Nurse Practitioner Reimbursement Parity: An Advocacy Strategy For Washington State

Justin Gill
justingill90@gmail.com

Follow this and additional works at: https://elischolar.library.yale.edu/ysndt

Recommended Citation

This Open Access Thesis is brought to you for free and open access by the School of Nursing at EliScholar – A Digital Platform for Scholarly Publishing at Yale. It has been accepted for inclusion in Yale School of Nursing Digital Theses by an authorized administrator of EliScholar – A Digital Platform for Scholarly Publishing at Yale. For more information, please contact elischolar@yale.edu.
Nurse Practitioner Reimbursement Parity:
An Advocacy Strategy for Washington State

Submitted to the Faculty
Yale University School of Nursing

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Nursing Practice

Justin Gill
March 31, 2019
This DNP Project is accepted in partial fulfillment of the requirements for the degree Doctor of Nursing Practice.

Lisa Summers, DrPH, FACNM

Date ________________________________
This material is protected by Copyright Law (Title 17, US Code). Brief quotations are allowable without special permission, provided that accurate acknowledgement of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part must be granted by the copyright holder.

Signed: ___________

March 31, 2019
Nurse Practitioner Reimbursement Parity: An Advocacy Strategy for Washington State

Justin Gill, MS, ARNP, FNP-C

Advisor: Lisa Summers, DrPH, FACNM

Committee Members: Louise Kaplan, PhD, ARNP, FNP-BC, FAAN, FAANP, & Jane Dixon, PhD

Yale University School of Nursing

March 31, 2019
Abstract

Nurse practitioners (NP) play a vital role in the United States health care system. Nurse practitioners belong to a category of Advanced Practice Registered Nurses (APRN). APRNs in Washington State, licensed as Advanced Registered Nurse Practitioners (ARNP), are able to practice without the requirement of physician supervision or oversight. This facilitates NP practice ownership. NPs are qualified, autonomous, clinicians that can help address the primary and mental health care needs in Washington State. Washington State, unlike Oregon, does not require third-party insurers to reimburse NPs the same rate for the same services provided by a physician. This has financial implications for NP-owned practices. This project included working with a project mentor on a survey of ARNPs and ARNP practice owners in Washington State, development of an advocacy strategy and political endorsement process, and draft parity language for the 2019 Washington legislative session.
# Table of Contents

Chapter 1 ................................................................................................................................. 4  
**Introduction and Background** .......................................................................................... 4  
  Development of the Consensus Model ................................................................................. 4  
  Titling Section of Consensus Model ................................................................................... 6  
  APRNs as Independent Practitioners ................................................................................... 6  
  Washington State APRN Practice ....................................................................................... 6  
  Nurse Practitioners in Primary Care and Mental Health ..................................................... 7  
  Scope of Practice and Healthcare Delivery ........................................................................ 8  
**The Problem** ..................................................................................................................... 9  
  Reimbursement Dilemma ...................................................................................................... 9  
**Significance of Addressing the Problem** .......................................................................... 10  
  Primary Care and Mental Health Access .......................................................................... 10  
  The Time is Ripe for Change .............................................................................................. 11  

Chapter 2 ............................................................................................................................... 12  
**Review of the Literature** ................................................................................................. 12  
  Search Strategy .................................................................................................................... 12  
  Summary of Evidence Themes ........................................................................................... 13  
  Interaction Between Reimbursement and Primary Care Practice ...................................... 14  
  Interaction Between Reimbursement and Scope of Practice ............................................. 15  
  Difficulty with Data Collection ......................................................................................... 16  
  Psychiatric Mental Health Nurse Practitioners ................................................................. 18  
  Oregon Policy Efforts ........................................................................................................ 19  
  Prior Attempt at Changing NP Reimbursement In Washington State ................................ 21  
**Advocacy Framework** ....................................................................................................... 22  
**Overall Goal and Aims of the Project** .............................................................................. 23  
  Project Aims ...................................................................................................................... 23  

Chapter 3 ............................................................................................................................... 25  
**Methodology** ................................................................................................................... 25  
  Aim 1 ............................................................................................................................... 25  
  Aim 2 ............................................................................................................................... 28  
  Aim 3 ............................................................................................................................... 32  
  Evaluation ......................................................................................................................... 33  
  Implications ....................................................................................................................... 34  
  DNP Project and Immersion ............................................................................................ 34  
  Proposed Timeline ............................................................................................................ 35  

Chapter 4 ............................................................................................................................... 36  
**Implementation and Results** .......................................................................................... 36  
  Aim 1: ARNP Survey ......................................................................................................... 36  
  Aim 2: Advocacy Strategy ................................................................................................. 37  
  Outside strategies ............................................................................................................... 38  
  Inside strategies ................................................................................................................. 41  
  Aim 3: Draft Legislation .................................................................................................... 43  
**Discussion** ....................................................................................................................... 43  
**DNP Role in Policy Change** ........................................................................................... 44  
**References** ....................................................................................................................... 47  
**Tables** ............................................................................................................................... 55  
**Figures** ............................................................................................................................ 58
Chapter 1
Introduction and Background

Nurse practitioners (NP) play a pivotal role in the delivery of primary and mental health care services in the United States. According to the American Association of Nurse Practitioners (AANP) (2017), there are 234,000 NPs in the United States; over 77% have a primary care focus. State scope of practice regulations and reimbursement from public and private insurers has an effect on NP practice. According to the AANP (n.d.), 23 states have “full practice authority,” allowing them to practice without mandated supervision or collaboration with physicians (AANP, n.d.). Washington State is one of the states with full practice authority, but still faces issues with regard to NP and physician reimbursement parity. Understanding reimbursement parity barriers requires an understanding of the four advanced practice registered nurse (APRN) roles, scope of practice regulations, and existing evidence on reimbursement practices.

Development of the Consensus Model

The Consensus Model for APRN Regulation was developed by the National Council for State Boards of Nursing (NCSBN) and the APRN Consensus Work Group (APRN CWG). APRNs initially lacked consistency in standards of education requirements and certification. As early as 1993, the NCSBN began to address this issue (NCSBN & APRN CWG, 2008). In the early to mid 2000’s, the APRN Advisory Panel “developed criteria for ARPN certification programs and for accreditations agencies”, and developed a “vision paper in an attempt to resolve…concerns such as the proliferation of APRN subspecialty areas” (NCSBN & APRN CWG, 2008, p.18). After multiple meetings and discussions, the APRN Consensus Work Group (APRN CWG), the NCSBN, and other work groups worked over a period of years to develop a
consensus document that was released in 2008. The underlying assumptions of the work groups included the following:

- “Recommendations must address current issues facing the advanced practice registered nurse (APRN) community but should be future oriented.
- The ultimate goal of licensure, accreditation, certification, and education is to promote patient safety and public protection.
- The recognition that this document was developed with the participation of APRN certifiers, accreditors, public regulators, educators, and employers. The intention is that the document will allow for informed decisions made by each of these entities as they address APRN issues” (NCSBN & APRN CWG, 2008, p. 20).

The model aims to define and to promote consistency in the profession titles that are used for advanced practice nurses. Nurse practitioners are one of four Advanced Practice Registered Nurses (APRN) roles: certified nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists (NCSBN & APRN CWG, 2008). These roles all require nurses to pursue certification and education beyond that which is required of Registered Nurses (RNs). APRNs are required to obtain a graduate level education for certification and licensure (NCSBN & APRN CWG, 2008).

The target date for implementation was 2015 (NCSBN & APRN CWG, 2008). Only 15 states have fully adopted the Consensus Model, with other states varying in their level adoption (NCSBN, 2017). Various states still utilize different acronyms for similar roles; WA state uses the title Advanced Registered Nurse Practitioner (ARNP).
Titling Section of Consensus Model

The Consensus Model includes a written description and figure (see Figure 1) of the four APRN roles. The document states that the APRN title is:

“The licensing title to be used for the subset of nurses prepared with advanced, graduate-level nursing knowledge to provide direct patient care in four roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, and certified nurse practitioner. This title, APRN, is a legally protected title. Licensure and scope of practice are based on graduate education in one of the four roles and in a defined population” (NCSBN & APRN CWG, 2008, p. 9).

APRNs as Independent Practitioners

The Consensus Model consistently refers to APRNs as “independent practitioners” within the profession of nursing. APRNs are prepared to deliver patient care without the requirement of physician supervision oversight. APRNs are able to independently identify situations that require further consultation with other healthcare professions. As part of its “Foundational Requirements for Licensure”, the Consensus Model calls for states to “license APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision” (NCSBN & APRN CWG, 2008, p. 14).

Washington State APRN Practice

Washington State recognizes ARNPs as independent and autonomous providers. Despite efforts to implement the recommendations of the Consensus Model nationwide, Washington State still designates all APRNs as Advanced Registered Nurse Practitioners (ARNPs). According to the Washington Administrative Code (WAC), this title includes Nurse Practitioners (NPs), CRNAs, CNMs, and CNSs (WAC 246-840-302). Additionally, ARNPs in Washington
State can practice to the full extent of their professional certification, without the requirement of physician supervision (WAC 246-840-300). This facilitates the ability to own a private practice. The Revised Code of Washington (RCW) further specifies that ARNPs may prescribe Schedule II-IV medications, so long as the activity and prescription fall within the certification and training of the clinician (RCW 18.79.250). Understanding the scope of practice regulations for NPs in Washington State is needed in order to move forward with the development of a rationale for reimbursement parity.

