2021–23 Advanced Registered Nurse Practitioner Supply in Provider Networks:

Estimates for Washington

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2021–23 Advanced registered nurse practitioner supply in provider networks: estimates for Washington

Executive summary

This report adds the latest information to the previous report *2017–21 Advanced Registered Nurse Practitioner Supply in Provider Networks: Estimates for Washington.*[1] The current report presents the annual estimates of the Advanced Registered Nurse Practitioner (ARNP) supply within Washington's *private health provider networks* for the years 2021 to 2023. In Washington, ARNP is a professional health provider license category that encompasses four roles: nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist, and clinical nurse specialist.[2] The nurse practitioner role is the most prevalent under the ARNP category. ARNPs are authorized to practice independently, including admitting, managing, and discharging patients from health care facilities, as well as prescribing medications.[3]

Here is what we found

- **Overall ARNP supply continued to increase.** Licenses for ARNP increased 23% from 2021 to 2023 (now totaling 14,158). Licensed ARNPs practicing in Washington's provider networks increased by 22% during the same period (totaling 7,174). The increase in the latter figure means the number of ARNPs in private insurance networks has increased from 76 per 100,000 population to 90 per 100,000 in that time.
- **Primary care ARNPs had a large increase in 2022, and specialist care ARNPs had a large increase in 2023.** In both categories, there were significantly more ARNPs in 2023 than in the two years prior. However, approximately 90% of the net increase in primary care ARNPs occurred in 2022, while *all* of the net increase in specialist care ARNPs came from 2023.
- **The ARNP workforce is still predominantly women.** Despite a slight decrease, the percentage of women in the ARNP workforce continued to be in mid-to-upper 80s. The share of women in primary care ARNPs was about three percentage points higher than the share of female specialist care ARNPs.
- **The current ARNP workforce has gotten younger.** The median age of ARNPs dropped by one year (to 43 years old) in 2023 compared to the previous two years.
- **Male ARPNs were one year younger than female ARNPs on average**. Based on the median age, male ARNPs were about one year younger than female ARNPs in overall, primary care, and specialty care categories. In general, male ARNPs had a median age of 43 while female ARNPs had a median age of 44.
- **There were significant differences in the availability and attributes of ARNPs across counties.**
    - King County accounted for about 39% of the total ARNPs, the largest share of all counties. The next group of 15 counties accounted for 1% to 11% each, and the remaining 23 counties accounted for less than 1% each.
    - Benton County had the highest **overall ARNP rate**, while seven counties (Adams, Douglas, Grant, Island, Klickitat, Pacific and Stevens) had the lowest overall rates. Ferry County had the highest **primary care ARNP rate**, while three counties (Clark, Franklin and Island) had the lowest. Benton County also had the highest **specialist care ARNP rate**, with Douglas County and Stevens County having the lowest.

[1] See *2017–21 Advanced Registered Nurse Practitioner Supply in Provider Networks: Estimates for Washington*
[2] Advanced Registered Nurse Practitioner | Nursing Care Quality Assurance Commission (wa.gov)
[3] WAC 246-840-300 (ARNP Scope of Practice)

- The three-year average percentage of female ARNPs ranged from 64.2% in Adams County to 91.1% in Island County. The three-year average median age of the ARNPs ranged from 42 years in King County to 56 years in Ferry County.

- **Disparities in the availability and attributes of ARNPs were also present across the ACHs**.
  - Of the nine Accountable Communities of Health (ACH) in Washington the HealthierHere ACH (King County) had the largest share of total ARNPs at approximately 39%. It also had the highest rate of specialist care ARNPs and highest rate of ARPNs overall. The remaining ACHs had shares of the total ARNPs ranging from 2.5% to 13.5% each year.
  - Two of these ACHs, Better Health Together and Greater Health Now (along with HealthierHere) had overall and specialist care ARNP rates that were *higher* than the statewide rates. Better Health Together ACH also had the highest rate of primary care ARNPs.
  - The three-year average share of women in the ARNP supply among the ACHs ranged from 83% in Greater Health Now to 88% in HealthierHere. The three-year average median age of the ARNPs among the ACHs ranged from 42 years in HealthierHere to 49 years in the Olympic Community of Health.

Our data sources and method

The main data source for our analysis is the Network Adequacy Reports (NARs) that health insurance carriers are required to file each month with the Washington State Office of the Insurance Commissioner. These reports contain individual provider information. These providers are affiliated with one or more private provider networks that provide direct care in Washington.

We matched ARNP records in the NARs with records in the state's health provider license database and the national provider identifiers in the National Plan & Provider Enumeration system. When we found that an ARNP had multiple practice locations, we used a record weighting system that accounts for the different locations without overcounting the total ARNP workforce.[4]

[4] For detailed information on the data sources and method, see the "Data sources and method" section.

State's supply of advanced registered nurse practitioners in provider networks

Overall supply

Total ARNP licenses issued by Washington state continued to grow during the 2021–23 period. During this period, the total number of licenses increased by 23% from 11,476 to 14,158. Of the five subcategories comprising the total ARNP licenses, four had an increase and only the "temporary permit/other" subcategory had a decrease. The subcategory of "nurse practitioner" is the largest of the five and accounted for most of the overall growth in ARNP licenses. Licenses for this subcategory increased from 9,224 in 2021 to 12,026 in 2023, accounting for 80.4% and 84.9% of the total licenses, respectively. The next largest subcategory is "anesthetist," which increased from 1,180 licenses to 1,302. However, its share of the total ARNP licenses decreased slightly, from 10.3% to 9.2%. The shares in the smaller subcategories for "clinical specialist," "midwife," and "temporary permit/other" also decreased.

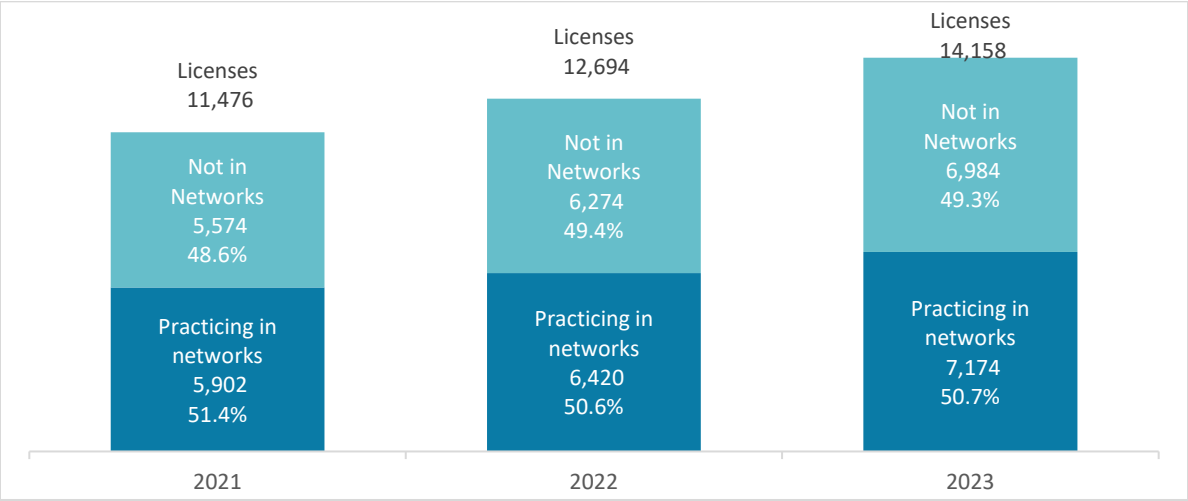
ARNP licenses by subcategories: 2021–23

	2021		2022		2023	
ARNP subcategory	N	%	N	%	N	%
Anesthetist	1,180	10.3	1,247	9.8	1,302	9.2
Clinical specialist	87	0.8	98	0.8	101	0.7
Midwife	560	4.9	597	4.7	620	4.4
Nurse practitioner	9,224	80.4	10,625	83.7	12,026	84.9
Temporary permit/Other	425	3.7	127	1.0	109	0.8
Total	11,476		12,694		14,158	

(A license was selected for each year if its initial date of issuance was on or before June 30 and its expiration date was after June 30 of the respective year.)

Of the total ARNP license holders each year, approximately half practiced in Washington through private insurance networks. The other half practiced in Washington outside of the private insurance networks, practiced in other states, or were not practicing as ARNPs. The number of ARNPs practicing in Washington's private insurance networks increased by nearly 1,300 (or 22%) from 5,902 in 2021 to 7,174 in 2023. However, their share of total ARNP licenses decreased slightly from 51.4% to 50.7% (see Figure 1).

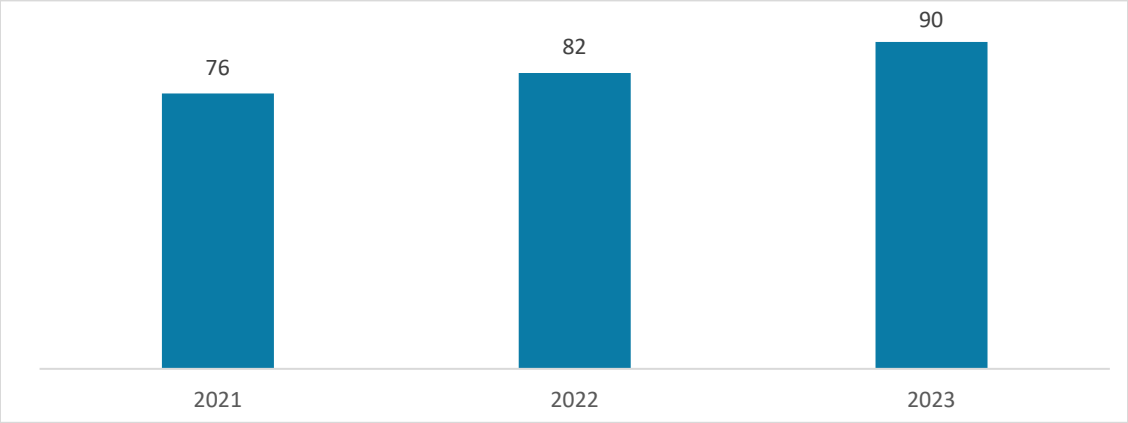
Figure 1. ARNPs with Washington licenses, number, and percentage practicing in provider networks: 2021–23



We use the term ARNP in the rest of this report to refer to ARNPs practicing in Washington's provider networks regardless of the subcategory of license.

