



The Doctor of Nursing Practice: Current Issues and Clarifying Recommendations

June 2026 Update

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Executive Summary

In 2015, an AACN task force was charged with developing a white paper that clarified the purpose of the Doctor of Nursing Practice (DNP) final scholarly product and the clinical learning practice hour requirements described in the 2006 *DNP Essentials*. In addition, the task force was charged with exploring, clarifying, and finding new and innovative ways to meet DNP education and practice requirements. This 2026 white paper provides clarification of DNP program expectations aligned with AACN's 2026 *Essentials* as well as examples for programs to prepare DNP graduates with the advanced-level competencies and sub-competencies needed for future advanced nursing practice.

Introduction

The *AACN Position Statement on the Practice Doctorate in Nursing* (AACN, 2004) changed the course of nursing education by recommending that advanced nursing practice education be moved to the doctoral level. Two decades later, the Doctor of Nursing Practice (DNP) is recognized as one of the discipline's two terminal degrees and the preferred pathway for those seeking preparation at the highest level of nursing practice. A national study commissioned by the AACN Board of Directors and conducted by RAND Corporation in 2015 found that there was near universal agreement among the nursing community on the value of DNP education in preparing nurses to meet future healthcare needs (Auerbach, 2015). According to AACN's 2025 annual survey, 452 DNP programs – available in all 50 states, the District of Columbia, and Puerto Rico – are enrolling students in entry-level, post-baccalaureate, and post-master's options (AACN, 2026). Despite this strong support for the practice doctorate, challenges and variability exist among DNP programs with some states limiting the number of doctoral programs, changes in the higher education landscape, fiscal concerns, and different pathways to the DNP.

The national dialogue about the DNP amplified the need to clarify and restate how advanced nursing practice is defined as well as the expected outcomes of the programs. *Advanced nursing practice* is defined as any form of nursing intervention that influences healthcare outcomes for individuals or populations, including the provision of direct care or management of care for individual patients or management of care populations, and the provision of indirect care such as nursing administration, executive leadership, health policy, informatics, and population health. It is important to remember that the DNP is an academic degree, not a role.

Considering the changing landscape in healthcare and higher education outlined in AACN's *Vision for Academic Nursing* (2019), the AACN Board of Directors charged a task force to consider new approaches to nursing education and how to prepare the nursing workforce of the future. *The Essentials: Core Competencies for Professional Nursing Education*, released in 2021

and updated in 2026, provided a framework for preparing individuals for the discipline of nursing and delineates the competencies expected for entry into professional practice and advanced nursing practice students across 10 Domains of practice. Naturally, a professional transition of this magnitude has generated many questions and provides an opportunity for reflection and clarification.

The DNP Implementation Task Force published a white paper in October 2015 to provide guidance to faculty engaged in developing and sustaining DNP programs. This revision of the 2015 white paper clarifies and aligns the expectations for DNP programs and graduates with AACN's 2026 *Essentials*. This white paper includes clarifications regarding the characteristics of DNP graduate scholarship, the DNP project, and practice experiences. The document also features a glossary, references, and appendices to provide examples that support the individual expectations.

I. Advanced-Level Nursing Education

The 2026 *Essentials* set in place a model for preparing professional nurses, which includes a transition to competency-based education. This model provides the structure and pathway to navigate across education programs (baccalaureate, master's, and DNP) and adapt to future changes within healthcare, which may include new areas of advanced nursing practice. With the call in 2004 for all advanced nursing practice to evolve to the doctoral level and the reaffirmation of this position by the AACN Board of Directors in 2019, the 2026 *Essentials* Level 2 (advanced-level) sub-competencies were written to reflect competencies required of *all* graduates entering advanced nursing practice preparation. However, the model allows schools to differentiate degree paths (master's and DNP) using these same advanced-level sub-competencies and distinguish their own program through alignment with their institutional mission, program outcomes, and environment.

Programs preparing nurses to advance their education beyond entry-level professional nursing practice are expected to incorporate diverse experiential learning opportunities across the curriculum that prepare graduates with the ability to demonstrate the advanced-level (Level 2) sub-competencies. The Level 2 subcompetencies delineate the behaviors demonstrating competency attainment at the advanced nursing practice level. The Level 2 sub-competencies intentionally build on the Level 1 sub-competencies and therefore require attainment of the Level 1 sub-competencies prior to or subsequent to the Level 2 sub-competencies. Although the advanced-level nursing education sub-competencies were intentionally written with doctoral-level education in mind, the differentiator for the degree attained may occur through the advanced role or specialty requirements that may include differentiated master's and doctoral level competencies as well as the institutional degree and program requirements, such as the scholarly project, credit hours, and course requirements.

II. DNP Graduate Scholarship

The 2026 *Essentials* state, "There are many past, present and future healthcare dilemmas that call for healthcare transformation. Nurses, as members of the healthcare team, are expected to assume a prominent role in addressing these dilemmas. Nurses cannot be expected to significantly impact healthcare transformation unless their educational preparation provides them

with opportunities to learn and employ scholarship, leadership, and teamwork skills to advance practice.” The student’s scholarship or scholarly work that aims to improve clinical practice is a hallmark and is demonstrated through the DNP project required of students completing a DNP program.

The scholarly work and final project may take on various forms depending on the academic institution’s requirements and the student’s identified area of practice. Key elements expected in the scholarly work include:

- Problem identification;
- Search, analysis, and synthesis of the literature and other evidence;
- Translation of evidence to construct a strategy or method to address a problem;
- Design of a plan for implementation and initiate implementation or implement when possible;
- At minimum, an evaluation of the outcomes, process, and/or experience; and
- Dissemination in some way determined by the student in consultation with faculty.

The final scholarly project may also include any other elements deemed necessary by faculty to meet the expected outcomes of the curriculum. Programs are encouraged to support innovation in the design and dissemination of the final project. A literature review that lacks applicability to affect a practice improvement would not constitute a scholarly work that aligns with the *Essentials* model (2026). Similarly, a portfolio may be used as a tool to enhance the development and presentation of a project but may not be the sole product of the student’s scholarly work (AACN, 2026, p. 25).