**Nurse Practitioners in Primary Care and Mental Health**

**Primary Care.** Primary care NPs, including pediatric, adult, and family NPs, serve as an important component of primary and care delivery. While scope of practice may vary in each state, studies have shown that NPs provide care similar to that of physicians (Kurtzman & Barnow, 2017). A systematic analysis by Swan, Ferguson, Chang, Larson, and Smaldone (2015) highlights the equal and/or superior outcomes of advanced practice nurses as compared to physicians in the areas of patient satisfaction and physiologic outcomes. This is an important concept, because if clinical outcomes are similar to that of physicians, then this helps support an argument for reimbursement parity.

NP graduates enter a primary care specialty at a significantly higher rate than allopathic and osteopathic medical graduates (Pohl, Thomas, Barksdale, & Werner, 2016). NPs can help serve the primary care need and need to be supported in their efforts to do so (Figueroa, 2013). The NP role has important implications for the future of primary care access and the primary care workforce.

**Mental Health Care.** Psychiatric Mental Health NPs (PMHNP) are prepared to provide comprehensive mental health care services for all ages (Condi, 2015; Delaney, 2017). A
qualitative study conducted in public health care centers in California by Phoenix, Hurd, and Chapman (2016) revealed that medical directors felt that PMHNPs provided care similar to that of psychiatrists. With regards to communication, one medical director stated, “the average communication skills of NPs are higher than those of physicians and they’re more patient-centered” (Phoenix et al., 2016, p. 220). The study noted that no “informants [psychiatrists] expressed concerns about the quality of care provided by PMHNPs” (Phoenix et al., 2016, p. 220). These findings show that PMHNPs provide safe and high-quality care.

**Scope of Practice and Healthcare Delivery**

Health care providers, including APRNs, provide care in an increasingly multidisciplinary system. Scope of practice affects the ability of the APRN to provide care in a geographic location or setting. The American Nurses Association (ANA) (n.d.) states that “Scope of practice describes the services that a health professional who is educated / trained and deemed competent to perform; and for some professions, depicts under what conditions the services may be delivered”. In 2002, Barbara Safriet, J.D. highlighted the challenges that exist with regards to scope of practice and care delivery.

Safriet (2002) acknowledges the efforts of other health care provider groups and their activities to promote their profession, including the powerful lobbying and advocacy force of medicine. Safriet (2002) emphasizes that the gap between “legal authority and clinical ability” of health care providers (HCP) and physicians ultimately affects everyone, because of a lack of access to care and increased healthcare costs (p. 305). In addition, scope of practice gaps limits the ability of HCPs and physicians to work collaboratively to improve outcomes.

States vary in their scope of practice standards for HCPs, especially in comparison to physicians. Increasing the availability of health care requires a multifactorial approach by
policymakers. Safriet (2002) summarizes this by stating that “The availability of competent, affordable health care surely depends on many factors, but chief among them must be the rationality of the education, utilization and payment systems for the human care providers” (p. 331). In order to address issues that affect the healthcare provider workforce, policymakers and stakeholders must understand the political and financial influences that impact care delivery.

**The Problem**

**Reimbursement Dilemma**

NPs are often reimbursed at lower rates as compared to physicians for similar services (Hansen-Turton, Ware, Bond, Doria, & Cunningham, 2013). In addition, NPs are often not recognized as primary care providers (PCP) by managed care organizations (MCO), impacting their ability to provide primary care services. (Hansen-Turton et al., 2013). There is variation among states with regards to reimbursement by public and private payers (Hansen-Turton, et al., 2013). Primary care and psychiatric NP-led clinics in Washington State have experienced across-the-board rate cuts by specific insurers (Premera Blue Cross, 2012; Regence Blue Shield, 2017).

Some progress has been made in Washington State with regards to publicly administered insurance programs. For example, Washington Medicaid MCOs reimburse NPs at an equal rate to that of physicians (Kaiser Family Foundation, 2012). In 2016, the Washington State Department of Labor and Industries (WA L&I) changed their policy with a rule update to reimburse NPs at par with the physician rate for labor/job related claims (WA L&I, 2016). Presently, there is no statutory regulation of private payers with regard to reimbursement parity for NPs. This allows insurers to establish variable and reduced reimbursement, creating financial constraints for NPs that own their practice. Currently in Washington State, Regence and Premera reimburse NPs at 85% of the physician fee schedule (Premera Blue Cross, 2012; Regence Blue...
An assessment of the effect of these constraints is lacking and represents a gap in the evidence in Washington State.

**Significance of Addressing the Problem**

**Primary Care and Mental Health Access**

The shortage of primary care and mental health providers has been thrust to the forefront of health policy discussions due to an increase in the number of insured (Naylor & Kurtzman, 2010). NPs are well positioned to help address the need for primary and mental health care services (Delaney, 2017; Naylor & Kurtzman, 2010). This is particularly important in rural areas (Figeuora, 2013). Removing financial and regulatory barriers that hinder NP practice in shortage areas is essential to maximize their benefit (Naylor & Kurtzman, 2010).

In states where NPs can practice independently in private practice, such as Washington, the role of NPs as part of the solution to the primary care crisis has local implications. According to the Kaiser Family Foundation (KFF) (2016), only 45.52% of the primary care need and 42.37% of mental health care need is met in Washington State. There are 121 mental health and 155 primary care Health Professional Shortage Areas (HPSA) in the state (KFF, 2016). The Health Resources and Services Administration (HRSA) (2017) defines HPSAs as:

“Designated by HRSA as having shortages of primary care, dental care, or mental health providers and may be geographic (a county or service area), population (e.g., low income or Medicaid eligible) or facilities (e.g., federally qualified health centers, or state or federal prisons)”.

More Washingtonians now have health coverage after implementation of the Affordable Care Act (ACA). According to the Office of the Insurance Commissioner (OIC), the uninsured rate in Washington State dropped from 14.5-7.3% between 2012 and 2016 (OIC, 2016). An
independent survey of the non-elderly population in Washington State by the Kaiser Family Foundation (2017) show an increasing number of people with insurance: the uninsured rate dropped from 13.4% to 8.1% between 2013 and 2016, a decrease of about 299,746 uninsured individuals. However, these newly insured patients might encounter difficulty in accessing primary and mental health care because of the demand.

**The Time is Ripe for Change**

Reimbursement parity is a longstanding issue that requires change. In the Institute of Medicine (IOM) Committee on the Robert Wood Johnson Initiative on the Future of Nursing, Safriet (2011) created specific recommendations as part of an “ideal framework” for the healthcare workforce. One of these recommendations states that payers should “base payment for covered services on what and how well a service was provided, rather than on who provided it” (p. 467). This represents the main problem with reimbursement inequity today, where payment is based on the provider instead of the service alone.

It is evident that access to primary care and mental health services is an issue in Washington State and supporting NP practice is one way to address this problem. Elected representatives, who want to be responsive to their constituents, have the ability to make policy changes that improve access to health care services. Reimbursement parity will work synergistically with the independent ARNP practice statute in Washington State to expand access to care. Because NPs are increasingly more relevant in care delivery and practice ownership in Washington State, reduced NP reimbursement issues require the attention of policymakers and stakeholders.
Chapter 2

Review of the Literature

Search Strategy

**Databases.** For peer-reviewed literature, five databases were included as part of this literature review. This included Scopus, PubMed, PAIS, Google Scholar, and CINAHL. The first three databases chosen found all the articles in the matrix, while CINAHL found the duplicate articles as it was used last in the search. CINAHL and PubMed are clinical databases, whereas PAIS is a social science database. Scopus was utilized given its ability to search multiple databases for a more comprehensive search. PAIS was chosen given that the issue of reimbursement and APRN practice has public policy implications. Google Scholar provided a broader search that included biomedical and/or social science results. This was helpful for searching the literature specific to psychiatric nurse practitioners, and supplemented the articles found in the formal databases regarding nurse practitioner reimbursement. Policy analysis requires one to extend beyond the confines of peer-reviewed literature, and identify other forms of evidence. Because of this, government data reviews, statutes, news reports, press releases, and direct outreach to government agency officials were included as part of the evidence review.

**Search Terms.** The search was designed to find existing literature regarding the role of reimbursement on nurse practitioner practice in the primary care and mental health setting. Initial searches included the terms “(APRN or nurse practitioner) AND reimbursement AND primary care access”. While this yielded results, the return from the search was scarce, and the terms were simplified to “Nurse practitioner AND reimbursement AND primary care”. For specific literature regarding psychiatric NPs, the term “mental health AND nurse practitioner AND reimbursement” was used. In Google Scholar, the term “psychiatric NPs AND mental health
“access” was used. These searches were narrowed further, with dates after 2008. This was chosen given the passage of the Affordable Care Act, and its impact on primary care demand. While classic literature will still be considered moving forward, the initial search was focused on finding recent literature after implementation of health care reform. In addition to this, a few articles were identified from reference lists within articles obtained from the databases.

