ten years of progress: The Council for the Advancement of Comprehensive Care

The Council for the Advancement of Comprehensive Care (CACC) is celebrating its tenth anniversary, but the foundation of this movement and its mission is rooted in Columbia University School of Nursing's innovations and decisions from nearly a quarter century ago.

In late 1985, academic nursing across the country was floundering. With newly opened access for women to other professions, nursing's conventional pipeline experienced serious competition for the first time. In nursing schools where faculty were active in moving the profession forward, research was now becoming a significant part of the academic role, while at the same time faculty clinical practice was falling out of favor. The vast majority of students, however, were pursuing advanced practice clinical careers, but had no faculty to guide them as state-of-the-art-mentors and role models.

Nursing Faculty Contract for their Services

Columbia recognized these challenges. With the nursing school's tuition equal to that of other professional school costs, Columbia acted to change the paradigm of traditional nursing education. The faculty instituted an innovative faculty practice plan in which faculty would contract for their services, as academic physicians had for decades. This would provide reimbursement to the School for valuable services of faculty in roles in which students could participate and contribute. This led not only to added revenue for the School, but was also a powerful plus to potential students who were clearly attracted to an education where their faculty were clinically active.

While Columbia's innovation succeeded in terms of the short term financial challenge and became a recruitment success in attracting clinical experts to faculty roles, it was also the fertile seed for a professional revolution that would profoundly change academic nursing. In 1986, Columbia was translating existing advanced nursing practice into faculty roles and expectations; what the School did not envision was that this would provide the access to begin to fundamentally change the scope of practice that nursing could achieve and anchor. All this, because one small and determined faculty grasped the opportunity.

A New Role as Independent Primary Care Providers

Within the next few years, into the early 1990's, the School's faculty practice thrived. During that time, physicians in training were identifying careers with sophisticated specialty professional roles which carried appropriately high financial rewards. Primary care had lost its luster. But the need for primary care had never been more crucial. Academic health centers (AHC), where most graduate education for physicians takes place, felt the deficit particularly hard, as their specialist cadres were unable to provide adequate primary care resources for patients. In New York City, one such hospital, Columbia Presbyterian, saw a solution. Dr. William Speck, the president, envisioned a nursing presence in primary care that would ameliorate this deficit. He was unique among his AHC colleagues in his vision, but he had a model at hand that helped. Columbia's nursing school faculty was in practices — primary care practices — in the Columbia Medical Center already. They were accepted in those practices and were part of the fabric of the Center. Dr. Speck, however, had something else in mind. Why not advance these nurses into independent roles, giving under-served patients in the community access to not only primary care, but also to professionally determined access to specialists. New York State viewed his proposal favorably. Dr. Speck partnered with the state and with the School of Nursing to advance

primary care, and by doing so, was successful in bringing needed funds for construction of a new building for the hospital.

A Landmark Study

These new practices at the hospital were staffed by faculty nurse practitioners (NPs) in some sites, and by primary care physicians in others. This unique opportunity to compare two practices with similar patients (Medicaid insured), but with differing clinicians, was the impetus for the resulting landmark study — randomized clinical trial (RCT) that compared nurses and physicians in these primary care practices. The study was funded by the federal government, New York State, the W.K. Kellogg Foundation, the Teagle Foundation, the Arthur Vining Davis Foundations, the Commonwealth Foundation and the Robert Wood Johnson Foundation.

The Establishment of CAPNA

As the study was unfolding, the School decided to open a similarly independent practice for commercially insured patients. Since the inception of Medicare and Medicaid in 1965, nurse practitioners had been increasingly authorized in federal and state legislation to provide reimbursable care to these populations. With no deficit in access for commercially insured patients, there had not been similar efforts by commercial insurers to cover care by nurse practitioners. Columbia saw the opportunity to change this. If the School's faculty practitioners were eligible for attending privileges at the hospital for their Medicaid patients, why not for other patients as well? Our physician and hospital colleagues agreed, and Columbia Advanced Practice Nurse Associates (CAPNA) was established in midtown Manhattan in 1997.

The American Board of Comprehensive Care

As the RCT was designed, nursing faculty were to have the same privileges and authority for care as physicians in the study. Otherwise, comparisons about effectiveness and cost would be compromised. Nurse practitioners in the practices were therefore given admitting privileges to the hospital; were credentialed jointly through the School of Nursing and the appropriate medical school department; and functioned as attending staff, providing referrals and making decisions with their medical colleagues about the inpatient or emergency room (ER) management of their patients. Medical school colleagues taught the nurse faculty who participated in these practices, the expanded skills necessary to admit and medically manage ER and hospitalized patients, how to select and work with referral specialists, and how to manage the system across all sites of care.