Practice-focused doctoral programs prepare experts in specialized advanced nursing practice. These programs focus heavily on practice that is innovative and evidence-based, reflecting the application of credible research findings. The development of the advanced knowledge and skills necessary to fulfill this outcome is what constitutes the scholarship of the DNP graduate. The *Essentials* provides a foundation and guide for this knowledge development.

DNP practice-scholarship is demonstrated when the principles of nursing scholarship are combined with the 10 Domains delineated in the 2026 *Essentials* to produce a graduate prepared to improve health and care outcomes. The integration of these competencies improves outcomes through organizational/systems leadership, quality improvement processes, and translation of evidence into practice, among other ways.

Scholarship is the mechanism that provides knowledge development within a discipline. Graduates of DNP programs advance scholarship in ways that differ from the development and application of research-focused scholarship. Rather than a knowledge-generating research effort, the student in a practice-focused program carries out a practice application-oriented final DNP project. As DNP programs have evolved, questions emerged regarding the *development of new knowledge* and, in some instances, have been a source of debate in nursing education and practice communities (Kesten, et al, 2022; Reynolds & Sabol, 2023; Martsolf, et al, 2023). Practice-based evidence is generated through outcomes management, quality improvement, and evidence-based practice projects that translate evidence into practice and policy to improve care and outcomes (Melnik, 2013). The practice scholar applies evidence to practice, incorporating

implementation and translation science. Scholarship is guided by a multitude of innovative methods of inquiry that are informed through clinical practice with the aim of improving and transforming healthcare delivery and patient outcomes. Practice scholars apply and integrate evidence to and from clinical practice and conduct quality improvement using methodologies to improve care processes (AACN, 2018, p. 3). Therefore, DNP graduates are prepared to generate practice-based knowledge, translate evidence into action, lead practice improvement, and evaluate outcomes to improve patient and system care.

Following a review of the federal definition of research (Department of Health and Human Services, 2019), AACN's position statement on *The Research-Focused Doctoral Program in Nursing: Pathways to Excellence* (2022), the *Essentials* (AACN, 2026), and models of implementation science (Gannon, 2014), the following conclusions were reached:

1. The distinction between research- and practice-focused scholarship should be clarified to state:

Graduates of both research- and practice-focused doctoral programs are prepared to generate new knowledge. However, research-focused graduates are prepared to generate knowledge through rigorous research and statistical methodologies that may be broadly applicable or generalizable; practice-focused graduates are prepared to generate new knowledge through innovation of practice change, the translation of evidence, and implementation of quality improvement processes in specific practice settings, systems, or with specific populations to improve health or health outcomes. New knowledge generated through practice innovation, for example, could be of value to other practice settings. This new knowledge is considered transferrable but is not considered generalizable.

2. Organizational and systems leadership knowledge and skills are critical for DNP graduates to develop and evaluate new models of care delivery and to create and sustain change at the organization and systems levels. Practice includes leadership; advancing the quality of nursing care and the profession of nursing through policy evaluation, development, and advocacy; and the creation and maintenance of healthy work environments. The development and trial of new models of care delivery may be partially based in generalizable evidence, based in transferrable evidence from another practice site, or when no evidence exists, based on experience and new/innovative thinking. The ability to develop and adapt care delivery and evaluate outcomes is essential for DNP graduates to mold practice and improve the health and well-being of populations. For example, evaluation of outcomes may include rapid cycle testing or prototyping used in quality improvement processes (see Glossary and Appendix C).
3. These delineations in knowledge generation are not to be construed as a hierarchical structure of the importance of these two types of knowledge generating methods. The application and translation of evidence into practice is a vital and necessary skill that is currently lacking in the healthcare environment and nursing profession. The DNP graduate will help to fulfill this need. Optimally, DNP and PhD graduates will have the opportunity to collaborate and work synergistically to improve health outcomes.

III. DNP Project

The 2026 *Essentials* recognizes the need for a final DNP project that demonstrates practice scholarship focused on improving health and healthcare outcomes. With the continuing growth of new programs and increased interest in the DNP, it is crucial that the profession clarify the scope of the final DNP project, the level of implementation, the impact on system/practice outcomes, the extent of collaborative efforts, the expected dissemination of findings, and the degree of faculty mentorship/oversight. It also is important that the translation of knowledge into the practice setting by way of the final DNP project be clarified to ensure consistency of learning outcomes.

Post-master's and the post-baccalaureate DNP students – who begin their doctoral programs with different education and practice backgrounds – should graduate with the same comprehensive set of sub-competencies as delineated in the 2026 *Essentials*. Although the DNP competencies represent new learning for students pursuing the practice doctorate, the scope and impact of DNP projects can greatly differ because some are undertaken by post-baccalaureate students and others by experienced nurses in post-master's programs. Collaboration with practice partners whenever possible will maximize the impact of the student's experience.

1. **Title:** The final scholarly project should be called the **DNP Project** to avoid confusion with the term capstone, which is used at varying levels of education. The DNP Project is not a research dissertation; therefore, the term “dissertation” should not be used.
2. **Scholarly Product:** The product of the DNP Project may take on various final forms depending on the academic institution's requirements and the student's area of advanced nursing practice. Programs are encouraged to support innovation in the design and dissemination of the final project to reflect the changing healthcare environment. However, the elements of the DNP Project should be the same for all students and include design, planning, evaluation, and dissemination components. As an outcome of the program, students must have the opportunity to integrate all advanced-level (Level 2) sub-competencies (*Essentials*, 2026) into practice. However, all 10 *Essentials* Domains and sub-competencies do not have to be demonstrated in the DNP Project. All DNP Projects should:
 - a. Focus on a change that impacts healthcare outcomes either through direct or indirect care.
 - b. Have a system (micro-, meso-, or macro-level) or population/aggregate focus.
 - c. Align with the student's advanced specialty or role in practice.
 - d. Include a plan for sustainability (e.g., financial, systems or political realities, not only theoretical abstractions).
 - e. Include an evaluation of processes and/or outcomes. DNP Projects should be designed so that processes and/or outcomes will be evaluated to guide practice and policy. Clinical significance is as important in guiding practice as statistical significance is in evaluating research. Provide a foundation for future practice scholarship.

Faculty may identify additional elements deemed necessary to meet the expected outcomes of the curriculum. Programs are encouraged to support innovation in the design and dissemination of the final project without reducing the substantive nature of the work.

