participating schools were asked to list, from a national perspective, newly emerging *subspecialties* that are likely within the next 10 years. Almost two-thirds of the respondents (N=179; 60.7%) stated that there were none; 16 others (5.4%) were unsure and eight (2.7%) gave no answer. A total of 88 respondents (29.8%) listed one or more emerging *subspecialties*. The remaining respondents (N=4; 1.4%) referred to the emergence of the DNP degree.

Differentiation between *specialties* and *subspecialties,* however, was problematic. Although 88 respondents listed *subspecialties*, 50 repeated responses given for Q20 regarding emerging *specialties* (see Table 42). Responses from the 38 participants who listed non-repetitive emerging *subspecialty* practice areas are shown in Table 46 if two or more participants identified the same area.

Emerging *subspecialty* areas identified by just one participant were: auto-immune demyelinating disorders, bioterrorism, colposcopy, developmental disability, e-health (telehealth), end-of-life care, forensics, geriatrics, health care coordination, holistic health, home health, infectious disease, informatics, interventional radiology, neurology, obesity, pain management, pediatric mental health, orthopedics, pediatric oncology, physiologist, pre-symptom care, respiratory, retail clinic, rheumatology, sports health, surgical assistant,

ultrasonography, urban health (environmental influences, stress, associated diseases), and women's primary health. While some of the emerging *subspecialty* areas were unique, many were listed by other respondents as emerging *specialty* areas.

Table 46. NP *Subspecialty* Practice Areas Gaining Impetus or Expected to Emerge Over the Next Ten Years (N=38 Schools)[a]

***Subspecialty* Practice Areas**	**N**
Palliative Care/Hospice	8
Oncology	5
Aesthetics/Cosmetics	4
Cardiology/Cardiovascular	3
Endocrinology/Diabetes	3
Hospitalist/Acute Care	3
Cardiac Rehabilitation	2
Chronic Care	2
Dermatology	2
Emergency Care	2
Genetics	2
Long-Term Care	2
Transplant	2

[a]Multiple responses were possible

Added Comments About Emerging *Subspecialties*. One survey participant described the area of cosmetics, which was listed by four respondents, as one in which physicians and other groups frequently request education for NPs. Consumer demand and fee-for-service reimbursement were addressed by two respondents in relation to this area.

Several participants acknowledged that they were unclear about the use of the term, *subspecialty*. One respondent stated the belief that the DNP will standardize practice requirements for *specialties* and *subspecialties*.

D. SUMMARY OF PHASE III MAJOR FINDINGS

Survey questions were organized in eight sections: 1) *Use of Terms to Describe NP Clinical Tracks;* 2) *Subspecialty Preparation;* 3) *Dual Tracks;* 4) *Individualization of Programs;* 5) *Clinical Hours;* 6) *Regulation;* 7) *Marketability;* and 8) *Emerging Specialties and Subspecialties.* Overall, analysis of the survey data confirm, amplify, and quantify information obtained from the focus groups.

Major findings in the section, *Use of Terms to Describe NP Clinical Tracks*, were:

- Half of the 295 respondents (N=149; 50.5%) indicated use of the word, *specialty*. Among the 146 schools (49.5%) not using the word, most were unsure of the reason why the word was not used (N=59). A wide variety of words were used among schools

when the word, *specialty* was not used; the most frequently used was the word, track (N=69).

- A total of 39 schools (13.2%) offered clinical tracks that might be considered *subspecialties* but only nine of these schools used the term, *subspecialty*.
- The number of words used by each school to identify NP clinical tracks was summed. A total of 88 schools (61.5%) used one word, another 27 schools (18.9%) used two words, and 28 schools (19.6%), used between three and six different words.

Major findings in the section, *Subspecialty Preparation*, were:

- In 21 (53.9%) of the 39 schools offering *subspecialty* preparation, the subspecialty tracks are unique to a specific NP *specialty* track.
- In 24 (61.5%) of the 39 schools with *subspecialty* clinical tracks, *subspecialty* coursework is offered concurrently with *specialty* coursework.
- Graduates completing *subspecialty* clinical tracks in 16 (41.0%) of the 39 schools are eligible to sit for NP certification examinations related to their *subspecialty* preparation.

Major findings in the section, *Dual Tracks*, were:

- A total of 78 (26.4%) of the 295 responding schools offer, by curricular design, opportunities for students to enroll in two NP clinical tracks concurrently with eligibility to sit for two NP certification examinations upon graduation.

Major findings in the section, *Individualization of Programs*, were:

- Almost all (N=266; 90.2%) of the 295 responding schools offer students some opportunity for program individualization. The most frequently listed methods were:
  - Election of last required hours in an area of interest (N=179).
  - Taking additional elective coursework to meet individual goals (N=149).
  - Adding clinical hours in an area of interest concurrently with required clinical coursework (N=140).
- Almost a quarter of the schools (N=71; 24.1%) experience some type of pressure from employers for students to have clinical experiences and/or coursework in an area of interest to the employer. Interests are addressed most often by:
  - Allowing students to precept with the employer during their final required clinical hours (N=45).
  - Students have additional elective coursework and/or clinical experiences in the area of interest to the employer (N=26).

Major findings in the section, *Clinical Hours*, were:

- Respondents for half (N=149; 50.5%) of the 295 schools indicated that they use clinical simulations in the education of NPs; another third (32.9%) are planning to do so.
- Among the 149 schools that use clinical simulations, 39 (26.2%) count clinical simulation time as direct care hours; 25 of these schools count 10 hours or fewer as direct care hours.

- When asked if clinical simulation hours should be included in direct clinical care hours in the future, almost two-thirds (N=192; 65.1%) of the 295 respondents answered affirmatively.
- When asked to comment on the components of clinical hours at their school, almost two-thirds of the 295 participants (N=190; 64.4%) responded to this open-ended question by summarizing *components of clinical hou*rs as follows:
  - Clinical hours are direct care hours only (n=104).
  - Laboratory and clinical hours are differentiated in various ways (n=40).
  - Some skills laboratory, simulation, or other experiences are included in clinical hours (n=35).
  - Skills laboratory, simulation, and clinical hours are not differentiated (n=11).
- Another 38 (12.9%) of the 295 participants gave clock hours data as either hours per credit (n=24) or total clinical clock hours required (n=14) when asked to comment on the components of clinical hours at their school.
  - The range of clinical hours per credit was wide (2 to 200; median = 4 hrs per credit[n=7]).
  - The range of total clinical clock hours was from 540 to 960.
- The remaining 67 (22.7%) participants described the ways clinical hours are tracked, provided other unique responses, or gave no clear response.

Major findings in the section, *Regulation*, were:

- A total of 129 respondents (43.7%) indicated that state Boards of Nursing place limitations on recognition of NP *specialties* in their states. Among these, 30 (23.3%) indicated that the limits create problems.
- Just over a third of the 295respondents (N=110; 37.3%) indicated the Board placed limitations on how *specialty* NP credentials could be displayed in their title.
- State regulatory limitations on the way *subspecialty* preparation is marketed were identified by 28 (9.6%) of 295 participants; half of this group (n=14) indicated that NPs were prohibited from openly marketing their *subspecialty* preparation.
- Nearly half (N=131; 44.4%) of the 295 schools indicated a concern in their states about NPs with initial broad preparation (e.g., FNP) being allowed to continue to practice in narrowly-focused *specialty* areas (e.g., adult acute care, pediatric acute care) now that national certification examinations exist for these *specialties*.

Major findings in the section, *Marketability*, were:

- The majority of respondents (N=246; 83.4%) indicated that NPs with broad preparation were more marketable than those with narrowly-focused preparation. The most frequently given reason(s) were:
  - Graduates have greater employment flexibility (N=223).
  - Graduates can narrow their focus with additional *subspecialty* preparation if their career coals or employment requires it (N=207).
  - Rural communities employ graduates and require NPs who can address health care needs across the lifespan (N=192).

- Just over half (N=166; 56.2%) of the participants indicated that *subspecialty* preparation did not enhance marketability.
- Among the 126 (42.7%) participants who indicated that *subspecialty* preparation enhances marketability, the most frequently identified reason(s) were:
  - Graduates can market themselves in a specific area in which they want to practice (N=115).
  - Employers in our area are looking for NP graduates with specific expertise (N=82).