Organized medicine was greatly disturbed by the opening of CAPNA. Their stated concern about competition was masked as a concern for patient safety; nurse practitioners caring for poor or elderly people (i.e. Medicare/Medicaid patients) did not pose concerns for members of the American Medical Association, but NPs were somehow not safe practitioners for mainstream paying patients. Nonetheless, CAPNA thrived.

In the January 2000 *Journal of the American Medical Association*, the results of the RCT were published, and demonstrated equivalency in outcomes of care between the nurse practitioners and primary care physicians. As a result of this study, admitting privileges at the hospital for faculty nurse practitioners became permanent and this model has now grown to include faculty nurse practitioners in a variety of

settings, including traditional primary care and in both the inpatient and outpatient care of acutely ill individuals.

Columbia then knew that it had the beginning of a revolution in nursing practice and in nursing education.

A New Doctoral Degree

The best way to replicate these advancements was to embody the learning and outcomes into a new degree structure. This new set of competencies clearly justified a doctoral degree program. The faculty determined that the most appropriate title would be Doctor of Nursing Practice, or DrNP (now DNP). This would be analogous to the Columbia University doctorate in public health, the DrPH.

Education in any field, but perhaps especially in nursing, is as variable as the setting, resources and mission of the nursing school. The School knew that its grounded new scope of practice worked, but also that it had taken almost 14 years to develop, test, and measure. Could other schools adopt this model if they were helped with curricular and competency tools? Would they want to replicate CUSON's model or simply do it their own way? What was certain was that nursing nationally would want to find a way to achieve the new level of practice authority and recognition it had been able to accomplish in partnership with Columbia physicians. Those who followed would need medical partnerships similar to CUSON's, in order for the scope of advanced practice nursing to measurably increase. Thus was born the idea for an interdisciplinary council that would advocate and formulate standards for this new doctoral degree. Columbia sought members from leading academic health center schools of nursing, representatives of professional nursing organizations, international nursing contributors, and leaders

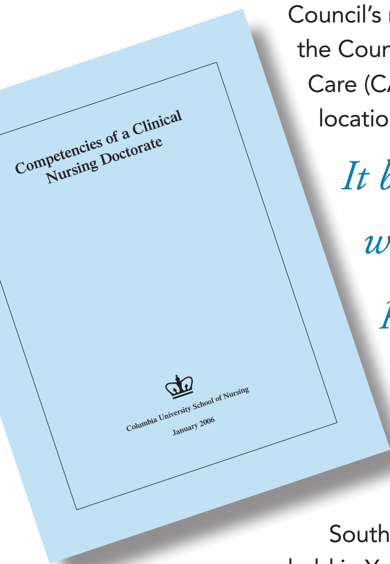
left: CACC members thank Dean Mundinger for her contributions to the CACC at the 2004 meeting in Bergen, Norway. From left to right (standing): Joan Shaver, Mary Mundinger, Ada Sue Hinshaw, Nancy Woods (with camera)

right: CACC members and guests at the 2005 meeting in Prague, Czech Republic

in medicine and health policy. In August 2000, the School of Nursing convened the first invitational conference to discuss the advanced practice nurse's (APRN) role in assuring quality and access to comprehensive health care.

The Founding of the Council for the Advancement of Comprehensive Care

The initial name for this council was "The Council for the Advancement of Primary Care," to reflect conventional medical primary care. In time, it became clear that these new, highly educated advanced practice nurses were developing practice competencies across sites of care which would provide a comprehensive, sophisticated practice which would transcend traditional site specific, outpatient care. The Council's name, and its mission, evolved to become the Council for the Advancement of Comprehensive Care (CACC), meeting at least yearly in various locations (Phoenix, London, Rome, Bergen, Prague, St. Petersburg, Istanbul, St. John, USVI, Galapagos Islands and Cape Town, South Africa. The summer 2010 meeting will be held in Yosemite National Park.)



It became clear that these new, highly educated advanced practice nurses were developing practice competencies across sites of care which would provide a comprehensive, sophisticated practice which would transcend traditional site specific, outpatient care.

