



# South Carolina Commission on Higher Education

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CHE  
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Agenda Item 7.02A

Dr. Garrison Walters, Executive Director

October 2, 2008

## MEMORANDUM

**To:** Dr. Layton R. McCurdy, Chairman, and Members, Commission on Higher Education

**From:** Dr. Bettie Rose Horne, Chair, and Members, Committee on Academic Affairs and Licensing *Beth/gm*

Please find attached the staff write-up for a proposal leading to the Doctor of Nursing Practice from MUSC. If you wish to review the full proposal submitted by the institution, it is posted on the CHE website:

[http://www.che.sc.gov/AcademicAffairs/CAA\\_Meeting/Sept4-08/AgendaItem\\_2c\\_DNP\\_MUSC.pdf](http://www.che.sc.gov/AcademicAffairs/CAA_Meeting/Sept4-08/AgendaItem_2c_DNP_MUSC.pdf)

At the request of the Committee on Academic Affairs and Licensing, the staff write-up includes six attachments as follows:

1. Additional information submitted by MUSC: "MUSC's DNP Proposal Fact Sheet"
2. and 3. Enrollment and Degrees Awarded Data for all Graduate Nursing Programs
4. and 5. National Data on Nursing Doctoral Program Enrollment, Graduates, and Employment Commitments of Graduates
6. Edited Transcription of Committee questions and institutional answers related to the proposed DNP from the September 4, 2008, meeting

As always, please do not hesitate to call me should you have any questions.

/dr

**New Program Proposal  
Doctor of Nursing Practice  
Tracks in Adult Nurse Practitioner, Family Nurse Practitioner, and Pediatric Nurse  
Practitioner  
Medical University of South Carolina  
On-Line Delivery**

Summary

The Medical University of South Carolina requests approval for a proposal to offer a program leading to the Doctor of Nursing Practice (DNP) with three clinical tracks (Adult, Family, and Pediatric Nurse Practitioner) to be implemented in Fall 2009.

As required by the policy on new program approval for doctoral-level programs, this proposal was reviewed by an external evaluator prior to submission. The MUSC Board of Trustees approved the proposal on April 11, 2008. It was submitted to the Commission on May 13, 2008, and reviewed by the Advisory Committee on Academic Programs without substantive comment on July 17, 2008. Because of a number of changes which had occurred since the submission of the original proposal, a revised proposal was prepared and sent to the Commission on July 21, 2008. The original proposal (May 13, 2008) had contained five tracks in the proposed program, but two of these five tracks—Nurse Administrator and Nurse Educator—were removed from the revised proposal because they were not clinically-based. This staff analysis is based on the revised proposal, subsequent correspondence with the institution, and materials requested by the Committee on Academic Affairs and Licensing after its meeting on September 4, 2008.

At the meeting of the Advisory Committee on Academic Programs on July 17, in keeping with the perceived needs of the nursing profession to create more doctorally-prepared faculty to address the nursing shortage, institutional representatives expressed enthusiastic support for this new program. The program will be offered full-time to students either as a three-year, post-baccalaureate model, or as a one-year, post-master's model. Students may take both the post-baccalaureate and post-master's models on a part-time basis. The proposal states that the proposed program is a "clinically-focused doctoral program in nursing that will award the Master of Science in Nursing degree and the terminal degree of Doctor of Nursing Practice (DNP)" (underline included in proposal).

The program will be offered only on-line. However, students enrolled in the program will be required to demonstrate clinical competencies in psychomotor and psychosocial skills through performance-based assessments which "will be conducted in our simulation laboratory or one located near the student's residence," since the institution has found this practice improves student pass-rates on national certification examinations required in order to gain designation as Advanced Practice Nurse in the state.

The proposal states that employment opportunities for graduates of the DNP will be excellent. Since current Advanced Practice Nurses (prepared at the master's level) are employed at exceptionally high levels, it must be assumed that such employment opportunities for DNP graduates will be at least equal to MSN-prepared nurses who have passed their certification examinations as Advanced Practice Nurses. The proposal states that it is not possible to get accurate data from hospitals about their future needs owing to the dynamic situation of employment in the healthcare industry. Thus, no data on hospital demand for graduates is provided.

The purpose of the program is two-fold: 1) to provide sufficient breadth and depth of preparation for advanced practice nursing, which the narrative suggests is inadequate in the current MSN program; and 2) to produce significant numbers of doctorally-prepared nurses for positions as faculty members in baccalaureate and above programs, who are "primarily responsible" for curriculum, consistent with a March 2008 policy of the American Association of Colleges of Nursing (AACN) that by 2015 all such faculty be doctorally-prepared.

The revised proposal 1) limits clinical tracks in the new DNP to three; 2) states that the Nurse Administrator and Nurse Educator tracks will lead only to the MSN, which will make graduates of one of these tracks eligible to continue to a doctorate in the Ph.D. program but not in the DNP program; 3) requires that all coursework within the MSN will be offered at the doctoral level; and 4) clarified several other points. The revised proposal also makes clear that any student in one of the three clinical tracks within the DNP will be able to "stop out" and receive the MSN, albeit only after taking more semester hours than is currently the case to earn the MSN. According to institutional officials, these added credit hours enhance the psych-mental health and geriatric portions of the curriculum for today's health needs.

The proposal states that the institution will award both the MSN and the DNP to all students who complete the DNP. Finally, the revised proposal states that students in the clinical tracks will also be able to take a "minor" in education. This minor will consist of a total of nine semester hours of coursework (in addition to the coursework required in the student's chosen DNP clinical track) for the purpose of providing students interested in teaching nursing with skills in curriculum, instructional methods, and evaluation.

Depending upon the clinical track of study which a student selects, the curriculum will consist of 69 (ANP), 78 (FNP) or 72 (PNP) credits for those entering the program at the post-baccalaureate level (i.e., without any graduate degree in Nursing at the master's level.) For those entering the DNP who have already completed a master's degree in Nursing, the program will require a minimum of 42 additional credit hours, according to the chart on page 8 of the revised proposal. Thus, a student completing the entire degree path post-baccalaureate at MUSC will be advantaged by having to take a reduced number of semester hours.