The number of ARNPs per 100,000 population in Washington increased at a faster pace than state's general population growth, increasing from **76** per 100,000 population in 2021, to **82** in 2022, and **90** in 2023 (see Figure 2).

Figure 2. Total practicing ARNPs in provider networks per 100,000 population: Washington, 2021–23



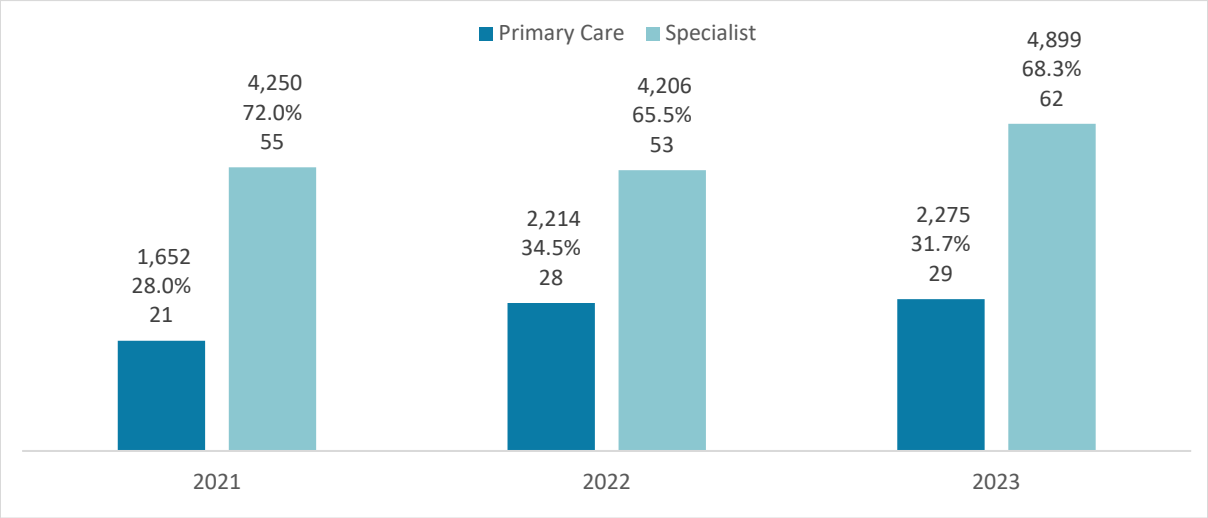
Supplies in primary care and specialist care

ARNPs in the provider networks are designated as "primary care" or "specialist care," or "both" by the health insurance carriers.[5] According to this grouping, two-thirds or more of the ARNPs are specialist care providers, though both groups had increases from 2021 to 2023. Primary care ARNPs increased by 38% from 1,652 in 2021 to 2,275 in 2023. Specialist care ARNPs increased by 15% from 4,250 to 4,899. However, approximately 90% (562) of the increase for the primary care providers took place in 2022 and all the increase for the specialist care providers took place in 2023.

The share of primary care providers increased from 28% in 2021 to 31.7% in 2023, while the share of specialist care providers decreased from 72% to 68.3%. The rate of primary care ARNPs increased from 21 per 100,000 population in 2021 to 29 per 100,000 in 2023. The rate of specialist care providers also increased, from 55 to 62 per 100,000 (see Figure 3). The growth for both groups surpassed the growth of the general population.

[5] Information on what criteria are used to make the primary/specialist care designation is not available in the NAR data source. We observed similar trends, though, in the share of primary care providers between ARNPs and physicians. For both types of providers, the share of those in primary increased in 2022 and dropped in 2023 but still ended higher than in 2021. We performed our analyses for both types of providers using the same data source and for physicians, we assigned the categories for primary and specialist care providers using provider taxonomy codes. For our reports on physician supplies, visit https://ofm.wa.gov/washington-data-research/health-care/health-care-workforce.

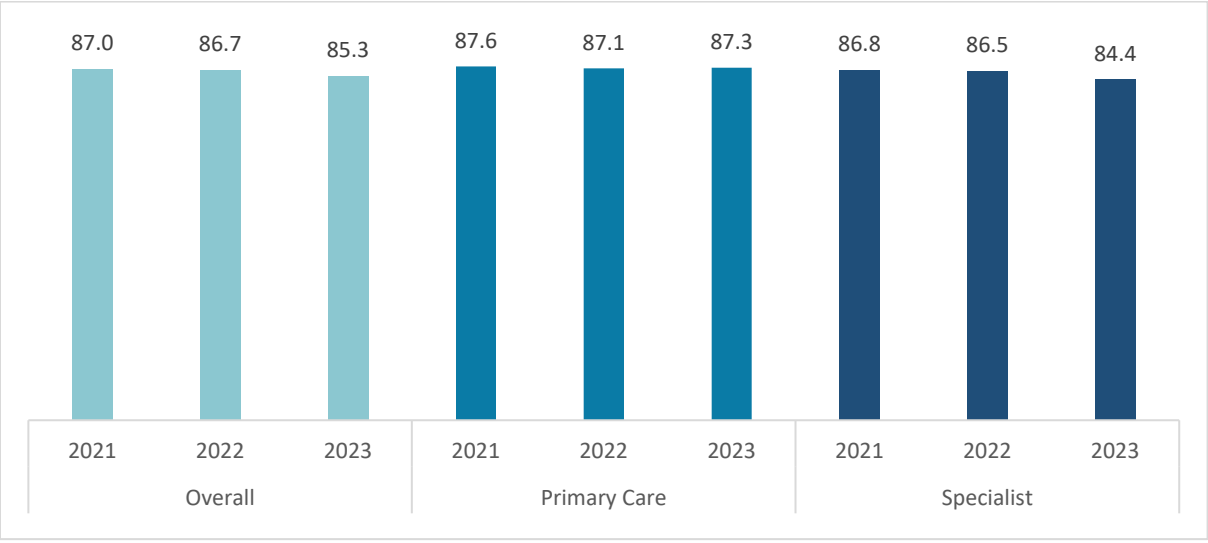
Figure 3. Number, percentage, and rate (per 100,000) of primary care and specialist care ARNPs in provider networks: Washington, 2021–23



Gender

While women continued to form the overwhelming majority of ARNPs, their share decreased slightly from 2021 to 2023, more so among the specialist care providers. Overall, the share of female ARNPs decreased from 87% in 2021 to 85.3% in 2023, a reduction of 1.7 percentage points. Among the primary care providers, their share decreased by 0.3 percentage points, from 87.6% to 87.3%. Among the specialist care providers, their share declined by 2.4 percentage points, from 86.8% to 84.4% (see Figure 4).

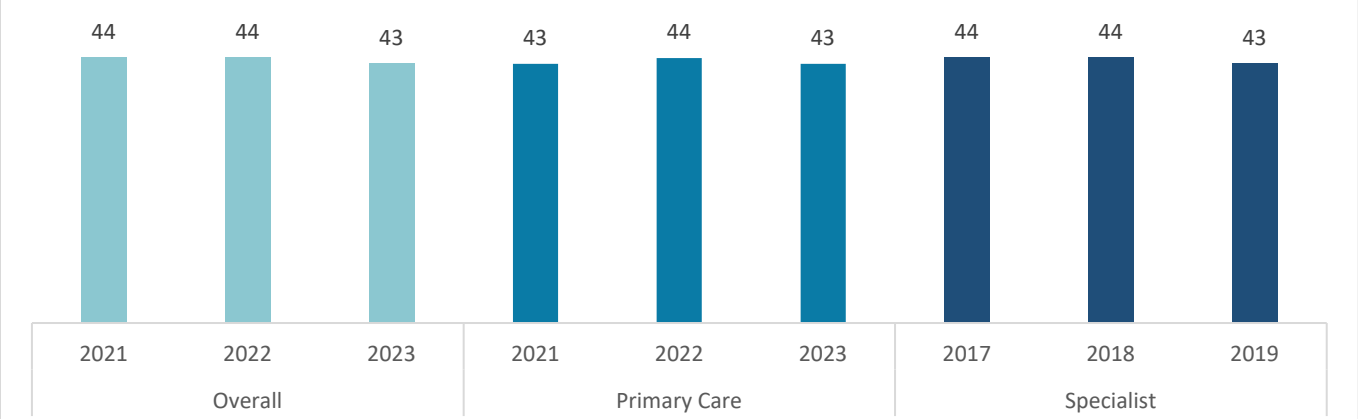
Figure 4. Percentage of females in overall, primary care, and specialist care ARNPs in provider networks: Washington, 2021–23



Median age

The median age of total ARNPs dropped by one year from 44 years in 2021 to 43 years in 2023. This drop came primarily from the specialist care providers whose median age also dropped from 44 to 43 years while the median age of the primary care providers stayed the same at 43 years (see Figure 5).

