

THE DRNP DEGREE

The Evolution of Nursing and Primary Care

by Gary Goldenberg

How best to meet the growing need for primary care has become a central issue for makers of health policy. Judging by recent trends, the solution won't come from the physician workforce. Doctors are increasingly eschewing primary care in favor of specialty medicine. At Columbia University College of Physicians & Surgeons, just five percent of the incoming class intends to pursue generalist medicine, a pattern seen around the nation.

Fortunately, the opposite is occurring in nursing. Advanced practice nurses (APNs, known as nurse practitioners in New York State) are assuming greater responsibilities in primary care, with demonstrable success. This situation is not ideal, however. The problem is that nurse practitioner (NP) education emphasizes site-specific care. NPs are not sufficiently prepared to independently manage patients across the health care spectrum, from clinics to emergency rooms to hospitals — what is known as full-scope, cross-site primary care. Since no educational programs offer this type of training, nurse practitioners have been gaining the required competencies on an ad hoc basis.

"Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

— INSTITUTE OF MEDICINE

"Informal learning is of questionable quality and reliable competency, leaving the public vulnerable to less-than-adequate care," notes Mary O. Munding, RN, DrPH, Dean and Centennial Professor in Health Policy at Columbia University School of Nursing.

In light of these trends, the School of Nursing has proposed a new doctoral program for nurse practitioners seeking to practice primary care, leading to the Doctor of Nursing Practice (DrNP) degree. Graduates of this program will be able to care for patients in an outpatient office, evaluate their needs in the emergency room, admit and co-manage hospitalized patients, initiate referrals to specialists and evaluate their advice, and co-manage patients as they receive specialty care.

Importantly, these new practitioners would bring added value to the primary care encounter, namely nursing's unique focus on health promotion, disease prevention, and health education.

Some have criticized the DrNP proposal, wondering why nursing needs yet another degree, if nurses are even up to the proposed task, and whether the profession is wrongfully

encroaching on physician territory. But those familiar with recent advances in nursing practice — especially at Columbia — have welcomed the innovation. To them, this new doctoral program represents not only the logical next step in the evolution of the nursing profession, but also in the delivery of primary care.

The birth of the nurse practitioner

Why the DrNP degree? Why now? And why at Columbia? A brief look at recent changes in nursing in general, and at Columbia in particular, provides the answers.

In 1965, Lee Ford, a nurse with a doctorate, and Henry Silver, a physician, devised a new curriculum for teaching public health nurses expanded skills (including advanced physical assessment and pathophysiology) in order to detect and monitor illness in their home-bound patients. Thus was born the nurse practitioner.

NPs quickly became one of the country's primary care resources, especially for the underserved. They had traditional nursing skills from their baccalaureate-degree programs, including care of critically ill patients, leadership abilities to oversee a hospital nursing staff, and public health experience in providing care to patients in community settings. These nurses also had extensive education in managing patients' responses to their illnesses, including helping to reduce the risk of disease recurrence, strengthening healthy behaviors, and teaching patients how to believe in and comply with often complex and onerous treatments. In the ensuing years, NP education expanded to include pharmaceutical prescribing and management training, differential diagnostic skills, more in-depth biophysical knowledge of illness, and additional training in ordering and interpreting basic lab and radiology tests.

Another revolution

Columbia University School of Nursing, long a leader in clinical practice, was quick to join the NP revolution and, by the late 1970s, offered a half-dozen different specialty programs for NPs.

Soon, the School would be fomenting a revolution of its own.

In the early 1980s, declining enrollments began to threaten the survival of nursing schools around the country. Columbia was not immune to this trend, nearly succumbing to the University's budget ax at mid-decade. The faculty, however, was determined not to let a century-long legacy of clinical excellence disappear. Rallying around its new dean (Dr. Munding), the

faculty reinvented the School along classic academic lines, putting it on a par with other schools in the University. The result was the Columbia Model of Nursing Education, built on the three pillars of practice, research, and education.