**Summary of Evidence Themes**

The literature review serves as the foundation for understanding the role that reimbursement plays on NP practice, and how the issue interacts with scope of practice regulations and access to care. Six articles identified or directly measured some relationship between NP reimbursement, scope of practice, and primary care access (Barnes et al., 2017; Chapman, Wides, & Spetz, 2010; Hansen-Turton et al., 2012; Poghosyan & Carthon, 2017; Poghosyan et al., 2013; Yee, Boukus, Cross, & Samuel, 2013). Four of these articles found that reduced reimbursement has an effect on the ability of NP practice in primary care settings (Barnes et al., 2017; Hansen-Turton et al., 2012; Poghosyan et al., 2013; Yee et al., 2013). Two articles highlight the limitation of data gathering for NP reimbursement policies, specifically due to potentially omitted data from some clinics that bill NP services through a physician’s billing number (Chapman et al., 2010; Kuo, Loresto, Rounds, & Goodwin, 2013). Two articles identified the billing difficulties, specifically with regard to psychiatric NPs (Condi, 2015; Delaney et al., 2017). News releases and policy analyses from Oregon and Washington State assist in understanding the local relevance of the themes that are extracted from the peer-reviewed literature. These findings collectively show the importance of reimbursement policy on NP practice, and help support the need for data collection locally in Washington State with a legislative advocacy strategy.
Interaction Between Reimbursement and Primary Care Practice

Reimbursement plays a significant role in primary care practices, especially for NPs that own their practice. A typical payer mix includes Medicare, Medicaid, and multiple private insurance companies (Hansen-Turton et al., 2012). Insurance reimbursement, and its impact on the financial sustainability of a clinic, has implications for primary care access within a community. If clinics are unable to stay in business, then their ability to provide services is curtailed.

Themes extracted from the literature support the relationship between reimbursement and primary care practice stability. A legislative and regulatory assessment by Chapman, Wides, and Spetz (2010) emphasizes that reimbursement policies can have an impact on maximizing the potential effect that NPs have on primary care access. The authors note that reduced reimbursement “from Medicare and Medicaid for APRN services make it harder for APRN-only practices to survive financially” (p.94). The article does not cite a specific study to support this claim, however, but acknowledges that it is difficult to obtain data because of incident-to-billing practices (Chapman et al., 2010). The authors also state “There is reason to expect that changing payment regulations could result in market-generated changes in the way primary care is delivered” (Chapman et al., 2010, p.95). With regard to private insurance company practices at the time of this regulatory assessment, Chapman et al. (2010) indicate that current state of statutes and regulations have been unsuccessful at achieving NP reimbursement parity.

A policy analysis by Bodenheimer and Pham (2010) focused on primary care workforce issues and private practice more broadly. The authors emphasize that primary care providers often maintain large patient panels in order stay financially stable. Because of these monetary constraints, fewer providers enter primary care. As possible solutions, Bodenheimer and Pham
(2010) highlight more NP training programs as part of the solution, in addition to team-based care and incentives for medical graduate entry into primary care. When applying these concepts to Washington State, NPs likely face high odds at maintaining a practice because of reduced reimbursement, as compared to physicians.

**Interaction Between Reimbursement and Scope of Practice**

A discussion about NP reimbursement requires an understanding of the interplay between NP scope of practice (SOP), and recognition of NPs as PCPs by private insurance companies. Recognition of NPs as PCPs by insurers, analogous to primary care physicians, is an important component of the reimbursement parity issue (Hansen-Turton et al., 2013). Scope of practice laws provides the statutory authority for NPs to practice autonomously in a privately-owned clinic. In a market-based system, however, NPs need reimbursement parity in order to realistically maintain a privately-owned NP practice.

If NPs are unable to be credentialed as a PCP by an insurer, they can face difficulty in receiving reimbursement at a physician rate (Hansen-Turton et al., 2013). Even with PCP status, they are still instances when a plan may fail to reimburse at an equal rate. A study by Hansen-Turton et al. (2013) revealed that 74% (192/258) of surveyed health maintenance organizations (HMO) credentialed NPs as PCPs. Of this group, the reimbursement practices were as follows:

“39 (27%) reported that they reimburse NPs at the same rate as primary care physicians, 39 (27%) reported reimbursing at a lower rate, and 66 (46%) reported that their reimbursement rates varied and that sometimes NPs were reimbursed at the rate of primary care physicians” (p.307-308).

These findings are similar to other advance practice nursing groups. Certified Nurse-Midwives (CNMs) receive 100% of the physician rate through Medicare but have similar issues
with private insurers. A 2014 marketplace survey by the American College of Nurse-Midwives (ACNM) revealed that 50% of marketplace insurers did not reimburse midwives at 100% of the physician rate (ACNM, 2014). This shows that private plans do not necessarily emulate the practices of Medicare. While this survey is specific to midwives, it supports a more thorough understanding of the broader reimbursement practices by private payers.

Barnes et al. (2017) conducted a cross sectional study that looked at the impact of SOP laws and Medicaid reimbursement levels. Interestingly, NPs were more likely to practice in a primary care setting that allowed full SOP for NPs, and where NPs received 100% reimbursement of the physician rate (Barnes et al., 2017). The authors go on to state “collaborative agreement requirements and low Medicaid reimbursement rates appear to be barriers to states increasing the distribution of NPs into needed settings” (p. 442-443). Although this study looked at Medicaid, not private insurance, the themes related to the interaction between reimbursement and scope of practice are relevant.

**Difficulty with Data Collection**

**Incident-To Billing.** Recognition of common billing practices is essential to understand the major factors that impact NP practice and reimbursement. “Incident-to” billing is the practice of billing a NP or PA service under a physician in order to receive enhanced reimbursement (Buppert, 2016). The Federal government defines specific conditions that govern incident to billing: 1) the physician must be the initial provider for a new problem or new patient, 2) both the NP and the physician must be in the same office facility, and 3) the physician must remain “involved” in the care provided (Centers for Medicare and Medicaid Services (CMS), 2016). While these rules have some flexibility in interpretation, multiple cases of fraud have been identified due to violations (Buppert, 2016). This is important because fraudulent cases of
incident-to billing may be inadequately measured. For example, in a qualitative analysis by Poghosyan et al. (2013), one NP respondent stated “You know, 100% is way better than 85% . . . particularly for some with private insurers . . . We don’t get audited on whether he [physician] sees the patients on not” (p. 11). This highlights how important 100% reimbursement is for primary care clinics, especially when there are some clinics that appear to exercise willful ignorance on the issue. Incident-to billing indirectly represents the desire for clinics to be reimbursed at the same rate for the equivalent work.

Fraud and abuse represent a problem that is associated with reimbursement parity, particularly in clinics that have both physicians and NPs. NPs must be knowledgeable about the rules that are included in incident-to billing in order to prevent fraud (Summers, 2011). With reimbursement parity, NPs will have the ability to bill directly without a loss of revenue. This will serve as a mechanism to reduce the risk of engaging in fraud, since it is evident that inappropriate use of incident-to billing already exists.

While incident-to billing is a known component of Medicare reimbursement, private insurers have different incident-to practices. Some insurers have policies similar to Medicare, whereas other insurers may have different criteria (Barney, Nicoletti, & Savarise, 2014). There are challenges that exist with the collection of NP reimbursement practices, particularly due to incident-to billing. Much of this is due to the variability in clinic reimbursement and billing practices (Kuo, Loresto, Rounds, & Goodwin, 2013). This can be a limiting factor in assessing the role of NPs in primary care, and how they bill. Kuo et al. (2013) state “Some institutions may have policies against NPs’ billing independently for their services” (p.1238).

**Third-Party Reimbursement Variability.** While Medicare and Medicaid may have more transparent reimbursement policies, there is considerable variability among private
insurers. Medicare provides reimbursement at 85% of the physician rate for NP services, and Medicaid in Washington State provides 100% of the physician rate (Kaiser Family Foundation, 2012; Yee et al., 2013). Private insurer reimbursement information is not public information, and varies considerably based on state, region, and clinic (Buppert, 2002). This variability is highlighted in the Hansen-Turton et al. (2012) survey of plans in which “46% reported that…sometimes NPs were reimbursed at the rate of primary care physicians” (p.308). This shows that even with a survey of private insurer plans, there is still considerable uncertainty and lack of consistency in how they reimburse NPs. This variability makes it difficult to obtain data among third party payers.

**Psychiatric Mental Health Nurse Practitioners**

Many of the above studies discuss the relationship between primary care NP practice and reimbursement, but similar themes apply to PMHNPs. Like NPs in primary care, PMHNPs receive 85% of the physician rate for services under Medicare, and often bill under a physician to receive a higher rate (Condi, 2015). An article with policy recommendations by Delaney et al. (2017), calls upon public and private insurers to update policies that facilitate direct billing by PMHNPs.

Condi (2015) highlights an increase in those with mental health care access through commercial Qualified Health Plans (QHP). The article reinforces the need for PMHNPs to possess, “a general understanding of how payments and reimbursements are processed so they are able to help themselves as well as their clients” (Condi, 2015, p. 888). In Washington State, PMHNPs have been susceptible to reimbursement rate decreases. Premera BlueCross’s NP reimbursement notice in 2012 provides explicit evidence of this (Premera BlueCross, 2012). This notice informed independently billing NPs, with the exclusion of a few groups in urgent care and
community health settings, that their reimbursement rate would be cut to 85% (Premera BlueCross, 2012).

**Oregon Policy Efforts**

In order to develop policy solutions for the reimbursement dilemma in Washington State, it is helpful to assess successful strategies in other states. Oregon addressed the issue of reimbursement inequity for NPs and physician assistants (PA) in primary care and mental health through state Senate Bill (SB) 1530, which was passed and enacted into law in 2016 (Oregon Revised Statute (ORS) 743A.036, 2016). This requires insurers to reimburse independently practicing NPs and PAs at the same rate as physicians for the same service (ORS 743A.036, 2016). A follow up study by the Oregon Health Policy Board (OHB) revealed “3140 independent PAs and NPs received increases in reimbursement rates…as a result of ORS 743A.036” (OHB, 2016). Across five insurance companies, the total increase in costs to insurance between 2014-2016 totaled $747,273.47 (OHB, 2016). This demonstrates that improvements in reimbursements to NPs and PAs results in only a modest overall expense to multiple insurers.