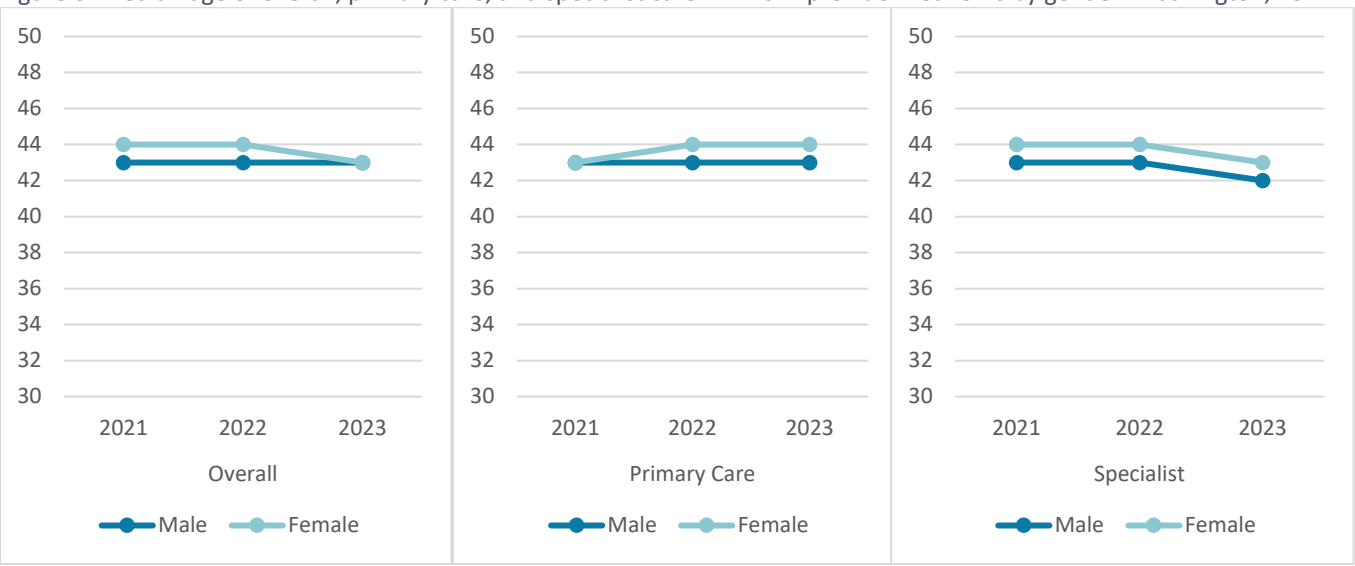
Figure 5. Median age of total, primary care, and specialist care ARNPs in provider networks: Washington, 2021–23



Median age of female and male ARNPs

In 2021 and 2022, the median age of women in the ARNP workforce was 44, one year older than that of men, which was 43. By 2023, the median age for women decreased to 43, aligning with the unchanged median age for men at 43. Among primary care providers, both sexes had a median age of 43 in 2021. Over the next two years, female ARNPs' median age increased to 44, while male ARNPs' median age stayed at 43. In specialist care ARNPs, the median age for women in the ARNP workforce remained one year higher than that of men across all three years, with women's median age at 44 in the first two years dropping to 43 in the last year, and men's median age dropping from 43 in the first two years to 42 in 2023 (see Figure 6).

Figure 6. Median age of overall, primary care, and specialist care ARNPs in provider networks by gender: Washington, 2021–23

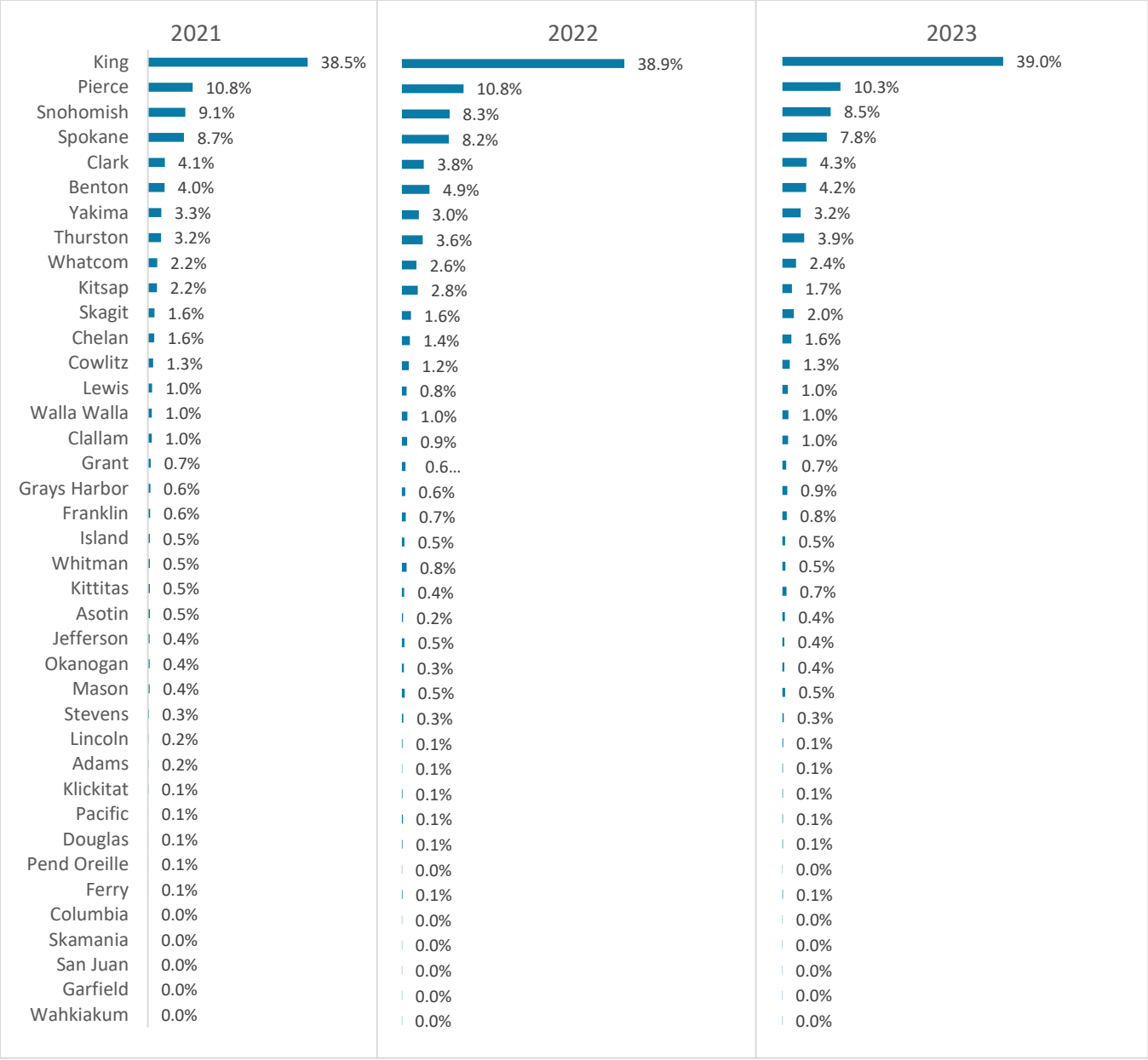


County supplies of ARNPs in provider networks

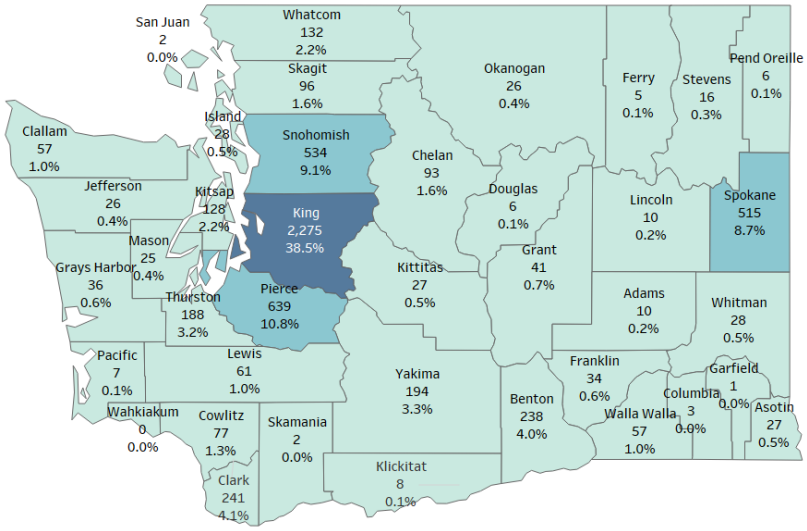
Counties: Overall supply

The distribution of ARNPs across counties saw minimal changes from 2021 to 2023. King County still stood out significantly, with its share nearing 40%. Its share increased slightly from 38.5% in 2021 to 39% in 2023. The next tier consisted of Pierce, Snohomish, and Spokane counties, each holding shares between 8% and 11%. The shares for these three counties experienced slight decreases from 2021 to 2023. Additionally, twelve more counties each had a share ranging from 1% to 4%. The remaining 23 counties each had a share of less than 1% (see Figure 7).