Major findings in the section, *Emerging Specialties and Subspecialties,* were:

- Most of the 295 participants (N=184; 62.4%) do not have plans to add new NP *specialties* within the next two years, whereas 50 (16.9%) plan to add new NP *specialties* and another 37 (12.9%) would do so if they had the resources.
- Of the 50 schools planning to add *subspecialties,* acute care (N=15) and gerontology (N=12) were the areas most frequently identified. Likewise, these areas were also the areas most frequently identified to be added if resources were available (acute care, N=11; gerontology, N=12).
- The most frequently listed resources lacking among the 37 schools that would like to add *specialties* were faculty (N=34) and/or fiscal resources (N=29).
- The most frequently identified emerging NP *specialty* practice areas over the next 10 years were: hospitalist/ acute care/critical care (N=21); genetics/healthcare genetics (N=13); and gerontology/ geriatrics (N=12).
- Likewise, the majority of schools (N=240; 81.4%) do not have plans to add new NP *subspecialties* within the next two years. A total of 13 (4.4%) plan to add new NP *subspecialties* and another 16 (5.4%) would do so if they had the resources.
- The most frequently identified NP *subspecialties* to be added were palliative care or palliative care in the gerontology track (N=3) and acute care or acute care in the ANP track (N=2). If resources were available four schools would add gerontology or a geriatric focus in the ANP track and three would add a psychiatric-mental health clinical track.
- As was true among schools lacking resources to add *specialties,* faculty (N=14) and fiscal resources (N=13) were the most frequently listed resources lacking among schools that would like to add *subspecialties*.
- Emerging *subspecialties* over the next 10 years listed most frequently were palliative care/hospice (N=8) and oncology (N=5).

Overall, the survey responses indicated:

- There is overlap and confusion distinguishing *specialties* and *subspecialties*.
- A wide range of words are used to describe *specialty* and *subspecialty* clinical tracks.
- The nature, scope, and execution of tracks considered *subspecialties* are highly individualized among schools and, at times, among the various clinical tracks within schools.
- NP programs have a wide variance in the number of clinical hours and number of credit hours.

- The ways precepted clinical hours, laboratory hours, and clinical simulation hours are defined and differentiated lacks consistency and clarity.
- Regulatory and credentialing requirements differ among states; these differences impact NP practice, marketing, and recognition of specialty and subspecialty preparation as well as potentially confusing the public.

V. PROJECT PHASE IV: PRIORITY-SETTING FORUM

A. AIM OF PHASE IV

The aim of Phase IV was to prioritize future directions for NP education based on the project findings with the NONPF membership at a Priority-Setting Forum during the 2009 NONPF annual meeting. Priorities were based on the findings from the first three phases of the project and a review of the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education* (APRN Consensus Work Group and the NCSBN APRN Advisory Committee, 2008).

B. METHODS

The Principal Investigator, NONPF Advisory Group, and Berlin Sechrist Associates met via conference call in March 2009 to discuss the findings from the first three phases of the project and to plan the Priority-Setting Forum. The Principal Investigator, Berlin Sechrist Associates, and NONPF Executive Director then scheduled a second conference call to establish the logistics and format for the Forum with the Forum moderators, Janet D. Allan, PhD, RN, FAAN, Dean, University of Maryland School of Nursing; and Ann L. O'Sullivan, PhD, FAAN, CRNP, Professor, Primary Care Nursing-Clinician Educator, University of Pennsylvania School of Nursing. Both Dr. Allan and Dr. O'Sullivan are past presidents of NONPF.

The Forum was held during a two-hour plenary session in April 2009 at the NONPF annual meeting in Portland, Oregon. To set the stage for discussion, the findings from the first three phases of the project were summarized by Berlin Sechrist Associates with emphasis on the findings from the Phase III Survey. The Principal Investigator then summarized key points from the *Consensus Document* and introduced the session moderators.

A form was provided to participants that provided the titles of the presentations and guidelines for the discussion. Based on the findings from the first three phases of the project and key points from the *Consensus Document*, four topic areas were identified as a starting point for discussion and for priority ranking by participants. In addition to providing opportunity for discussion of the priority topics, participants were asked to rank the priority areas on a scale of 1 to 4, with 1 being the highest ranking, based on the priority with which the topic should be addressed by NONPF and other national organizations. The four topic areas were: *Implementation of the Consensus Document; Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours, Credentialing,* and *Content and Organization of School of Nursing Web Sites*. Opportunity was provided on the form for participants to write comments related to both the session discussion topics and other issues for NONPF to address. A copy of the form is provided in Appendix E.

The estimated attendance at the Plenary Session was 350 participants. Participants were reminded that the session was being taped and that providing comments either verbally or in writing was agreement to have comments included in the written report. Participants were also assured that individuals would not be identified. Comments made during the discussion were transcribed verbatim from the taped recording for inclusion in the summary of taped and written comments. Priority topic rankings and written comments were obtained from a total of 209 forms provided to Berlin Sechrist Associates for analysis.

Priority rankings given to each topic area were tabulated. Verbal and written comments were content analyzed and grouped together by theme under one of the four topic areas. Other issues
for NONPF to address not related to the NCSBN-funded project or implementation of the *Consensus Document* were provided separately to NONPF and are not included in this report.

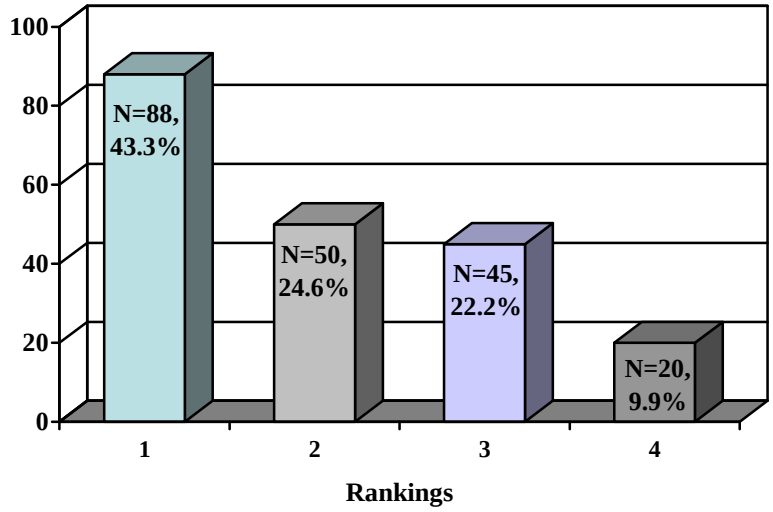
C. FINDINGS

Comments and priority rankings were organized under the following four topic areas: 1) *Implementation of the Consensus Document;* 2) *Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours;* 3) *Credentialing*; and 4) C*ontent and Organization of School of Nursing Web Sites*. The priority ratings given to each of the areas precedes the summary of written comments for the topic area. Comments applicable to all of the topic areas were summarized as additional comments following findings from the four topic areas.

1. IMPLEMENTATION OF THE *CONSENSUS DOCUMENT*

Priority rankings for the topic area, *Implementation of the Consensus Document*, are shown in Figure 4. Among the four topic areas, this area was selected most often as the top priority for NONPF to address. Just over two-thirds of the participants, further, ranked this topic area as either a first or second priority (N=138; 67.9%).

Figure 4. Priority Rankings for Implementation of the Consensus Document (N=203)



Written and verbal comments related to Implementation of the *Consensus Document* were summarized under three themes. They were: a) *Additional Clarification Needed*; b) *Relationship of the Consensus Document to the DNP Degree*; and c) *Role of NONPF in Facilitating Implementation.*

a. Additional Clarification Needed. One of the *Consensus Document* areas in which participants indicated uncertainty and a need for additional clarification involved the concept of "population foci" in the APRN Model. Specifically, participants raised questions about the placement of acute care, psychiatric-mental health, overlapping roles, and programs with multiple population foci. Locating Certified Registered Nurse Anesthetists (CRNAs) and Certified Nurse-Midwives (CNMs) within population foci was of concern to two participants who suggested these groups have separate "bubbles" going directly to APRN status rather than being required to identify a population focus.

Use of the word, family, was considered too general to be included in *specialty* practice by one participant who suggested that family practice be the basis for *specialty* practice. Another individual noted that the word, *specialty*, in the *Master's Essentials* and the *Competency for Specialties Monograph* is inconsistent with the way the term is used in the *Consensus Document*.

In addition to the placement of acute care within the Model, the relationship or crossover between primary and acute care was identified as a clarification need by several participants. Questions were also raised about educating students across settings within population foci and how that could be accomplished if faculty were not prepared in that manner. Clarification of requirements, such as formal certification or education, to move from one APRN Model population base to another was also identified as a need.

The word, lifespan, was unclear to two participants in relation to the psychiatric-mental health area. Further dialogue was requested.

General comments related to clarity were included by several individuals. One noted that the document was clear and could be used for curriculum planning but another commented that there was "lots of confusion." One additional participant stated that there generally needs to be more clarity. Another asked for clarification of the timeline for implementation. Another participant asked for clarification on the ways in which accreditation fits into the Regulatory Model.

b. Relationship of the *Consensus Document* to the DNP. Nine participants provided comments related to incorporation of the DNP in the *Consensus Document.* They either urged immediate action to update the document to include the DNP or asked for clarification about the relationship of the document to the DNP.

c. Role of NONPF in Facilitating Implementation. Twenty-eight participants specifically stated that NONPF should take leadership in clarifying and implementing the *Consensus Document.* Alternately, three individuals stated that NONPF should not help schools with implementation, one adding that there was a lack of support for the document in its current form. Another person stated that other areas, such as clinical hours and credentialing, need to be fixed first.

