2021 NCSBN APRN Roundtable- The Re-envisioned AACN Essentials Video Transcript

Event
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Presenter
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- [Joan] Hello, everyone, and greetings. I'm Joan Stanley, chief academic officer at the American Association of Colleges of Nursing. And I want to thank the National Council, particularly, Michelle Buck, for inviting me to share some of the work about the re-envisioning the AACN Essentials.

I have no conflict of interest to disclose, except for the amount of time over the last two and a half years that we have spent working on this and probably long before that with a lot of the planning and the thinking. So thank you for being here. I want to give credit and introduce our Essentials Task Force Leadership Team, who have done much of the heavy lifting and have been instrumental in moving this work forward.

We have three co-chairs, Dr. Jean Giddens, who is dean at Virginia Commonwealth University, Dr. John McFadden, who is at Barry University, and we have Dr. Cynthia McCurren, who's now at the University of Michigan-Flint.

We also have three consultants, Dr. Nancy DeBasio, Dr. Jean Bartels, and Dr. Linda Caldwell, all of whom you may know from their past work both in education, accreditation, and leadership. We also have our board liaison, Dr. Lin Zhan, and, of course, three staff liaisons, myself, Rick Garcia, and Kathy McGuinn.

We also have a fantastic task force. Our members come from all different types of schools, from different geographic regions, different backgrounds in expertise. So we want to thank them for all the work that they've put into making this possible. So what am I going to focus on in today's presentation?

I'm not sure how many of you have been and how closely you've been following this work. So I'm going to provide a brief overview and an update on the re-envisioned Essentials and where we are now. I'm going to talk a little bit about the new model for nursing education, and its impact, and the expectations

for APRN education, and I'm going to talk briefly about the transition to competency-based education, which is one of the key components of this work.

However, that could be a presentation in and of itself. But I will touch the highlights and give you some ideas about our expectations for moving forward. And then also, I will talk about the implementation and what's next. So, just for background, I'm sure you are all, particularly if you're in education, you are familiar with the three Essentials, current three Essentials documents that we have, one for baccalaureate, one for master's, and one for DNP education.

These documents have provided and continue to provide the guidance for the development and revision of the nursing curricula at each degree level. Also, foundational to the work of our task force is we relied heavily on several previous initiatives that AACN has led.

One was our "Futures Task Force Report" that came out in 2015. So you can see how far back some of these discussions and work started. Also, the "Common APRN Doctoral-Level Competencies" that were published in 2017, and many of you were part of that work. And if not, your organizations were represented in that work that developed those common doctoral-level competencies.

And that was our first initiative to move to competency-based education. And then finally, AACN's "Vision for Academic Nursing Education" which was published in 2019, really provided the groundwork for the work that was charged to this task force. On the task force, and I forgot to mention that we do have 25 practice partners, which have been instrumental in partnering with our work.

They are an active members of the task force and have really brought a very important perspective to this work. We had messages from the very beginning from our practice partners. Here's one example of a message from Susan Mullaney, many of you know. She's Senior Director for the Center for Clinician Advancement at UnitedHealth Group.

One of the comments was there is such inconsistency among our graduates across all degree levels in terms of knowledge, skills, and abilities. And there is variability in the length and expectations of programs, and we just don't know what your product is. If you get a graduate from one school, it's very different from a graduate in another.

And not just based on their experiences but really, what's expected of them as they graduate. We all know, and we knew this before, but I think through our work, it became even more evident that what we have in nursing education, we have a number of issues, and some of it gets pretty messy and confusing.

There are multiple degree paths. We have variability in program length, scope, and expectations. There's variability in quality of programs and the graduates. There is an inability to articulate what is uniquely the discipline of nursing. Now, this is some data that we pulled from our 2020 IDS database at AACN, just to kind of give you a picture of what we're talking about, some of the messiness.

And you can see on this that there are four different pathways listed for getting a baccalaureate degree, there are four for a master's degree, and there are four for a doctoral degree. We also have the number of programs there. And we have noticed some trends in some of these numbers, which really, as far as the

post-baccalaureate DNP programs are trending up, the entry-level master's have continued to trend up, and actually, the RN to baccalaureate have dropped down a little bit.