A total of 19 new courses, according to the revised proposal, will be added to the Medical University's catalogue to initiate this "practice" doctorate degree program. At the same time, a total of 66 courses which have been offered under the MSN degree will be eliminated. This paring down will result both from the elimination of three tracks

previously offered in the MSN and from the sharing of many core courses by the remaining tracks to be offered in the DNP. One of the tracks eliminated will be Gerontological Nurse Practitioner which the institution argues is no longer necessary because of its low productivity and because the redesigned core at the DNP level will essentially incorporate gerontology.

If approved, this program at MUSC will become the second DNP program in the state. The other program is located at USC-Columbia and was approved in 1999. At that time, USC-Columbia administrators estimated that between 10-20 students per year would graduate with DNP degrees after Spring 2002. Through 2006-2007 academic year (the last year for which official data exist), the program had graduated a total of six students since its inception.<sup>1</sup> Until 2007-2008 (when unofficial statistics show the program graduated four students<sup>2</sup>) the program had graduated a total of six students since its inception. The USC-Columbia program has never reached the minimum annual number of graduates that USC estimated in its program proposal. A total of 52 students were registered in the USC-Columbia DNP in the Fall 2007.

According to the MUSC narrative, a comparison of the DNP at USC-Columbia with the proposed MUSC program is invalid, since the USC-Columbia program is provided through blended delivery (a mix of on-site and interactive off-site delivery) rather than on-line; advertises that it has 16 different concentrations (including several non-clinical concentrations); and--according to the MUSC narrative (but unsubstantiated by the USC-Columbia proposal or materials available on-line)--is focused on "leadership." However, research shows that both the USC and MUSC programs are DNP programs by nomenclature, both contain all three of the clinical specializations to be part of the MUSC program, both promote the concept of "nursing leadership," and both lead to certification of Advanced Practice Nurses once graduates pass the respective national certification examination. As such, this program will constitute duplication within the state, although the program modality (i.e., on-line vs. "blended") is different.

A "web-enhanced" DNP with a track in Family Nurse Practitioner is also offered through the University of Tennessee Health Science Center campus at Memphis (UTHSC-Memphis). However, the proposal states that implementation of the new DNP at MUSC will not constitute unnecessary duplication of programs in the Southern region by pointing out that the program at UTHSC-Memphis is a post-master's program and offers only the Family Nurse Practitioner track. Yet, the MUSC program has a post-master's model available. Historically, the Family Nurse Practitioner track has been the most highly enrolled and market-accepted of all nurse practitioner offerings. (In 2006-2007, the American Association of Colleges of Nursing reported that a majority of all nurse practitioner students in the United States--54.6%--were enrolled in the Family Nurse Practitioner track.) Thus, by name, by delivery method and function, the MUSC degree will also be duplicative of the on-line UTHSC-Memphis program in the Southern region.

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<sup>1</sup> The staff paper for the 9/4/08 meeting of the Committee on Academic Affairs had stated that there were a total of four DNP graduates since the program began, because two graduates of what is now the "DNP" (but earlier had been known as the "ND" or "Nursing Doctorate") were not included in the initial count.

<sup>2</sup> Likewise, the staff paper for the 9/04/08 meeting had stated there were seven graduates of the DNP this year, because the first report had bundled all doctoral graduates in nursing rather than separating them into Ph.D. (N=3) and DNP (N=4).

A second partial revision to the MUSC proposal (received August 12, 2008) projects the DNP students and graduates during the first five years of implementation as follows: DNP students will account for a total of 31 (35.6 FTE) in the first year, rising to 61 (74.7 FTE) in the second, 94 (104.3 FTE) in the third, 118 (128.2 FTE) in the fourth, and 142 (142.1) in the fifth year. Graduates in the program will be zero in the first and second years; rising to 11 in each of the third and fourth years; and then rising to 31 in the fifth year. These numbers mirror the kind of optimistic projection presented in the 1999 proposal for the DNP at USC-Columbia, which has never been realized. If these estimated numbers of enrolled students and graduates are met, the program will exceed greatly the statewide productivity standards for doctoral programs by the fifth year of the program's implementation.

No new faculty, staff, and graduate assistants will be necessary to initiate the program in its first year, according to the proposal. In the next four years, however, a total of two new faculty (.3 FTE) will be necessary to add to the faculty. No net increase of staff members will be added the first five years of the program.

At the time of the next accreditation visit to MUSC, the Commission on Collegiate Nursing Education (CCNE), one of two national nursing professional accreditation groups recognized by the Commission on Higher Education and the United States Department of Education, will "review" the DNP program. The proposal indicates that the CCNE is "likely" to require preparation of all "advanced practice nurses" at the doctoral level by 2015. However, attendees from South Carolina at the June 26-27, 2008 National Summit on Nursing Education Capacity in Washington, DC, have reported that a CCNE spokesperson who spoke at that meeting did not confirm any commitment by the DDNE to change accreditation standards to require the DNP to be the entry-level professional practice degree for clinical Advanced Practice Nursing.

Neither the proposal nor other information suggests an imminent crisis related to accreditation or need for the program will result if the DNP proposal at MUSC were not implemented. For example, 1) MSN graduates through 2015 will be grandfathered into advanced practice for their entire careers; 2) the other national accrediting body for nursing does not accredit nursing doctoral degrees; 3) the DNP is so novel that the American Nurses Credentialing Center (ANCC) has not even developed a separate credentialing examination for its graduates; 4) the DNP at USC-Columbia has a record of low productivity thus far with respect to graduates and another program in the region is available electronically; 5) market demand figures are not supplied in the proposal; 6) other states including North Carolina are continuing to initiate MSN clinical track programs; and 5) the proposal acknowledges that 140 competing DNP programs are being developed throughout the country. (The American Association of Colleges of Nursing reported in 2006-2007 that there were 20 institutions which actually had functioning, implemented DNP programs.)