The Council's Challenges

Two major obstacles quickly appeared after this first conference. A DNP degree was developed by the University of Kentucky that contained no advanced clinical training. It was a degree for nurses which encompassed additional learning in a variety of courses beyond the master's degree, but did not focus on clinical education beyond that offered in master's degrees. Schools were quick to adopt this model because it was inexpensive to establish, faculty were not required to be clinicians with skills beyond traditional master's degrees in order to teach in the program, and these programs could be developed quickly and often offered totally online. Advanced practice nurses, who before could only study for a research doctorate, found the non-clinical DNP programs just what they wanted. This doctoral degree was easy to obtain, and for educators and administrators, it provided a mechanism to be doctorally prepared without studying clinical care or research.

The second obstacle was the belief held by many faculties, schools, and professional organizations, that the traditional clinical master's degree programs had so evolved over time that these programs could essentially stay the same and merely be renamed as doctoral degrees. With some MS degree programs requiring 90 credits post-baccalaureate, many believed that these programs were already long enough and packed with enough credits to be re-titled as DNP degrees. There was little if any attention given to the fact that master's level competencies (as evidenced in certification exams) would not change or advance if the degree was renamed a doctoral degree.

These obstacles — a broad and un-standardized DNP degree focus and the potential for degree creep without higher competency requirements — eroded the Council's efforts to assure to the public that a DNP graduate is a clinical expert with skills and competencies required for independent delivery of comprehensive care.

The Council worked diligently to have national competency standards for advanced clinical education adopted for all DNP programs, particulary on

promulgating standards for DNP programs whose emphasis was for clinical training (as opposed to DNP programs in administration or systems change).

Certification of the DNP Degree

Believing that it was vital to promote the Council's mission to advance and distinguish common clinical competencies of DNP graduates aspiring to careers in comprehensive care, efforts were focused to certification of these graduates. Such a standard was not being built into the degree itself as it was established nationally, but CACC believed a standardized certification would be the mark of distinction the public and the payers could rely on when authorizing a DNP for independent practice.

Ten years after Columbia University School of Nursing first announced its intent to develop a clinical doctorate, 92 other schools have formally opened programs and another 102 are in the planning stages. Because most of the advanced clinical and management competencies required were already being incorporated into medical education, the most appropriate certification process would measure those same medical and management competencies. This was the rationale behind the Council's choice of the National Board of Medical Examiners (NBME) as its certification partner. This competency-based examination, which was administered to DNP graduates for the first time in November 2008, assesses the knowledge and skills necessary to support advanced clinical practice. It is comparable in content, similar in format and measures the same set of competencies and applies similar performance standards as Step 3 of the United States Medical Licensing Examination (USMLE), which is administered to physicians as one component of qualifying for licensure.

Ten years after Columbia University first announced its intent to develop a clinical doctorate, 92 other schools have formally opened programs and another 102 are in the planning stages. The number of students enrolled in DNP programs doubled in 2007 – 2008.

The number of students enrolled in DNP programs doubled in the years 2007-2008 (1,874-3,415) and there are now 362 graduates from these programs. This rapid expansion of the new degree by faculties who have not gone through Columbia's iterative scientific and clinical process of development has created a polyglot of programs that are distinguished by their lack of standardization. Standardization of graduate competencies is fundamental to the safe and successful national expansion of this new degree as patients, payers, policy makers and the public at large will demand high reliable standards in order to accept these advanced clinicians. CACC believes the most crucial challenge is to assure that common standards for graduate competencies are adopted by schools that award this degree, and that the graduates who attain these competencies are reliably recognizable.

The certification exam given by CACC, through its certification arm, the American Board of Comprehensive Care (ABCC) will become the mark of comprehensive care excellence as the evolution of this degree goes forward. Patients and payers will recognize that this subset of DNP graduates (Diplomates of Comprehensive Care) are the clinical experts of choice. Results of the first two ABCC exams are as follows: in 2008, there were 336 multiple choice questions given over the course of one day. It was taken by 45 graduates and the pass rate was 50%. In 2009, the test was given over two days and consisted of 336 multiple choice questions and two computer simulation scenarios (CCS). Nineteen DNP graduates took this test and the pass rate for first time test takers was 57%.