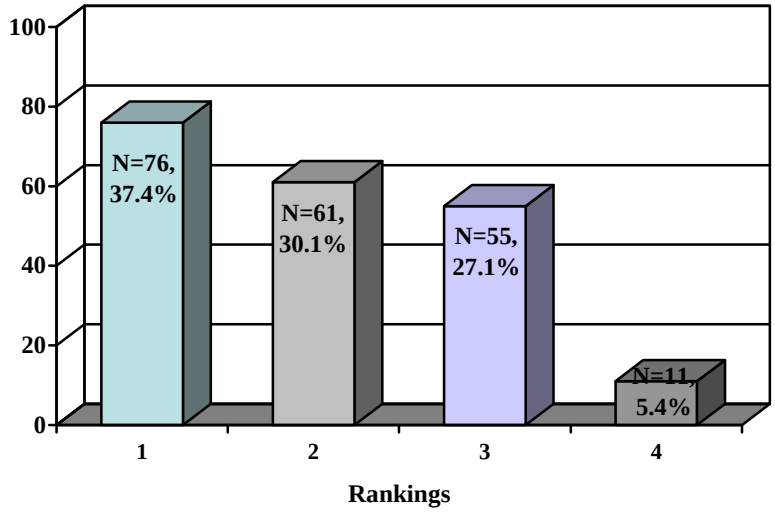
Among those supporting NONPF involvement, there were requests for resources. Specifically, participants requested position or clarification papers on issues arising from the document and a prepared presentation that could be shared within universities/colleges. One individual suggested an action plan that defines steps with frequent updates to members. Another suggested regional meetings or work groups. An additional participant suggested that there needs to be more communication with constituents since there is fear about how changes will impact them personally in their practice.

Concern was expressed by some participants that the need to change nurse practice acts in order to implement the *Consensus Document* will result in opportunities for other professionals to attempt insertion of supervisory language. One suggested that training workshops be conducted by NONPF on working with Boards of Nursing where state regulations need to be changed. A second participant discussed the risk in implementing the *Consensus Document* to APRN practice from a physician coalition known as the Scope of Practice Partnership (SOPP). This participant indicated that a second licensure is a mistake and that NONPF needs to move carefully and work with the Coalition for Patient's Rights (CPR), regarding nursing's response to SOPP. The participant suggested that NONPF provide additional information on both SOPP and CPR as well as facilitate leadership from successful states to members involved in legislative issues in their states.

2. CLARIFICATION OF SIMULATION HOURS, CLINICAL HOURS, AND LABORATORY HOURS

Priority rankings for the topic area, *Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours*, are shown in Figure 5. Although the topic did not receive as many first priority rankings as did *Implementation of the Consensus Document*, almost the same proportion of participants ranked this topic area as either a first or second priority (N=137; 67.5%).

Figure 5. Priority Rankings for Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours (N=203)



Written and verbal comments related to *Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours* were summarized under five themes. They were: a) *Simulation and Clinical Hours*; b) *Competency-Based Education and Clinical Hours*; c) *Credentialing and Clinical Hours*; d) *Number of Clinical Hours*; and e) *Role of NONPF in Simulation and Hours Clarification*.

a. Simulation and Clinical Hours. By show of hands, it appeared that the majority of participants use some type of simulation, from complex models to standardized patient simulations. Several of the participants, further, expressed interest in discussion about

inclusion of simulation as clinical hours. Two participants stated that the simulation hours should be counted as clinical hours.

The value of simulation was noted by six individuals. One stated that simulation and standardized patient experiences provide opportunities for faculty feedback to students for skills improvement. The value of simulation in pediatrics was noted as vital since children cannot volunteer for advanced health assessment. Including high fidelity and Objective Structured Clinical Examination (OSCE)-type simulations were identified as assistive in areas where competition for sites is difficult. Another participant identified the removal of preceptor evaluation variability as a potential benefit. One person noted that simulation should be used for both learning and evaluation. An additional participant stated that simulation is important but did not elaborate.

Among those considering inclusion of simulation in clinical hours, several stated that inclusion should be optional and that a specific range of clinical hours should be retained. One participant suggested counting simulation hours only when they mimic clinical hours. Another stated that "case studies" should not be counted.

Among those concerned about simulation hours inclusion, one participant stated that students need a foundation in direct clinical care. Another indicated that some state Boards of Nursing do not allow skills labs and simulations to be counted in the total number of clinical hours. Two others stated that they do not support inclusion of simulation hours as clinical hours.

b. Competency-Based Education and Clinical Hours. By show of hands, approximately three-fourths of Forum attendees indicated they were interested in moving toward a competency-based approach to NP education. In written and verbal comments, three avenues of thought were identifiable on competency-based education and clinical hours. One group encouraged a change from clinical hours to competency-based education. A second group encouraged retaining clinical hours rather than moving toward competencies. The third group suggested retaining minimum clinical hours and integrating competencies in some way.

Competency-based Education. Thirteen participants stated that education should be competency-based and that there should be a move away from clinical hours. One participant stated that faculty need to be open to how this is achieved. Another stated that simulation and lab should be included as clinical hours to achieve learning based on adult education principles.

A participant noted other advanced practice groups (CRNAs and CNMs) do not use clinical hours but have competency-based education and evaluation. The participant added that no studies have been done to determine the appropriate number of clinical hours for NPs and that either studies need to be done or NPs should move toward competency-based education.

In the area of competency assessment, one participant stated that there is need to validate the tools that are used. Another asked how standards, if met, will be verified. An additional participant noted that graduates, who obtain special training, are going to areas of specialized need resulting in a need for ways to verify "*sub-subspecialty*" competencies.

Retain Clinical Hours. Among participants who advocate retaining clinical hours, comments included:

- Dropping clinical hours would create an "academic nightmare" relative to the number of credit hours required, cost of the program, and time required for program completion;
- It has been important to the faculty/student ratio that NONPF has insisted on a minimum number of clinical hours;
- Cannot ask busy preceptors to focus on competencies; and
- There is a lot to do, so keep clinical hours.

Clinical Hours and Competencies. Ten participants stated that a minimum number of clinical hours should be retained and competencies added. One participant stated that setting benchmarks for clinical experiences, along with percentages of patients to be seen, should assure that competencies are met. Another noted that, while competency-based education was excellent, there were risks and a minimum number of hours should be retained. An additional participant stated that a minimum number of hours were needed since there is no consistent way to measure and quantify successful competency achievement. Another indicated that clinical hours and competencies could not be separated and that benchmarks, including percentages of patient types, were needed. An additional participant stated that competency needs to be demonstrated within a certain number of hours. Two individuals stated that the minimum number of hours is helpful for student planning; another stated that competencies may actually increase clinical hours.

This group of participants included comments on ways in which clinical hours and competencies could be included. One participant suggested that faculty should focus on competencies while preceptors focus on providing a quality reality experience. Another suggested a flexible model but did not elaborate.

Two participants spoke to the need for a flexible model. One stated that the number of clinical hours a student accumulates does not necessarily assure competency. This participant also mentioned that, with distance education, there is lack of control over clinical experience and that, on occasion, students have needed to work with faculty or have simulation experiences to assure competence.

c. Number of Clinical Hours. Some participants indicated that there should be a minimum number of required hours or suggested specific numbers of clinical hours. One individual indicated that a minimum number of clinical hours should be identified with schools left alone to determine the maximum. One participant stated that a fundamental number of 500 hours was not unrealistic to ensure competencies and that additional hours could be added, if needed.

Comments related to standardization of clinical hours were mixed. Two participants stated that there is a need to standardize required clinical hours, one relating the standardization to *specialties* and *subspecialties.* Two others indicated that the number of clinical hours should not be standardized. One person added that creativity would be suppressed and that the wide range of hours was not a concern as long as the number of hours was disclosed to applicants. Another individual noted that the lack of consensus on programs and hours makes it difficult for others, such as MDs, to understand and trust abilities and experiences.

Standardization of post-master's DNP hours was requested by one participant. This participant suggested that the number of clinical hours should be the 1,000 hours as indicated by AACN minus the number of clinical hours already completed in the master's program.

d. Credentialing and Clinical Hours. Two participants noted that credentialing requirements for Board certification will be an issue if clinical hours are eliminated or if competency-based education is instituted. Another individual noted, that while the concept of outcomes instead of clinical hours is appealing, it is unclear how certification bodies will react.

e. Role of NONPF in Simulation and Hours Clarification. Comments about NONPF's role in clarification of simulation were provided by several participants. Two individuals stated that NONPF should address simulation and the utilization of simulation for clinical education in some way. One participant suggested that NONPF develop a white paper on the use of simulation. A definition of clinical simulation was requested by six participants. Three individuals added that there is a need to have a percentage of clinical time that can be allotted to simulation.