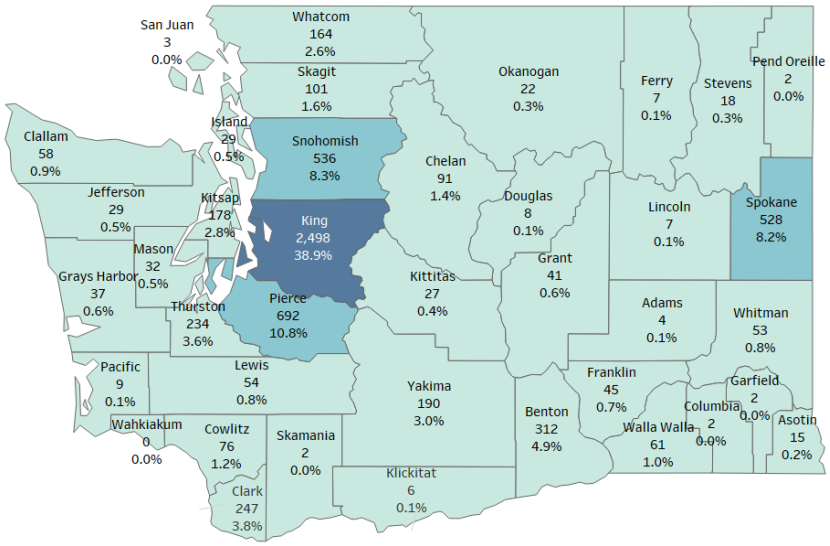
Figure 7. Percentage of state total ARNPs in provider networks: counties, 2021–23
(sorted by 2021 distribution); See Table 2 in the appendix for an accessible version of this data.



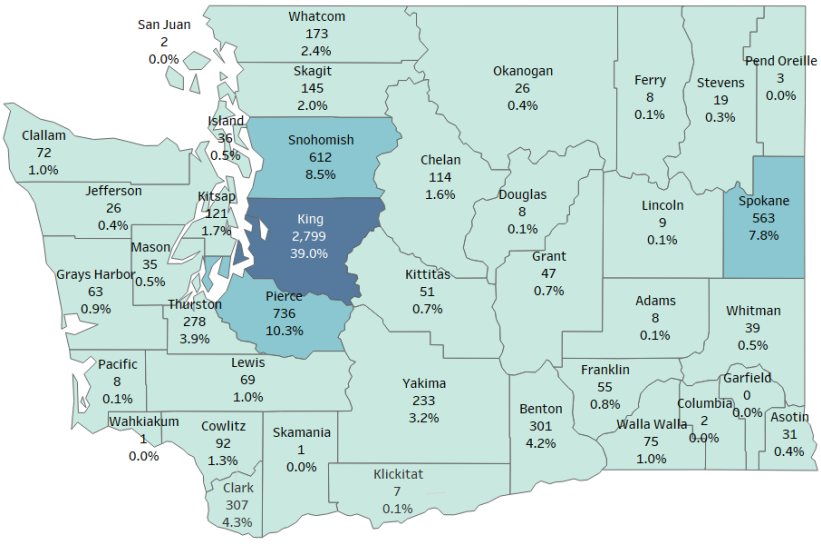
Map 1. Number and percent of ARNPs in provider networks: counties, 2021–23
See Table 2 in the appendix for an accessible version of this data.



2021



2022



2023

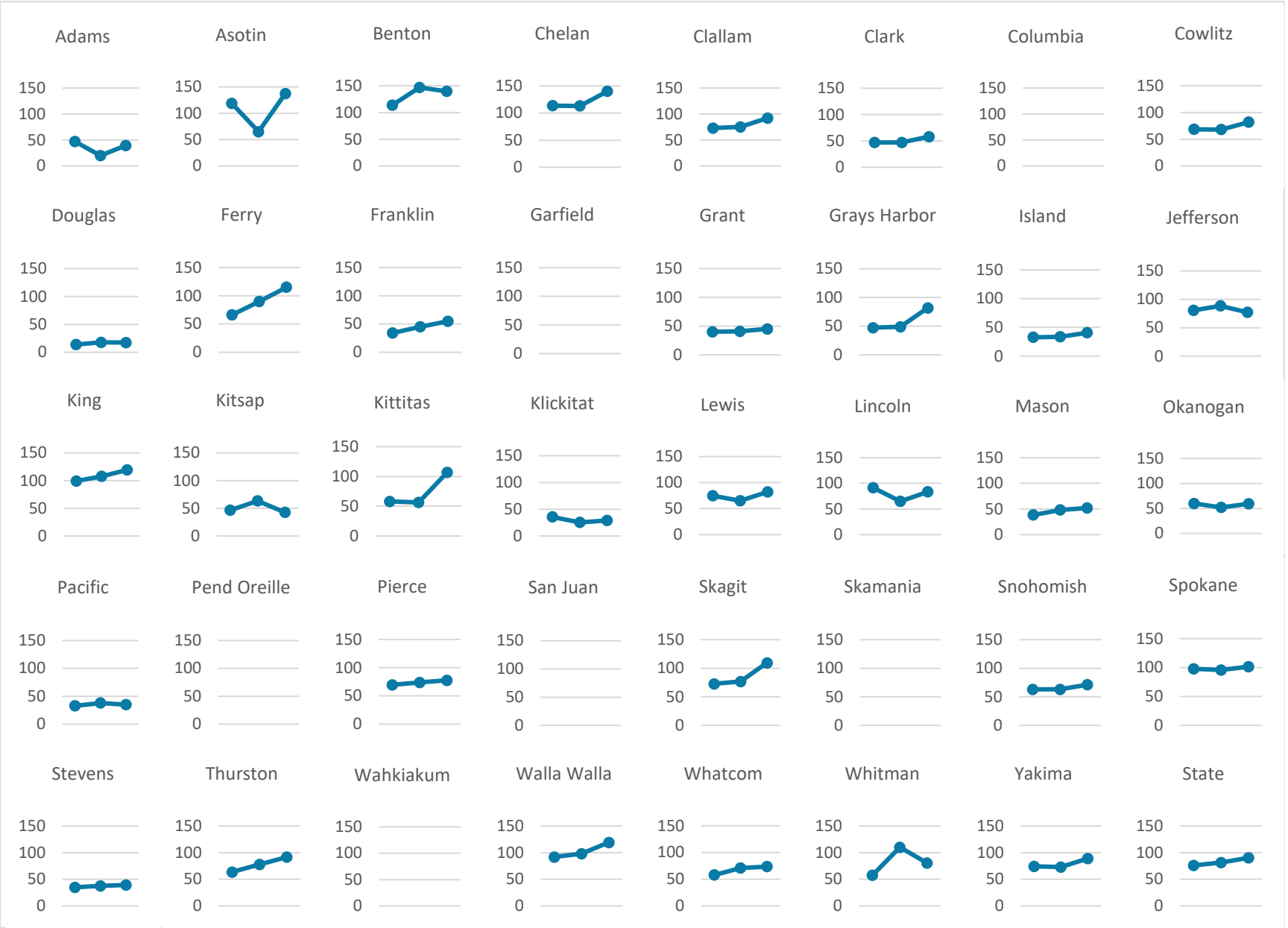
Counties: Number of overall ARNPs per 100,000 population

The estimates presented above indicate that the state's overall ARNP rate increased consecutively from 76 per 100,000 population in 2021, to 82 in 2022, and to 90 in 2023. Fourteen counties followed a similar pattern of consecutive increases, including Ferry, Franklin, King, Thurston, and Walla Walla. Meanwhile, six counties, such as Jefferson and Kitsap, had slightly lower rates in 2023 than in 2021. Thirteen other counties had higher rates in 2023 than in 2021, though the increase was not consecutive. Among these counties are Asotin, Lewis, and Whitman. Finally, six counties had too few ARNPs to calculate reliable rate estimates. Therefore, no estimates are provided for Columbia, Garfield, Pend Oreille, San Juan, Skamania, and Wahkiakum counties in this report.