The publicly available OHB health policy analysis did not include survey methodology and total survey population. Direct communications with OHB staff revealed that 553 insurers were identified and surveyed (S. Peacock, personal communication, October 13, 2017). Five insurance companies had to change their reimbursement policies in order to comply with the parity law. At first glance, this appears to be a small proportion of insurance companies that needed to change reimbursement practices. While many insurers may operate through sale of policies, or reimbursement of services provided within the state borders, five health insurance companies control over 60% of the market share in Oregon (Sawyer, 2016). These plans include Kaiser, Regence BlueCross BlueShield, Providence Health Plan, Moda Health Plan, and Trillium
Community Health Plan (Sawyer, 2016). This shows the relative dominance that a handful of insurers have in a state insurance market. While it is uncertain whether all five of these insurers were required to change rates, Regence BlueCross BlueShield was an insurer that was historically known to cut NP reimbursement prior to passage of the law (Gray, 2016). The OHB analysis, and initial communications with OHB staff do not disclose which insurance companies had to change reimbursement. The responses to pending public information requests may highlight the identity of all the insurance companies that had to change reimbursement practices as a result of the law.

A communications release specific to the passage of SB 1530, by the Nurse Practitioners of Oregon (NPO), states that the law “became necessary after one of Oregon’s largest private insurance companies arbitrarily cut reimbursement rates to non-physician health care providers; seriously limiting Oregonians’ access to care, particularly in communities where NPs and PAs are the only health care providers” (NPO, 2016). Through news reports, Regence BlueCross BlueShield, which covered 446,322 individuals in Oregon in 2015, was identified as one of the insurers that cut NP reimbursement (Gray, 2016; Sawyer, 2016). This shows that while only a few insurers in Oregon needed to change reimbursement practices, these changes have a significant effect on the finances of a practice, given the market share of the large payers.

While the OHB study shows that 3,140 clinicians received increased reimbursement, there is no analysis of how the law has impacted NPs or PAs in Oregon. This information would be helpful to better understand how this law has impacted access to care in the state. Continued efforts at reviewing the evidence in Oregon, through identification of public reports, and contact with officials in Oregon are needed to provide a better understanding of the impact of SB 1530.

[72x745]WA NP REIMBURSEMENT PARITY
[528x745]20
These efforts will help understand the logical relationship between increased third-party reimbursement and

**Prior Attempt at Changing NP Reimbursement In Washington State**

A previous attempt at changing NP reimbursement in Washington State included litigation through the judicial branch. In 2002, Regence BlueShield reduced reimbursement rates for NP services to 95% of the physician reimbursement rate. A complaint was filed with the Office of the Insurance Commissioner (OIC) by Dr. Louise Kaplan, a practicing ARNP and health policy advocate. This complaint was initially upheld by the OIC, but later overturned after an appeal from the insurance company (State of Washington OIC, 2004). The Washington State Nurses Association (WSNA) brought a case before the King County Superior Court, arguing that the rate cut violated the Health Care Services Contract Act (“The Same Pay For the Same Service”, 2008). The Health Care Services Contract Act states that:

> “benefits shall not be denied under such contract for any health care service performed by a holder of a license for registered nursing practice or advanced registered nursing practice… if (1) the service performed was within the lawful scope of such person's license, and (2) such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to chapter 18.71 RCW” (RCW 48.44.290).

Ultimately, the court did not side with WSNA, and stated that the statute “referred to contracts between the health plan and the insured individual and did not extend to the health care provider” (“The Same Pay For the Same Service”, 2008, p. 25). The court indicated that reimbursement equity for NPs was not relevant in the statue since the language pertains to the contract between the patient and the insurer, not the provider (“The Same Pay For the Same
Service”, 2008). Since the courts have not provided relief, a legislative solution is needed to achieve NP reimbursement parity in Washington State. This will require an advocacy strategy supported by data and evidence.

**Advocacy Framework**

A framework, titled *The Advocacy Strategy: A tool for articulating an advocacy theory of change*, by Coffmann and Beer (2017) will be helpful for organizing the various components of an advocacy strategy. While frameworks for certain change projects may have a more sequential approach to achieve a result, an advocacy strategy will require more flexibility. Coffmann and Beer (2017) state that “strategies may need to shift in response to a variable political context, or if advocacy tactics are not as effective as anticipated” (p. 1). The framework allows the change seeker to look at an advocacy strategy with a focus on audiences, outcomes, and other stakeholder positions on an issue. It allows the advocate to identify who they want to influence or engage, and what change they wish to seek with that audience (Coffmann & Beer, 2017).

The tool asks questions that help guide an advocacy strategy. These questions allow the advocate to identify who they want to change, how they want to effect change, what stakeholders are already involved in the change, and what short-term and long-term outcomes are sought with the change (Coffmann & Beer, 2017). This framework will help categorize activities and outcomes in the advocacy strategy, provide the advocate with the ability to display the strategy in an organized fashion, and help the advocate stay on track towards their established goals. The framework includes two diagrams, one that assists the advocate with mapping a strategy (see Figure 2), and one for evaluating interim outcomes (see Figure 3). This will serve as an important component of Aim 2.
Overall Goal and Aims of the Project

The goal of this project is to develop a legislative advocacy strategy, and participate in drafting language for a law that requires equal reimbursement for services provided by NPs and physicians in primary and mental health care. The legislative strategy may not necessarily result in passage of a law, or introduction of bill language in a specific legislative session. Success will be achieved through the development and implementation of strategy and drafting of bill language. A survey of NP practice owners in Washington State, with the project mentor, regarding the impact of reduced reimbursement will help address a knowledge gap and inform/support the advocacy strategy.

Project Aims

Aim 1: To develop and execute a survey of Washington State primary care and psychiatric NP-owned practice, in order to assess the impact of reduced third party reimbursement on clinic ownership and financial sustainability.

Aim 2: Develop an advocacy strategy for NP reimbursement parity, in consultation and collaboration with ARNPs United of Washington State (AUWS), legislators, and stakeholder groups.

- Lead and set agenda for monthly calls with AUWS parity committee
- Lead advocacy engagement and training sessions with NPs.
- Meetings with key legislative leaders in House, Senate, and Governor’s office.

Aim 3: Draft legislation, in consultation and collaboration with AUWS, champion legislators, and stakeholder groups for consideration in the 2019 legislative session.

- Develop agenda for and lead bill drafting sessions with stakeholder groups
- Draft bill may or may not be officially introduced in legislative session
**Dissemination Plan:** Present the findings of the survey and the outcomes of the advocacy strategy to Washington State nursing organizations, and national nursing organization conferences.
Chapter 3
Methodology

The methodology for the project is outlined below. The activities include a survey of primary care and psychiatric NP practice owners in Washington State, the implementation of a legislative advocacy strategy for advocates in Washington State, and the development of draft legislation.

Aim 1: To develop and execute a survey of Washington State primary care and psychiatric NP-owned practices, to assess the impact of reduced third party reimbursement on clinic ownership and financial sustainability.

Survey Goal. The goal of the survey will be to obtain data from NP practice owners in Washington State regarding the effect of reduced reimbursement on clinic financial sustainability. This data is lacking in Washington State. As previously noted in the literature review, there is difficulty with tracking data on NP billing practices and reimbursement. In part, this is due to the proprietary nature of private third party insurance reimbursement rates. The survey in this project will assess the problem through a different approach, by engaging NPs directly. This survey will help inform and support the advocacy strategy outlined in Aim 2, with results presented to legislators and professional organizations to substantiate the impact of third party reimbursement inequity. The survey will help move the advocacy strategy forward by highlighting the extent to which third party reimbursement inequality affects NP practice ownership in Washington State.

Proposed Survey Design/Outline

The population to be surveyed will be primary care and psychiatric NPs who own practices in Washington State. Identification of the population will be based on data obtained
from the Washington State Department of Revenue (DOR) and/or Licensing (DOL). Depending on the clinic demographics provided by the DOR/DOL, it may not be possible to distinguish between a primary care, psychiatric, and specialty care clinic to create a primary care/psychiatric clinic-sampling frame. Consequently, all clinics identified will be included in the survey. If data from the DOR/DOL is not sufficient, the project team may move forward with sending a survey to all licensed ARNPs in the state, and include filter questions at the beginning of the survey to identify NP practice owners. The survey will include questions relating to the specialty/type of clinic in order to identify clinics that are not applicable to this study.

The survey administration will be multimodal and include both paper and electronic questionnaires for participants to respond. The questionnaire will collect data regarding the practice’s structure including the number of employees and patients, insurance accepted by the practice, whether this has changed in the last five years, and the effects of the reduction of reimbursement by identified insurers. Through the development of the survey questions, a priority will be placed on questions that ask for ranges of values (e.g. $50,000-$70,000) as opposed to asking for exact values. Questions that allow the participant to select range options are easier to respond to rather than an answer that requires an input of a value (Fowler, 2014).

Each potential participant will be mailed a letter requesting participation in the survey from the project lead and mentor. The letter will include a print copy of the questionnaire with a stamped, addressed return envelope. The letter will also include a link to the electronic questionnaire. If e-mail addresses are available, a reminder message will be sent one week later. Two weeks after the initial contact, a second letter and survey will be mailed to non-responders. One week later an email reminder will be sent. The survey will be open for 6 weeks. The electronic questionnaire will be available using Qualtrics through Washington State University.
The development of the survey will be completed with the project mentor and myself. The AUWS parity committee will participate in a review of the questionnaire. Some members of the committee are NPs that presently own, or have previously owned, a practice. The committee’s input will provide helpful feedback regarding the survey format and content. Analysis and interpretation of the results will occur within the three months following the survey close date. The DNP project lead and mentor will write a project report, and the AUWS parity committee will review it.