Three participants stated that there is a need for more clarification and discussion on the issues of both simulation and clinical hours. One stated that there is a need to define clinical hours more carefully.

In the area of competency-based education, several individuals stated that NONPF should take a leadership role in competency-based education. One participant stated that NONPF should encourage movement toward use of competencies and another that NONPF should assist in implementing competencies in programs. One participant suggested discussion on competency-based education and how to integrate it into programs. Two participants called for development of competencies and measurement tools as well as standardization of competencies. An additional participant suggested that there be competency-based guidelines.

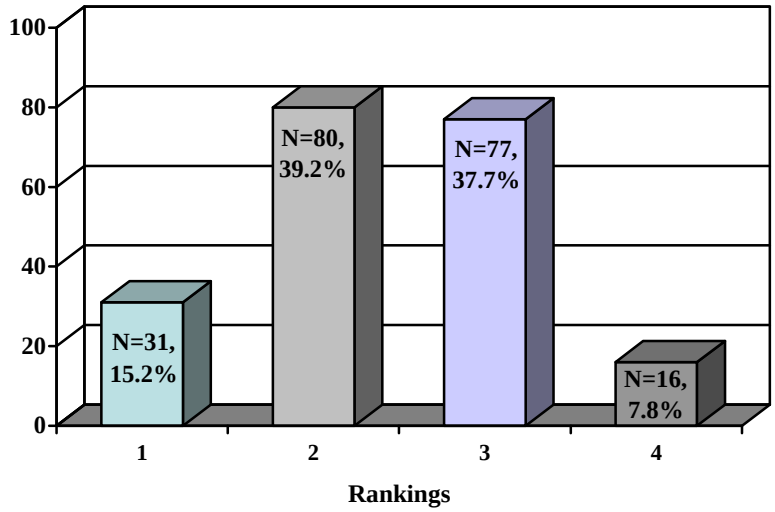
One participant stated that there needs to be a strong NONPF demand for accountability and standards in competency-based education. Two participants asked for clarification of the need to move toward competency-based requirements.

Research was suggested by four participants. One suggested that research be conducted to determine if there is equivalence of simulations to clinical experiences. Also identifying the need for research related to simulations, another participant suggested a study of the effectiveness of various types of simulation and clinical experience to achieve competence. Other competence studies were suggested by two individuals. One suggested that NONPF study a percentage-based/competency-based process for clinical rotations. Another stated that research focusing on measuring competency and scope of practice is needed.

3. CREDENTIALING

Priority rankings for the topic area, *Credentialing*, are shown in Figure 6. This topic did not receive as many first priority rankings as the first two areas; the majority of participants ranked this topic area as either a second or third priority (N=157; 76.9%).

Figure 6. Priority Rankings for Credentialing (N=204)



Written and verbal comments related to Credentialing were summarized under six themes. They were: a) *Educational Preparation*; b) *Certification Examinations*; c) *Scope of Practice*; d) *Regulation*; e) *Titling*; and f) *Role of NONPF in Credentialing.*

a. Educational Preparation. One of the main areas of discussion under this theme was acute care. Two participants expressed a need for additional definition of the overlap between acute care and primary care in the context of educational preparation and credentialing. One added that the distinction should be eliminated altogether as setting has more to do with skills training than educational preparation for advanced decision making. The other individual suggested more discussion on the ways certification will differentiate the two areas. Another participant requested discussion on ways to add acute care to all programs. An additional participant expressed concern about making the distinctions of adult and gerontology with acute vs. primary specialization. The words, acute care and urgent care, were entered on the forms without additional comment by two individuals.

Other educational preparation issues were also listed. One participant indicated that there is a lack of clarity about requirements for obstetric clinical experience in FNP programs. Another participant stated that spirituality coursework should be mandated across programs. Mental health was listed by one participant but without further explanation of the nature of the issue.

b. Certification Examinations. A need for further differentiation of *specialty* and *subspecialty* preparation related to certification examinations and credentialing was requested by one individual. Another participant urged *specialty* groups offering certification examinations to require master's, post-master's, or DNP education rather than continuing education. A third individual stated that credentialing should be competency-based.

One participant expressed concern that ACNP students would need to take two examinations. Two participants raised questions about the role of hospitalist and which *specialty* can meet the demand for this role. They asked, further, if the role will require another certification.

A participant who is teaching in a program moving from separate adult and geriatric *specialties* to the combined clinical track requested information on when ANCC and AANP will change their certification examinations. An additional participant asked if students who are taking the adult/gerontology track and want to also do the ACNP work can sit for both the ACNP and ANP certifications.

c. Scope of Practice. The overlap between acute and primary care was again addressed in the context of scope of practice by one participant who stated that FNPs may be prepared for acute infections but not for acute myocardial infarctions. Another participant stated that FNPs should not be working in critical care and that it was an issue of patient safety.

A slightly different perspective was expressed by another individual who stated that NPs should be able to practice in any area in which they are educated either in their program or on a post-graduate basis. This participant also indicated that the generalist can function in the tertiary care setting since primary care NPs and MDs may be the only providers for hospitalized patients in some communities. Another participant raised the issue of FNPs filling hospitalist and emergency room positions because of a lack of MDs and the fact that they may be the only provider in a given geographic area. There is concern that the Board of Nursing, which has already identified this as a regulatory issue, will impact the ability of NPs to function in outlying communities. An additional participant suggested there be dialogue about the role of experience in credentialing and scope of practice.

A specific scenario was provided by one participant who asked for information about graduates of FNP programs with prior expertise in critical care who then take jobs in critical care following graduation. A second participant stated that educators cannot take responsibility for roles graduates assume and that this should be a regulatory issue with the Boards of Nursing assuming this responsibility. Another participant indicated that graduates practicing outside of their scope is both an academic and regulatory issue in that schools need to inform graduates that they will be held to the certification standards of experts in the area in which they are practicing if there are malpractice suits. Three participants noted that students need to be educated about what scope of practice means beginning with enrollment and continuing throughout their educational preparation. An additional participant suggested that employers be educated regarding scope of practice.

Two participants stated that credentialing and scope of practice need to occur by role and population foci as suggested in the APRN model, not by acuity or setting. One of the individuals added that education needs to set the standard.

d. Regulation. Regulation and its role were addressed by four participants. Three of these individuals stated a concern about over-regulation. A fourth participant expressed the opinion that experience and other education should be considered in regulatory action so that practice opportunities are less limited.

e. Titling. The importance of appropriate credentialing/titling was noted by four individuals. One added that credentialing clarity is important for the sake of the public and another added that continual changing of titling adds to the confusion. One participant shared the view that it would be amazing to have one title nationally. Another asked what it would take to standardize titles. A suggestion was made by one participant that funding be obtained for a public education campaign to clarify the change in titling and education.

One individual stated that the credentialing body wants their title used rather than use of CNP, an issue that may require conflict resolution, according to this participant. Another suggested that the title not be CNP but a different format (NP-A for Anesthesia, NP-F for family, etc.).

f. Role of NONPF in Credentialing. Participants suggested that NONPF take a leadership role in defining scope of practice and in credentialing. Two participants suggested that NONPF work with state Boards of Nursing, one adding the goal of standardizing credentialing. Another participant stated that NONPF needs to address congruence in credentialing, certification, and *Consensus Document* recommendations. Seven participants stated that NONPF should take a leadership role in LACE (Licensing, Accreditation, Certification, and Education).

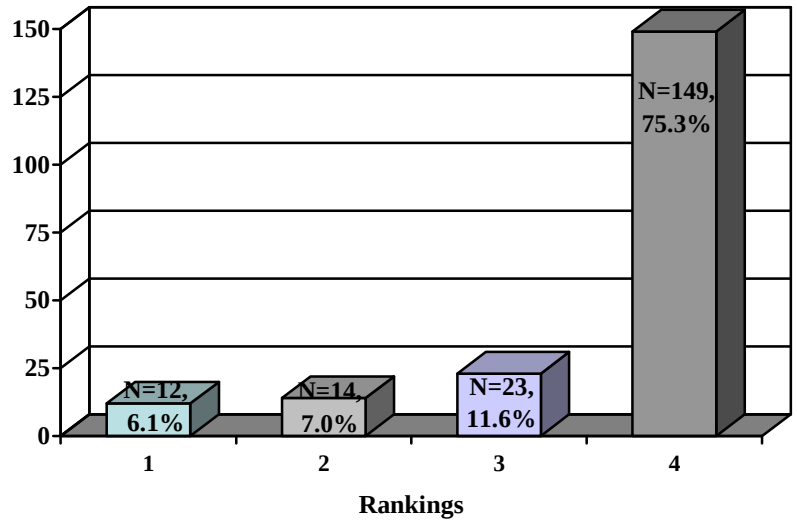
One participant indicated that NONPF should clarify the related access to care issue and overlap between acute and primary care particularly as it relates to care for hospitalized patients, many of whom may not be critically ill.