3. **Integrative and Systematic Reviews:** A literature review that lacks applicability to affect a practice improvement or other elements identified above would not constitute a scholarly work that aligns with this *Essentials* model. Therefore, an integrative and systematic review alone is not considered a DNP Project and does not provide opportunities for students to develop and integrate scholarship into their practice.
4. **Portfolios:** Similarly, a student portfolio may be used as a tool to enhance the development and presentation of a project but may not be the sole deliverable product of the student's scholarly work (*Essentials*, 2026, p. 25).
5. **Group/Team Projects:** While they can be a valuable experience, helping to prepare graduates to function in interprofessional teams in the future, group/team projects often present challenges, particularly for student evaluation and grading. Group projects are acceptable when appropriate to the students' area of practice (role or specialty) and goals, and the project aims are consistent with the focus of the program. Guidelines for the entire project, as well as for individual contributions to the project, and a rubric used for each individual's assessment should be developed and shared with students prior to the initiation of the project. Each member of the group must meet all expectations of designing, planning, and evaluation of the project, and be evaluated accordingly. Each student must have a leadership role in at least one component of the project and be held accountable for a deliverable. The following serve as illustrative examples:
 - a. The student serves as a vital member of an interprofessional team, responsible for planning, implementing, and evaluating a component of a larger project.
 - b. Students work on the same project, for example, improving hand washing, across multiple units within the same organization or across multiple organizations.
 - c. Students focus on different aspects of improving diabetic outcomes of care by meeting criteria for guidelines for diabetes care such as eye exams, time frames for HbA1c screening, and foot care.
 - d. Students analyze and implement changes in immunization policies to improve access to immunizations and increase immunization rates in different states or regions.
6. **Dissemination:** The DNP Project should include a product that describes the purpose, planning, implementation, and evaluation components, and should be required for each project. Dissemination of project outcomes is essential and may include a variety of forms depending upon the focus and area of advanced nursing practice and should be targeted to appropriate audiences to ensure impact (see Appendix A on Dissemination). Dissemination may include a final written product that is presented to a defined group of stakeholders, such as members of the practice and/or university community or participants at a local, state, or national professional meeting. Other possible examples

of dissemination include poster presentations, a manuscript under review and/or submission for publication, a podcast, or an educational presentation for an interprofessional team, staff, policy makers, or community.

7. **DNP Project Team:** Replace the term “committee” with “DNP Project Team” to minimize confusion between the PhD dissertation committee and the faculty and mentors who oversee the DNP project. The DNP Project Team should consist of a student or group of students with at least one doctoral prepared faculty member and one practice mentor who may be from outside the university. In some instances, additional experts/mentors/partners/facilitators can be formal or informal collaborators and may provide intermittent or limited support throughout the project stages as needed.
8. **Evaluation:** The final DNP Project should be evaluated by faculty. In addition, faculty with appropriate specialty and academic credentials need to be involved in the planning, formation, and evaluation of the student’s scholarly work. Evaluation includes a review process, which may include a combination of methods, with faculty, expert, and/or peer evaluation. Review and input from stakeholders outside of academia are important to ensure rigor, applicability, and impact of the work as well as to disseminate outcomes. Programs should tailor scholarly work evaluation and approval processes per the requirements of the institution, program, and/or appropriate committee.
9. **Repository:** A digital repository for DNP final projects should be used to advance nursing practice by archiving and sharing the work and outcomes.

IV. Resources, Logistics, and Curriculum Considerations

Questions regarding program length, program resources, and curricular design continue to be raised. Based on these questions, it is evident that there are a variety of approaches and interpretations of the 2004 DNP position statement and 2026 AACN *Essentials*. The 2026 *Essentials* establishes national, consensus-based competencies and sub-competencies for all DNP programs. Until the competencies/sub-competencies, including reliable assessment methods are fully implemented across all DNP programs, metrics such as program length, credit hours, and clinical hours should be based on the program track, student experiences, and meeting overall program outcomes. Programs need to provide evidence of achievement and show that graduates are engaged in experiential learning opportunities and able to demonstrate the 2026 *Essentials* competencies, which are demonstrated by the Level 2 sub-competencies in all 10 Domains, as well as role or specialty competencies.

1. **Mapping the DNP Curriculum:** Mapping the *Essentials* Level 2 sub-competencies ensures they are integrated across the curriculum and transparent to students. Mapping student learning objectives to expected outcomes is an important strategy for DNP programs. Using an electronic student portfolio or digital platform is one effective tool for tracking individual and aggregate student progress and can serve as an excellent mechanism for documenting program outcomes, including competency attainment, for accreditation reporting. The student’s demonstrated achievement of program outcomes provides evidence that the curricular design and teaching/learning experiences support

the student's attainment of the expected advanced-level competencies and readiness to practice as a new DNP-prepared nurse.

2. **Guidelines for Length of Program:** Based on past experiences and more traditional educational metrics, a post-baccalaureate full-time program of study should be 3 years including summers or 4 years on a traditional academic calendar. For a post-master's program of study, a *minimum* of 12 months of full-time study is needed to acquire Level 2 and specialty/role doctoral-level outcomes and completion of the DNP Project. AACN recognizes that policies of institutional, state, and various accrediting bodies can dictate minimum or maximum length and/or credit hours needed to award specific academic degrees. These guidelines for length of program may change as the transition to competency-based education (CBE) evolves considering that some students may require more or less time to attain and demonstrate the expected *Essentials* competencies as well as the advanced-level role or specialty competencies.
3. **Efficiency:** To maintain high quality outcomes and effective use of resources, programs and curricula should be designed with attention to efficiency. In addition to the project team described above, other resources may be needed to support DNP quality program outcomes and ultimately achieve efficiencies. (See Appendix B for examples of Program Efficiency.)
4. **New Models:** Consider new models and processes for implementing DNP Project teams that provide efficient use of resources and support student learning. Maximizing faculty and other resources by cohorts of students produces enhanced learning as well as efficiencies. Adopt a process that allows for oversight and evaluation of DNP Projects to ensure quality and equity of resources. For example, using a standing proposal review committee to review and approve all DNP Project proposals ensures that the proposed project meets expected requirements, scope, and focus. (See Appendix B.)
5. **Academic–Practice Partnerships:** Strong academic–practice partnerships are critical for successful implementation of CBE as well as the production of nurses prepared to practice in any advanced area of nursing. Strong partnerships also promote sharing expertise and resources, which produces more efficient, quality outcomes. Examples of such partnerships can be accessed in the AACN/AONL Academic–Practice Partnership Playbook (2025).
6. **Faculty Development:** It is important to ensure quality student learning outcomes and efficient use of resources. Areas for faculty development include, but are not limited to:
 - a. Curricular design of competency-based DNP programs
 - b. Development of new, innovative learning strategies, particularly methodologies for hybrid and distance education, including instructional design, development of course objectives, guiding and facilitating student learning, and assessment of student learning and attainment of competencies.
 - c. Development of innovative, new practice opportunities and partnerships to support achievement of learning outcomes