And we believe that this is because a lot of those programs have been in existence and we're actually reaching our goal of partnering, and leading, and having individuals prepared at the entry-level more and more at the baccalaureate level or going seamlessly from associate degree to the baccalaureate level. But this is just to show you, and this doesn't even include all of the little nuances and different kinds of programs that many schools have created, let's say from an entry all the way up to a DNP.

So the new framework we're proposing has 10 domains with competencies under each domain and sub-competencies under the competencies at 2 levels. Now, domains are broad, distinguishable areas of competence that, in the whole, constitute a general descriptive framework for the profession or the practice of nursing.

So these are the 10 domains that we have now in our final document. For those of you who worked on the APRN common level doctoral competencies, you may remember that we had eight domains, that we were using an interprofessional framework. What we discovered as we began to work on the new Essentials, because we started with those 8 domains, were that, one, they had been created over 10 years ago, so they were somewhat outdated based on what was happening in the current healthcare environment.

Also, they did not uniquely share what we felt was nursing practice. And therefore, we did add a few domains and we modified the titles of some of them. But these are the 10 domains that we currently have in the document. There are also eight concepts.

And concepts are not any less important. In fact, many ways, they are more important than the 10 domains. But they are not as definitive and defined areas of practice. Rather, they are threaded through crossed and throughout all the domains. Now, you won't find every concept in every domain, but you will find them in multiple domains and you will also find multiple concepts in every domain.

So this, if you haven't looked at our document, this is what the document is and the way it's framed. We have the 10 domains for each domain, and this happens to be domain 5, quality and safety, I'm using for an example. But under each one, we have a descriptor that describes and defines what that domain is.

Also, not shown on the screen because of the size is we have a contextual statement that provides a little more context, and meaning, and description around what we expect that domain to encompass, and when we talk about the competencies, the context in which they should be taught, and learned, and demonstrated. So we have competencies under each domain.

Each domain may have anywhere from three competencies up to, I believe the most is about eight. And then under each competency, now, competencies cross all levels of professional nursing education from entry into professional nursing practice, on up to advanced nursing practice. And under each competency then, we have two levels of sub-competencies.

And just also to point out that these competencies, there is not necessarily a competency at the entry level and a matching competency at the advanced level. They don't, as we say, bloom up. But rather, the

advanced nursing education competencies build on the sub-competencies for entry into professional practice.

And we assume that an individual has attained the level 1 before they move on, or at least while they're moving on to the advanced level, they continue to demonstrate the level 1 competencies. So this is the model. Many of you saw a version 2 or 3 iterations ago if you came to our regional meetings or if you attended the national faculty meetings, either the first one or the second one, at your institution.

We have attempted to clarify it and we think that this does express what we want the intended of this new Essentials model. There are two levels, one for entry-level professional nursing education. The level 1 competencies and sub-competencies are used by all programs preparing a nurse for initial professional nursing degree.

This could be an initial licensure and/or progression to their first professional nursing degree. Level 2 are the advanced-level nursing education sub-competencies. And these programs are…these competencies are used to prepare a nurse for advanced specialty nursing practice or an advanced practice nursing role.

Now, a key component of level 2 is that all programs preparing individuals at the advanced level, no matter what the degree level, will also have and include requirements for a national advanced nursing specialty and/or the role. So the specialty requirements and competencies are a key component of level 2 or advanced nursing education programs, in addition to these essential sub-competencies.

So, where are we now with the revision and the final document that has gone forward? Let me share a little bit about the feedback and the steps that we have taken to reach consensus around this final document. Many of you may have participated.

We have been seeking feedback through regional meetings, both face-to-face and remotely, that occurred at the very beginning of this pandemic. We also asked schools to have our first national faculty meeting a year ago. But over the last several months, we have had an intense phase of seeking feedback from their diverse stakeholders, groups, faculty, schools, whatever.

And we asked schools to have their second national faculty meeting asynchronously, somewhere between the middle of November and the middle of January. Over 260 schools submitted our surveys that we had requested within asking for feedback on specific areas and questions for that second faculty meeting.

We had over 7600 faculty participate in those national faculty meetings. And many of the schools did indicate that they included their practice partners. We also, throughout December, had a series of three invitational forums. We had 38 organizations participate in those forums, 15 specialty nursing organizations, and 18 APRN organizations, and 5 accrediting and licensing organizations.