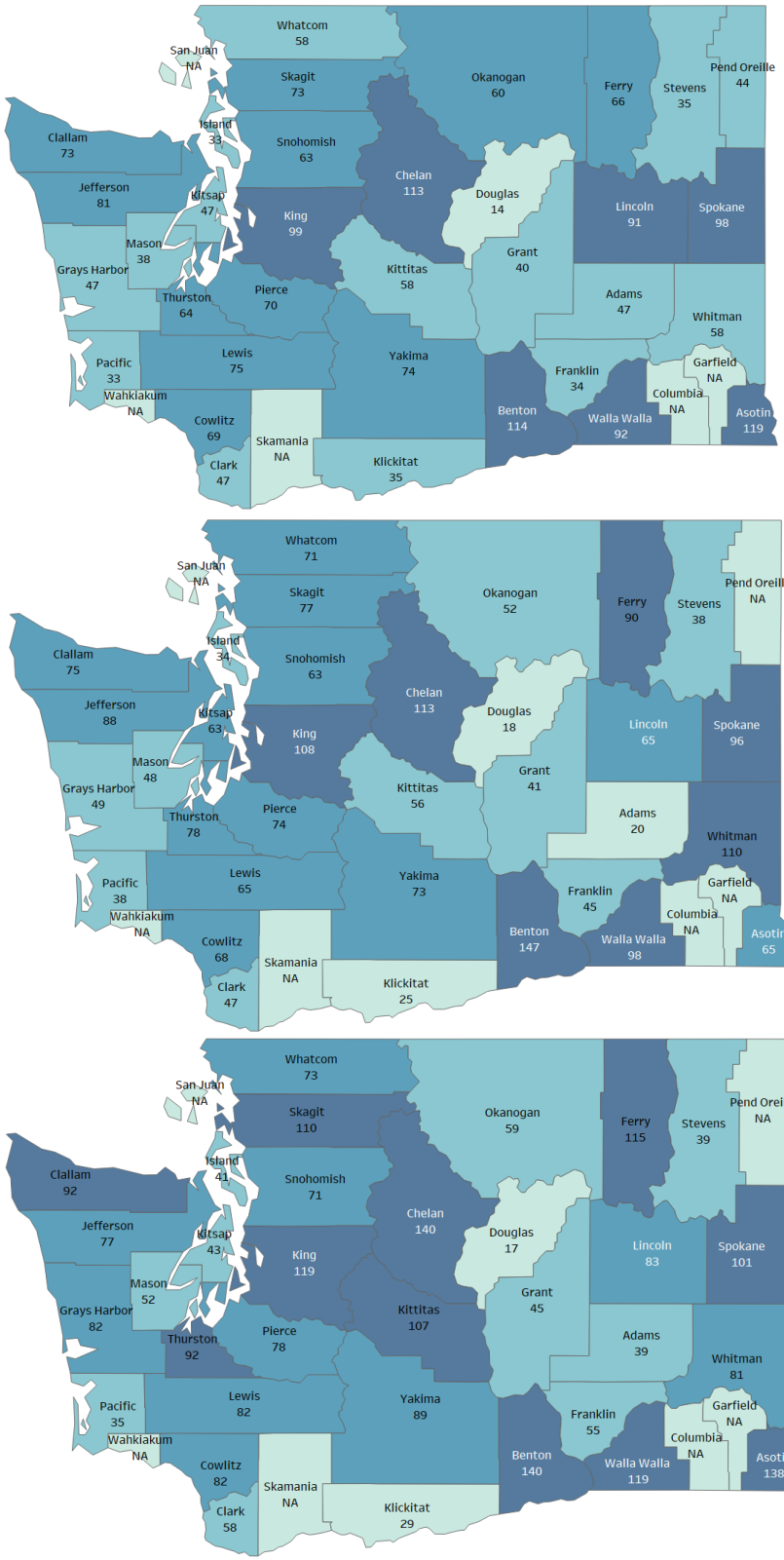
Five counties had higher rates than the state rate in all three years: Benton, Chelan, King, Spokane, and Walla Walla. Of these five, Benton had the highest rates in all three years. In 2022 and 2023, Benton's rate was above 140. On the opposite end, seven counties had the lowest rates of all counties, below 50 in all three years. These seven counties are Adams, Douglas, Grant, Island, Klickitat, Pacific, and Stevens (see Figure 8).

Figure 8. Number of overall ARNPs in provider networks per 100,000 population: counties, 2021–23

See Table 3 in the appendix for an accessible version of this data. If no data are shown, it means in one or more years, the number of ARNPs is less than 3.



Map 2. Number of overall ARNPs in provider networks per 100,000 population: counties, 2021–23
See Table 3 in the appendix for an accessible version of this data.



Counties: Number of primary care ARNPs per 100,000 population

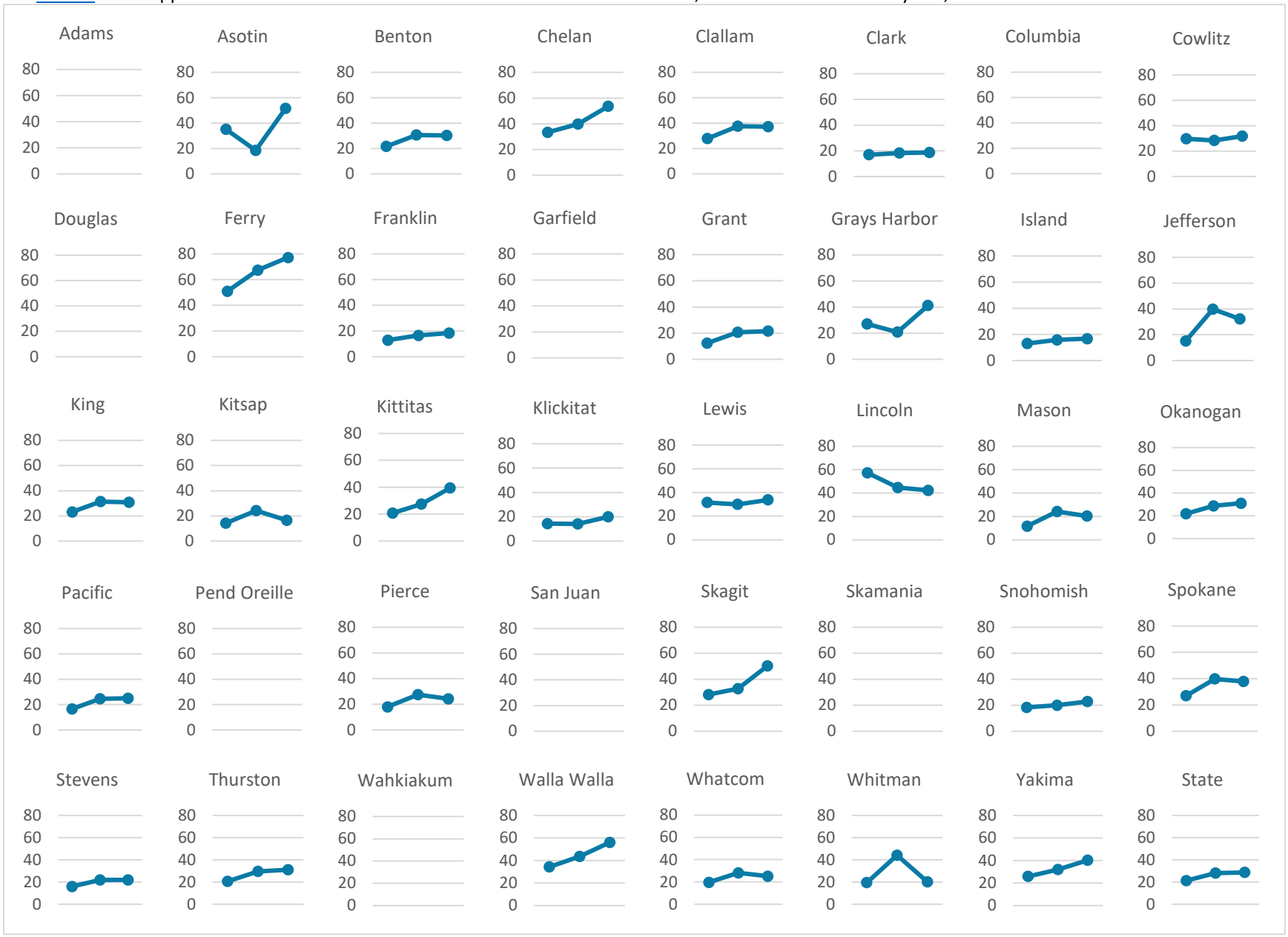
Of the 31 counties with sufficient data in estimating rates for primary ARNPs, only Lincoln county showed a lower rate in 2023 than 2021. Lincoln County's rate of primary care ARNPs in 2021 was 57 per 100,000 population, the highest of all counties. Its rate declined to 45 in 2022 and 42 in 2023. Despite the decline, its rate in 2023 was still above the state rate and was higher than rates of most counties.

Ferry County's rate of 51 in 2021 was the second highest in that year. The county's rate had consecutive increases in the next two years, to 67 in 2022 and 77 in 2023, the highest in these two years.

Clark County, Franklin County, Island County, and Klickitat County had rates among the lowest in all three years. Their rates were always at or below 20 per 100,000 population (see Figure 9).

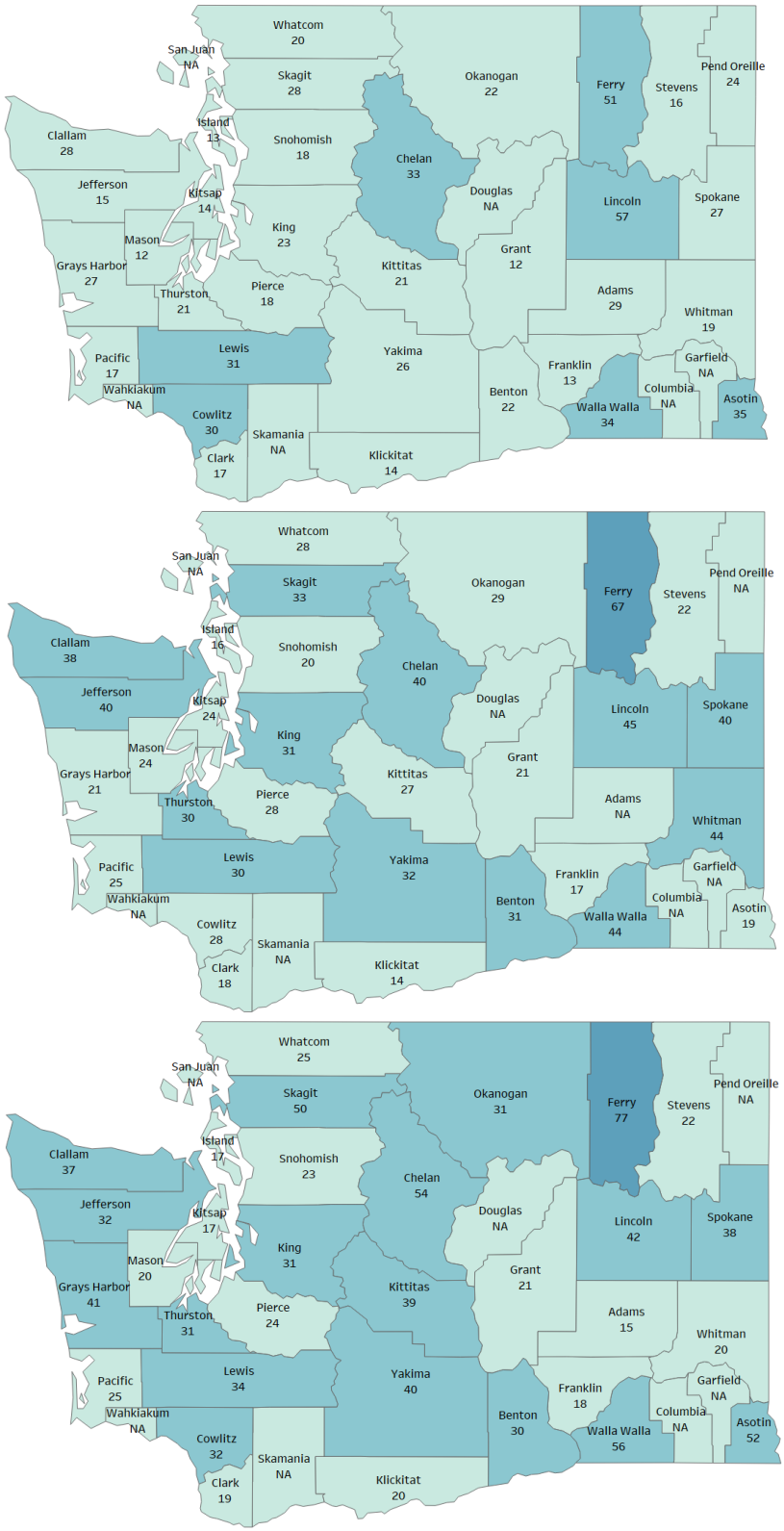
Figure 9. Number of primary care ARNPs in provider networks per 100,000 population: counties, 2021–23