- d. Strategies to support and evaluate the DNP Project
 - e. Implementation of quality improvement processes. (To further address faculty development in the use of quality improvement methods, see Appendix C on Faculty Development.)
 - f. Interprofessional education and practice
7. **Preparation for the Nurse Educator Role:** Nurse educators are critical to sustaining pathways into nursing and the workforce. Graduates of practice-focused doctoral programs have expertise and preparation for the highest level of nursing practice. DNP graduates are eligible to teach at the collegiate level because they have a terminal degree in the discipline of nursing.
- a. However, consistent with expectations for graduates of research-focused doctoral programs, it is recommended that graduates of practice-focused nursing programs who aspire to hold a faculty position or teach, have additional preparation in the educator role and pedagogies **in addition to preparation in an area of advanced nursing practice** (AACN, 2004; AACN, 2017). The discipline of education encompasses an entirely separate body of knowledge and competence (AACN, 2004, p. 13) and is a component *of* but not an advanced nursing role or specialty.
 - b. Additional preparation in the nurse educator role may be included as optional coursework within the DNP program or in a separate certificate program.

V. Practice Experiences, Practice Hours, and Immersion Experience

Advanced-level nursing education programs provide varied experiential (practice) learning opportunities (both direct and indirect care experiences) to prepare graduates with *Essentials* Level 2 sub-competencies as well as nationally recognized, applicable advanced nursing practice specialty/role competencies and requirements. DNP practice experiences build on Level 1 sub-competency achievement and are designed to assist the graduate to achieve Level 2 sub-competencies and applicable specialty competencies upon completion of the program. Practice experiences are required to integrate didactic learning, promote innovative thinking, and provide multiple increasingly complex practice opportunities to demonstrate attainment and integration of these competencies into one's practice. Therefore, the development of new skills and practice expectations can be facilitated through use of creative learning opportunities in diverse settings. All graduates of advanced-level nursing education programs have structured, faculty-designed practice experiences, which may include precepted or mentored experiences with faculty oversight and/or experiences with direct faculty supervision. The program is responsible for providing sufficient and appropriate clinical sites/placements as well as other practice settings for students to demonstrate attainment of Level 2 sub-competencies and applicable specialty competencies.

Practice Experiences

All learners in advanced nursing programs need to engage in practice learning activities (both direct and indirect care experiences) to demonstrate all Level 2 sub-competencies as well as competencies required by applicable national organizations for advanced nursing specialty or role certification. Programs need to document and provide clear evidence of competency

achievement. In addition, some but not all practice learning experiences may be accomplished through diverse methodologies, including simulation and virtual technology, and assist the graduate to develop greater proficiency in these competencies, including cognitive, psychomotor, and affective competencies. The use of simulation should align with specialty requirements.

The specific clinical experiences and number of practice hours and/or credit hours required depends on the 2026 *Essentials* expectations, advanced nursing practice specialty or advanced nursing practice role requirements, and regulatory standards for specialty certifications and licensure. Therefore, the program must include adequate experiences (in terms of time, diversity, depth, and breadth) to allow demonstration of all relevant competencies and successful transition to practice through program outcomes. The number of in-person practice hours will vary based on student needs and curriculum design. Participation in a *minimum* of 500 practice hours in the discipline of nursing, post-entry-level education, and attainment of Level 1 sub-competencies is required to demonstrate *Essentials* Level 2 sub-competencies. Some students may require more. These practice hours also provide a foundation for the time-based requirements set by specialty organizations or external licensing/certifying bodies. Hours of practice do not need to be delineated by competency type (*Essentials* or specialty/role). Some Level 2 sub-competencies and specialty/role competencies may be demonstrated and assessed concurrently. It is expected that faculty will create practice learning experiences that provide for active learning, repetition, interprofessional engagement, and increasing levels of difficulty. As the strength of evidence supporting valid and reliable assessment techniques evolves, the need for designated practice experiences and number of hours (e.g., time-based requirements) may change.

Practice experiences for the DNP student should include both direct and indirect patient care and practice in healthcare settings or related environments that broaden the experiences of the student and provide opportunities to demonstrate the *Essentials* Level 2 sub-competencies. Both direct and indirect care experiences are needed by *all* DNP students. The definition of direct care is a professional encounter between a nurse and an actual individual or family, either face-to-face or virtual, that is intended to achieve specific health goals or selected health outcomes. Indirect care refers to nursing decisions, actions, or interventions that are provided through or on behalf of individuals, families, or groups. These decisions or interventions create the conditions under which nursing care or self-care may occur (AACN, 2026, p. 62). Examples of direct and indirect care experiences for DNP students can be found in Appendix D.

Opportunities for inter- and intraprofessional collaboration, between DNP and PhD nursing students as well as between DNP students and other health professions' students, are important to prepare the graduate with leadership, communication, and team practice capabilities that are critical to advanced nursing practice. There is potential for DNP students to work with students in other fields such as engineering, public health, healthcare administration, and business. Documenting and disseminating these experiences will provide a rich resource of outcomes and exemplars for the discipline.