So I believe that all or almost all, the organizations that are here in attendance at this APRN roundtable, were invited and did participate in these invitational forums. Also, National Council and the accrediting bodies participated in their specific invitational forum.

We also made a number of presentations to specific groups, either at their request or at our request. We did a presentation for the National Council of State Boards of Nursing education consultants for several of the AONL regional groups, for the CCNE board of directors, for the Commission on Nurse Certification Board, and for leaders from CRNA organizational reps.

We also received a great deal of feedback from special interest groups, schools, other schools then at the national faculty meeting, and from many individuals. So what did we hear?

Well, what we heard that they liked most was that there was one document and not three documents, and that it was easy to read and use. And it provided clarity and continuity from the entry to professional nursing to the advanced-level nursing education. They also liked and are very favorable comments about the transition to competency-based education, that they've been waiting for this for a long time.

Also, that it included practice input and that there was a strong of emphasis on DEI and racism. And also, that it went beyond the acute care, particularly for entry level, that it really included and focused on the entire healthcare continuum and was very future-thinking and provided pathways for moving forward to advance nursing education.

Now, we also got questions, that's what we asked them, "What questions do you still have?" And we hope that many of these we have addressed by clarifying some of the sections in a new section of the document that I will explain and share with you. You can see some of the questions that came up frequently.

How do you differentiate the master's from the DNP? Differentiate the entry-level master's from the baccalaureate? They even said, why not mandate the DNP? And also, a lot of questions about competency-based education. I think the most frequent questions, however, were not about the document, but about the logistics.

I think the most frequent area that we received feedback on was really the how, and the when, and what do they do now? And that had to do with the implementation of the new Essentials, the new framework, and the transition to competency-based education. You will see in the document that we did receive feedback primarily on four domains, 2, 3, 5, and 9. So that if you look at these, there will be some changes to the descriptors, the contextual statements, and/or the competencies and sub-competencies.

Also, several...five of the concepts, we received a lot of feedback on. Now, I will promise you, we received thousands of pages, and information, and comments from all of our stakeholders, from all the feedback that we received. Every single piece of feedback and comment was reviewed and considered as part of the revision process.

Now, if you send in feedback, you may not…when you look at the document, you may not see exact words, you may not see where your changes were made, but I assure you, it was reviewed. The task force and the leadership team took into consideration all of the feedback. We may have gotten feedback in one direction and then other feedback in a disparate direction. So all of the feedback was taken into consideration and within the context of the entire document, not just one particular area.

Now, I will also say that a lot of the feedback we received was very specific with specific resources and content. And I'm going to talk a little bit later on about the tool kit that we're developing. So a lot of this information was put aside and has been put in a folder and is being populated or considered for inclusion into our tool kit that will be a supplement to the Essentials document.

When you look at the document, like I said, where will you see most of the revisions? If you've looked at the document, let's say, two months ago or even one month ago, this is where you will see many of the revisions. We've also added a section to the Essentials, which you did not see if you were part of the national faculty meeting or looking at the version we had posted on our website.

And this is implementing the Essentials considerations for curriculum. There is a section on general considerations for all programs at all levels, and then a section for entry-level professional nursing education, and one for advanced-level nursing education. Now, I want to focus primarily on the requirements and the expectations for the advanced-level nursing education programs.

This is the level 2 that comes right out of our model for nursing education. And as I said, the advanced-level nursing education includes the essential sub-competencies, as well as specialty requirements and competencies required for a national specialty practice or national practice, advanced-level nursing role.

In the document, it does say that participation in a minimum of 500 practice hours. Now, this includes both direct and indirect practice hours to acquire the level 2 sub-competencies. These are considered practice beyond or post-entry level professional nursing education. So once somebody has already attained and demonstrated the level 1 sub-competencies, we believe and we state that a minimum number of 500 practice hours, like I said, this is direct or indirect practice care as we have defined it and it is defined in the document, are needed to just demonstrate attainment of the level 2 sub-competencies.

Additional practice hours and/or specialty or role requirements are a key component of the curriculum and are also expected at level 2, no matter what degree is being awarded. To clarify, what we mean by advanced-level education or advanced nursing practice specialty and/or advanced practice nursing role, we've used… the task force has adopted and included the definitions that came from the previous Essentials documents, and also the Consensus Model, the APRN Consensus Model.