**Survey Integrity and Security.** While there will be few areas of potential bias in the survey, consideration of this concept is necessary in any survey. The survey should avoid leading questions, as to avoid bias. The parity committee and project team will review the wording of the questions, with specific attention to avoid misleading statements or questions. A pilot questionnaire of NPs in Oregon may be considered. With regard to survey security, the Qualtrics official website states that encryption is utilized, and meets or exceeds federal standards (Qualtrics, n.d.).

**Survey Project Team.** The project team will include the DNP project mentor, the AUWS parity committee, and myself.

**Statement Related to Human Subjects.** This project will not require institutional review board (IRB) review for research of human subjects for Yale University. The questions will inquire about the business of the NP owner, and not the NP personally. As a faculty member of Washington State University, the DNP project mentor will submit the survey proposal to their institution’s IRB.
Aim 2: Develop an advocacy strategy for NP reimbursement parity, in consultation and collaboration with ARNPs United of Washington State (AUWS), legislators, and stakeholder groups.

Aim 1 will help support the advocacy strategy. In addition to this, ongoing evidence collection through public information requests from Oregon and Washington State government agencies will further support the strategy, and the argument(s) to be made to policymakers.

Utilization of Advocacy Framework. The resource *The Advocacy Strategy: A Tool for Articulating an Advocacy Theory of Change* by Coffman and Beer (2017) will be utilized to help map and monitor the advocacy strategy. Overall, the framework encourages the advocate to identify the audience(s) for the strategy, and the type of change that sought. Multiple groups and individuals will be involved with the advocacy strategy, and there will be different change expectations with each audience.

With regard to audiences, the framework identifies three broad categories: the public, influencers, and decision makers (Coffmann & Beer, 2017). For the public category, nurses and nurse practitioners will be the key target audience. Influencer groups will include the state nurses association, the state nurse practitioner organization, and local nurse practitioner groups. Decision makers will include Washington State House and Senate leadership, health committee chairs, the Governor, and the governor’s health policy staff. This list of audiences not an exhaustive list, and may require input from other related groups and stakeholders throughout the process.

The goals for change will vary based on the type of audience group. For individual nurses and nurse practitioners, organization and mobilization will be needed in order to support the change efforts of professional organizations and lawmakers (Coffmann & Beer, 2017). Change
activities for the influencer groups will include research (i.e. NP-owned clinic survey), messaging, and lobbying. For policymakers, the goal will be to provide education, identify key legislative champions/sponsors, and develop draft legislation text (Coffmann & Beer, 2017). While the above change expectations have an association with each audience group, many of the changes will interact with the efforts of the other audience groups.

**Stakeholder Assessment and Engagement.** Stakeholder engagement and outreach will be a key component of this advocacy strategy. Stakeholder groups will include the audiences listed above, in addition to outside groups that may be affected by the change. Examples of these groups include, insurance companies, physician groups, PA groups, patients, and regulatory leaders (i.e. Insurance Commissioner). Meetings with these groups, at strategic time points in the advocacy process, will be required. Assessment of counterproductive/opposition efforts of some of these stakeholder groups will need to be monitored constantly throughout the strategy (Coffmann & Beer, 2017).

While the goal for the advocacy effort may initially focus on primary care and psychiatric NP specialties, other APRN or provider groups may be included in the effort. For example, the opportunity may arise to form a coalition with CNM groups. Decisions regarding coalition building and inclusion in the effort will be made based on the political climate and inter-organizational dynamics at the time. In addition to ARNPs, it will be essential to unify and engage the broader nursing profession within Washington State. The state nurses association has historically endorsed and advocated for ARNP-specific issues (“ARNP Global Signature”, 2015). Unification and coalition building will be needed in order to speak with one voice. This will strengthen the argument that will be made to policymakers.
**Member Engagement and Mobilization.** Engagement with nurses and nurse practitioners, via professional nursing organizations, will be key to the advocacy effort. This engagement may take the form of email messaging, advocacy alerts, and advocacy training with local county-level nurse practitioner organizations. Advocacy training may include educational resources and advocacy training videos that were previously developed by my colleagues and I at the Yale School of Nursing DNP program. Political advocacy training tools developed by the state and national professional organizations will also be included. Avenues to facilitate mobilization will include the state nurse legislative day, and advocacy training camps. These efforts will require me to collaborate and strategize with stakeholder groups.

**Historical Context and Future Strategies.** The advocacy strategy will need to reflect on prior change attempts in Washington State. This includes recognition of previous encounters with the Washington House Health Care Committee chair on the reimbursement issue. Prior attempts at addressing the reimbursement issue have been met with resistance from the House Health Committee chair, who still currently holds this position. A legislation fact sheet was created with plans to request official draft legislation in 2009 (Kaplan, 2008). When this advocacy effort was brought to the House chair, it was met with opposition, and the effort ultimately failed (L. Kaplan, personal communication, Jan 10, 2018).

Another meeting with the chair of this committee will need to be scheduled in order to reassess any possible changes in their opinion on the issue. Data from the survey in Aim 1 may help sway the chair’s position. Including NP practice owners in the chair’s individual district, as part of these meetings, will add political strength and local context to the case being made to the chair. This roadblock represents the relative difficulty of moving this issue forward, but
continued efforts in other areas of the legislative and political process can lay the groundwork for successful efforts in the future.

While engagement with the WA House Health Committee chair will be a key step in the advocacy strategy, it will not be the only component of navigating the political environment. The Senate Health Care Committee Chair will need to be introduced to the issue. The Senate chairperson is new to the role given the recent 2017 special elections, which flipped control of the state Senate to the Democratic Party (Bendery, 2017). Because of this, the Senate chairperson may rely heavily on the advice and experience of the House chair. This means that advocates may want to avoid engaging with the Senate chair first, and be open with the House chair about advocacy plans first in order to limit the potential for further tensions. These activities will need to remain flexible based on the political environment at the time.

Additional activities outside of the legislative process will include the 2018 elections. A portion of the state Senate seats, and all of the state House seats will be up for election in November 2018. This represents an opportunity to secure allies early on, in partnership with the state nursing organizations. WSNA has a political action committee (PAC) that provides political contributions to candidates running for state office. Advocates should request that a question on ARNP reimbursement parity be asked on the candidate questionnaire, given WSNA’s historical support on the issue. Outreach to the WSNA-PAC leadership and the WSNA executive leadership will be needed in order to secure this question on the candidate survey. Meeting with and engaging newly elected legislators will serve as an investment for future advocacy activities.

**Nursing Coalitions.** While the focus of this project will be on NP reimbursement parity, other nursing groups may be considered as part of the strategy. While CNMs and CRNAs were not recently affected by recent rate reductions, they are not immune to future rate decreases.
Working with these ARNP groups will be considered in order to move the advocacy effort forward. In addition, inclusion of these groups will help solidify a sense of unity among the specialty groups. By including these groups in the strategy, advocates will have the opportunity to demonstrate the diverse services that ARNPs provide in the state. Engagement with the nursing profession as a whole, including WSNA, will add strength through a larger membership pool and logistical support.

**Aim 3: Draft legislation, in consultation and collaboration with AUWS, champion legislators, and stakeholder groups for consideration in the 2019 legislative session.**

**Bill Drafting in Washington State.** A bill draft will serve as one of the deliverables for this DNP project. This bill draft will be developed with the input and collaboration of stakeholder groups, the project mentor, and any policymaker champions that are identified in state government. The Washington State Office of Code Reviser (OCR) (2017) provides a comprehensive outline and guide for bill drafting. The webpage provides information on how to structure the language, headings, and grammar for a bill draft. Other states’ legislation, such as SB 1503 from Oregon can be used to help guide some of the policy in the bill draft. Work sessions with the project mentor, the OCR, and outside stakeholder groups will be needed in order to develop a draft bill. If legislative champions/sponsors are identified prior to the bill drafting sessions, their input and staff involvement will weigh heavily on the development of the legislation.

While any individual or organization may request bill drafting through the OCR, they must first obtain permission from a legislator to submit a request to the OCR (K. Buchli, personal communication, February 4, 2018). The before the request is approved, the OCR “will call the member’s office to confirm that the individual has permission to request a bill on behalf
of that member of the legislature” (K. Buchli, personal communication, February 4, 2018). The advocacy strategy in Aim 2 will play a vital role in engaging state lawmakers, and identifying a specific legislator that will allow a bill draft request to be submitted to the OCR on their behalf. If a legislator is not identified, then an outline of key legislative language and policy priorities will be developed, which could potentially be submitted to the OCR in a future legislative session. This document will include specific policy language that will build upon the issue white paper written in 2008.

**Evaluation**

This project will have short term and long-term evaluation goals. Some of these goals fall within the bounds and timeline of the DNP project, whereas other goals may extend years beyond the DNP project completion. A formative and summative evaluation will be important to ensure that the project remains on track and can be compared to project aims set in the planning stage.

**Formative Evaluation.** A formative evaluation of the advocacy strategy will utilize questions from the advocacy framework to determine where the strategy stands in the advocacy process. The same questions will be addressed at multiple points in the process in order to track progress. It will also allow the me to acknowledge changes in the strategy due to unanticipated events in the political arena.

**Summative Evaluation.** A summative evaluation will occur at the end of the DNP project. This evaluation will assess whether the aims of the project were met. It will allow the me to present the findings from the project implementation. A summative assessment within the context of this project will include the following:
-Survey Evaluation: Findings from the survey, proportion of those that responded, and completion of a summary of findings

-Advocacy Strategy Evaluation: Number of completed meetings with stakeholders, number of advocacy training sessions held, and number of meetings held with legislators, and a written and visual description of the advocacy strategy utilizing Figure 3.