Among other things, the Columbia Model required every full-time faculty member to participate in a salaried clinical practice or to conduct funded research. There were many benefits. For example, the plan ensured that students were learning from professors with current clinical experience. Moreover, since many of the faculty practices were based at Presbyterian Hospital (now part of New York-Presbyterian Hospital), doctors at the medical center learned firsthand how significantly the latest generation of advanced practice nurses could contribute to clinical care.

This set the stage for further innovation. In 1993, Presbyterian Hospital began planning a new inpatient facility (the Milstein Hospital Building). To secure a preferred mortgage from New York State — an essential prerequisite for financing the project — the hospital agreed to develop more primary care services for the underserved local community. But there was a problem. Among its staff, the hospital had only three physicians who were willing to shift their practices toward this population; at least eighteen were needed.

Presbyterian Hospital President William T. Speck, MD, a strong supporter of the School of Nursing, turned to Dr. Munding and her faculty for help.

In a bold move, the nursing faculty agreed to participate *if* they were given hospital admitting privileges, a radical notion at the time. Because faculty had already established their own scholarly practices, the only reason to switch to a Presbyterian initiative was an academic one: conduct the first, and carefully designed, randomized clinical trial to compare outcomes of NPs and primary care MDs. To do so required that each profession have the same practice authority, including admitting privileges. Admitting privileges would also help build authoritative relationships with patients and clinical colleagues.

Dr. Speck readily agreed to this request and, remarkably, so did all but one department chair at the hospital. This grand experiment began within a year, with the School's faculty staffing two community-based primary care clinics, one staffed solely by nurse practitioners and the other by NPs and MDs in a collaborative practice.

The NP/MD comparison

The clinics provided a much-needed source of primary care for the community, as well as a unique research opportunity to

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— Dean Munding

¹ Munding MO, et al. (2000) Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *JAMA*, 283:59-68.

compare how NPs compared to MDs in identical independent primary care practices. The resulting study, published in the January, 2000 *Journal of the American Medical Association*, found no statistical differences between the health outcomes of patients managed by the physicians and those managed by the nurse practitioners.¹ Both groups of patients had the same number of primary care visits, specialist visits, hospitalizations, and out-of-system medical encounters for one year; health outcomes for three chronic diseases for six months; perceived health status; and patient satisfaction.

In 1997, the School upped the ante. If NPs were capable of providing primary care for Medicaid patients, why not offer it to a commercial insurance population? Why not give more people access to this kind of care? Before the year was out, the School of Nursing opened Columbia Advanced Practice Nurse Associates (CAPNA), a full-service primary care practice run by NPs, all with hospital admitting privileges. CAPNA, located in midtown Manhattan, the heart of physician country, was the first practice of its kind in the nation.

Oxford Health Plan, the metropolitan area's largest health insurance organization, and the one selected by Columbia as a preferred choice for employees, quickly came on board, believing that CAPNA would expand consumer choice. As Oxford understood, CAPNA could offer patients a different form of care, what the nursing profession refers to as differentiated practice. The NPs received the same reimbursement rates as physicians; this was designed to assure patient choice was not purely a financial one.

As Dr. Mundinger explains, "*Differentiated practice* is primary care that attends to the patient's preference when possible and to engagement with the patient always, and that fosters the patient's abilities to follow a new regimen through the strategies of risk reduction, health promotion, health education, and counseling. APN primary care also involves assessment of community and home-environment resources in tailoring an intervention, a sustained perspective of overall health protection and advancement, careful use of the family as a precious and non-renewable resource, and accessible responsive encounters. While the basics of medical primary care — diagnosis and treatment of undetected or chronic illness — are inherent in every primary care practice, the *different outcome* more common with APN care is a patient who is (1) more informed, more invested, and therefore more cooperative about care; (2) more empowered in self-care aimed toward illness resolution or health advancement; and (3) more confident that his or her

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total health parameters are being addressed on a routine basis. This leads to health outcomes that are different from those achieved by conventional symptom or disease resolution. While many physicians address their patients in this comprehensive way, this style is more routinely and reliably delivered by APNs, and APNs are the only clinicians trained scientifically to provide this scope of engagement and care."²

CAPNA: a success

CAPNA has succeeded, steadily winning new patients as well as new insurance contracts. According to recent practice data, CAPNA has much higher compliance with nationally established quality benchmarks than that of conventional medical practices, and patients stay longer with CAPNA than with New York City physician practices.