So those are the definitions. And currently, for advanced nursing practice specialty, the current specialties are administration or leadership, public and population health, health policy, and informatics. Now, there is a statement that additional or new specialties are expected to evolve over time depending upon population needs and changes within the healthcare system.

The advanced practice nursing roles are defined as the four APRN roles that are defined in the Consensus Model. And I do not need to go through and explain to you what those are, I am sure. So there are other expectations for advanced nursing education in the new Essentials.

I want to be clear that these expectations or requirements that are delineated in this new Essentials do not modify or supersede other national specialty role requirements, including the 3P courses that are delineated in the Consensus Model.

So let me talk a little bit specifically about what some of these other expectations are. The practice experiences have faculty oversight and are part of a formal plan of study so that faculty need to be responsible for the planning, and the implementation, and the oversight of all practicum experiences.

And these experiences should be part of their formal coursework or formal plan of study. Also, that there is a focused sustained practice experience or experiences, sometimes called immersion experiences, within the program. There is no set time for what that would include, but there should be sustained focused practice experiences within the program.

Also, simulation is defined as a valuable tool to augment learning. Simulation should meet national standards and it cannot substitute for all direct and indirect care experiences that are included within the program. Yes, some but not all.

And also, that simulation requirements are also determined by specialty education, certification, and regulatory bodies so that some of the specialties or roles may have requirements that are much more specific about when and how much simulation can be used. The DNP scholarly project or product, all DNP students are expected to complete a scholarly work that aims to improve clinical practice.

Faculty involvement is needed. This would be from the planning, implementation, and definitely the evaluation of the product. Students and programs are strongly encouraged to collaborate with practice. And these products or projects may take a variety of forms.

And it should not be a standalone component. It should not have a life of its own just at the end of the program. But it should be this learning that comes through doing the project or product, needs to be threaded throughout the curriculum, and an integral part of the curriculum. The goal of the product, or project, or work, let's just call it a scholarly work, is to create, for the student, an understanding of the application of these competencies to future practice.

And finally, I would add that there must be some dissemination, which can take a variety of forms, of the scholarly work. So now, let me move to do a brief overview of what it is that we mean by a move to competency-based education.

And like I said, this topic in itself could be an entire hour or two-hour presentation. We do have several videos that have been done on competency-based education. There are several by Dr. Jean Bartels, who I've posted and there are links to them on our AACN Essentials webpage.

And I encourage you, several schools have used them for faculty meetings and have found them extremely helpful to begin a conversation about this transition with all their faculty. So what is competency-based education? We're talking about a system of instruction, assessment, feedback, self-reflection, and academic reporting.

Now, this competency-based education, at least in, you know, the way the term has been used is not new to nurse educators. They have been some of the pioneers of putting forth behavioral competencies and outcomes. And the nursing literature has a great deal about competencies and assessing nurse performance. And also, some of the specialty bodies already require specific competencies.

But what is it that makes this different and what has been missing from nursing's education up till now? We have had no widely accepted definitions of what common competencies for our graduates should possess. We have not had common definitions. The definitions that are adopted in this document are also the same definitions that were used for the common APRN common doctor…I always get the title of that document flipped, but it's the "APRN Common Doctoral-Level Competencies" that many of you participated in developing.

Those definitions are what we used in this document as well. There also has not been any common understanding of what should those competencies be? What do we expect nurses across entire professional nursing education to be able to demonstrate?

And that's what this document lays out and also creates pathways for moving forward as we try to get rid of some of the messiness that we have in nursing education. But not to say that we are going to define what the curriculum is. There's not a standard curriculum but rather, a framework for developing the curriculum. So a competence is an array of abilities across multiple domains or aspects of performance.

But a competency is an observable ability of a health professional integrating multiple components such as knowledge, skills, values, and attitudes. And the competencies as a whole should paint a picture of what that person's individual ability is, of what they can do with what they know.

It's not just what they know, but what they can do with what they know. Competencies are not a checklist of tasks. When we first started talking about transitioning to competency-based education, people had this mindset about little checklists that they would go in and go, "Yeah, check, check, check. They've demonstrated all those psychomotor skills or those skills and we're done."

It's not a once and done experience, it's not a checklist, it's not isolated to one particular kind of context, one particular population, or one particular care setting. And they must be assessed over time in different contexts. And also, should have different external reviewers, other people assessing what this person…it should not just be one person's decision but over time.