Two individuals stated that NONPF should help faculty understand scope of practice boundaries and suggested that a session be held at the NONPF annual meeting. Another participant stated that NONPF should develop a process for increasing the breadth of practice through acquisition of additional skills. This individual suggested development of a syllabus, having academic review, and then having the NP take it to their Board of Nursing for review.

3. CONTENT AND ORGANIZATION OF SCHOOL OF NURSING WEB SITES

Priority rankings for the topic area, C*ontent and Organization of School of Nursing Web Sites*, are shown in Figure 7. The majority of participants ranked this topic as a fourth priority (N=149; 75.3%).
Although this area was generally given a low priority, several participants wrote on their forms that this warranted attention. Written and verbal comments related to Web Sites were summarized under two themes: a) *Guidelines Development*; and b) *Role of NONPF with Regard to Web Sites*.

Figure 7. Priority Rankings for Content and Organization of School of Nursing Web Sites (N=198)



a. Guidelines Development. A total of 28 individuals stated that some type of guidelines or a template should be developed for NP program Web sites. Seven of these participants suggested that guidelines rather than templates be developed providing suggestions and data elements to be included. Comments included the value of uniformity in information and standards, help for prospective students looking for information, and the possibility that standardized Web sites might be of assistance with credentialing. An additional participant commented that Web sites need to reflect consistent data, especially with the number of distance students, so they are aware of all requirements and the certification for which they will be prepared.

The importance of accurate Web site information was addressed by two participants. One participant noted that students are keeping Web pages. This participant also stated that information needs to be current and accurate so that the student, as a consumer, does not receive inaccurate information. The other participant shared the results of an informal survey of first time college applicants indicating that almost 80% obtained all of their information about a program from the Web and made their decision based on that information. This participant also noted that credentialing bodies look for currency and accuracy in Web sites.

Four additional participants were unsure that guidelines could be developed that for uniformity across programs with sufficient flexibility to allow for customization. Another participant stated that there was little control at the program level of how materials are posted or updated at the school.
Seven participants stated that there should not be templates. Reasons included the fact that all Web sites should not look alike, design and publication of materials is not controlled at the program level, and the Web site was perceived as a marketing tool.

b. Role of NONPF with Regard to Web Sites. One participant stated that NONPF should have a specific strategy to develop guidelines and that there should be some requirement for use. Another participant similarly stated that NONPF should require that Web sites be current and accurate.

Two participants stated that a template or guidelines need to reflect the changes in the *Consensus Model* so credentialing groups know where the school stands. One participant stated that the guidelines need to be completed for both the master's program and the DNP. An additional participant stated that there needs to be a common language and description of NP programs with guidance to the schools on this issue.

Conversely, one participant indicated uncertainty that this was a NONPF issue. The participant added that the sites should be clearer and reflect what the program offers.

5. ADDITIONAL COMMENTS

Several participants included comments that apply to all of the priority topic areas. Additional written and verbal comments were summarized under two themes: a) *General Comments*; and b) *Role of NONPF with Priorities Generally*.

a. General Comments. Three participants indicated a need to achieve balance between flexibility and standardization in all of the issues. Another stated that the priorities are interchangeable and need to move forward together in a concerted way.

b. Role of NONPF with Priorities Generally. One of the participants suggested that NONPF write papers on all four of the priority topic areas. Another stated that more studies similar to the *Consensus* study need to be done.

D. SUMMARY OF PHASE IV MAJOR FINDINGS

Four topic areas were identified as a starting point for discussion and for priority ranking by participants. The four topic areas were: 1) *Implementation of the Consensus Document*; *Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours*; 3) *Credentialing*; and 4) C*ontent and Organization of School of Nursing Web Sites*.

The ranking of priority topics showed the following:

- Among the four priority topic areas rated by Forum participants, *Implementation of the Consensus Document* received the largest number of first priority rankings.
- When the numbers of first and second priority rankings were combined for each topic area, *Implementation of the Consensus Document* and *Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours* each received approximately two-thirds of the combined first and second priority rankings.

Major findings related to *Implementation of the Consensus Document* were:

- Participants requested additional clarification of the concept of "population foci" in the APRN Model particularly related to the placement of acute care, psychiatric-mental health, overlapping roles, and programs with multiple population foci.
- Further definition of the words lifespan and family was requested, particularly as they related to psychiatric-mental health.
- Concern was expressed by some participants that the need to change nurse practice acts in order to implement the *Consensus Document* will result in opportunities for other professionals to attempt insertion of supervisory language.

Major findings related to *Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours* were:

- Interest was expressed in discussing inclusion of simulation hours as clinical hours.
- A majority of attendees expressed, by a show of hands, interest in moving toward a competency-based approach to NP education; comments written by other participants indicated the need to retain clinical hours or create a combined approach of competency-based education/evaluation and minimum clinical hours.
- A need for clarification of the impact on credentialing related to competency-based education was noted.

Major findings related to *Credentialing* were:

- The distinctions and overlap between acute and primary care were issues for many participants in relation to implications for education, credentialing, and scope of practice.

Major findings related to *Content and Organization of School of Nursing Web Sites* were:

- Although this area was generally given a low priority, several participants wrote on their forms that guidelines should be provided to schools.

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APPENDICES

APPENDIX A

FOCUS GROUPS: LIST OF PARTICIPATING SCHOOLS BY REGION

East

Columbia University
Emory University
Medical University of South Carolina
Pennsylvania State University
University of Massachusetts-Worcester
University of Maryland
University of Rochester
University of South Florida

Midwest

Case Western Reserve University
The Ohio State University
University of Kansas
University of Kentucky
University of Nebraska
University of Pittsburgh
University of Texas-Arlington

West

Oregon Health and Science University
University of Arizona
University of California, Los Angeles
University of California, San Francisco
University of Colorado-Colorado Springs
University of Washington

APPENDIX B

MEMORANDUM

Date: July 16, 2008

To:

From: The National Organization of Nurse Practitioner Faculties (NONPF)
Mary Anne Dumas, PhD, RN, CFNP, FAANP, President
Monica Scheibmeir, PhD, RN, FNP, Principal Investigator, *Clarification of NP Specialty and Subspecialty Clinical Track Titles, Hours, and Credentialing*
Kitty Werner, MPA, Executive Director

Subject: ***Advance notice of a major national survey of NP programs***
RESPONSE REQUESTED

Survey Purpose

NONPF will be conducting an online national survey of schools of nursing that offer NP programs. The survey will be launched in **mid-*August 2008*** with a due date of mid-September.

This survey, part of a two-year research initiative, contains approximately 25 questions and will explore the conceptual basis about how decisions are made with respect to what has been traditionally called NP specialty and subspecialty preparation. The survey questions will address issues germane to the titling of clinical tracks, organization of subspecialty coursework, clinical practice hours, and new and emerging subspecialties.

Survey Background

NONPF received funding in 2007 from the National Council of State Boards of Nursing Center for Regulatory Excellence Research Program for implementing a study aimed at amplifying and clarifying information about current and emerging NP educational pathways leading to specialty and subspecialty preparation.

Importance of the Survey

Many of you are aware that in the near future the organizing framework with respect to the meaning of specialty and subspecialty areas of clinical practice may change based on the APRN Consensus Work Group and the NCSBN APRN Advisory Committee. ***However, all parties involved believe that what is currently in place in NP educational programs will serve as a baseline for future change and will help elucidate critical issues currently germane to NP educational policy.***

Survey Logistics

Only one survey will be submitted per school, since the survey addresses conceptual underpinnings about NP educational programs rather specific details about the various clinical tracks offered by your school.

Therefore, we ask that each school designate one person who has the institutional knowledge required to address these concepts to assume responsibility for completion of the survey. Depending on the particular structure of the school, the survey leader may be able to address all survey questions. However, in schools of nursing with multiple departments or NP program directors, the survey leader may need to devise a method to obtain input from all parties.

PLEASE REPLY to this email by July 24 with the contact information about the person who will serve as survey leader.

Name:
Credentials:
Title:
Name of School:
Address:
Email:
Area Code and Phone Number:

Further Information

In the near future you will receive an email containing an advance copy of the survey questions so responses can be thought about prior to submitting the survey online.

If you have any questions, please contact Kitty Werner, Executive Director, The National Organization of Nurse Practitioner Faculties (NONPF) at NONPF@NONPF.org or at 202-289-8044

We are acutely aware of the effort required for this task and thank you in advance for your participation in this important survey that will have a major impact on NP educational policy.