According to the proposal, facilities and library needs are adequate to initiate the DNP in its first year. New costs for the program are estimated to begin at \$22,000 in year one and include supplies/materials, equipment, and a consultant. Estimated new costs decrease in the second and third years of the program's implementation to \$15,000 in each of those years; costs then increase to \$40,000 in the fourth and \$53,400 in the fifth year. Total new costs for the first five years of the program's implementation are listed

in the proposal at \$145,000. These include faculty salaries, supplies/materials, library resources, equipment, consultants, and outcomes evaluations.

The proposal also estimates revenues for the first five years at \$545,406, of which \$508,406 are shown in Table 9 of the proposal to be coming from “other” legislative appropriations which the institution defines as internal funds transfers to the DNP program. The proposal does not show revenue coming from new students’ tuition, so staff has used the tuition figures calculated from the semester credit hours estimated by the institution.

Shown below are the estimated Mission Resource Requirement (MRR) costs to the State and new costs not funded by the MRR associated with the implementation of the proposed program for its first five years. Also shown are the estimated revenues projected under the MRR and the Resource Allocation Plan as well as student tuition.

<b>Estimated Program Costs and Revenue</b>							
<b>Estimated Program Costs</b>		<b>Estimated Program Revenue</b>					
<b>(A) MRR Cost</b>	<b>(B) Other Costs*</b>	<b>(C) Actual State Funding</b>	<b>(D) Tuition</b>	<b>(E) Additional Revenue</b>	<b>(F) Total Revenue (C+D+E)</b>	<b>(G) Total Revenue - Total Costs (F-(A+B))</b>	
<b>Year 1</b>	\$313,387	\$0	N/A	\$715,646	\$0	\$715,646	\$402,259
<b>Year 2</b>	\$657,085	\$0	\$160,499	\$1,498,558	\$0	\$1,659,057	\$1,001,972
<b>Year 3</b>	\$918,160	\$0	\$336,811	\$2,097,481	\$0	\$2,434,292	\$1,516,132
<b>Year 4</b>	\$1,127,899	\$0	\$471,219	\$2,575,412	\$0	\$3,046,631	\$1,918,732
<b>Year 5</b>	\$1,250,614	\$0	\$578,745	\$2,855,297	\$0	\$3,434,042	\$2,183,429

\*Includes costs of an extraordinary nature not otherwise included in the MRR cost calculation (e.g., costs for a new building required to support a program).

These data demonstrate that if the Medical University can meet the projected student enrollments and contain costs as they are shown in the proposal, the program will be able to cover new costs with revenues it generates in the first year of implementation and every year thereafter.

On September 4, 2008, the Committee on Academic Affairs reviewed the proposal. As a result of the institution’s presentation and the dialogue at that meeting, the Committee asked that the staff supply additional information in several areas, including:

- Any additional reasons and support for the proposed program from MUSC representatives.

- Enrollments and graduates of the graduate nursing programs over several years at all three research institutions in the state.
- Most recent enrollments, graduates, and labor market acceptance for Ph.D.s and DNPs in the United States.
- A transcription of the questions and answers related to the proposal from the meeting of the Committee on Academic Affairs and Licensing.

Accordingly, staff has included this kind of information here as six attachments. Sources for the information contained in these attachments has been noted.

In summary, MUSC insists that it is vitally important for its institutional mission and student acceptance to offer this program. Given that situation, staff had commended the program proposal to the Committee on Academic Affairs and Licensing on condition that the program be reviewed in five years for productivity and be discontinued at that time if it fails to meet state productivity requirements.

#### Recommendation

The Committee on Academic Affairs and Licensing refers the MUSC program proposal leading to the Doctor of Nursing Practice (DNP) with concentrations in Family Nurse Practitioner, Adult Nurse Practitioner, and Pediatric Nurse Practitioner to the full Commission on Higher Education for further discussion in light of the additional information provided in Attachments 1-6.

Attachments: (6)

## Attachment 1

Below are points provided by MUSC's College of Nursing to staff on 9/9/08 in response to questions at the Committee on Academic Affairs and Licensing meeting of 9/4/08. This sheet was entitled:

### "MUSC's DNP Proposal Fact Sheet"

- **The Need for the DNP (also see pages 1-3 of the full proposal):**
  - 1) South Carolina has a nursing shortage as reported by hospitals across the state, and it is one of the unhealthiest states in that nation
  - 2) The lack of faculty prevent nursing programs in the state from expanding their enrollments
  - 3) Preparing nurses with the DNP is the easiest way to solve the faculty shortage
  - 4) DNP graduates are prepared with the highest level of critical thinking skills focused on clinical practice
  - 5) PhD graduates also can become faculty, but most nurses do not want to pursue the PhD which takes twice as long as the DNP and prepares them to be nurse researchers, not clinicians
- **Nursing in South Carolina:**
  - 1) The 32, 399 registered nurses in this state are among the least educated in the nation:
    - 75% have an AND degree; 25% have a BSN degree;
    - 5% have a Masters degree; 0.4% a PhD degree**
  - 2) 41% of newly licensed nurses come from out of state
  - 3) 68% of PhD prepared nurses are over age 50 and will retire in the next 10-15 years
  - 4) **We must feed the nurse faculty pipeline now**
- **Financial Implications if MUSC's DNP Request is Not Approved:**
  - 1) Without the MUSC DNP program, students wanting a DNP will enroll in a program out of state—thus SC will lose these tuition dollars
  - 2) MUSC's masters program will decrease enrollment—thus SC will lose these tuition dollars
  - 3) Nurses wanting a DNP will leave the state to get this degree in another state—thus SC hospitals will lose them as a part of our nursing workforce, negatively impacting the state's economy
  - 4) The University of Tennessee (Ut) will be phasing out their MSN program entirely and only offering the DNP. Their DNP has 6 specialty areas, only one of which (Family Nurse Practitioner) will overlap with our DNP offerings. Their program is "web-enhanced " and not totally online thus **it is not duplicative**. It will, however, **cost SC students \$3500 more than MUSC's tuition each semester to attend the University of Tennessee.**
- **MUSC's College of Nursing Performance**
  - 1) this proposal should be evaluated based on the past and current performance of MUSC's College of Nursing as apart of the only academic health sciences center in SC
  - 2) In 2008, we have the highest enrollment in our history with 400 students