-Bill Draft Evaluation: Number of bill drafting sessions/meetings, completion of a draft bill

Implications

This project has immediate and long-term implications for nursing practice and patient access to primary and mental health care. Immediate implications include increased engagement within the nursing community, and education and awareness among policymakers. The immediate implications of the survey are increased awareness of how the reimbursement parity issue affects privately owned NP practices in Washington State. Longer-term implications include a mapped advocacy strategy for future advocates to base their efforts on when attempting to address the parity issue in future legislative sessions. For the public, future legislative action on NP reimbursement parity will increase access to primary care services due to the sustainability of NP-owned practices.

DNP Project and Immersion

The project immersion will take place in multiple locations within Washington State. Many of the advocacy efforts will take place in Olympia, WA, the state capitol. Advocacy training sessions and meetings with NPs will take place in various counties and locations in Washington State. Project hours will be accumulated through the development, implementation,
and analysis of the survey, meetings with stakeholder groups, and time spent on bill drafting and advocacy efforts in the state legislature.

**Proposed Timeline**

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Proposal Defense</td>
<td>January 10&lt;sup&gt;th&lt;/sup&gt;, 2018</td>
</tr>
<tr>
<td>Survey Development with project mentor, including review and/or pilot of survey</td>
<td>~February 2018</td>
</tr>
<tr>
<td>Survey Send Out</td>
<td>~March 2018</td>
</tr>
<tr>
<td>Survey Closed</td>
<td>~April 2018</td>
</tr>
<tr>
<td>Survey Data Analysis Complete</td>
<td>~April-May 2018</td>
</tr>
<tr>
<td>Summarized Findings of Survey Results</td>
<td>~May-June 2018</td>
</tr>
<tr>
<td>Strategy Sessions with WSNA and AUWS</td>
<td>~May 2018-August 2018</td>
</tr>
<tr>
<td>Scheduled Meetings with Chair of WA House and Senate Healthcare Committees</td>
<td>~September-November 2018</td>
</tr>
<tr>
<td>Advocacy Engagement/Training Sessions with NPs in key legislative districts</td>
<td>~September-November 2018</td>
</tr>
<tr>
<td>Meetings with non-nursing stakeholder groups/representatives</td>
<td>~September-November 2018</td>
</tr>
<tr>
<td>Advocacy Strategy Mapping and Bill Draft</td>
<td>December 2018</td>
</tr>
<tr>
<td>Nurse Legislative Day</td>
<td>January 2019</td>
</tr>
<tr>
<td>WA State Legislative Session</td>
<td>January~April 2019</td>
</tr>
<tr>
<td>Manuscript Completion and DNP Project Presentation</td>
<td>February-March 2019</td>
</tr>
</tbody>
</table>

WSNA: Washington State Nurses Association  
AUWS: ARNPs United of Washington State
Chapter 4

Implementation and Results

Aim 1: ARNP Survey

The goal of this questionnaire was to survey NP-owned practices across the state in order to understand the impact of reduced private-insurer reimbursement on practice sustainability. In order to fulfill this aim, a collaborative partnership was developed with a mentor to work on a state-wide survey of ARNPs. I served as a co-investigator on a survey which was financially supported by the Washington Center for Nursing (WCN), Washington State University, and the American Association of Nurse Practitioners (Kaplan & Gill, 2018). In order to satisfy the objectives of WCN, the survey contacted all actively licensed ARNPs with addresses in the state in order to obtain workforce data, with filter questions to assess practice ownership and reimbursement. The subsequent sections regarding the questionnaire summarizes the survey report from Kaplan and Gill (2018).

Survey Sample and Design. 6,188 licensed ARNPs were surveyed, and 1,235 (20.7%) responded. This cross-sectional, mixed-mode study was accomplished through the delivery of a 51-item questionnaire via email and mail. The list of ARNPs was obtained through a public disclosure request from the Washington State Department of Health. This list was combined with 222 businesses registered on the Secretary of State and Department of Revenue’s website for a total sample of 6,188, after the removal of duplicates. Contacts were made with the sample using email and postal mail contacts outlined in Table 1.

Practice Ownership and Reimbursement. Of all respondents, 10.3% (n=118) indicated that they own their own practice, and 7.4% (n=85) work as an independent contractor. Previous and current practice owners include CRNAs, CNMs, and NPs (see Table 2). Among current
practice owners, most (n=98) owned their practice alone while some owned the practice with ARNPs, physicians, physicians and ARNPs, or others.

ARNP practice owners were asked about their insurance contracting relationships. Premera Blue Cross and Regence Blue Shield, the two insurance companies that reduced their reimbursement to 85% in 2013 and 2015 respectively, were the top two insurance companies that contracted with practice owners (see Table 3). Among practice owners, 35.4% reported a decrease in revenue, and 28.6% reported a decrease in financial viability as a result of these reductions. Interestingly, over one-third of respondents were unaware of how these reductions impacted their practice. This highlights a potential gap in business knowledge among some practice owners. Additional impacts from the Premera and Regence reductions are outlined in Table 4.

This survey provided valuable insight into the characteristics of ARNP practice owners in Washington State. Assessing the impact of reimbursement on practice ownership was helpful, but identified a potential knowledge gap regarding the business acumen of ARNPs. As a DNP student, my participation in the survey process with the project mentor represents the importance of a collaborative relationship between original research and implementation into practice. Portions of the survey findings contributed to advancing proposed ARNP reimbursement parity legislation.

**Aim 2: Advocacy Strategy**

The advocacy strategy was wide-ranging and required multiple projects in order to advance the concept of ARNP reimbursement parity. The strategy included collaboration with the AUWS board of directors and legislative committee, a candidate endorsement process, and communication with AUWS and legislative members. The advocacy strategy is best described
by categorizing the activities into inside and outside strategies as seen in Figure 4. This strategy was guided by concepts outlined in Coffman and Beer (2015) and Carbert (2004).

**Outside strategies.** Outside strategies include grassroots efforts that engage and organization’s membership and coalition partners to effect change. These activities exist outside the normal institutions that govern policy but may work in collaboration with inside strategies synergistically (Carbert, 2004). For this project, implementation of the strategy involved collaboration and coordination with the AUWS legislative committee, leading a political endorsement process, and communication with AUWS membership.

**Collaboration with AUWS legislative committee.** Collaboration with the AUWS legislative committee and leadership was a key component of the advocacy strategy. These activities involved attending 15 phone conference calls with AUWS leaders and legislative committee members, working with the project mentor on agenda items for a portion of the conference calls, and obtaining endorsement from the AUWS board of directors on choosing reimbursement as a legislative priority for the 2019 legislative session. The project mentor, who serves as the chair of the legislative committee, played an instrumental role as liaison for this project.

**Political endorsement process.** The political endorsement process was an outside strategy that helped inform the inside political strategy. I assumed the leadership role in the development of the endorsement questionnaire, communication with political campaigns in Washington State, organizing responses for AUWS leadership review, and announcement of the endorsements. Political endorsements were granted to state Senate and House candidates on behalf of AUWS after the primary election. These endorsements did not include a monetary contribution. The candidate responses and campaign data were confidential and maintained
solely by AUWS. A draft of the questionnaire was approved by AUWS leaders and the project mentor. Relevant feedback was incorporated into the questionnaire prior to sending it out to the legislative campaigns.

Primary elections were held in Washington State on August 8, 2018. Election results were certified by the Washington Secretary of State (SOS) on August 24th, 2018. On August 15th, 2018, endorsement questionnaires were sent via email from an AUWS email account to most state legislative campaigns in the state. A few races that were too close to call, or within one half of a percentage point of one another, were closely monitored. The remaining candidates were sent a questionnaire on August 24th, 2018 after certification by the Washington SOS. In total, all 231 state legislative campaigns were sent a questionnaire.

Responses were received by 75 state House and Senate candidates. I reviewed and evaluated these responses and organized them into a candidate tracking spreadsheet. A rubric was developed to score the responses and were included in the spreadsheet. Additional components to assess the candidates’ campaigns included the political lean of the district, party, incumbency status, leadership role in the legislature if an incumbent, and whether the candidate was endorsed by other nursing organizations. After this, I solicited AUWS leaders, board members, and legislative committee members to recruit volunteers for the committee to review the responses and make decisions on endorsements. Given the volume of responses and content, I performed a review of the races, and made a preliminary recommendation for some of the races. These recommendations were made for races that included candidates without a challenger, or a very high/low likelihood of success in the general election based on political leanings of the district. I then listed priority races for the review committee to focus on, where input was needed from the lobbyist and committee members. Review committee members were
sent a copy of the candidate review spreadsheet and had access to a digital copy of all individual
candidate questionnaire responses to review before a scheduled conference call. The review
committee, made up of the AUWS president, project mentor, contract lobbyist, 3 other AUWS
leaders, and myself made final decisions on bipartisan endorsements via conference call on
September 19, 2019.

Endorsement letters were sent to 33 House candidates and 13 Senate candidates. These
endorsements were publicly announced on the AUWS website and Facebook page. Many of the
candidates promoted the endorsement using their campaign media. The General Election was
held on November 7th, 2018. After the election, 22 out of 33 (66.7%) House candidates and 10
out of 13 (76.9%) Senate candidates were successful (see Table 5). These results were shared
with AUWS leadership.