DNP program practice experiences are designed to provide:

- Systematic opportunities for feedback and reflection
- In-depth work/mentorship with experts in nursing as well as other disciplines
- Meaningful student engagement within practice environments

- Opportunities for building and assimilating knowledge for advanced nursing practice at a high level of complexity
- Further application, synthesis, and expansion of learning
- Experience in the context of advanced nursing practice within which the DNP Project is completed
- Opportunities for integrating and synthesizing all advanced role and specialty competencies

Immersion Practicum Experiences

Development of competency attainment is facilitated through use of focused and sustained practice experiences. Immersion experiences, expected in all advanced nursing education programs, are designed with a greater number of hours for practice in one or a limited number of related settings/environments. Immersion practice hours may be part of the minimum 500 practice hours expected in the AACN *Essentials* for DNP programs. Some advanced specialty or role practice requirements may require additional practice hours but these may include the immersion experience. The immersion experience provides the learner with the opportunity to integrate the advanced level sub-competencies and applicable specialty or role competencies. An immersion also provides an opportunity for the learner to focus on a population of interest, advanced nursing role, or specialty area of study. Placement of integrated or immersion experiences within the curriculum may vary and depend upon the program's design and specialty requirements.

DNP programs prepare graduates for the highest level of nursing practice and demonstrate synthesis and application of the *Essentials* advanced level sub-competencies as well as nationally recognized role or specialty competencies for the student's area of study.

Faculty are responsible for assessing students' learning needs and designing practice experiences that allow students to attain and demonstrate advanced-level competency as well as integrate these *Essentials* outcomes into one's practice.

Practice immersion experiences afford the opportunity to apply, integrate, and synthesize the *Essentials* necessary to demonstrate achievement of desired outcomes in an area of advanced nursing practice.

1. Practice Hours

The *Essentials* outline that all DNP students are expected to complete a minimum of 500 post-baccalaureate practice hours as part of an academic program. Variability in the ways practice hours are defined, awarded, and designed by DNP programs currently exists, particularly for post-master's DNP programs. To provide clarification and guidance to programs, expectations include the following:

- a. Programs must validate that graduates have demonstrated all the *Essentials* competencies at an advanced level of practice, demonstrated by the Level 2 sub-competencies. All students must complete sufficient time in supervised practice hours to integrate and demonstrate the Level 2 sub-competencies as well as the appropriate role and specialty competencies. This expectation applies to *all* DNP

students, including those focusing on organizational and executive leadership, health policy, and all direct care roles. (See the definition for practice hours that are designated direct or indirect practice.)

- b. Students who have completed more than 500 practice hours in their master's program will need to complete additional hours in the DNP program to demonstrate the expected competencies and sub-competencies as well as the ability to integrate their new learning into the role or specialty practice. *Hours spent in the practice environment related to the DNP Project may be counted.*
- c. Practice hours spent in graduate, advanced-level nursing programs (master's or DNP) can be counted as post-baccalaureate or post-entry into professional nursing practice hours, provided they can be verified. Practice hours spent in a program preparing graduates for entry into professional nursing practice only (i.e., BSN, RN-BSN, or entry/generic master's) would not be included. Verification of hours can be completed in various ways, including forms sent to the student's master's degree program, transcript review, and documentation of national certification requiring academically supervised practicum hours. Faculty are responsible for validating the practice experiences in previous academic programs are relevant and appropriate for developing competencies in the student's advanced area of nursing practice.
- d. DNP students may be employed in settings or positions that appear to overlap with some of the outcomes delineated in the *Essentials*. Other DNP students may have the opportunity to engage in learning experiences in an area or setting in which they are employed. Practice experiences in the DNP program should have well defined learning objectives and provide experiences over and above the individual's job responsibilities or activities. The DNP student must also have the opportunity to gain knowledge and skills beyond employment expectations and incorporate these into their advanced nursing practice.
- e. To provide some additional clarity and flexibility, schools may credit practice hours to a post-master's DNP student who holds current national certification:
 - 1. In an area of advanced nursing practice, as defined in the 2026 *Essentials*; and
 - 2. Requires a minimum of a graduate degree.
 - 3. Cannot credit/waive all required practice hours even if more than the required number. Practice hours, if waived, must be validated by faculty as relevant to the student's current degree program and area of study.
 - 4. All DNP students, in post-baccalaureate, post-master's, and certificate programs must have practice experiences that provide the opportunity to demonstrate *Essentials* Level 2 sub-competencies and specialty/role doctoral-level competencies. (See examples Appendix D p. 26-27 for types of direct and indirect care experiences for graduates preparing for diverse roles including administration, policy, public health, or APRN roles.)

- f. Faculty-supervised practice hours should be spent achieving and demonstrating the *Essentials* Level 2 sub-competencies as well as doctoral-level specialty/role competencies. Programs must demonstrate or validate how graduates meet the *Essentials* requirements, in addition to including an area of preparation in advanced nursing practice.
- g. If a student is seeking a degree and national certification in an area of advanced nursing practice different from their previous area of practice – for example, a pediatric primary care nurse practitioner entering a certified registered nurse anesthetist track or a public health nurse seeking to become a psych/mental health nurse practitioner – the student must complete all didactic and clinical course work required to be eligible for certification in that role in addition to preparation with the *Essentials* Level 2 sub-competencies.
- h. Practice as a nurse educator may be included in the DNP program but should not substitute for the minimum 500 practice hours to demonstrate the Level 2 sub-competencies or the advanced nursing specialty/role competencies. The focus of a DNP program, including practicum and DNP Project, should not be on the educational process, academic curriculum, or educating nursing students.

In summary, all post-master's students, regardless of education and experience, must have faculty-supervised practice hours (both direct and indirect) in the DNP program that provide the opportunity for the student to integrate all *Essentials* Level 2 sub-competencies as well as the doctoral level competencies for an identified advanced nursing specialty or role.

Collaborative Partnerships

Academic–practice partnerships are critical to establish and sustain progressive nursing education and practice. Programs should follow the Academic–Practice Partnership guiding principles developed jointly by AACN and the American Organization for Nursing Leadership (2025). The guidelines offer a systems approach as most appropriate to develop a collaborative relationship that can create or support these educational and practice experiences. The rapid changes in healthcare practice and environment make strong partnerships between academia and practice even more imperative. Partnerships provide more efficient sharing of resources and expertise by both academia and practice.

Programs are encouraged to consider a broad range of academic–practice partnerships, e.g., with school systems, prison systems, and public health departments, that afford students the opportunity to engage in the full planning, implementation, and evaluation of a project that impacts healthcare outcomes. Academic and practice partners are encouraged to collect outcome data to demonstrate the added value that DNP graduates bring to healthcare. (See examples of lessons learned and successful models in the AACN/AONL Academic-Practice Partnership Playbook.)