- 3) Each of our programs, BSN, MSN and PhD, is filled to capacity with a 95% graduation rate
- 4) No new financial resources are requested to open the MUSC DNP program
- Additional Information on Scope of Nursing Practice:
  - 1) ADN Graduate—Entry level bedside nurse with emphasis on technical skills
  - 2) BSN Graduate—Entry level bedside nurse with ability to assume progressive management responsibilities
  - 3) MSN Graduate—Advanced practice clinical nurse specializing in a patient population (such as pediatrics, adult, psychiatric-mental health, etc.)
  - 4) DNP Graduate—Expert advanced practice nurse clinician with ability to provide evidence-based approaches for quality and safety improvement in various roles and practice settings, organizational and systems leadership and management, and the translation of research to improve practice; **length of study is 3 years post-BSN**
  - 5) PhD Graduate—Nurse who conducts research for the advancement of nursing and health sciences and who has expertise in theoretical, methodological, and analytic approaches to discovery, testing, application and dissemination of new knowledge; **length of study is 6 years post-BSN**

Attachment 2

**Nursing Enrollment in South Carolina: Advanced Practice Nursing Programs by Degree, Institution, and Year**

Source: CHEMIS (data available online at [http://www.che.sc.gov/New\\_Web/Rep&Pubs/DataRepts.htm](http://www.che.sc.gov/New_Web/Rep&Pubs/DataRepts.htm))

**Master's Degrees**

	1999	2000	2001	2002	2003	2004	2005	2006	2007
<b>Clemson</b>	65	55	48	60	75	89	78	82	84
<b>MUSC</b>	140	123	130	129	199	182	213	201	197
<b>USC-Columbia</b>	142	127	87	72	141	119	116	121	121

**Doctoral Degrees**

	1999		2000		2001		2002		2003		2004		2005		2006		2007	
	Ph.D	DNP																
<b>MUSC</b>						18		22		21		20		21		29		
<b>USC-Columbia</b>	29		20		36		22	15	15	15	29	18	31	14	48	11	52	

Attachment 3

Graduates of Advanced Nursing Degree Programs (MSNs, Ph.D.s and DNPs) in South Carolina

Source: CHEMIS (data available online at [http://www.che.sc.gov/New\\_Web/Rep&Pubs/DataRepts.htm](http://www.che.sc.gov/New_Web/Rep&Pubs/DataRepts.htm))

**MSNs**

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007
Clemson	15	27	20	18	17	37	21	32
MUSC	60	57	52	61	53	52	51	51
USC-Columbia	68	41	34	34	18	20	23	25

**Doctoral - Ph.D.**

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008 (unofficial)
MUSC	NA	NA	NA	NA	1	1	4	7	
USC-Columbia	7	3	4	2	4	3	1	2	3

**Doctoral - DNP**

	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008 (unofficial)
USC-Columbia	NA	NA	1	1	2	1	1	0	4

Attachment 4

**National Data on Nursing Doctoral Program Enrollment, Graduates, and Employment Commitments of Graduates**

Source: Fang, D., Htut, A.M., Bednash, G.D. *2007-2008 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington, DC. American Association of Colleges of Nursing, 2008. p. 46.

	2003	2004	2005	2006	2007
<b>Headcount Enrollment</b>	3174	3403	3601	3811	3843
<b>Graduates</b>	397	405	416	431	513

- Number of Institutions in which enrollments and degree completion were counted = 110
- In 2006-2007, American Association of Colleges of Nursing (AACN) had a total of 575 member institutions
  - In 2006-2007, there were 722 institutions in the US and its territories with baccalaureate and graduate programs in Nursing
  - In 2006-2007, ENROLLMENTS in these programs were: 56,028 students in Masters' programs in Nursing; 3,927 in research-focused doctorates (mostly Ph.D.); and **862 in DNP programs**.
  - In 2006-2007, GRADUATES from these programs were: 13,470 from Masters' programs in Nursing; 437 from research-focused doctorates (mostly Ph.D.); and **74 from DNP programs**.

(Source: *2006-2007 Enrollment and Graduations in Baccalaureate and Graduate Programs of Nursing*. American Association of Colleges of Nursing . Washington, DC, 2007. p. 1)

Attachment 5

**Employment Commitment of Doctorally-Prepared Nurses 2007-2008**

Source: Table 38. "Employment Commitment of Doctoral (Research-Focused) and Doctor of Nursing Practice Graduates." American Association of Colleges of Nursing. *Ibid.*, p. 80

	Research-focused (Ph.D. et al)		Doctor of Nursing Practice	
	Number	Percentage	Number	Percentage
Faculty Positions and Post-Doctoral Fellowships	308	58.0%	45	36.9%
Research, Administration, and Executive (both hospital and non-hospital ambulatory care)	81	15.3%	38	31.2%
Private Consulting, Federal / State Agencies, Military, and Business / Industry	23	4.3%	5	4.1%
Other / Do Not Know	119	22.4%	34	27.9%
<b>Total</b>	<b>531</b>		<b>122</b>	

NOTE: Percentages may not total to 100.0 due to rounding

Attachment 6

**Edited Transcription of Questions and Answers about Proposed Doctor of Nursing Practice with Tracks in Adult Nurse Practitioner, Family Nurse Practitioner, and Pediatric Nurse Practitioner**

**Participants in Discussion**

Dr. Bettie Rose Horne, Chair of Committee  
Mr. Hood Temple, Member of Committee  
Mr. Neal Workman, Member of Committee  
Dr. Gail Stuart, Dean of Nursing at MUSC  
Dr. Sally Stroud, Associate Dean of Nursing at MUSC  
Dr. Doris Helms, Clemson  
Dr. Aileen Trainer, University of South Carolina  
Dr. Cheryl Cox, South Carolina Technical College System  
Dr. Gail Morrison, Commission Staff  
Dr. Lynn Kelley, Commission Staff

**Horne:** From the Medical University we have Dr. Gail Stuart, the Dean, Dr. Sally Stroud, the Associate Dean. Thank you for coming we appreciate it, all right. Do I have a motion to accept for discussion the Medical University of South Carolina's request for a new program Doctor of Nursing Practice with three tracks Adult Nurse Practitioner, Family Nurse Practitioner, and Pediatric Nurse Practitioner?