*Communication with membership.* Communication with the membership is a necessary
component of the outside advocacy strategy. Much of the communication was delivered via the
AUWS website and AUWS Facebook page. AUWS held its annual meeting at the University of
Washington Advanced Practice Nursing Conference on October 11, 2018. Current and
prospective AUWS members received updates on the legislative strategy and political
endorsement process. AUWS also held a breakout session at the WSNA Lobby Day on February
28th, 2019. Information was provided to attendees on the bill and effective ways of lobbying.
After this session, ARNPs and ARNP students met with their legislators to advocate for HB
1433/SB 5647. Efforts were made to encourage the attendees to become members of AUWS or
participate in the advocacy process. As potential legislation continues to move through the
process via implementation of the inside strategies, activation of AUWS membership and the
broader nursing community will be necessary.
Inside strategies.

Meeting with key legislative leadership. Meeting with key leadership was necessary in order to initiate inside political strategies involving the nurse practitioner reimbursement issue. A key committee chairperson was a previous source of resistance to this issue. After meeting with her to present key results from the survey data, and outlining bipartisan support as evidenced by the political endorsement process, the chair allowed the organization to move forward with draft legislation. I participated in preparing materials for the meeting, writing talking points, active discussion during the meeting, and communicating with other attendees before and after the meeting. This meeting was necessary before moving forward with other steps in the advocacy strategy.

Outreach to endorsed candidates. Welcome letters were sent to the endorsed candidates that were successful in the general election prior to the Christmas break. This was meant to serve as a transition between the campaign and the upcoming legislative session in January, and outline policy priorities for AUWS. Multiple legislators responded, including a newly elected senator that expressed an interest in supporting reimbursement legislation.

Preparation for legislative session. Preparation for the legislative session included writing talking points, identifying and collaborating with a new contract lobbyist, and outlining a strategy for bill introduction. Part of this process involved discussions with other organizations and professions, such as the physician assistant group, the medical associations, and other nursing organizations. Monitoring other health policy priorities was important in order to identify potential agenda items that could compete with reimbursement legislation. The 2019 Washington State of Reform conference held on January 10th, 2019 provided an opportunity to hear about these competing priorities from legislators and stakeholders. These included the state
budget, consideration of a state-wide public option health insurance bill, advancing behavioral health care, and addressing workplace violence in healthcare.

**Bill sponsor recruitment.** Identification of a prime sponsor for the ARNP reimbursement bill was necessary in order to formally introduce legislation in the 2019 legislation session. Because of the endorsement process and welcome letters after the 2018 General Elections, one of the senators requested a meeting to discuss the possibility of sponsorship. The newly elected Senator represented the district of my legislative district, and was appointed as Vice-Chair of the Senate Health Care Committee. I developed a professional relationship and met with the Senator as a candidate during the campaign. I maintained the relationship and was present at the meeting in the district, along with the contract lobbyist and the DNP project mentor. During the meeting, the I outlined the local benefits of payment parity in the district and worked with the lobbyist and project mentor to discuss the background of the bill. The senator endorsed the bill and volunteered to serve as prime sponsor for Senate Bill 5647 (2019), which had 12 bipartisan sponsors. This process highlights the importance of maintaining professional relationships in politics, as they can serve as a foundation for successful partnerships in the future.

In the House, the vice-chair of the House Healthcare and Wellness Committee served as prime sponsor for House Bill (HB) 1433 (2019), which had 11 total sponsors. Unfortunately, the House and Senate bills were not heard in committee, which killed the bill for the 2019 session. The goal for next session will be to secure hearings and vote the bills out of committee. Efforts to ensure success of these steps will include close collaboration between the AUWS leadership, and the contract lobbyist, and myself in order to send action alerts to AUWS members in committee members’ districts at specific times in the process. This represents the close
synergistic relationship between inside and outside tactics that are necessary to help the legislative effort move forward (see Figure 4).

**Aim 3: Draft Legislation**

Draft legislation was successfully developed in collaboration with legislative staff. Prior to meeting with staff for the House Health Care Committee in November 2018, an outline of the scope and impact of the legislation was necessary in order to identify policy priorities. I created an outline that referenced the current statute in Washington State and the sections outlined in the Oregon law. This required identification of sections that needed reconciliation, such as the inclusion of other health professions, and language regarding health maintenance organizations and physician reimbursement. I worked closely with the project mentor and AUWS leadership to identify a bill title and policy priorities. The project mentor and I both met with the House Health Care Committee staff and outlined the policy objectives. Draft legislation was developed after this meeting that would serve as the initial negotiating position for AUWS.

**Discussion**

This wide-ranging project demonstrates the impact that nurse-led advocacy can have on institutional and legislative change. While the project was broken down into multiple deliverables and objectives, each of these components contributed to the effort of achieving legislative change in Washington State. The survey represented the important role that evidence plays on fostering change. The survey data provided a solid foundation for the arguments that would later be made to legislators. This survey, as well as the overall strategy, can be useful to other states that examine ARNP practice ownership.

The bipartisan political endorsement process helped AUWS gain visibility among campaigns on both sides of the aisle. AUWS gained a valuable understanding of the political
positions of both supporters and opponents to ARNP reimbursement parity; this helped position the organization better for the legislative session. The process also highlighted areas for improvement in the future. The endorsements were limited to just general election candidates and did not include live interviews for follow-up questions. Expanding the process to the primary election, or including live interviews for specific races, may provide more information in the next election.

The process of bill drafting and introduction in the 2019 legislative session highlighted potential areas for strategy adjustment for the 2020 legislative session. While the bill did not pass either legislative chamber, the process provided more insight into opponent arguments. In future legislative sessions, advocates may consider adjusting bill language, building more coalition relationships with other industries or interest groups, and activating the membership earlier in the session. The bill will need to secure a hearing in the committees of jurisdiction, which will require active dialogue with committee chairs and party leadership.

**DNP Role in Policy Change**

Nurses are natural advocates in the clinical setting. This project provides an example of how nurses can improve the clinical environment through political advocacy. Nurses are present at all levels of the health care system and are the experts in policy that relate to nursing practice. Because of this, the voice of nursing must be present in the political arena to improve clinical practice and patient outcomes. This project worked on changing policy at the state level to improve ARNP practice and access to care.

The DNP prepared nurse can play a pivotal role in implementing systems-level change. While clinical projects play an important role in improving clinical practice, change is still necessary at higher levels to change the institutions that govern or oversee the healthcare system.
today. This project can serve as an example for other DNP students that look to make a
difference in the political arena. The scope of policy project deliverables need to be specific to
the issue(s) or institution(s). For example, a project working on an issue in a region with a
limited organizational infrastructure may need to focus on building the infrastructure to support
the initiative in the future. In areas with an established infrastructure, a project may need focus
on a strategy to work within existing organizations. Examples of these activities may include
mapping an advocacy strategy, building coalitions, leading a political endorsement process,
design a lobby/legislative day for an organization or coalition, or designing a legislative
advocacy curriculum for an organization or population.

Conclusion

Advanced practice nurses will continue to play an important role in solving access-to-
care issues in the United States. As a state with full practice authority for ARNPs, Washington
State is uniquely positioned to address its provider shortage. NP-owned practices, particularly in
primary care and behavioral health settings, serve patients in rural and urban settings. Adequate
reimbursement for services provided by NPs is necessary in maintaining the financial viability of
these practices. Washington State, unlike Oregon, does not require private insurance companies
to pay NPs the same amount for the same service provided by physicians. Regence Blue Shield
and Premera Blue Cross both reimburse NPs at 85% of the physician fee schedule in Washington
State. This rate reduction does not translate into lower premiums or costs to consumers that use
NPs as a provider. Reductions in revenue and financial viability were listed as the top two
consequences of rate reductions by Regence Blue Shield and Premera Blue Cross (Kaplan &
Gill, 2018).
An advocacy strategy was developed and implemented in Washington State to achieve reimbursement parity for NPs from private insurers. This advocacy strategy included collaboration with state ARNP leaders, a political candidate endorsement process, and implementation of both inside and outside political strategies. This strategy ultimately led to introduction of legislation in the Washington State House and Senate in the 2019 session. While the bill did not pass, the process laid the groundwork for future sessions. The DNP-prepared nurse can play a major role in advancing policies that improve advanced nursing practice and patient care. Engagement in the policy arena represents an important area where DNP prepared nurses can make a significant change.
References

Advanced registered nurse practitioner—Activities allowed. Revised Code of Washington § 18.79.250


ARNP designations, certification, and approved certification examinations. Washington Administrative Code § 246-840-302


ARNP scope of practice. Washington Administrative Code § 246-840-300


http://bulletin.facs.org/2014/05/billing-for-services-performed-by-nonphysician-practitioners/#.WhHp_Gdryso

https://www.huffpost.com/entry/washington-state-senate-special-election_n_5a00a45be4b0baea2633bfae


doi:10.3109/01612840.2015.1062581

doi:10.1177/1527154410382458


doi:10.1176/appi.ps.201600405


https://www.thelundreport.org/content/leading-nurses-union-wants-make-equal-pay-nurse-practitioners-permanent


Kaiser Family Foundation (2012). *Medicaid benefits: Nurse practitioner services*. Retrieved from: https://www.kff.org/medicaid/state-indicator/nurse-practitioner-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22%22Location%22,%22sort%22:%22%22asc%22%7D

Kaiser Family Foundation (2016). *Primary care health professional shortage areas (HPSAs)*. Retrieved from: https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22%7B%22washington%22:%7B%7D%7D%22%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D


Services provided by certified nurse practitioner or licensed physician assistant. Oregon Revised Statute § 743A.036


The same pay for the same service (2008). *The Washington Nurse.* 38(3). Retrieved from:
https://cdn.wsna.org/assets/washington-nurse-issue-archive/wn38.3-Fall-2008.pdf