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Glossary

Advanced nursing practice: Any form of nursing intervention that influences healthcare outcomes for individuals or populations, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and healthcare organizations, and the development and implementation of health policy (AACN, 2004).

Advanced Practice Registered Nurse (APRN): The title given to a nurse who has met education and certification requirements and obtained a license to practice in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP) (APRN Consensus Model, 2008).

Collaboration: When multiple health workers from different professional backgrounds work together with patients, families, caregivers, and communities to deliver the highest quality of care (WHO, 2010).

Competence: The array of abilities across multiple domains or aspects of performance in a certain context. Statements about competence require descriptive qualifiers to define the relevant abilities, context, and stages of training. Competence is multidimensional and dynamic. It changes with time, experience, and setting (Frank & Snell, 2010, p. 641).

Competency: An observable ability of a health professional, integrating multiple components such as knowledge, skills, values, and attitudes. Because competencies are observable, they can be measured and assessed to ensure their acquisition. Competencies can be assembled like building blocks to facilitate progressive development (Frank & Snell, 2010, p. 641).

Direct care: Refers to nursing care provided to individuals or families that is intended to achieve specific health goals or achieve selected health outcomes. Direct care may be provided in a wide range of settings, including acute and critical care, long-term care, home health, community-based settings, and educational settings (AACN, 2024; Suby, 2009; Upenieks et al., 2007).

Education outcomes: Indicators of achievement that may be quantitative or qualitative, broad or detailed (Commission on Collegiate Nursing Education, 2024).

- Student outcomes: Statements, including those focused on learning, explicitly describing the characteristics or attributes attained by students as a result of program activities.
- Faculty outcomes: Statements explicitly describing the achievements attained by faculty as part of their participation in the program.
- Program outcomes: Statements of levels of achievement, which encompass student achievement, faculty achievement, and other program-selected indicators of achievement. Program outcomes may be expressed in the form of overall program goals, end-of-program outcomes, curricular outcomes, and/or faculty outcomes.
- Expected outcomes: Statements of desired and predetermined levels of student, faculty, and program achievement.
- Actual outcomes: Results describing real student, faculty, and program achievement.

Evidence-based practice: The integration of best research evidence, clinical research, and patient values in making decisions about the care of individual patients (IOM, 2003).

Healthcare outcomes: The end result of healthcare practices. There are many kinds of outcomes. How long people live following a healthcare treatment is one kind of outcome, known as survival. Other outcomes measure the effects a treatment has on people's lives, such as changes in their ability to function or changes in their quality of life. Outcomes also include undesirable events such as side effects of drugs. Another type of outcome is whether people needed to change to another kind of treatment (AHRQ, 2015).

Immersion: Practice experiences with a substantive number of hours in a consistent practice setting over a concentrated period of time (AACN, 2008, p. 37).

Implementation science: The study of methods to promote the integration of research findings and evidence into healthcare policy and practice (NIH, 2015).

Indirect care: Indirect care refers to nursing decisions, actions, or interventions that are provided through or on behalf of individuals, families, or groups. These decisions or interventions create the conditions under which nursing care or self-care may occur. Nurses might use administrative decisions, population or aggregate health planning, or policy development to affect health outcomes in this way. Nurses who function in administrative capacities are responsible for direct care provided by other nurses. Their administrative decisions create the conditions under which direct care is provided. Public health nurses organize care for populations or aggregates to create the conditions under which care and improved health outcomes are more likely. Health policies create broad scale conditions for delivery of nursing and healthcare (AACN, 2024; Suby, 2009; Upenieks et al., 2007).

Informatics: The use of information and technology to communicate, manage knowledge, mitigate error, and support decision-making.

Interprofessional collaborative practice: When multiple health workers from different practice professional backgrounds work together with patients, families, caregivers or caretaker, and communities to deliver the highest quality of care across settings (IPEC, 2023).

Interprofessional education: Involves shared learning experiences among health profession students across disciplines, with the goals of building strong clinical teams and improving health outcomes (World Health Organization, 2015).

Macro-, Meso-, and Microsystems: The health system is composed of basic parts – frontline clinical microsystems, mesosystems, and overarching macrosystems. At the *macrosystem* level senior leaders are responsible for organization-wide performance. Within the *mesosystem*, midlevel leaders are responsible for large clinical programs, clinical support services, and administrative services. Clinical microsystems are the small, functional frontline units that provide most healthcare to most people. They are the building blocks of larger organizations and of the health system. They are the place where patients, families, and care teams intersect or meet (Nelson et al., 2007).

Population health: Inclusive of aggregates, community, and/or clinical populations that consider the environmental, occupational, cultural, socioeconomic, and other dimensions of health (Allan et al., 2004), and derives evidence from population-level data and statistics (Starfield et al., 2008).

Practice experiences: Planned learning activities in nursing practice that allow students to understand, perform, and refine professional competencies at the appropriate program level. Practice experiences may be known as clinical learning opportunities, clinical practice, clinical strategies, clinical activities, experiential learning strategies, or practice (Commission on Collegiate Nursing Education, 2013). Practice experiences can be direct or indirect care experiences (defined below).

Direct Care/Indirect Care

- Direct care refers to a professional encounter between a nurse and an actual individual or family, either face to face or virtual, that is intended to achieve specific health goals or achieve selected health outcomes. Direct care may be provided in a wide range of settings, including acute and critical care, long-term care, home health, community-based settings, and telehealth (AACN, 2004; Suby, 2009; Upenieks et al., 2007).
- Indirect care refers to nursing decisions, actions, or interventions that are provided through or on behalf of individuals, families, or groups. These decisions or interventions create the conditions under which nursing care or selfcare may occur. Nurses might use administrative decisions, population or aggregate health planning, or policy development to affect health outcomes in this way. Nurses who function in administrative capacities are responsible for direct care provided by other nurses. Their administrative decisions create the conditions under which direct care is provided. Public health nurses organize care for populations or aggregates to create the conditions under which improved health outcomes are more likely to occur. Health policies create broad scale conditions for delivery of nursing and healthcare (AACN, 2004; Suby, 2009; Upenieks et al., 2007).