And it should not just be an objective test. That may be one component of assessment about the knowledge base, but it should not be a sole measure of somebody's competence, ability to demonstrate competencies. What are they? A set of expectations, which as I said, collectively demonstrate what learners can do with what they know.

They are demonstrated across time and in different contexts and different areas of care. They're also clear expectations that are made explicit to the learner. The learner has to be the first one to know what the expectations are and what competencies they are expected to obtain, also for employers and the public. And that's one thing we've heard very recently when we've taken this to our practice partners and they say, "We really get it. We appreciate this. And this is something that then we can use these same domains to build on as we transition individuals into practice and even up the career ladder and build on it rather than have to go back to ground zero and figure out where we start and what every single graduate comes to us with."

And competencies are visibly demonstrated and assessed over time. Some of the feedback, a lot of the feedback as a matter of fact, that we got from some faculty are that they didn't think all of the sub-

competencies that we had in the document were measurable. We have gone over every single sub-competency and competency in the document with our experts on competency-based education, and I can ensure you, some of them may be more difficult to observe, but they are observable and able to be demonstrated.

So what do competencies do within the curriculum? They provide guidance for how we teach, they provide direction for what we expect of students, and they provide a framework for performance assessment. And I would also say that these cannot just be done as a single course or a single faculty, it must be done as a whole faculty component coming together to see where the competencies are threaded and assessed across the entire curriculum.

So what are the benefits of competency-based education? And they could go on to more and more pages, however, I have tried to condense them, and limit them, and pick some of the most important. It makes the learner responsible for his or her own learning. They understand what they need to obtain and they are expected to know and be able to self-assess also when they have obtained that competency.

It clarifies faculty expectations regarding learner performance. And it provides an overall cohesive framework for course design. And it promotes faculty development regarding teaching and creates a community of faculty with common goals and provides a framework.

So where are we and next steps? The document was approved by the AACN board of directors in January of 2021. It was presented to the AACN membership for a vote in March of 2021. And since that meeting, because we're all still in pandemic lockdown, that meeting was held remotely or virtually so that we had to conduct an electronic voting, which ends actually today, the day of the…today.

So I am not able to share, I do not know what the results are, but they should be revealed and reported very soon. This, I think, has become the mantra of our leadership team. How do you eat an elephant? And the answer is one bite at a time.

We know we have a huge task in front of us but and also for many of our schools and our specialty and other organizations, our certifiers and our accreditors. However, we know that this...we have planned a roadmap. This roadmap will have more detail on it.

This roadmap is actually available on our website. It begins to lay out what their expectations are and a timeline for implementation. We know that the path to fully implement the Essentials will be an extended process. It's not going to be overnight.

It may take and last up to three years or longer for this all to be put into place and to be implemented. AACN is committed to support and to facilitate the implementation of the Essentials and this transition to competency-based education. We have agreed we will appoint an advisory group to monitor the process, identify issues, and recommend resources.

We also know that there is a tremendous need for ongoing continuous faculty development and also, I would say, to practice for our practice partners. We will continue to have multiple webinars, conferences, workshops, it will come in many forms, written and verbal. So please, stay tuned. We also,

I mentioned an Essentials Tool Kit, which we've already started populating with a lot of the resources that have been submitted by some of our content experts and some of our specialty groups.

I would also say that National Council has already submitted resource materials that we requested to be integrated across a number of the domains. This is the framework for the tool kit, that it will have competency-based education resources for all types of education development.

There will be competency-based assessment resources, not that we're going to do standardized assessments. There will be integrative learning strategies, teaching resources, recommended content, and recommended assessment strategies for each of the 10 domains. Now, this is going to be a living document. It's not going to be in concrete or static once we put it out there.

We already have made available the document with a couple of the initial domains populated so that you can see what we are working on. But we will be reaching out to others for content expertise and potential resources for consideration in this document.

We've also considered and we'll continue to have a discussion about how we might facilitate the documentation and reporting of the curriculum in competency attainment. We are working with our colleagues at AAMC and part of the MedBiquitous organization which sets standards for technology.