**Workman:** So moved.

**Horne:** All right.

**Temple:** Second.

**Horne:** This is online delivery, of course, as you know. Here we have a motion and a second. Are there questions for Drs. Stuart and Stroud, please?

**Workman:** Yes, I have a couple of questions. First, you know, [the staff paper] goes through and talks about how [a similar program] did not work well with the University of South Carolina and then you point out or it has been pointed out that there are significant differences in what was done there versus here. With an enrollment of five what makes your program different [from USC's DNP]? I see what you're saying but you're using a forecast as to why this program is going to work. That may be just as optimistic as the one that USC used that was so far off the mark in predictions for students and graduates.

**Stuart:** Let me respond in two ways to that. First of all, I do not want to speak for USC, but they established their program in 1999. This degree program is one which really was not endorsed by the nursing profession until more recently—the last four or five years. So they were an earlier innovator and it really didn't take off. Now I believe they have 52 enrolled since this was endorsed by the profession. We have had just innumerable requests from students who would

consider not taking the master's program for this. I think you are looking at a ten-year period in nursing where things have changed.

In addition, we started our Ph.D. program in 2002, we faced some of the same challenges about enrollment numbers, etc. [that USC faced with beginning its DNP]. We are now at capacity with 39 students in our Ph.D. program. So we believe that there is a demand out there, and we are the state's only higher education academic health sciences center. I think this proposed program also reflects where Nursing has moved in the last decade.

**Workman:** Specifically, having a doctorate in Nursing versus a master's degree--how do you distinguish what that difference is? I can see what is written here but elaborate.

**Stuart:** In many ways the DNP is the equivalent of an M.D. It's the terminal professional degree, and a masters is not a terminal degree. So, you have a scope of practice issue but the additional coursework in the DNP really involves financial aspects of the healthcare system. It involves translating research into practice and case management. These are the kinds of skills that I think our healthcare system needs now. It will be the terminal professional degree, and so nurses would either have a DNP or a Ph.D. much as a physician could have a M.D. and a Ph.D.

**Temple:** I have a couple of questions. One of the things is obviously that on first read I think this gives us all some concerns because of the failure or the perceived failure of the USC-Columbia program [i.e., the difference between what they said they'd produce as graduates and what they have produced as graduates]. My first question is--as I look at your estimated program cost and revenue--what number of students are you all using to show that your financial projections are likely to be a success? The reason I ask that is if you fall short of those projected numbers of students, how will the numbers be different? What are the assumptions for your one, two, three, four, five years? How many students do you have to have before you can break even and make it a success?

**Stuart:** We are thinking that we will have a cohort similar to the numbers we have now for the master's program, and we actually have the largest cohort of students working to become master's-prepared in the state. We are expecting that we will hold to that same total number of students, but they will become a mix of master's-level and doctoral (DNP) students—and, of course, we'll have some who will drop out. So we are seeing that number as being a constant [in the first year]. We believe we have that market.

**Temple:** Okay.

**Stuart:** Again, I think to explain the situation of the DNP at USC-Columbia a little bit. We have to understand that they also lost their Dean during that time

period and also had some other transition issues that I am sure played into [the discrepancy between projected and actual enrollments and graduations.]

**Temple:** Well, we certainly don't hold that against you. I guess practically speaking, you do such a great job but we are talking about the need and where it is. Could you in this DNP program have the ability to have courses transfer into, say, a nurse anesthetist [program] or something like that? Does it benefit people going into other areas or is this doctoral program in nursing just something very specialized?

**Stuart:** There are three clinical tracks, so it is not for nursing anesthetists, in fact, that area—i.e., nurse anesthetist—is not in our College of Nursing. It is in the College of Health Professions. Really the three areas for which we have the greatest demand from students are Family Nurse Practitioner, Adult Nurse Practitioner, and Pediatric Nurse Practitioner. Those are our largest tracks and there is a market demand for those folks. So the DNP which we are proposing doesn't really tackle all the other specialties.

**Temple:** Is the end result of the salary increases for students taking the DNP going to justify the additional cost of the education [beyond the master's program] to get there or is there [a cap to the salaries for these advanced practice nurses]? If you are talking about pediatrics, those guys are the lowest in terms of salary to start off with. So then you have to wonder what the benefit to these folks is going to be in completing the DNP—a year or more in addition to the current MSN. On the other hand, there are a lot of MSN-prepared nurses who are probably making close to what the doctors are making right now. So, for two reasons—those in specialties that don't pay that much and those in specialties that are paying a lot already—what would be the incentive of the DNP over the existing MSN?

**Stuart:** It's one extra year of schooling over and above the traditional master's, and it's hard to know what's going to happen with the economics of healthcare, especially with the election coming up. But, clearly, nurses in practice make a very good salary--better than the nurse faculty instructors who are teaching them. So, will it add tens of thousands of dollars to their salaries? At this point in time, we don't know, but we do know there are good clinical salaries for nurses with advanced practice degrees.

**Temple:** How is this proposed degree being received in healthcare circles? There were some comments made early in this discussion which I tend to agree with. How is this being received by the MD community in terms of doctoral level? Likewise, is there a push at some point if a DNP program is successful for these nurses to be able to write prescriptions and things of that nature? Is that going to be part of it as well?

**Stuart:** Right now, a master's prepared nurse practitioner can write prescriptions and so these nurses will do this as well. In South Carolina the physicians are very

supportive of advanced practice nurses. They hire nurse practitioners into their practice for rural areas of the state. We really need those advanced practice nurses prepared in South Carolina. In other states maybe there is a little bit more competition between advanced practice nurses and physicians, but basically the AMA has endorsed it. There is a group of nurses and physicians working together to develop a potential certification exam for the DNP. They are working on that. But in our region, these nurses are clearly in demand to work in our community.

**Temple:** Do you foresee a time when an advanced practice DNP nurse could open up a practice in a rural area without being under the supervision of a medical doctor, do evaluation, treatment and prescription of medicine?