Public health: Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention, and detection and control of infectious diseases (CDC, 2015).

Quality improvement: In healthcare, quality improvement (QI) refers to routinely giving the right patients the right care at the right time and in the right place of service. Typically, QI efforts are strongly rooted in evidence-based procedures and rely extensively on data collected about processes, outcomes, and infrastructure (Ogrinc et al., 2013).

Quality improvement in public health: The use of a deliberate and defined improvement process, such as a four-step model Plan-Do-Check-Act, which is focused on activities that are responsive to community needs for carrying out change in public health practice and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community (American Public Health Association, 2026).

Research: A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities (Department of Health and Human Services, 2015).

Simulation: An attempt to mimic essential aspects of a clinical situation with the goal of understanding and managing the situation better when it occurs in actual clinical practice. A technique that uses a situation or environment created to allow persons to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions (NLN, 2026). Simulation scenarios represent a continuum and can include an activity or event replicating clinical practice using high fidelity manikins, medium-fidelity manikins, standardized patients, role playing, skills stations, and computer-based critical thinking simulations (Hayden et al., 2009).

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APPENDICES

- A. Dissemination of DNP Project Examples
- B. Examples of Program Efficiencies
- C. Faculty Development
- D. Description and Examples of DNP Practice and Projects
- E. Academic-Practice Partnership Guidelines for DNP Programs

Appendix A: Dissemination of DNP Project Examples

- Publishing in a peer-reviewed print or online journal (individual faculty or a faculty committee/team should carefully evaluate any manuscript for publication probability and select those appropriate for submission. Requiring all students to publish in a peer-reviewed journal should not be an expectation and poses a tremendous burden on editors if the papers are not ready and of high quality for publication).
- Poster and podium presentations.
- Presentation of a written or verbal executive summary to stakeholders and/or the practice site/organization leadership.
- Development of a webinar presentation or video, e.g., for YouTube or other public site.
- Submission and publication to a non-refereed lay publication.
- Oral presentation to the public-at-large.
- Development and presentation of a digital poster, a grand rounds presentation, and/or a PowerPoint presentation. Providing financial and production resources to assist students is recommended.
- A student's portfolio is not considered a DNP Project or a form of dissemination but rather a tool to document and evaluate professional development and learning. A minimum of an executive summary or a written report that is disseminated or shared beyond the academic setting is recommended for dissemination of the DNP Project outcomes.

Appendix B: Examples of Program Efficiencies

- Resources could be made available to a cohort of students (students whose project focus or phase of the project are similar) and may be provided in groups, online, or through collaboration with other departments to promote effective and efficient use of resources.
- Collaboration with other departments; for example, pre-requisites or some courses may be taken from a partnering university or department to reduce the need for faculty resources and to encourage interprofessional course work.
- Guiding groups or cohorts of students through the DNP Project via classroom or online learning through a series of courses/seminars integrated throughout the curriculum that allows for faculty efficiency and for students to support and learn from one another. Peer interaction could enhance learning through activities such as collating and synthesizing evidence, discussing issues regarding project implementation, team communication, access to or gathering data, and outcome evaluation methods.

- Providing scholarly writing support, individually or in groups; sharing resources with other institutional departments when available.
- Faculty advisement done with groups or cohorts of students to create efficient use of faculty time and maximize peer learning.
- Developing a DNP student toolkit with information regarding such topics as requirements, available resources, timelines, scholarly writing, and publishing guidelines.
- Providing statistician support for faculty and students to assist the student to understand the methods needed to evaluate and present project outcomes. This support may most effectively be provided for groups of students.
- Using online modules to accompany courses. External or practice experts can assist with creation of modules.
- Sharing courses with other university departments such as informatics, epidemiology, and business.
- Inviting faculty with particular expertise from other schools of nursing or other schools in a university to present in person or online and serve as the lead on particular topics in online discussions.
- Enlist the expertise of the nurse executives and expert practice partners in teaching in the DNP program and in providing guidance/oversight along with faculty for DNP Projects.
- Enroll DNP and PhD students in course work together as an opportunity to examine overlap between roles as well as differentiation; for example: Health Policy and Advocacy, Epidemiology, Ethics, Scientific Underpinnings, Biostatistics, and Leadership.
- Intraprofessional nursing projects with faculty/student collaboration.
- International health project with collaboration of DNP and PhD students.
- Co-curricular opportunities for working together such as participating in an IHI Open School to implement patient safety initiatives via interprofessional teams.

Appendix C: Faculty Development Resources

Interprofessional Education

Interprofessional Education Collaborative. (2023). *Core Competencies for Interprofessional Collaborative Practice: Version 3*. https://www.ipecollaborative.org/assets/core-competencies/IPEC_Core_Competencies_Version_3_2023.pdf

TeamSTEPPS, Agency for Healthcare Research and Quality: <http://teamstepps.ahrq.gov>

National Center for Interprofessional Practice and Education: <https://nexusipe.org>

Quality Improvement

Agency for Healthcare Research and Quality: <http://www.ahrq.gov/clinic/epcix.htm>

Baldrige National Quality Program. Criteria for Performance Excellence: <http://www.nist.gov/baldrige/>

Clinical Microsystems and Quality Improvement from Dartmouth Institute for Health Policy and Clinical Practice: <http://dms.dartmouth.edu/cms>

Institute of Medicine: Crossing the Quality Chasm: A New Health System for the 21st Century: <https://www.ncbi.nlm.nih.gov/books/NBK222274/>

Lean Six Sigma in the Healthcare Sector: <https://pmc.ncbi.nlm.nih.gov/articles/PMC8820448>

National Quality Forum (NQF): <https://www.qualityforum.org/en-us>

Plan-Do-Study-Act (PDSA) Worksheet, Institute for Healthcare Improvement: <http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>

Quality and Safety Education for Nurses (QSEN) bibliography and teaching strategies around the following topics: Patient-Centered Care, Teamwork and Collaboration, Evidence-Based Practice, Quality Improvement, Safety, and Informatics: <https://www.qsen.org/post/resources>

Rapid Cycle Testing, Institute for Healthcare Improvement: <http://www.ihl.org/about/pages/innovationscontributions.aspx>

Simulation

INACSL. (2025). Healthcare Simulation *Standards of Best Practice*: [https://www.nursingsimulation.org/article/S1876-1399\(21\)00093-1/fulltext](https://www.nursingsimulation.org/article/S1876-1399(21)00093-1/fulltext)

Simulation Innovation Resource Center: <http://nln.org/education/education/sirc/sirc/sirc>

Appendix D: Examples of Settings for DNP Practice and Projects

The following are examples of settings, areas of practice, and final projects that could be considered to provide a broader array of opportunities particularly in geographic areas with limited access to traditional practice sites. Each of these examples includes opportunities for both direct and indirect care experiences and should include interviews or contact with patients, families, groups, or community members. A project developed in any of these settings or areas of practice delineated here should include designing, planning, initial or full implementation, and evaluation.