APPENDIX C

National Organization of Nurse Practitioner Faculties

1522 K Street, NW, Ste. 702, Washington, DC 20005
Tel. (202) 289-8044 Fax: (202) 289-8046 E-mail: nonpf@nonpf.org

NONPF Survey of Master's-Level NP Programs
Clarification of NP Specialty and Subspecialty Clinical Track Titles, Hours, and Credentialing

Dear Colleague:

Thank you for agreeing to respond to the NONPF survey entitled *Clarification of NP Specialty and Subspecialty Clinical Track Titles, Hours, and Credentialing*. This landmark survey is one of four components of a two-year research effort that NONPF is conducting through funding from the National Council of State Boards of Nursing Center for Regulatory Excellence Research Program. You will receive an email from NONPF in the next few days containing instructions for accessing your school's online survey. **The survey due date is Monday, November 24, 2008**.

The purpose of the survey is to explore issues relevant to the titling of *specialty* and *subspecialty* clinical tracks, organization of *subspecialty* coursework, clinical practice hours, and new and emerging *subspecialties* as they *currently* exist. Questions are based on the results of three regional focus groups conducted with selected schools identified through Web review as offering *subspecialty* NP clinical tracks.

As you are aware, the organizing framework with respect to the meaning of *specialty* and *subspecialty* areas of clinical practice may change in the near future. *However, all parties involved believe that what is currently in place in NP educational programs will serve as a baseline for future change and will help elucidate critical issues currently germane to NP educational policy.*

We intend to summarize aggregated survey responses at the April 2009 NONPF meeting in Portland and in the final project report. We would like to acknowledge those institutions who participated by listing the name of the institution in the project appendices. Participants will be among the first recipients of the final published report. If for any reason you prefer that your school NOT be listed in the final report or have other concerns, please notify NONPF by e-mail by December 1, 2008.

On behalf of NONPF President Mary Anne Dumas and the NONPF Board of Directors, I thank you in advance for your participation in this important survey that will have a major impact on NP educational policy.

Sincerely,

Monica Scheibmeir, PhD, RN, FNP
Associate Professor
University of Kansas School of Nursing
Principal Investigator

National Organization of Nurse Practitioner Faculties

1522 K Street, NW, Ste. 702, Washington, DC 20005
Tel. (202) 289-8044 Fax: (202) 289-8046 E-mail: nonpf@nonpf.org

National Organization of Nurse Practitioner Faculties Survey
Clarification of NP *Specialty* and *Subspecialty* Clinical Track Titles, Hours, and Credentialing

NOTE: We are sending you this advance copy of the survey so responses can be thought about prior to completing and submitting the survey online.

Also note that the text next to the response selections (skip patterns) will not be seen online. For example, if you select "yes" for question #1, the next question that will appear on the screen will be #2.

There is one answer per question unless otherwise directed. Comment boxes follow each of the questions, including "yes" or "no" questions. The purpose of the box is to permit you to qualify your answers or add additional information if you so desire.

Section 1. Use of Words to Describe NP Clinical Tracks

1. Is the word, *specialty*, used in your school's literature and/or Web site when referring to any of the NP clinical tracks offered by your school?
   - ☐ No [Continue to Questions1-1 and 1-2]
   - ☐ Yes [Go to Question 2]

Question1 Comment Box:

1-1. What are the reasons that the word, *specialty,* is avoided? Select all that apply.

- ☐ The word is associated with medical *specialties*
- ☐ Some NP clinical tracks are at the generalist level, therefore use of the word, *specialty,* does not seem to fit
- ☐ The word, specialist, is included in the titling for the CNS role
- ☐ Unable to use the word because of State regulations
- ☐ Unsure of the reason(s) why the word is not used
- ☐ Other reason 1, please specify

_____

- ☐ Other reason 2, please specify

_____

Question1-1 Comment Box:

1-2. What words are used to describe NP *specialty* clinical tracks at your school? Select all that apply.

- ☐ Major
- ☐ Minor
- ☐ Option
- ☐ Focus
- ☐ Focus area
- ☐ Area of Focus
- ☐ Clinical Focus
- ☐ Area
- ☐ Area of Study
- ☐ Area of concentration
- ☐ Role
- ☐ Functional Role
- ☐ Functional Area
- ☐ Track
- ☐ Other reason 1, please specify

_____

- ☐ Other reason 2, please specify

_____

Question1-2 Comment Box:

2. Does your school offer NP clinical tracks that might be considered *subspecialties*?
   - No [Skip to Question 7]
   - Yes [Continue to Question 2-1]

Question 2 Comment Box:

2-1. Is the word, *subspecialty*, used in your school's literature and/or Web site when referring to any of these NP clinical tracks?
   - No [Continue to Question 2-2]
   - Yes [Go to Question 3]

Question 2-1 Comment Box:

2-2. What words are used to describe NP *subspecialty* clinical tracks at your school? Select all that apply.

- ☐ Major
- ☐ Minor
- ☐ Option
- ☐ Focus
- ☐ Focus area
- ☐ Area of Focus
- ☐ Clinical Focus
- ☐ Area
- ☐ Area of Study
- ☐ Area of concentration
- ☐ Role
- ☐ Functional Role
- ☐ Functional Area
- ☐ Track
- ☐ Other reason 1, please specify

_____

- ☐ Other reason 2, please specify

_____

Question 2-2 Comment Box:

Section II. *Subspecialty* Preparation

3. Are the *subspecialty* clinical tracks available only to students enrolled in a specific NP *specialty* track?
   - Yes, *subspecialty* options are unique to individual NP *specialty* tracks
   - No, *subspecialty* clinical tracks are not unique to specific NP *specialty* tracks
   - Some NP *specialty* tracks have unique *subspecialty* options, others do not. Please elaborate in the comment box below

Question 3 Comment Box:

4. How is the timing of *subspecialty* coursework organized in NP clinical tracks?
   - *Subspecialty* coursework is completed only after completion of *specialty* coursework
   - *Subspecialty* coursework is offered concurrently with *specialty* coursework
   - Organization of *subspecialty* coursework varies among NP tracks, please elaborate

Elaborate:

   - Other, please elaborate

Elaborate:

Question 4 Comment Box:

5. Do *subspecialty* clinical tracks prepare graduates to sit for national certifying examinations?
   - Yes, for NP certifying examinations
   - Yes, for certifying examinations available to any advanced practice nurses, not just NPs
   - No, they are not prepared for national advanced practice certifying examinations
   - Some *subspecialties* prepare for national advanced practice certifying examinations and others do not.

Question 5A: You've indicated that some *subspecialty* clinical tracks prepare graduates for national advanced practice certifying examinations and others do not.
Please comment:

Question 5 Comments:

6. What criteria does your school use when deciding to offer *subspecialty* content? Select all that apply.
   - ☐ Student demand
   - ☐ Faculty interest
   - ☐ Need in the community
   - ☐ Need in the state
   - ☐ Employer interest
   - ☐ Interest of national organizations
   - ☐ Marketability of graduates
   - ☐ Resources required to offer coursework
   - ☐ Ability to offer the number of required hours in the *subspecialty*
   - ☐ Other, please specify the criterion

_____

Question 6 Comment Box:

Section III. Dual Tracks

7. Do you offer students the opportunity, by curricular design, to take dual NP clinical tracks, that is, students can enroll in two NP clinical tracks (e.g., ANP and GNP) concurrently and are eligible to sit for two NP certification examinations upon graduation?
   - ☐ No
   - ☐ Yes

Question 7 Comment Box:

Section IV. Individualization of Programs

8. Do you offer any opportunities for students in NP clinical tracks to structure any of their clinical experiences or coursework to meet individual interests or goals?
   - ☐ No [Go to Question 9]
   - ☐ Yes [Continue to Question 8-1]

Question 8 Comment Box:

8-1. How can an NP program of study be individualized at your school? Select all that apply.
- ☐ Students can take additional elective coursework to meet individual goals
- ☐ Students can elect their last required clinical hours in an area of interest
- ☐ Students can add clinical hours in an area of interest after completing their required clinical coursework
- ☐ Students can add clinical hours in an area of interest concurrently with required clinical coursework
- ☐ Other, please specify

Specify:

Question 8-1 Comment Box:

9. Is there pressure from employers for NP students to have coursework and/or clinical experiences in the employer's area of interest?
   - ☐ No [Go to Question 10]
   - ☐ Yes [Continue to Question 9-1]

Question 9 Comment Box:

9-1. How do you address employer interests? Select all that apply.
   - ☐ Students are allowed to precept with the employer during their final required clinical hours
   - ☐ Students have additional elective coursework and/or clinical experiences in the area of interest to the employer
   - ☐ Unable to accommodate employer interests at this time
   - ☐ Other, please specify

Specify:

Question 9-1 Comment Box:

Section V. Clinical Hours

10. Do you use clinical simulations in the education of NPs at your school?
- □ No [Go to Question 11]
- □ No, but the use of clinical simulations is being planned [Go to Question 11]
- □ Yes [Continue to Question 10-1]

Question 10 Comment Box:

10-1. Are clinical simulation hours counted as direct clinical care hours?
- □ No [Go to Question 11]
- □ Yes [Continue to Question 10-2]

Question 10-1 Comment Box:

10-2. On average, how many clinical simulations hours are counted as supervised clinical practice hours?
- □ Five (5) or fewer
- □ Six (6) to 10
- □ 11 to 15
- □ 16 to 20
- □ More than 20

Question 10-2 Comment Box:

11. Upon review of published curricular/plan of study materials, it is not always possible to determine the components of clinical hours. How does your school distinguish the number of clock hours that students provide direct clinical care to patients from other experiences such as skill laboratory hours and clinical simulation hours? Please explain in the comment box.