We are considering how we might build on what they have learned as they've transitioned to competency-based education and developed similar tools. And the most important thing is not the tools themselves, but the fact that the interoperability, the ability to use these types of tools for multiple purposes to communicate with, let's say, with your accreditation body or with your certification entity, or for students and graduates to actually have these as a documentation of what competencies they obtained as they go out for employment or even as they go to advance their education.

So this is something that we will be exploring. So listen, and we will be looking for input from different types of individuals. We will continue, we promise, to have stakeholder engagement. We have continued already to reach out to many of our practice partners and have planned dialogue with AONL, and their regional groups, and their members.

But also, we will be reaching out to other practice organizations, specialty organizations and regulatory bodies, the accrediting organizations, the certifying organizations, and the licensing bodies. Because we know that we cannot do this, this will not be successful unless we have participation, and buy-in, and a common understanding from all the various nursing organizations, as well as not just the schools and practice.

Practice is essential. So what can schools do now? We keep getting asked that. The first thing is to gain a full understanding of the document. Most people will immediately jump to and start reading the competencies themselves. But we encourage you not do that. Read the entire document.

The whole introductory section is extremely important to getting an understanding of what we are saying here and what we're setting up. Also, it's a great way to have a meeting, bring the faculty together or your organization together to have a conversation about what the Essentials means. Crosswalk, begin to crosswalk as a faculty whole, the Essentials to your current curriculum.

And this is not just individual courses but the curriculum as a whole. Have participation of faculty to talk about what this means and what might be brought forward. Where are you already in your curriculum? And we do assume that if you have been updating and having continuous quality improvement of your current curriculum, that you will find many and most of these Essentials or competencies are already in your curriculum, but it's how are you assessing them?

And we've heard from a couple of schools that have already done this as a curriculum, and we know that they have gotten extremely excited and have come up with many ideas for assessment and how this might be implemented, and have come up with some great ideas already about where these assessments can be integrated and how can they be built on what they already have?

And also, we encourage you to engage with your practice partners in true practice and partner academic relationships and partnerships, but also to think about what new partners you may need to bring in to implement the new Essentials. So I am going to stop now and we have time for some questions and I will be glad to answer any questions you have.

I also have listed several resources and particularly, the AACN Essentials webpage. There's a direct link here in the PowerPoint, which you should have access to, to access these documents that I've referred to. And also, stay tuned on the webpage because we will continue to update the tool kit and the frequently asked questions as we move forward with implementation.

So, thank you.

- [Female] Thank you, Joan, for a really informative overview of your important work which will profoundly impact APRN education.

I'd like to welcome everyone to post their questions in the Q&A function now. And actually, Joan, we already have some questions ready for you. So we'll just get right to it. First question is from Gina Pittman. "For NP students, do you know how the minimum of 500 clinical hours was established?"

- Well, if you're referring to the new Essentials, which is what I was focusing on, the 500 hours really has come from past experience with advanced-level nursing programs. I know that you're probably familiar with the current DNP Essentials which says that all individuals graduating from a DNP program must have a minimum of 5000 practice hours post-baccalaureate education.

We've decided in the new Essentials that we would say, based on experience from competency-based education, talking to experts, and also looking at our past requirements in our Essentials for both advanced and then the specific requirements for nurse practitioner programs, we decided to decrease it to 500.

We felt that that was a bare minimum that most students will require to attain the level 2 or advanced-level professional nursing competency, sub-competencies. But remember that the specialty competencies and requirements that are set by specialty organizations, certifiers, or regulatory bodies will build on those minimum 500.

They may overlap some, but they will build on those 500 practice hours, which are a combination of direct and indirect care practice.

- Thank you, Joan. Next question is from Mitzi Saunders. She asks, "A competency-based curriculum is congruent with a pass-fail grading system, either competent or not. Is that your intention to move away from a grading system to a pass-fail system? Also, in lieu of grade inflation in nursing education a real issue, is this the direction you are suggesting?"

- I don't believe that we have come out and said that. There has been a lot of conversation and there will be additional conversation as we transition to competency-based education. I know that there's a lot of issues we had early on in the discussion about what a grading system might do for people looking to enter other types of programs if they're moving from their professional-entry program into advanced level.

So no, we are not saying that schools should go to a pass-fail system at this time. But I think competency-based education also can be reflected in our current grading system and there are other ways to assess competencies and how they're applied in different contexts and other kinds of requirements and assignments.