See Table 3 in the appendix for an accessible version of this data. If no data are shown, it means in one or more years, the number of ARNPs is less than 3.



Map 3. Number of primary care ARNPs in provider networks per 100,000 population: counties, 2021–23

See Table 3 in the appendix for an accessible version of this data.

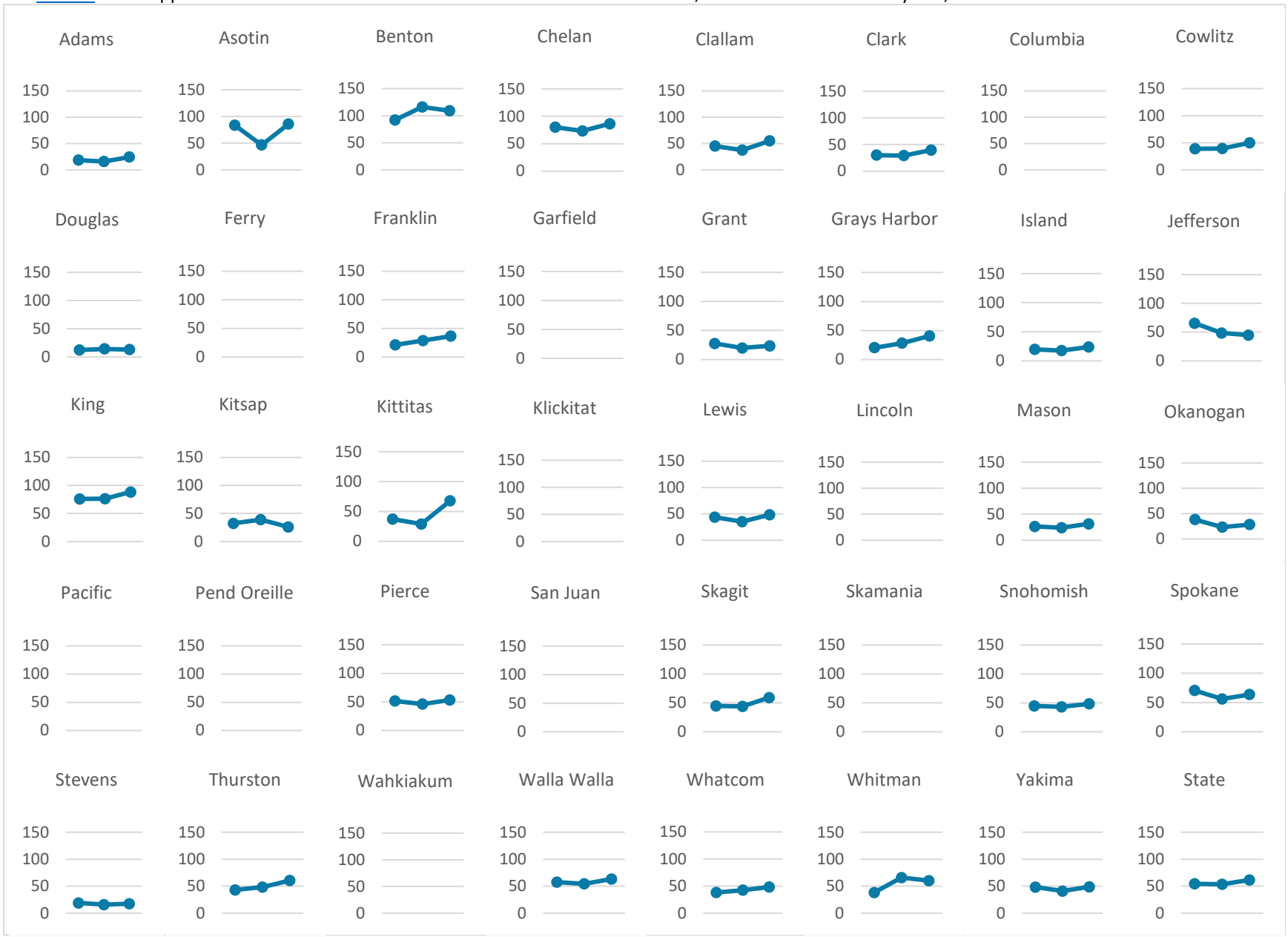


Counties: Number of specialist care ARNPs per 100,000 population

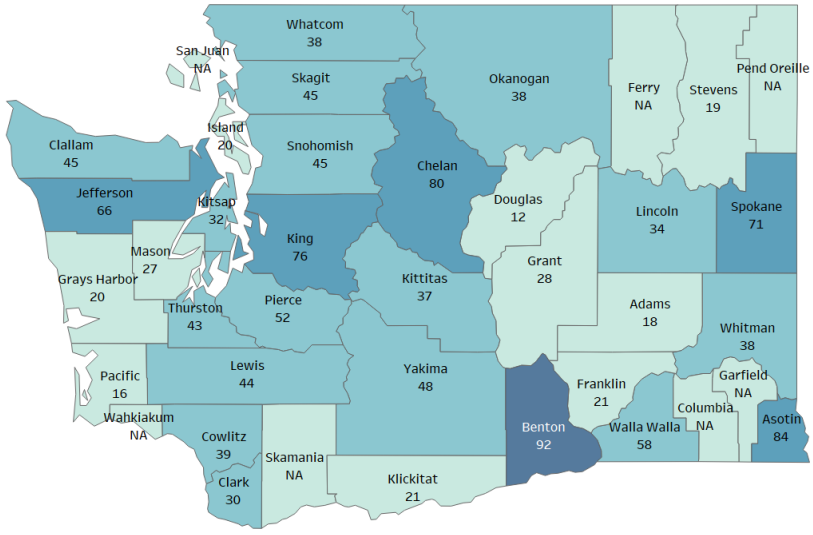
Among the 29 counties with sufficient data to calculate specialist care ARNP rates, all experienced higher rates in 2023 compared to 2021, except for these six counties: Grant, Jefferson, Kitsap, Okanogan, Spokane, and Stevens. Benton County consistently had the highest rates across all three years, with 92 per 100,000 population in 2021, 116 in 2022, and 109 in 2023. In contrast, Douglas County and Stevens County consistently had the lowest rates, always below 20 per 100,000 population (see Figure 10).

Figure 10. Number of specialist care ARNPs in provider networks per 100,000 population: counties, 2021–23

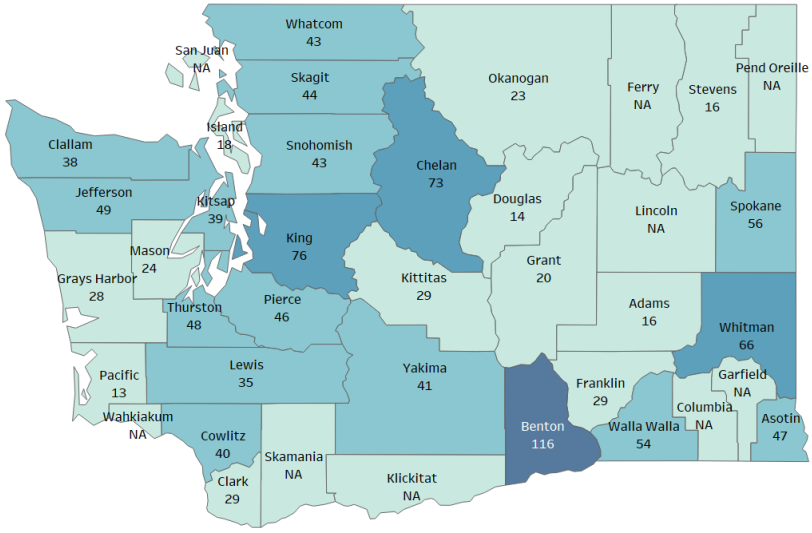
See Table 3 in the appendix for an accessible version of this data. If no data are shown, it means in one or more years, the number of ARNPs is less than 3.