Question 11 Comment Box:

12. With the increasing sophistication of clinical simulation models, do you think that some clinical simulation hours should be included as supervised clinical practice hours in the future?
    - ☐ No
    - ☐ Yes

Question 12 Comment Box:

Section VI. Regulation

13. Does the Board of Nursing in your state limit the NP *specialties* that it recognizes?
    - □ No [Go to Question 14]
    - □ Yes [Continue to question 13-1]

Question 13 Comment Box:

13-1. Has the limitation created problems in recognition of specific *specialties*?
    - □ No [Go to Question 14]
    - □ Yes [Continue to Question 13-2]

Question 13-1 Comment Box:

13-2. Please list the specific *specialties* that have not been recognized in the comment box.

Question 13-2 Comment Box:

14. Does the Board of Nursing in your state limit the way in which NPs can display their *specialty* NP credential in their title?
   - ☐ No [Go to Question 15]
   - ☐ Yes [Continue to 14-1]

Question 14 Comment Box:

14-1. How have NPs been limited in the way in which they can display their NP credential?
   - ☐ NPs may use only the title APRN and not the NP role designation
   - ☐ NPs are limited to displaying titles and credentials representing only a few national *specialty* certifications (e.g., FNP, ANP)
   - ☐ NPs are limited to displaying titles and credentials, but these titles and credentials can represent any national NP *specialty* certifications
   - ☐ Titles and credentials displayed by NPs are regulated but in another way. Please provide an example in the comment box

Question 14-1 Comment Box:

15. In your state, are there regulatory limitations on the way NPs can market their *subspecialty* preparation?

- ☐ No [Go to Question16]
- ☐ Yes [Continue to Question 15-1]

Question 15 Comment Box:

15-1. How do these regulatory limitations influence the way NPs market their *subspecialty* preparation? (Check all that apply)

- ☐ State titling and credentialing protections prohibit the NP from openly marketing *subspecialty* preparation
- ☐ Regulations impact the ability of the NP to market their *subspecialty* in other ways. Please elaborate in the comment box

Question 15-1 Comment Box:

16. Is there concern in your state that NPs who have practiced broadly will be prohibited from continuing to practice in *specialty* areas that now have their own certification examination (e.g., FNPs in acute care)?
    - ☐ No (Go to Question17]
    - ☐ Yes [Continue to Question 16-1]

Question 16 Comment Box:

16-1. Please comment on the impact of regulatory limitations

Question 16-1 Comment Box:

Section VII. Marketability

17. In your experience, is the NP's marketability enhanced by initial broad preparation in a *specialty* area (e.g., FNP) rather than in a more narrowly-focused *specialty* area?
    - ☐ No [Go to Question18]
    - ☐ Yes [Continue to Question 17-1]

Question 17 Comment Box:

17-1. From your perspective, what are the reasons broader preparation is more marketable? (Select all that apply)

- □ Rural communities employ our graduates and require NPs who can address health care needs across the lifespan
- □ Graduates have greater employment flexibility
- □ It is easier to move from one state to another
- □ Graduates can always narrow their focus with additional *subspecialty* preparation if their career goals or employment requires it
- □ Other reason 1, please specify

  _____

- □ Other reason 2, please specify

  _____

Question 17-1 Comment Box:

18. In your experience, is the NP's marketability enhanced by *subspecialty* preparation?

- □ No [Go to Question 19]
- □ Yes [Continue to Question 18-1]

Question 18 Comment Box:

18-1.In what ways is the NPs marketability enhanced by *subspecialty* preparation? Select all that apply.

- □ Employers in our area are looking for NP graduates with specific expertise
- □ Graduates can market themselves in a specific area in which they want to practice
- □ Other ways, please specify [If this item is selected, program to allow entry of two other ways]
- □ Other way 1, please specify

  _____

- □ Other way 2, please specify

  _____

Question 18-1 Comment Box:

Section VIII. Emerging *Specialties* and *Subspecialties*

19. Is your school planning to add any new NP *specialties* within the next two years?

- □ No [Go to Question 20]
- □ Yes [Continue to Question19-1]
- □ We would like to add an NP *specialty* but do not have the resources [Go to Questions [19-2 and 19-3]
- □ Don't know [Go to Question 20]

Question 19 Comment Box:

19-1. Please list the NP *specialties* your school is planning to add in the comment box . [Continue to Question 20]

Question 19-1 Comment Box:

19-2. Please list in the comment box the NP *specialties* your school would like to add if you had the resources.

Question 19-2 Comment Box:

19-3. What types of resources are you lacking? Select all that apply.

- ☐ Faculty
- ☐ Fiscal
- ☐ Clinical sites
- ☐ Clinical preceptors
- ☐ Classroom/educational space
- ☐ Student pool
- ☐ Other resource 1, please specify

  _____

- ☐ Other resource 2, please specify

  _____

Question 19-3 Comment Box:

20. From a *national* perspective, please list in the comment box any new *specialties* that you see emerging within the next 10 years.

Question 20 Comment Box:

21. Is your school planning to add any new NP *subspecialties* within the next two years
    - No [Go to Question 22]
    - Yes [Continue to Question 21-1]
    - We would like to add an NP *subspecialty* but do not have the resources [Go to Questions 21-2 and 21-3]
    - Don't know [Go to Question 22]

Question 21 Comment Box:

21-1. Please list in the comment box the NP *subspecialties* your school is planning to add [Continue to Question 22]

Question 21-1 Comment Box:

21-2. Please list in the comment box the NP *subspecialties* your school would like to add if you had the resources

Question 21-2 Comment Box:

21-3. What types of resources are you lacking? Select all that apply.

- ☐ Faculty
- ☐ Fiscal
- ☐ Clinical sites
- ☐ Clinical preceptors
- ☐ Classroom/educational space
- ☐ Student pool
- ☐ Other resource1, please specify

  _____

- ☐ Other resource 2, please specify

  _____

Question 21-3 Comment Box:

22. From a *national* perspectives, please list in the comment box any new *subspecialties* that you see emerging within the next 10 years.

Question 22 Comment Box:

Thank you for taking time to thoughtfully complete this survey.

APPENDIX D
LIST OF INSTITUTIONS THAT COMPLETED THE PHASE III SURVEY

Alabama
- Samford University
- Troy University
- University of Alabama at Birmingham
- University of Alabama in Huntsville
- University of South Alabama

Alaska
- University of Alaska Anchorage

Arizona
- Arizona State University
- Northern Arizona University
- University of Arizona
- University of Phoenix

Arkansas
- Arkansas State University
- University of Arkansas for Medical Sciences
- University of Central Arkansas

California
- California State University-Bakersfield
- California State University-Fullerton (includes collaborative program with University of California-Irvine)
- California State University-Sacramento (includes collaborative program with University of California-Davis)
- Holy Names University
- Loma Linda University
- Samuel Merritt College
- San Jose State University
- Sonoma State University
- University of California-Los Angeles
- University of California-San Francisco
- University of San Diego
- Western University of Health Sciences

Colorado
- Colorado State University-Pueblo
- Regis University
- University of Colorado at Colorado Springs
- University of Colorado Health Sciences Center
- University of Northern Colorado

Connecticut
- Fairfield University
- Quinnipiac University
- Sacred Heart University
- Saint Joseph College
- Southern Connecticut State University
- University of Connecticut
- Western Connecticut State University
- Yale University

Delaware
- University of Delaware
- University of Wilmington

District of Columbia
- Catholic University of America
- George Washington University
- Georgetown University
- Howard University

Florida
- Barry University
- Florida A&M University
- Florida Atlantic University
- Florida Gulf Coast University
- Florida International University
- University of Central Florida
- University of Florida
- University of Miami
- University of North Florida
- University of South Florida
- University of Tampa

Georgia
- Albany State University
- Armstrong Atlantic University
- Brenau University
- Emory University
- Georgia College & State University
- Georgia Southern University
- Georgia State University
- Kennesaw State University
- Medical College of Georgia
- North Georgia College & State University
- Valdosta State University

Hawai'i
- Hawai'i Pacific University
- University of Hawai'i at Mānoa

Idaho
- Idaho State University

Illinois
- DePaul University
- Illinois State University
- Lewis University
- North Park University
- Northern Illinois University
- Rush University
- Saint Xavier University
- Southern Illinois University Edwardsville
- University of Illinois at Chicago