Washington State Department of Health (2017). *Federally Designated Health Professional Shortage Areas for Primary Care.* Retrieved from:

Washington State Department of Labor & Industries (2016). *Advanced registered nurse practitioner (ARNP) reimbursement rate.* Retrieved from:

Tables

Table 1
Contact Dates

<table>
<thead>
<tr>
<th>Contact</th>
<th>Date</th>
<th>Number sent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction postcard</td>
<td>5/29/2018</td>
<td>6188</td>
</tr>
<tr>
<td>Introductory email</td>
<td>6/5/2018</td>
<td>5509</td>
</tr>
<tr>
<td>First reminder email</td>
<td>6/11/2018</td>
<td>5081</td>
</tr>
<tr>
<td>First paper questionnaire*</td>
<td>6/18/2018</td>
<td>209</td>
</tr>
<tr>
<td>Second reminder email</td>
<td>6/22/2018</td>
<td>4733</td>
</tr>
<tr>
<td>Replacement questionnaire*</td>
<td>7/6/2018</td>
<td>189</td>
</tr>
<tr>
<td>Final reminder email</td>
<td>7/6/2018</td>
<td>4538</td>
</tr>
</tbody>
</table>

*Practice owner list only


Table 2
Practice Ownership/Independent Contractor by Role

<table>
<thead>
<tr>
<th>Role</th>
<th>Practice now closed</th>
<th>Was a contractor</th>
<th>Currently owns practice</th>
<th>Currently contractor</th>
<th>Never owner or contractor</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRNA</td>
<td>0%</td>
<td>6%</td>
<td>8%</td>
<td>25%</td>
<td>54%</td>
<td>6%</td>
</tr>
<tr>
<td>CNS</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>NP</td>
<td>2%</td>
<td>4%</td>
<td>10%</td>
<td>5%</td>
<td>72%</td>
<td>7%</td>
</tr>
<tr>
<td>CNM</td>
<td>4%</td>
<td>1%</td>
<td>3%</td>
<td>0%</td>
<td>88%</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>3%</td>
<td>10%</td>
<td>7%</td>
<td>26%</td>
<td>52%</td>
</tr>
</tbody>
</table>

### Table 3
**Top Ten Private Health Plans and ARNP Contracting**

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premera Blue Cross</td>
<td>133</td>
<td>77.3%</td>
</tr>
<tr>
<td>Regence Blue Shield</td>
<td>126</td>
<td>74.6%</td>
</tr>
<tr>
<td>First Choice</td>
<td>109</td>
<td>66.9%</td>
</tr>
<tr>
<td>Aetna</td>
<td>106</td>
<td>63.5%</td>
</tr>
<tr>
<td>Lifewise Health Plan of Washington</td>
<td>101</td>
<td>61.9%</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>100</td>
<td>61%</td>
</tr>
<tr>
<td>Cigna</td>
<td>83</td>
<td>53.9%</td>
</tr>
<tr>
<td>Tricare</td>
<td>76</td>
<td>48.7%</td>
</tr>
<tr>
<td>Regence BlueCross BlueShield of Oregon</td>
<td>77</td>
<td>47.8%</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan of Washington</td>
<td>71</td>
<td>45.2%</td>
</tr>
</tbody>
</table>


### Table 4
**Effect of Reduction in Reimbursement by Premera and Regence**

<table>
<thead>
<tr>
<th></th>
<th>Stayed the same</th>
<th>Reduced</th>
<th>Increased</th>
<th>Don’t know</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours open</td>
<td>57.7%</td>
<td>3.2%</td>
<td>1.3%</td>
<td>37.8%</td>
<td></td>
</tr>
<tr>
<td>Panel size</td>
<td>46.3%</td>
<td>5.6%</td>
<td>5%</td>
<td>43.1%</td>
<td></td>
</tr>
<tr>
<td>Salaries of employees</td>
<td>41.2%</td>
<td>9.2%</td>
<td>1.3%</td>
<td>48.4%</td>
<td></td>
</tr>
<tr>
<td>Practice owner/contractor salaries</td>
<td>30.3%</td>
<td>26.1%</td>
<td>0%</td>
<td>43.6%</td>
<td></td>
</tr>
<tr>
<td>Financial viability</td>
<td>30%</td>
<td>28.8%</td>
<td>1.2%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td>28.6%</td>
<td>35.4%</td>
<td>0%</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>Medicaid patients</td>
<td>25%</td>
<td>7.8%</td>
<td>1.6%</td>
<td>37%</td>
<td>37% never accepted</td>
</tr>
<tr>
<td>Medicare patients</td>
<td>24.5%</td>
<td>9.6%</td>
<td>1.1%</td>
<td>26.1%</td>
<td>31.9% never accepted</td>
</tr>
</tbody>
</table>

### Table 5

**AUWS 2018 General Election Endorsements**

<table>
<thead>
<tr>
<th>House</th>
<th>Senate</th>
</tr>
</thead>
<tbody>
<tr>
<td>House 1, Position 2: Shelley Kloba (D)</td>
<td>Senate 6: Jeff Holy (R)</td>
</tr>
<tr>
<td>House 3, Position 2: Timm Ormsby (D)</td>
<td>Senate 13: Judy Warnick (R)</td>
</tr>
<tr>
<td>House 5, Position 2: Paul Graves (R)***</td>
<td>Senate 15: Jim Honeyford (R)</td>
</tr>
<tr>
<td>House 6, Position 2: Dave Wilson (D) ***</td>
<td>Senate 21: Marko Liaas (D)</td>
</tr>
<tr>
<td>House 12, Position 1: Ann Diamond (I)***</td>
<td>Senate 26: Emily Randall (D)</td>
</tr>
<tr>
<td>House 13, Position 2: Sylvia Hammond (D)***</td>
<td>Senate 30: Claire Wilson (D)</td>
</tr>
<tr>
<td>House 14, Position 1: Sasha Bentley (D)***</td>
<td>Senate 32: Maralyn Chase (D)***</td>
</tr>
<tr>
<td>House 16, Position 1: William Jenkin (R)</td>
<td>Senate 35: Irene Bowling (D)***</td>
</tr>
<tr>
<td>House 18, Position 1: Chris Thobaben (D)***</td>
<td>Senate 37: Rebecca Saldana (D)</td>
</tr>
<tr>
<td>House 18, Position 2: Kathy Gillespie (D)***</td>
<td>Senate 38: John McCoy (D)</td>
</tr>
<tr>
<td>House 19, Position 1: Erin Frasier (D) ***</td>
<td>Senate 45: Mankra Dhingra (D)</td>
</tr>
<tr>
<td>House 21, Position 1: Strom Peterson (D)</td>
<td>Senate 47: Joe Fain (R)***</td>
</tr>
<tr>
<td>House 21, Position 2: Lillian Ortiz-Self (D)</td>
<td>Senate 48: Patty Kuderer (D)</td>
</tr>
<tr>
<td>House 24, Position 2: Mike Chapman (D)</td>
<td></td>
</tr>
<tr>
<td>House 25, Position 1: Jamie Smith (D)***</td>
<td></td>
</tr>
<tr>
<td>House 25, Position 2: Brian Duthie (D)***</td>
<td></td>
</tr>
<tr>
<td>House 26, Position 1: Connie Fitzpatrick (D)***</td>
<td></td>
</tr>
<tr>
<td>House 27, Position 1: Laurie Jinkins (D)</td>
<td></td>
</tr>
<tr>
<td>House 27, Position 2: Jake Fey (D)</td>
<td></td>
</tr>
<tr>
<td>House 28, Position 1: Mari Leavitt (D)</td>
<td></td>
</tr>
<tr>
<td>House 28, Position 2: Christine Kilduff (D)</td>
<td></td>
</tr>
<tr>
<td>House 29, Position 1: Melanie Morgan (D)</td>
<td></td>
</tr>
<tr>
<td>House 32, Position 1: Cindy Ryu (D)</td>
<td></td>
</tr>
<tr>
<td>House 37, Position 1: Sharon Tomiko-Santos (D)</td>
<td></td>
</tr>
<tr>
<td>House 38, Position 1: June Robinson (D)</td>
<td></td>
</tr>
<tr>
<td>House 38, Position 2: Mike Sells (D)</td>
<td></td>
</tr>
<tr>
<td>House 39, Position 1: Ivan Lewis (D)</td>
<td></td>
</tr>
<tr>
<td>House 41, Position 1: Tana Senn (D)</td>
<td></td>
</tr>
<tr>
<td>House 41, Position 2: My-Linh Thai (D)</td>
<td></td>
</tr>
<tr>
<td>House 42, Position 2: Sharon Shewmake (D)</td>
<td></td>
</tr>
<tr>
<td>House 44, Position 1: John Lovick (D)</td>
<td></td>
</tr>
<tr>
<td>House 46, Position 1: Gerry Pollet (D)</td>
<td></td>
</tr>
<tr>
<td>House 47, Position 2: Pat Sullivan (D)</td>
<td></td>
</tr>
</tbody>
</table>

***: Candidate Not Successful
Figure 1. APRN Regulatory Model. Adapted from “Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education”, 2008, National Council for State Boards of Nursing & APRN Consensus Work Group. p.10
Figure 3. Relevant Interim Outcomes. Adapted from “The Advocacy Strategy Framework”, by J. Coffmann, and T. Beer, 2015, *Center for Evaluation Innovation*, p. 11
**Figure 4.** Inside and Outside Strategy for ARNP Reimbursement Parity. Concepts adapted from Coffmann & Beer (2015) and Carbert (2004).