- Thanks, Joan. Mitzi has a follow-up question. "If a program can meet the Essentials at all levels and do so at the master's level, would this be acceptable?"

- Okay. In our document, we say that the level 2 competencies should be used by all programs preparing graduates for any area of advanced nursing practice, so any specialty roles for advanced practice roles. We do not differentiate the level 2 sub-competencies.

However, so a program may decide whether they want to award a master's degree or a DNP degree for those advanced-level competencies. However, there are other...what we say is there are other ways to differentiate a master's at the DNP.

Now, the DNP, I'd like to point out that the level 2 competencies have been written with doctoral education in mind. However, the true differentiator between a master's degree and a DNP degree will also be determined by the specialty and role competencies and requirements expected. They may have additional requirements, they may differentiate what those requirements are for a master's versus a DNP.

I know that the informatics competencies and expectations for advanced-level programs are differentiated currently from master's to DNP. Others, there is no differentiation. The other differentiator will be that many institutions do have and require additional coursework or requirements to offer a doctoral degree.

So, these competencies in the Essentials alone do not differentiate a master's from DNP. However, I would reiterate that we have written those sub-level level 2 competencies at what we believe are the doctoral level.

- Thanks, Joan. Next question from Julie Sable. "Please define indirect and direct hours."

- Okay. Well, the definitions, I would refer you to the glossary in the Essentials, and I don't have it directly in front of me. But basically, the direct...and they are the same definitions that have been in our past Essentials documents. They are not new. But direct, and this is me talking, like I said, I'm not reading it directly from the Essentials, but direct care involves direct interaction with patients which can be individuals, families, or groups.

And they can be in traditional or non-traditional environments, but it requires direct interaction. Indirect are those activities and actions that are taken that may improve patient care but they are… and may involve, let's say, patient advocacy, policy development, or other kinds of initiatives, quality improvement initiatives, policy development outside and away from the direct interaction with the populations, groups, families, or individuals.

- Thanks, Joan. We have about a minute and 45 seconds left. "How do these changes..." this is a question from Jessica Estus. "How do these changes address the concerns that APRN education is not consistent across educational programs?"

- Well, we believe both, not only for advanced level but also for entry level, that a program must have their graduates demonstrate over time these competencies. And the competencies are very well defined, and the expectations of what somebody would need to demonstrate.

And as I said, the assessment that occur in different contexts, in different settings. We will become, as we work towards the implementation and faculty become more aware of what competency-based education entails, I believe that this consistency will occur. We've heard consistently from our practice partners when they read the document and they look at the competencies, they know what they will expect and what to expect out of graduates coming out of the program, both entry professional as well as the advanced-level competencies.

- Thanks. We're going to do one more question from Rita D'Aoust. She asks, "There is a concern about the clinical competence of nurse practitioner students upon graduation. APRN/NP residency program is to provide additional transition but not complete the APRN education. The revised Essentials include 214 competencies plus APRN competencies. How will the revised Essentials competency approach address the concern of APRN clinical readiness at graduation?"

- Okay, well, the level 2 sub-competencies are the basis for advanced-level education. The specialty competencies, for whatever specialty it is or whatever role, are intended to build on these level 2 sub-competencies. So it's not the level 2 sub-competencies by themselves that will prepare a nurse practitioner for entry into practice, but it is the level 2 sub-competencies as well as the specialty or role competencies.

And as we all transition to competency-based education, these expectations should become clear and clear about what's expected. And also, then you have to consider the other requirements whether they are specific course assignments, whether they're clinical, whether they're direct care assignments, practice immersion expectations.

So working together, I think that we can reach more consistency and hopefully continue to prepare quality graduates that employers know what they're expecting. And I think some of that will come out in

our next presentation when we start talking about the national task force criteria which are specific to nurse practitioner programs. Remember, these Essentials are focused on all areas of advanced nursing practice, not just the four APRN roles but any program who is preparing anybody for any area of advanced nursing practice.

- Thank you very much, Joan. And before we get to Mary Beth Begley, our next presenter on the national task force, we're going to take about a 10-minute break and we're encouraging everyone to go to the meetup lounges. And you can just click the tab on the left and you will be placed in…you can choose the lounge you'd like to join, and we will see you back in about 10 minutes.

Thank you.