Indiana
- Ball State University
- Indiana State University
- Indiana University
- Indiana Wesleyan University
- Purdue University-Calumet
- University of Indianapolis
- University of Southern Indiana

Iowa
- Allen College
- Briar Cliff University
- Clarke College
- University of Iowa

Kansas
- Pittsburg State University
- University of Kansas
- Washburn University
- Wichita State University
- Bellarmine University
- Eastern Kentucky University
- Frontier School of Midwifery & Family Nursing
- Murray State University
- Northern Kentucky University
- Spalding University
- University of Kentucky
- University of Louisville
- Western Kentucky University

Louisiana
- Grambling State University
- Loyola University-New Orleans
- McNeese State University (includes Southeastern Louisiana University and University of Louisiana at Lafayette)
- Northwestern State University

Maine
- University of Maine
- University of Southern Maine

Maryland
- Coppin State University
- The Johns Hopkins University
- Uniformed Services University of the Health Sciences
- University of Maryland

Massachusetts
- Boston College
- MGH Institute of Health Professions
- Northeastern University
- Regis College
- University of Massachusetts-Amherst
- University of Massachusetts-Boston
- University of Massachusetts-Dartmouth
- University of Massachusetts-Lowell
- University of Massachusetts-Worcester

Michigan
- Grand Valley State University
- Madonna University
- Michigan State University
- Northern Michigan University
- Oakland University
- University of Detroit Mercy
- University of Michigan
- University of Michigan-Flint
- Wayne State University

Minnesota
- College of St. Catherine
- Metropolitan State University
- Minnesota State University-Mankato
- The College of St. Scholastica
- University of Minnesota
- Winona State University

Mississippi
- Delta State University
- Mississippi University for Women
- University of Mississippi Medical Center
- University of Southern Mississippi

Missouri
- Barnes-Jewish College of Nursing
- Graceland University
- Maryville University-St. Louis
- Missouri State University
- Research College of Nursing
- Saint Louis University
- Southeast Missouri State University
- University of Central Missouri
- University of Missouri-Columbia
- University of Missouri-Kansas City
- University of Missouri-St. Louis

Montana
- Montana State University

Nebraska
- Clarkson College
- Creighton University
- University of Nebraska Medical Center

Nevada
- University of Nevada-Las Vegas
- University of Nevada-Reno

New Hampshire
- Rivier College
- University of New Hampshire

New Jersey
- Fairleigh Dickinson University
- Felician College
- Rutgers, The State University of New Jersey
- Seton Hall University
- The College of New Jersey
- University of Medicine & Dentistry of New Jersey
- William Paterson University

New Mexico
- University of New Mexico

New York
- Adelphi University
- Binghamton University
- College of Mount Saint Vincent
- College of New Rochelle
- College of Staten Island
- Columbia University
- Daemen College
- Dominican College of Blauvelt
- D'Youville College
- Hunter College of the City University of New York
- Lehman College
- Long Island University (Brooklyn Campus)
- Long Island University (C.W. Post Campus)
- Molloy College
- Mount Saint Mary College
- New York University
- Pace University
- St. John Fisher College
- Stony Brook University
- State University of New York Downstate Medical Center
- State University of New York Institute of Technology at Utica/Rome
- State University of New York Upstate Medical University
- University at Buffalo
- University of Rochester
- Wagner College

North Carolina
- Duke University
- East Carolina University
- The University of North Carolina-Chapel Hill
- University of North Carolina-Charlotte
- University of North Carolina-Greensboro
- University of North Carolina-Wilmington
- Western Carolina University
- Winston-Salem University

North Dakota
- North Dakota State University
- University of Mary
- University of North Dakota

Ohio
Case Western Reserve University
Franciscan University of Steubenville
Kent State University
Otterbein College
The Ohio State University
University of Akron
University of Cincinnati
Ursuline College
Wright State University

Oklahoma
University of Oklahoma

Oregon
Oregon Health and Science University

Pennsylvania
Bloomsburg University
Carlow University
Clarion University of Pennsylvania
(includes collaborative programs at Slippery Rock University and Edinboro University)
Desales University
Drexel University
Duquesne University
Gannon University
Gwynedd-Mercy College
La Salle University
Millersville University
Misericordia University
Neumann College
Pennsylvania State University
Temple University
Thomas Jefferson University
University of Pennsylvania
University of Pittsburgh
University of Scranton
Villanova University
Widener University

South Carolina
Clemson University
Medical University of South Carolina
University of South Carolina

South Dakota
South Dakota State University

Tennessee
Carson-Newman College
East Tennessee State University
Lincoln Memorial University
Middle Tennessee State University
Southern Adventist University
Tennessee State University
Tennessee Technological University
Union University
University of Memphis
University of Tennessee-Chattanooga
University of Tennessee-Knoxville
University of Tennessee Health Science Center
Vanderbilt University

Texas
Baylor University
Midwestern State University
Patty Hanks Shelton School of Nursing
(consortium: Abilene Christian University
and Hardin-Simmons University
Texas A&M International University
Texas A&M University-Corpus Christi
Texas Tech University Health Sciences Center
Texas Woman's University
University of Texas-Arlington
University of Texas-Austin
University of Texas-El Paso
University of Texas Health Sciences Center-
Houston
University of Texas Health Sciences Center-
San Antonio
University of Texas Medical Branch
University of Texas-Pan American
University of Texas-Tyler
West Texas A&M University

Utah
Brigham Young University
University of Utah
Westminster College

Vermont
University of Vermont

Virginia
- George Mason University
- Hampton University
- James Madison University
- Marymount University
- Radford University
- Shenandoah University
- University of Virginia
- Virginia Commonwealth University

Washington
- Gonzaga University
- Pacific Lutheran University
- Seattle University
- Washington State University

West Virginia
- Mountain State University
- West Virginia University
- Wheeling Jesuit University

Wisconsin
- Concordia University Wisconsin
- Marian University
- Marquette University
- University of Wisconsin-Eau Claire
- University of Wisconsin-Madison
- University of Wisconsin-Milwaukee
- University of Wisconsin-Oshkosh
- Viterbo University

Wyoming
- University of Wyoming

APPENDIX E
PLENARY SESSION
Friday, April 17
8:30-10:30 AM

Building a Stronger Tomorrow: Faculty Setting Priorities for NP Education

Presentations

Data Results from the NCSBN-Funded Project: Clarification of Nurse Practitioner *Specialty* And *Subspecialty* Clinical Track Titles, Hours, and Credentialing
Linda Berlin, DrPH, RNC and Karen Sechrist, PhD, RN, FAAN, Berlin Sechrist Associates, NONPF Project Research Consultants

Linking the Data to the APRN Consensus Paper and Program Standards
Monica Scheibmeir, ARNP, PhD, University of Kansas, NONPF Project Principal Investigator

Town Hall Meeting: Setting Priorities for NP Education
Facilitators:
Janet Allan, PhD, RN, FAAN, University of Maryland, NONPF Past President
Ann O'Sullivan, PhD, CRNP, FAAN, University of Pennsylvania, NONPF Past President

Town Hall Meeting Guidelines:
To maximize the participation in the discussion by as many attendees as possible, the facilitators shall generally follow Robert's Rules of Order. Attendees may speak only once per topic and must limit comments to no more than 2 minutes per topic at the microphone.

We encourage attendees to submit additional comments on the back of this page. **As well, we ask that attendees use the back of the page to identify and rank the topic areas discussed in the order that you feel NONPF should address them as a recommendation to the Board.** Please leave your comments and rankings on your table for pick-up at the end of the session.

Topics for Discussion:
Based on the findings from the research study, the facilitator and project team have identified the priority areas for discussion among the attendees. The goal is to identify faculty perspectives to guide development of initiatives, statements on common understandings, and/or standards in NP education.

(1) Implementation of the *Consensus Document*
- How do the findings from the study impact implementation of the *Consensus Document?*

(2) Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours
- Is standardization of definitions for simulation, clinical hours, and laboratory hours possible?
- When is *simulation* appropriate, how should it be defined, and how should simulation hours be be recognized in relation to clinical hours?
- Is the wide range of clinical hours required for completion of clinical tracks among programs of concern?

(3) Credentialing
- How should the profession address credentialing for people who practice in an area but do not have specific education preparation?
- Is this a regulatory or academic issue?
- How does setting-specific education vs. broadly-focused education impact credentialing?

(4) Web Sites
- Is there a need for a common Web site template for NP program descriptions?
- Would/could our program follow a template?

COMMENTS ON THE SESSION DISCUSSION TOPICS

PRIORITIZATION OF TOPICS

Please rank from 1 to 4 with 1 being the highest priority:

_____ Implementation of the *Consensus Document*

_____ Clarification of Simulation Hours, Clinical Hours, and Laboratory Hours

_____ Credentialing

_____ Web Sites

OTHER ISSUES FOR NONPF TO ADDRESS

If you wish to be contacted about your comments or to be included in NONPF work on priority topics, please provide your name and e-mail address:

_____