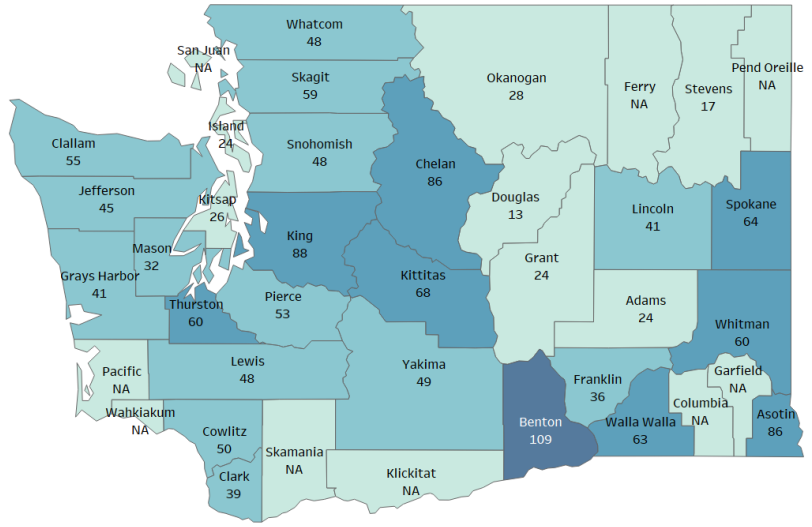
Map 4. Number of specialist care ARNPs in provider networks per 100,000 population: counties, 2021–23
See Table 3 in the appendix for an accessible version of this data.



2021



2022

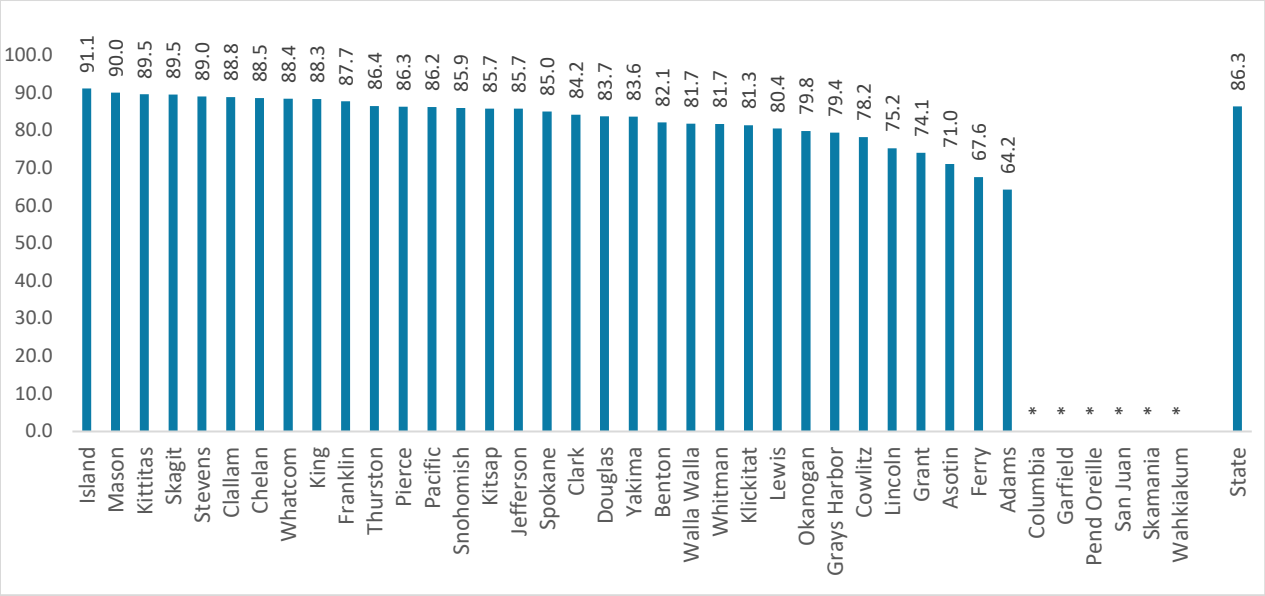


2023

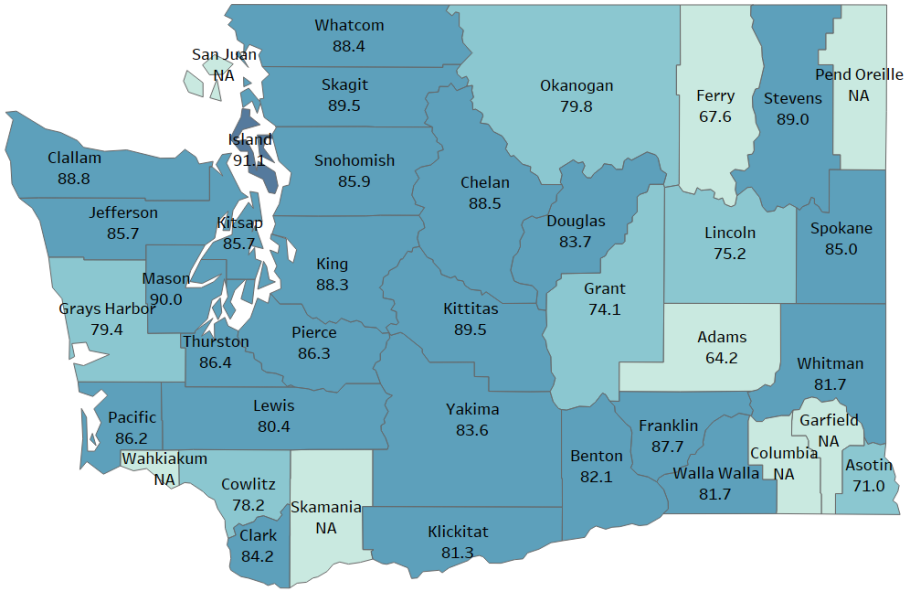
Counties: Percentage of female ARNPs

For all ARNPs in the provider networks, the three-year (2021–23) average share of women in the group was 86%. There was, however, a wide variation among the 33 counties that had sufficient data to calculate this number. Among these counties, the share ranged from 91.1% in Island County to 64.2% in Adams County, a difference of 27 percentage points between the highest and the lowest shares. Eleven of the 33 counties had shares for female ARNPs that were higher than the state's share (86.3%). The remaining 22 of the 33 counties had shares at or below the share for the state (see Figure 11).

Figure 11. Three-year average percentage of female ARNPs in provider networks: counties, 2021–23
(* denotes fewer than three ARNPs in the county in one or more years)



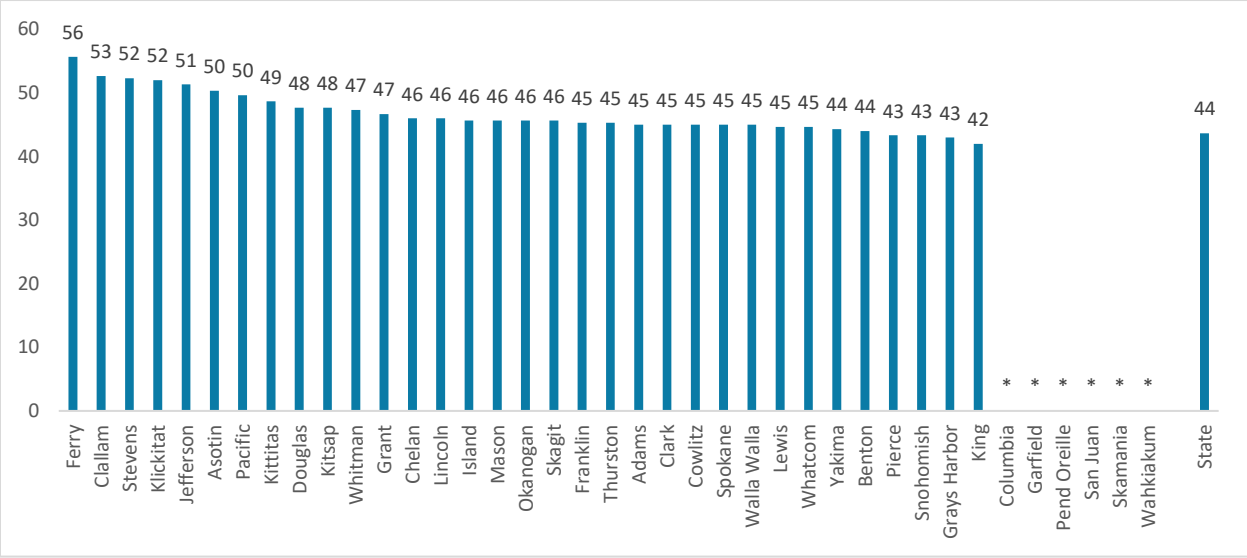
Map 5. Three-year average share of female ARNPs in provider networks: counties, 2021–23
See Table 4 in the appendix for an accessible version of this data.