- **Organizational Systems Leadership:** Work with the Director of the Red Cross exploring ways to improve disaster preparedness; Work with a director of system IT exploring the preparedness strategies to prevent an IT shutdown and strategies for communication and charting to continue during a shutdown, or focus on the nursing leadership role in leading IT design and implementation issues; Work with the System Safety Office evaluating the disaster plan incorporating national best practices and making recommendations for quality improvement of the system plan.

- **Population Health:** Partner with community organizations that affect the health of high-risk populations to address screening or health education processes, financial challenges (including how to raise money and manage money), volunteerism, and interactions/collaborative opportunities with the healthcare system. Examples of community agencies include: Habitat for Humanity, food pantries, Catholic Charities, homeless shelters, Salvation Army, and Hope Center. Other opportunities might include collaboration with private sector companies to design healthcare facilities, or design and implement wellness/health programs in conjunction with business such as the airline or auto industry.
- **Policy Projects:** Evaluate evidence to develop a policy to reduce major events that trigger an ED visit, e.g. by notifying a provider that a fall has occurred, document evidence of need for the policy change; Evaluate geriatric trauma screening for triage; make a recommendation leadership regarding implementation for policy change to revise criteria.
- **Long-Term Care Facilities:** Evaluate and implement a quality improvement program within a long-term care facility, e.g., Evercare or a Medicare Advantage plan, to improve antibiotic selection for symptomatic UTIs in older adults without indwelling catheters and to decrease the inappropriate use of nitrofurantoin. Implement a policy and care practice for antibiotic selection guided by the Infections Disease Society of America guidelines for treatment of UTIs.
- **Urgent Care:** Focus on achieving the national benchmark of urgent care visit times lasting less than 60 minutes, identifying and mitigating impediments to efficient patient flow at a Family Medicine Center Walk-in Clinic. Implement a quality improvement project to identify measure and rectify bottlenecks impacting patient flow through the clinic while tracking total visit times.
- **Prison Systems:** Explore the effectiveness of chronic disease management models and mental health services among the aging population in prison systems. Focus on the institution of mental health screening and care models to be integrated into the prison system of care.
- **School Systems:** Evaluate *Tobacco Free Teens* program as a mobile device application, introduce the mobile application in a middle school classroom and evaluate the adolescents' satisfaction with the tool; other areas of focus may include evaluating immunizations, weight loss, and healthy eating.
- **Community-based Care Network:** Implement a quality improvement project developed to address the gaps in APRN practice and evaluate the impact of a competency-based training program on the translation of evidence in the APRNs' practice. Specific projects may include:
 - Increase documentation of didactic training and skills validation for transvaginal ultrasounds and endometrial biopsy from 0% to 90%.
 - Increase the number of APRNs who perform transvaginal cervical length measurement in the assessment of symptomatic preterm labor patients from less than 40% to 75%.
 - Decrease the number of fetal fibronectin studies run without a corresponding cervical length measurement by 20%.
 - Decrease the number of inadequate endometrial samples from the current 25% to less than 10% by X date.
 - Increase the percent of endometrial biopsies being done by APRNs in the region to greater than 50%.
- **Rural Native American Reservation:** Form a working group with health department personnel to discuss and address the issues of health literacy and cultural sensitivity; Develop a

case management model for more complex patients that includes the development of a cost-sharing plan that proposes utilizing social workers from the senior center to coordinate this service and proposes to the community council the need to add a professional nurse FTE position to the clinic to help coordinate the effort of the social workers in ensuring regular follow up of patients; implement the use of community health workers as a means of further engaging the community and as a means of increasing follow-up visits.

- **Public Health Department:** Collaborate with state government units to improve access to health care, negotiating tribal governance, gender issues, language, and culture in a population by training lay health promoters e.g. to improve the diet and access to fresh foods or providing zinc supplementation to the under age 5 population in Guatemala.
- **Non-governmental Organizations and Community Health Organizations:** Collaborate with in country NGOs to decrease stigmatization and increase screening for breast cancer in Zambia; or collaborate with the American Heart Association or other organization to improve outcomes in the community.
- **Corporations:** Focus on decreasing the percentage of employees in a manufacturing plant with a BMI in the obese or overweight category by changing cafeteria food options, educational initiatives, and a voluntary, employer-based, 16-week wellness program.

Appendix E: Academic-Practice Partnership Guidelines

To substantially and sustainably contribute to the improvement of DNP program implementation, recommendations include:

- Performing a baseline measurement/description of existing successful academic-practice partnerships, existing programs, and interprofessional educational processes.
- Including national quality strategy and Triple Aim to focus initial partnership and interprofessional collaboration efforts.
- Increasing nursing school awareness of the evidence and value for interprofessional collaborative education and practice.
- Spreading collaborative relationship best practices to DNP programs using learning communities and toolkits.
- Stimulating a faculty desire to collaborate and integrate partners through resource allocation.
- Increasing existing faculty knowledge of existing/preferred partnership and translational research frameworks and models.
- Developing existing academic faculty's interprofessional communication competencies to initiate, facilitate, and sustain community partnerships.
- Reinforcing systematic progress in the direction of Academic-Practice Partnerships and interprofessional education by establishing DNP program quality improvement indicators and reporting.

See *The AACN/AONL Academic-Practice Partnership Playbook: From Shared Vision to Action*
<https://www.aacnnursing.org/Portals/0/PDFs/Academic-Practice-Partnerships/AACN-AONL-Academic-Practice-Partnership-Playbook.pdf>