"Differentiated practice has a growing market in today's health care system for several reasons," notes Dr. Mundinger. "Patients already expect to assume a more empowered and authoritative role in their health care. They want their questions answered, they want choice, and they want power in joint decision making. Similarly, they are more fitness- and health-oriented, as well as being riveted on making sure they get well when they fall ill. Many aspire to higher levels of health even without evidence of illness or disease, and it is highly likely that with the advent of individual genomic mapping, everyone will aspire to some new level of risk reduction in the future. Longer

life spans, improved medical care of previously fatal diseases, and the emergence of an ever-increasing burden of chronic illnesses — all point toward primary care that will require more comprehensive skills. These aspects of care draw on nursing expertise and take time, lots of time. NPs will fill the need."³

CAPNA's physician colleagues at Columbia are also pleased. They view CAPNA practitioners as full clinical partners and continue to accept referrals from, and make referrals to, the practice. CAPNA nurses are now full members of the Columbia Physician Provider Network (CPPN).

Not long after CAPNA opened, representatives of the New York State Health Department's Office of Professional Medical Conduct and Physician Discipline paid a surprise visit to the practice, following up a complaint by the New York State Medical Association (a branch of the AMA) that CAPNA nurses were practicing medicine without a license. The nurses were told their practice was under review and their licenses at risk. In the end, however, the State health officials concluded that CAPNA's services fell within the legally defined scope of nurs-

² Mundinger, MO. Twenty-first-century primary care: New partnerships between nurses and doctors. *NANPA News*: www.nanpainfo.org.

³ *NANPA News*.

⁴ *NANPA News*.

ing practice. They recognized what the medical association didn't — primary care is evolving, and nursing is driving that evolution.

NPs bring added value to specialty care

At the same time CAPNA was growing, the School's faculty were also making inroads into specialty-oriented medical departments at New York–Presbyterian Hospital, demonstrating that NPs bring added value to many clinical settings.

"These clinicians bring to those practices an approach, and attention to aspects of patient care, not provided by the physicians," explains Dr. Mundinger.⁴ "Each of these nurses is credentialed for full prescriptive authority and for admitting and co-management services in the medical center hospital. This allows them the access (and reimbursement potential) to see patients — usually follow-up patients in the ambulatory setting, but also inpatients who are stabilizing after surgery or extensive medical care. They provide discharge education for patients and their families, make home visits when necessary to smooth transition from hospital to home, plan for and arrange home-based resources, and may decide when a patient is ready and supported for discharge. In the office setting, these nurses may provide medically oriented services, such as follow-up monitoring, changes of medications or other therapies, or the perspective of health protection for aspects of the patient's condition other than the specific one being treated by the specialist. Patients who have chronic diseases (such as hypertension, asthma, diabetes, or cardiovascular or neurologic disorders) are in need of constant monitoring and assessment during any acute episode requiring focused medical intervention, but especially if they are being treated for another unrelated condition. NPs offer that critical continuity and protection."

Legitimizing NP's practice advancement

Today, thousands of NPs around the nation receive reimbursement and hold authority for cross-site care, and more nurses are sure to follow in their footsteps. All told, there are 200,000 NPs with master's degrees, and another 8,000 new NP graduates are added to the ranks each year (more than the number of physicians that enter primary care residencies) — a large pool of primary care nurses who stand ready to make the transition to full-scope, cross-site care.

While these numbers encourage Dr. Mundinger and her colleagues, they are concerned that the nursing profession is

getting ahead of itself. "We decided it is time for Columbia to take the lead in this evolution, and place these new skills and standardized education within a doctoral model," she states. "We would be sending the wrong message to our patients and the health system if we said that, as nursing practice takes on this enormously important role in primary care, we are willing to let people learn it informally. Developing this degree program is about assuring quality. Right now, there are no educational programs for nurse practitioners addressing in a formal, standardized way the expanded skills that our nurses have taken on over the past decades."