**Stroud:** A physician and a nurse practitioner together? Or just the DNP?

**Temple:** Just the DNP.

**Stroud:** Currently not. No. The advanced practice nurse—whether it be one who is master’s-prepared or doctorally-prepared--has to work in collaboration and have supervision from a physician.

**Workman:** Is there any chance that this new degree might create a question in the mind of the consumer? In other words, “Doctor, doctor which doctor.” Do you know what I’m saying?

**Stroud:** I know what you’re saying, but I believe the nurse practitioner groups have said that we will always say to patients, “I am Sally Stroud, Advanced Practice Nurse. I have a doctorate in nursing. I am not a medical doctor.” We would not present ourselves as a medical doctor. We are a doctor of nursing practice.

**Stuart:** Any more than a pharmacist or a psychologist is a physician.

**Temple:** I was going to make that comment because Pharm D’s are called Doctors.

**Stuart:** Psychologists are as well. Now there is even a doctor of physical therapy, so there are a lot of doctorally-prepared healthcare providers of different backgrounds out there in the field. You have to be very clear to consumers that they have to ask for and want to have a nurse practitioner take care of them if that is what they want. A lot of them feel they are grateful for the quality of that care.

**Horne:** I think it is probably naive on our part to think, though, that the general public is interested in and knowledgeable about all of the differences between Ed.D., Ph.D. M.D., DNP, and that kind of thing. I don’t think we should wear badges that say, “Not a real doctor.” I just think there is a lot of confusion. We have a lot of questions here because this DNP proposal is an extremely expensive

program and we are trying to be fair and get all of these questions answered. We appreciate your patience. One of my questions is based upon the proposal's statements that the new program will require a total of 19 new courses, but, of course, 66 courses previously offered under the MSN are being eliminated. So, I really thought you would show some decrease in faculty, but I see, on the one hand, no new faculty, except a graduate assistant necessary to initiate the program, but within the next four years here, the program will need two more faculty. I thought we would see that with those 66 courses disappearing, we would get to see we are actually saving some faculty salaries.

**Stuart:** Let me explain that. Right now, with the 66 courses it is a very inefficient system. We have small numbers, very small numbers, being taught in many of these classes--almost what I consider tutoring, they are so small. By consolidating the courses, we are not reducing our overall number of students. They still need to be taught, and they will need to be taught in larger groups that are broken down. But if you look at the student numbers, you can see that our student:faculty ratio stays the same because we're not reducing students. We're just reducing our inefficiencies which we feel very good about.

**Horne:** I am glad to hear that. Was there consultation with the University of South Carolina? Do they have any thoughts on the program proposal?

**Stuart:** Yes, we work closely with them and with our colleagues in Clemson. This state needs us to work collaboratively together. If we can ever share resources, we're always looking for those opportunities. And, in fact, we have a program going right now with those two campuses regarding simulation. We're working more closely together. We believe that's the way we need training for nurses to do things in the future.

**Horne:** Are we going to see Clemson wanting one [a DNP] of its own? Of course, Dr. Stuart, you can't speak for Clemson, but you can understand how that has to be a question that arises in our mind. That if you're having this collaboration with Clemson.

**Workman:** If your program is to be offered on-line where it can be accessed by anyone and everyone, why have it in several institutional places?

**Stuart:** We see the on-line [feature] as being a very valuable piece of this. We have nurses all around the state who aren't going to leave their communities or their jobs to relocate for education, so this allows them to stay working where we need them to grow as with their families. And we've been very successful with our on-line program.

**Temple:** So apparently if it is on-line, the same things we talked about earlier with the wet lab and all that clinical part? All the clinical supervision and laboratories

are done by the time the students have risen to the master's level. . . so the doctoral level degree programs are administrative solely?

**Stuart:** No, this would involve clinical courses as well. There would be some clinical. The majority of their clinicals are in their home environment, but there will be a period of time when they must come to Charleston for intense clinical skills as well.

**Temple:** So it's not a 100% on-line program after all?

**Stuart:** The coursework is 100% on-line, but in order to assess clinical skills they will have to come on campus for a short period of time for us to complete those assessments.

**Horne:** And so by mentioning the local hospitals, clinics and what not--will you require an agreement with all of those around the state as well? How will that be handled?

**Stroud:** We currently do have---I think--over 300 agreements around the state. For every agency that is willing to have our master's students on-site to provide patient services, we have to have an agency contract.

**Horne:** So this will automatically roll in as one more program?

**Stuart:** Right and the agencies are happy to have those contracts. They like having students who learn the latest. It is good for a hospital's staff to have students like that on board working with you. So, nothing will change in that regard.

**Horne:** Do you have to follow the same set of proscriptions that the site can accommodate no more than X number of students per each clinical supervisor?

**Stuart:** Right.

**Horne:** You come well within those guidelines?

**Stuart:** Yes, absolutely.

**Horne:** Let us move to questions about duplication. It appears that much of the proposed MUSC DNP is really duplication of the Tennessee program which is in fact on-line also, correct?

**Stuart:** Let me point out the distinguishing features of the programs. First of all, the University of Tennessee program is only a post-master's program whereas ours will be post-baccalaureate as well as post-master's. So theirs is just for folks who already have their master's and it only duplicates our program in one track--

family nurse practitioner. Not pediatric, not adult. But at MUSC half of our accelerated students go right on for a graduate degree and become leaders in the state. They want a post-baccalaureate program in order to continue their advancement immediately after receiving their BSN. So what Memphis represents or Tennessee represents is just one small little piece of the pie, and that in no way would meet the needs of the students in this state or the registered nurses in the state.

**Horne:** Then I am reminded of in the write-up that notes there are 140 such programs throughout the country now planned for immediate implementation. Given that fact and given the fact that we cannot enroll students or get graduates at the levels they projected in USC's program which is near Charleston, I think I am not yet convinced that the need seems to be overwhelming. I asked Dr. Morrison to pull some information and to tell us a little bit about these programs, which are so expensive. In fact, this will be the fifth nursing doctoral program requested and approved for our research institutions since 1994. That's just a lot--just a lot of programs for a state as small as South Carolina, particularly given that the one at Carolina is [historically] underperforming. And, if you go back to 1986, that's the sixth nursing doctoral program that will have been approved in South Carolina. Then I have some fears that Clemson's name may be raised. I don't know about the rest of you but that makes me really nervous.

