



Susan Kendig

From practice to policy: The WHNP as advocate

By Susan Kendig, JD, MSN, WHNP-BC, FAANP

As most of our readers know, the National Association of Nurse Practitioners in Women's Health (NPWH) and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) released the 7th edition of the *Women's Health Nurse Practitioner: Guidelines for Practice and Education* in December 2014. Many women's health nurse practitioners (WHNPs) use this document to outline their clinical competencies, and faculty use it as a framework in developing WHNP program curricula. But the guidelines go *beyond* describing clinical practice components and educational requirements; they also include policy and advocacy competencies. In particular, the guidelines enumerate participating in legislative/policy-making activities that influence women's health and serving as "a consultant and trusted source of information on women's health for healthcare systems and policy-makers" as key WHNP leadership competencies.¹

As core WHNP competencies, policy and advocacy align well with NPWH's mission and values. NPWH's mission is to "ensure the provision of quality primary and specialty healthcare to women of all ages by women's health and women's health-focused nurse practitioners." This mission includes protecting and promoting a woman's right to make her own choices regarding her health within the context of her personal, religious, cultural, and family beliefs. As a professional membership organization, NPWH strives to

continuously improve access and quality of healthcare for women through excellence and innovation in continuing education and professional development; to demonstrate leadership in policy, practice, and research; and to provide support and services for our members. These policy-related values are key to achieving our mission:

- To advocate for healthcare policies that support women and advanced practice registered nurses (APRNs) who care for them; and,
- To collaborate with strategic partners to enhance the effectiveness and timeliness of our efforts in the policy arena.²

How do these competencies affect clinical practice?

So, what does all of this mean in the real world of clinical practice? As most of our readers witness every day, policy decisions related to everything from reimbursement for healthcare service delivery to state-based APRN scope of practice regulations to decisions regarding availability of services, medications, or new technologies can affect women's health—and the realization of NPWH's mission. The following discussion provides just a few examples.

The Patient Protection and Affordable Care Act seeks to increase access to affordable health insurance, with the ultimate goal of increasing access to healthcare. One way that it does this is by providing a mechanism for federally supported Medicaid expansion to cover most low-income adults (i.e., those earning up to 138% of the federal poverty level). Yet, to date, approximately 20 states have not expanded Medicaid to this level of coverage.³ Most states provide Medicaid coverage during pregnancy; however, in non-Medicaid-expansion states, this coverage stops shortly after delivery. Although coverage of

prenatal care facilitates a favorable pregnancy outcome, lack of coverage for care needed before and between pregnancies can have devastating effects on women and their children.

Consider the reproductive-aged woman with type 1 diabetes mellitus (T1DM). Diabetes in pregnancy can adversely affect both maternal and infant outcomes. Women with T1DM have higher rates of maternal mortality and morbidity, including increased rates of pre-eclampsia and cesarean section. Likewise, maternal T1DM increases the risks for fetal and neonatal loss, congenital anomalies, macrosomia, and a host of other neonatal complications. A patient with T1DM who qualifies for Medicaid during pregnancy but loses coverage soon after delivery will not have access to care for her chronic disease prior to her next pregnancy. This gap in care can allow her T1DM to spiral out of control, contributing to increased maternal and infant health problems or even death during subsequent pregnancies.⁴

In June 2015, the House Labor, Health and Human Services (LHHS) Subcommittee marked up its fiscal year 2016 spending bill, which contained a complete elimination of Title X. The following week, the Senate released a funding bill proposing \$257.8 million for Title X, a decrease from the prior year's \$286.5 million budget.⁵ By the time this article goes to press, we should know how the Title X program fares in the 2016 budget. It is estimated that publicly funded healthcare providers, such as those funded through Title X, met an estimated 42% of the need for publicly supported contraceptive services and supplies in 2013.⁶ Cuts to, or elimination of, the Title X program would effectively bar many of these women from accessing similar services in the future. In the case of the patient with T1DM discussed earlier who has already lost access to care for her chronic disease, she will also lose family planning services, which may contribute to a shortened pregnancy interval and may increase the potential for a poor pregnancy outcome. Furthermore, because Title X clinics are staffed primarily by NPs, cuts to Title X could decrease women's access to quality care by WHNPs and other NPs who provide family planning services.

Professional competencies plus organizational values in action

Although many of our readers in clinical practice may have little time to "participate in legislative and policy-making activities that influence women's health" in the traditional sense, they are our greatest asset in terms of bringing women's stories to the forefront. NPWH staff keep our fingers on the pulses of policy-makers with power to make decisions about how, where, and from whom each woman can access care that is "within the context of her personal, religious, cultural, and family beliefs," but our organization's *members* provide the stories that give life to the policy. It is through our organization's members that we at NPWH learn about the challenges that women face in accessing woman-centric care to meet their needs, as well as the barriers faced by WHNPs in attempting to provide that care.

Conclusion

In keeping with the NPWH/AWHONN guidelines, WHNPs possess the leadership competencies to serve as trusted sources of information on women's health. As NPWH Policy Director, I invite all of our readers to collaborate with NPWH as "strategic partners to enhance the effectiveness and timeliness of our efforts in the policy arena." Please contact me at skendig@npwh.org to share your stories about policy issues affecting your practice and your patient population at the local, state, or national level. In this way, we can work together to become a collective voice for the women we serve in moving the policy needle to a place that supports women's full access to the care that they need delivered by the providers they choose. ●

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