In 1999, the School of Nursing began formulating plans for the Doctor of Nursing Practice degree, building on the model of full-scope, cross-site primary care that Columbia has developed and evaluated over the past ten years.

"In keeping with educational practice in other health professions," reads the DrNP proposal, "nurses at their highest level of practice competency should earn a doctorate, as has long been established in medicine (MD), dentistry (DDS), pharmacy (PharmD) and even physical therapy (DPT). The Doctor of Nursing Practice (DrNP) will be a clearly understood credential, which will provide peer recognition within the health professions, credibility with payers for quality assurance and accountability issues, and a signal to the public that the nurse who holds the degree has the education and authority

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for the highest level of practice. Such a degree is needed to prepare nurses for high-level, independent practice, of the kind that is already reimbursed by many third-party payers."

The School of Nursing currently offers three degrees. The Entry-to-Practice Program (BS) develops the competence required for general professional nursing practice and provides a firm base for graduate study. The Master's Program (MS) advances nursing competence by extending and deepening knowledge within a specific clinical specialty. The Doctor of Nursing Science Program (DNSc) prepares nurse researchers to examine, shape, and direct nursing practice within the evolving system of health care delivery.

The curriculum

The DrNP curriculum is envisioned as a four-year, post-BSN program of study. The first two years are the traditional Master's program in an APN role. The third year will teach cross-site, full-scope care with content in advanced differential diagnosis skills; advanced pathophysiology and advanced microbiology; selected issues of adherence and compliance; management of health care delivery and reimbursement;

advanced emergency triage and management; professional role collaboration and referrals. The content will be taught in a didactic framework with selected clinical experiences, grand rounds, and the start of a comprehensive clinical portfolio. The fourth year is composed of a full-time residency, providing targeted clinical experience.

Graduates of the program will:

- utilize skills and knowledge to independently provide expert nursing care across the continuum;
- provide evidence-based care;
- incorporate the application of population health concepts of advanced clinical practice;
- apply sophisticated information technology tools and techniques to manage the clinical and administrative components of full-scope advanced practice; and
- integrate ethical and legal considerations in all areas of advanced nursing practice.

Larger than nursing

Since proposing the DrNP, the School has been working to build a broad base of support for the new degree, both inside and outside the nursing profession. In 2000, Columbia invited seven other leading schools of nursing, and representatives from the American Association of Colleges of Nursing, the Association of American Medical Colleges, the Council of National State Boards, National Organization of Nurse Practitioner Faculties, and National Quality Forum to create

the Council for the Advancement of Primary Care. Under the Council's aegis, seven national and international conferences have been held. The goals of these conferences have been: to reach consensus on clear and uniform standards of advanced clinical preparation; to establish significant interest among academic nursing leaders and their national organizations to work toward such a standard; and to ensure that medical and health policy leaders understand and endorse the proposed doctoral-practice degree for nurses who meet the standard.

The DrNP

Still, there are those who believe the DrNP degree will put nurses and doctors in direct competition for primary care patients, a concern not shared by Dr. Munding. "This differentiated NP practice," she writes, "will not substitute for or even seriously compete with physician-provided primary care. Since the 1976 Mendenhall Report, we have known that specialists already provide significant amounts of primary care to their patients. Today, patients who are vulnerable and frail from unresolved or past life-threatening illnesses may be best served by their specialists, who know them best and who can distinguish rare or nuanced symptoms that could be related to their major diseases. Physicians in general enter their profession to diagnose and treat illness and disease. They usually do not seek a career in which they are patient guide and teacher as well. While they could learn the nursing paradigm, they have made other decisions about how they want to practice. Nurses, too, have made deliberate decisions; often they have selected the nursing profession because of the very aspects that distinguish it from medicine."⁵

"Physicians and NPs each offer a distinct set of services and outcomes that will enrich health care in the years to come," she adds. "To focus wrongly and shortsightedly on substitutional issues and the samenesses of these services is to miss the more important and fundamental issue: How can we build a system where patients thrive because both of these paradigms of care are equally accessible and available?"



⁵ NANPA News.