**Stuart:** If I may just address the issue: MUSC is the only academic health science center in this state. We attract the core of students who want to be exposed to the latest clinical and academic research. We are the largest producer of graduate students for any program in this state. These students are hearing what's being said nationally that they need the terminal degree--which is the DNP. My fear is that if we do not offer this program, these students will go out of state and we will see a reduction in our enrollment which will put us in financial jeopardy, quite honestly. So, we are wanting to give to the students and nurses in this state something in-state so they don't leave in order to fulfill their educational expectations.

**Temple:** Do you believe that five years is the amount of time necessary to see whether it's a success or not?

**Stuart:** You can see in the first two years we obviously will be enrolling [i.e., not yet graduating students]. So, in five years we will have our first graduates, but I will have to say our Ph.D. program is the most successful one in the state. Our graduation rate is 95%. I truly believe that we can deliver.

**Horne:** Anticipating that answer I also asked Dr. Kelley to do a little research on the difference in these various degrees because some of them seem to overlap into other ones, even though they might be slightly different. He says nursing personnel historically have made distinction between the Ph.D. as the research degree and the DNP as the practice degree, but now we're hearing that the DNP-

prepared faculty members will be eligible for tenure and will do “patient- based” research (or “evidence-based” research as opposed to double- blind studies and bench research as do the Ph.D. students. So would you respond to that?

**Stuart:** Yes, I appreciate that. The Ph.D. is a researcher. They have a research-intended program of study. The DNP is a clinical program. They are to apply research. They are not intended to be independent researchers. They can take someone’s research and the findings that they have to apply in practice, but it is not a research degree.

**Kelley:** But we do hear things about DNPs doing “evidence-based research.”

**Stuart:** Evidence-based practice, yes.

**Kelley:** But they will do research work themselves?

**Stuart:** Yes, they will identify a question, a problem that the patient has. Other researchers will have worked with this question in answering that problem or that question, then transfer it into practice. So that’s right. That’s what we need in the healthcare system, more evidence-based practice and evidence-based care.

**Horne:** But if the ultimate goal we are trying to meet is to prepare more teachers for the comprehensive universities and the technical colleges that are producing the nurses, why do we want to give another doctorate if we are just trying to produce more Registered Nurses?

**Stuart:** What we are trying to prepare are more nurses to practice. That’s the importance and reason for this practice degree. Will some of them [i.e., DNPs] teach? Yes. But it is not a teaching degree. If they want to do that, then they can get a master’s in nursing education. These [DNP’s] are the nurses who hopefully will populate South Carolina in these small communities that can’t attract physicians. Patients want the confidence to know that they are trained to be the best they can be.

**Workman:** I thought you said they could not go to a community and open up.

**Stuart:** They would have to have a collaborative relationship with a physician.

**Workman:** With an MD.

**Stuart:** Yes and that’s a benefit as well. I think we want to see team work and partnership. I mean we don’t want people solo practicing. So, yes, they will form collaborative relationships and have supervision, but they will also be able to provide healthcare in pockets in this state where we can’t really attract and retain [enough doctors].

**Kelley:** Dr. Stuart, I think part of the confusion is that the proposal states that there are two purposes for the DNP degree program, one of which is to turn out graduates who will be faculty at baccalaureate and above institutions.

**Stuart:** And with this degree, of course, folks could elect to teach. That is an option for them and we do need teachers. Institutions can hire either Ph.D. or DNP prepared nurses or master's prepared nurses. Obviously in a university setting, I look for more Ph.D.'s. A technical college might look for more masters. So there's a career opportunity for them in various settings. But this is a clinical degree as opposed to a research degree.

**Horne:** God forbid that in my next transformation I become the CEO of a hospital, but answer this question for me. I am trying to look at the bottom line, and I'm looking for RN's and the most inexpensive RN's that I can attract are clinically strong technical college graduates. Why do I want to hire your DNP as a practicing nurse since you're saying the intended outcome of the DNP program is to produce more of them for the practice setting? Why on earth would I be interested in paying for one of those when I get two clinically sound technical college grads?

**Stuart:** I'll answer that by [citing] the Institute of Medicine report that says that 94,000 patient deaths are preventable in the hospital due to staffing errors and mistakes. This nurse is the one who can look at a program, look at errors, look at a unit, and analyze patterns of care. There's more than just the person at the bedside. We have a *system* of care and hospitals that are seriously dysfunctional. 94,000 deaths per year among the population of hospital patients represent more than homicides and suicides combined in this country. Those are people who come into the hospital not with a terminal illness. Something bad happens to them while they're in the hospital. You need someone who is watching that, monitoring that, taking the evidence and translating it into a way to prevent those deaths and that is what this nurse is prepared to do. The two-year nurse is simply not prepared to do this. We don't turn out the same kind of nurse. We educate different products from what a two-year nursing program turns out.

**Temple:** I was just going to say the converse of asking the question would be the fact that it's cheaper to hire a nurse anesthetist than to hire an anesthesiologist. It may be cheaper to hire five nurse anesthetists than one anesthesiologist. Maybe one argument for this program is to have a very well educated person as a DNP supervising a whole floor of nurses.

**Stuart:** Right. We need to look at our system of care because hospitals are in serious trouble. And that's where we've identified what we need to really change—the way in which we deliver health care, particularly in hospitals.

**Horne:** Dori, do you want to jump in [to this conversation]? At Clemson, do you want one of these programs?

**Helms:** No. But I do have a few points. One, we send a lot of our students to the hospital where there is clinical work and clinical nursing and the DNPs who are there not only oversee the nurses in the hospital but also have a lot to do with making sure that the students we send there for their clinical work are overseen by somebody who has the qualifications to teach and oversee them in the clinical setting. The other thing I would say is that right now we have six vacancies in our nursing department, and we are really having difficulty finding Ph.D. prepared nurses because we are not going to hire master's degree-prepared nurses because they count against us in our ratings.