The Council's Visionary Proponents

Over the first 14 years of development of this new DNP role, several courageous and visionary physicians opened doors of opportunity for Columbia University's School of Nursing's Council for the Advancement of Comprehensive Care, and rode shotgun as their more conservative physician colleagues fought its progress on every front. Herb Pardes, MD, then vice president and dean of the College of Physicians and Surgeons at Columbia, was one of its earliest and most vocal advocates. Mike Weisfeldt, MD, then Chair of the Department of Medicine at Columbia, provided moral and political arguments, brought the Department of Medicine into the early informal training of the School of Nursing faculty, and took their message to his profession nationally and to the media. Dr. Speck provided the site and resources to test the model, and along with Drs. Pardes and Weisfeldt, facilitated hospital bylaw changes that authorized these faculty nurse practitioners as attending clinicians.

Recently, as CACC sought a certification partner, it found Donald Melnick, MD, who took on the entire medical certification community in order to offer DNPs a certification test that measured the same competencies as those in the final exam for MD licensure. Without this band of heroes, nursing's advancement would not have been possible.

As with the innovations spawned at Columbia University School of Nursing so many years ago, the ultimate achievements cannot be known or planned in advance. Surely CACC will be working on issues and challenges, and celebrating successes, in areas yet to be determined.

Looking Ahead

The Council of Comprehensive Care's work is not finished. A new mission statement for CACC was developed this year: to promote quality and access and accountability for comprehensive care. CACC meets this mission through system redesign, regulatory and policy reform and comprehensive care certification.

There remains a disparity of focus and competency among DNP programs, and even among the DNP programs that are considered "clinical." The public will continue to be confused by this unnecessary variability, and it could limit clinical DNP advancement and acceptance. CACC will continue to promote clinical standards for DNP program accreditation and to eventually develop a new and more appropriate title for programs and graduates which do not include doctoral level clinical competencies tested in the certification exam. These competencies are detailed in in publications from Columbia and the Council since 2004.

The Council will continue work in the public and regulatory arenas to build understanding and acceptance of DNPs with this certification.

Once these goals have been met, the Council will work to further influence nursing's educational systems to adopt competency based standards in their degree programs. As with the innovations spawned at Columbia University School of Nursing so many years ago, the ultimate achievements cannot be known or planned in advance. Surely CACC will be working on issues and challenges, and celebrating successes, in areas yet to be determined.

CACC members

GERALDINE BEDNASH, PHD
Executive Director, American Association of Colleges of Nurses

ROBERT BROOK, MD, SCD
Vice President & Director, RAND Health

MICHAEL CARTER, DNSC
University Distinguished Professor,
University of Tennessee Health Sciences Center College of Nursing

COLLEEN M. CONWAY-WELCH, PHD
Dean, Vanderbilt University School of Nursing

RICHARD COOPER, MD
Professor of Medicine, Leonard Davis Institute of Health Economics
University of Pennsylvania

CATHERINE D. DEANGELES, MD, MPH
Editor in Chief, *JAMA*

MELANIE DREHER, PHD
Dean, Rush University College of Nursing

DONNA HATHAWAY, PHD
Dean, University of Tennessee Health Sciences Center College of Nursing

MARTHA N. HILL, PHD
Dean, Johns Hopkins University School of Nursing

ADA SUE HINSHAW, PHD
Dean, Uniformed Services University of the Health Sciences Graduate School of Nursing

JUDY C. HONIG, EDD, DNP
Associate Dean, Columbia University School of Nursing

KAREN IGNAGNI
President & CEO, America's Health Insurance Plans

ROBERT KANE, MD
Minnesota Chair in Long-Term Care and Aging, University of Minnesota

THE HONORABLE THOMAS KEAN
Chairman, THK Consulting, LLC

KENNETH KIZER, MD, MPH
Chairman & CEO, Medsphere Systems Corporation

MARY O'NEIL MUNDINGER, DRPH
Dean, Columbia University School of Nursing

MARLA E. SALMON, SCD
Dean, University of Washington School of Nursing

JOAN SHAVER, PHD
Professor and Dean, University of Arizona College of Nursing

JENNIFER SMITH, MBA, MPH, DNP
Senior Associate Dean, Columbia University School of Nursing

JANICE SMOLOWITZ, EDD, DNP
Senior Associate Dean, Practice, Columbia University School of Nursing

PATRICIA STARCK, DSN
Dean and John P. McGovern Distinguished Professor, University of Texas Health Science Center at Houston School of Nursing

GAIL L. WARDEN, MHA
President Emeritus, Henry Ford Health System

MYRON L. WEISFELDT, MD
William Osler Professor of Medicine,
Johns Hopkins University School of Medicine
Director, Department of Medicine

NANCY WOODS, PHD
Professor, University of Washington School of Nursing