**Cox:** We'll take all the MSNs you find, and the ones you don't hire, we'll take them.

**Kelley:** Dr. Helms, when you say that hiring masters-prepared faculty "count against you" at Clemson, you don't mean this by SACS, do you?

**Helms:** Not for SACS, but they don't help us reach our goal [of being a top 20 research institution]. They are not research faculty. They are not doctorally prepared so they don't have to do research.

**Kelley:** You mean that they count against you for the *US News and World Report* ratings?

**Horne:** Have you been to visit USC, Dori, to let them know you're clamoring for some staff and they are not stepping up and producing? They have an undersubscribed program.

**Trainer:** I resent the language about the program. It is not a failing program; we bombarded it with way too many credit hours [in the beginning. Then,] we had a change in leadership and over the past ten years we have made modifications. . . but the [current] enrollment number, 52, that's significant. We're getting inquiries from out-of-state nurses with the Academic Common market with the on-line component of it. So, there is significant demand. If we can compare these people with DNPs and be satisfied that they can function as our clinical faculty, we can transition some of the Ph.D. faculty into the research slots. It is a balancing act but our program is not in disarray.

**Kelley:** The staff report does not indicate that the program is in disarray. The staff paper simply says that it has never turned out the minimum number of graduates the University said it would. That's all it says.

**Trainer:** I can't argue the sense of that. But I think based on the changes in the program, when you look at the fact that we are enrolling more and more students we consider it a healthy program that meets productivity. So I had to speak on our behalf.

**Stuart:** May I also interject there are over 32,000 nurses in South Carolina? We just heard that the DNP is at capacity at USC with 52 enrollees and there is such a need for nurses in this state. We don't even prepare enough—over 40% of nurses who work in South Carolina come from out-of-state. We need to provide ongoing education for nurses in this state. Now there are 32,000. If USC has 50 and let's say we have 50, that's 100 in these programs out of 32,000. I think we have to look at the pool that we are trying to address.

**Horne:** We don't disagree on that. We're just trying to get at the most efficient way to make sure that the numbers are coming out in ways that make sense to the taxpayers. We have to answer for those folks as well who don't have a voice in this discussion.

**Helms:** The purpose of USC and MUSC doing this degree is that they both have medical schools. The only way we would ever offer this degree is if it were ever to be required as part of the license to practice. If it ever got to the point where you could not be a nurse practitioner without the DNP or Ph.D.--in other words, if the masters degree no longer works to become an Advanced Practice Nurse---that's the only way we would ever come back and say, "Wait a minute. We're going to have graduates that might not have a job." But we have not discussed this at all at Clemson or among the three research institutions. The level of our collaboration among the nursing group is to say, "You do this, you do that, and we do genetics and then we are not duplicating."

**Stuart:** Might I also add that there is a shortage of nursing faculty in this state and at the technical colleges. We love our master's prepared but we need doctoral prepared nurses to teach and when we go back to our accreditation group, we have to say that we are not producing them.

**Horne:** I would agree with that. The problem that I see is that-and perhaps this is an endorsement of the Study Committee's position that we need a strategic plan- it is like we are all in the ball park of saying, "Okay, well now clinical needs this" and they come forward and then you can see that it is easy to assume on the part of those who feel that they've been disenfranchised that this big school gets this piece; and the next one comes forward and gets a piece--and it just goes on. Then nursing educators go before the legislature and do the end run [to get special funding]. And so it does seem like we are in disarray sometimes in trying to make sense of how this is fitting into an overall plan. In actuality, it really isn't fitting; and that lends itself to a lot of [questioning].

**Morrison:** One of the frustrations is that over the last twenty years the country has invested millions and millions of dollars in establishing doctoral programs (Ph.D.) in nursing- over a hundred and however many there are.

**Kelley:** Over 106.

**Morrison:** And so we have all these programs that have not solved the problem of creating sufficient numbers of practitioners or faculty. There are many, many, very small programs all over the country, so building a program is not always the answer. We have tons of programs [nationally] and we all know that you recruit your faculty and Dr. Helms recruits her program faculty nationally, not just in South Carolina. So you have access to all of the graduates of all these hundred-plus programs. What is it about the profession that is making this [producing Ph.D. graduates] such a difficult task? Are people enrolling and then stopping out because of their ability to earn such a good living without a doctoral degree to which you alluded earlier and they are stopping out at the master's degree?

**Stuart:** I can answer that honestly. The Ph.D. is a research degree. There are five statistics and research methodologies courses. Honestly, that is not what most nurses want. So it is a very small subset of nurses who want to do research and go through the Ph.D. route. The majority of nurses are practicing clinical nurses and that's what this degree addresses. So, if I had a program that had a very small number--and we've seen that in the programs that we closed when there is no longer marketing-- I think that it is only sensible [to close them]. But the Ph.D. is not what the majority of nurses seek in higher education, and it is not where the majority of nurses will ever work. The number of Nurse Researchers will always be small--important but small. With 39 in our Ph.D. program, we are delighted to be producing them, and I do hire the best and brightest to stay on as faculty. But the largest group of nurses are the clinical nurses—that is, the nurses who are really given to patient care, not doing research. It is simply a fact that most nurses don't want a Ph.D.

**Horne:** Dr. Cheryl Cox, you had a question?

**Cox:** It was [to address the question of why you as a CEO in a hospital would hire two technical college graduates of associate degree nursing programs at a lower cost campuses to one Advanced Practice Nurse.] Part of that answer is scope of work. The people who graduate within a nurse practitioner program do a very different job than an entry-level RN, whether they have a two- or four-year degree. So there is a difference. They are apples and oranges; you don't hire the Ph.D. or the nurse practitioner to do the job of an entry-level nurse.

**Cox:** We do hire frequently in-state whenever we can. So we do need a local supply. Many of the people we hire are career changers, not that they've moved [from another career to become] nurses, but [they have] moved to teach nursing from practice. Many of those times we have to grow our own from bachelor's on up, and an on-line program will be very beneficial to them. Now, whether that's a master's or a Ph.D., I am not in the profession, so I can't address that question. But the fact that [this proposed DNP program] is an on-line program is very attractive.