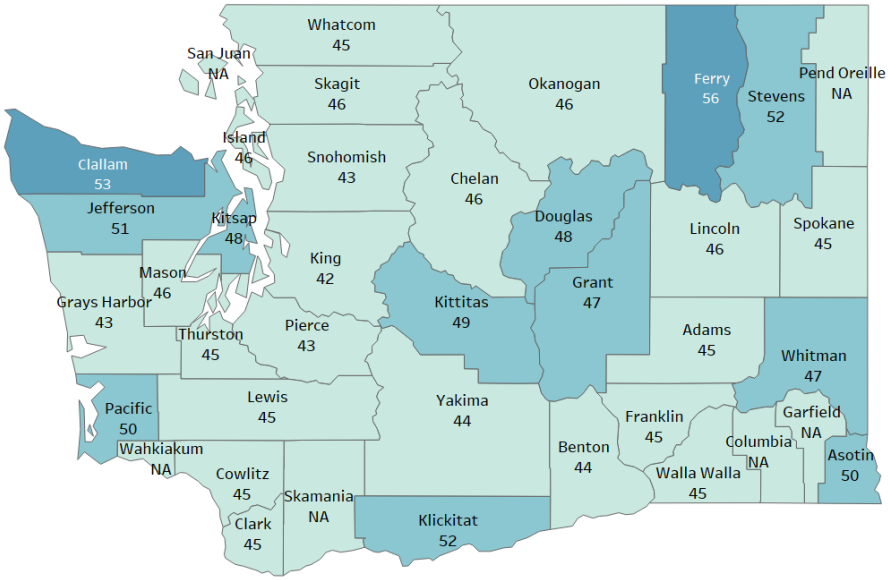
Counties: Median age of ARNPs

The younger ARNP workforce in King County significantly influenced the three-year average median age of ARNPs in the provider networks. For the overall ARNP workforce statewide, the three-year average median age was 44 years, while in King County it was 42 years. King County had the lowest median age among the 33 counties with sufficient data to calculate this average. Apart from King County, only three other counties — Pierce, Snohomish, and Grays Harbor — had a median age below the state's total ARNP median age of 44. In the remaining 29 counties, the median age of ARNPs was 44 years or higher, with Ferry County having the highest median age of 56 years (see Figure 12).

Figure 12. Three-year average median age of ARNPs in provider networks: counties, 2021–23
(* denotes fewer than three ARNPs in the county in one or more years)



Map 6. Three-year average median age of ARNPs in provider networks: counties, 2021–23



See Table 4 in the appendix for an accessible version of this data.

ACH supplies of ARNPs in provider networks

An Accountable Community of Health, or ACH, is a regional coalition made up of representatives from a variety of sectors who work together to improve population health. Each ACH represents a county or a group of adjacent counties. The nine ACHs (and the counties and/or Tribes in each) are:[6]

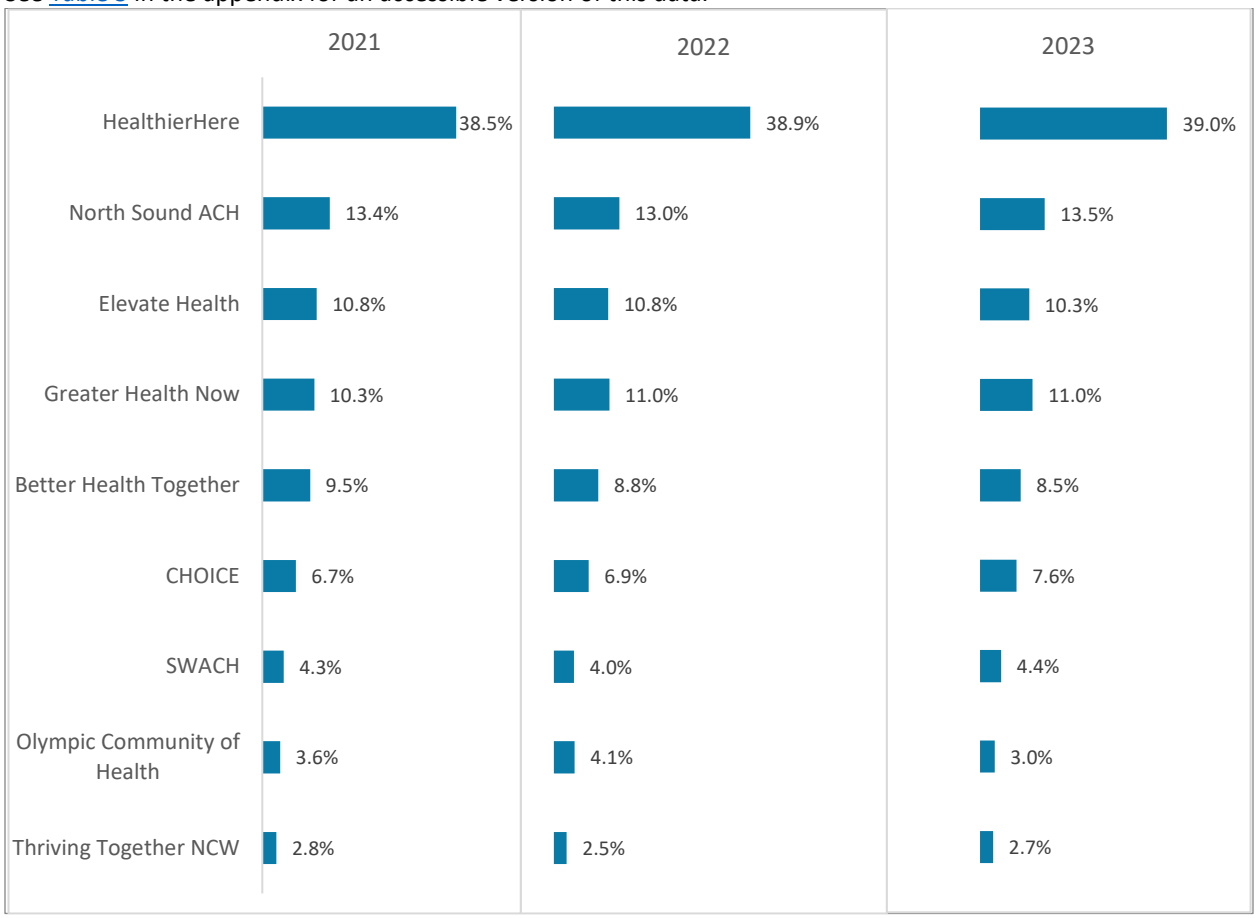
1. Better Health Together: (Adams, Ferry, Lincoln, Pend Oreille, Spokane and Stevens counties, and the Reservations of the Kalispel Tribe of Indians, Spokane Tribe of Indians, and the Confederated Tribes of the Colville Reservation)
2. CHOICE (Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston and Wahkiakum counties, and the sovereign nations of Chehalis, Cowlitz, Nisqually, Quinault, Shoalwater Bay, Skokomish, and Squaxin Island Tribes)
3. Elevate Health (Pierce)
4. Greater Health Now (Asotin, Benton, Columbia, Garfield, Franklin, Kittitas, Walla Walla, Whitman, and Yakima counties, and the Yakama Nation)
5. HealthierHere (King)
6. North Sound ACH (Island, San Juan, Skagit, Snohomish and Whatcom counties and the Lummi Nation, Nooksack Tribe, Upper Skagit Tribe, Samish Indian Nation, Swinomish Indian Tribal Community, Stillaguamish Tribe of Indians, Tulalip Tribes, and Sauk-Suiattle Indian Tribe)
7. Olympic Community Health (Clallam, Jefferson and Kitsap counties and the Sovereign Nations of Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute, and Suquamish)
8. SWACH (Southwest Washington ACH) (Clark, Klickitat, and Skamania counties)
9. Thriving Together NCW (Chelan, Douglas, Grant, and Okanogan counties, and the Confederated Tribes of the Colville Reservation)

[6] See https://www.hca.wa.gov/assets/program/achfactsheet.pdf.

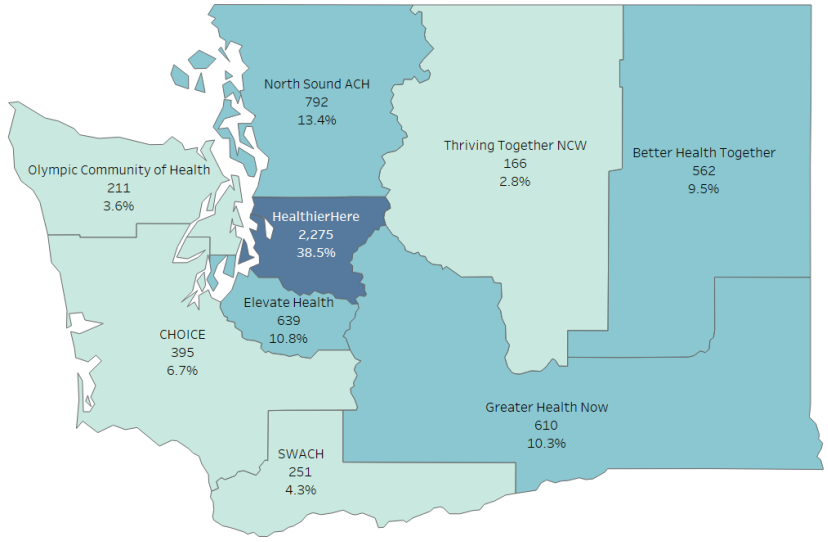
ACHs: Overall supply

The rank order of the ACH shares of total ARNPs in the provider networks saw slight changes from 2021 to 2023. HealthierHere ACH consistently held the largest share, about 39% of the total, across all three years. In the second tier, North Sound ACH, Elevate Health, and Greater Health Together each maintained shares between 10% and 14%. The remaining five ACHs each had shares below 10% each year, with Thriving Together NCW consistently having the lowest share at less than 3% annually. Greater Health Now's share increase in 2022 and 2023 elevated its ranking to the third-largest share from fourth in 2021. Meanwhile, the Olympic Community of Health saw its share increase in 2022 but decrease in 2023, shifting its rank from the eighth largest share in 2021, to seventh in 2022, and then back to eighth in 2023 (see Figure 13).

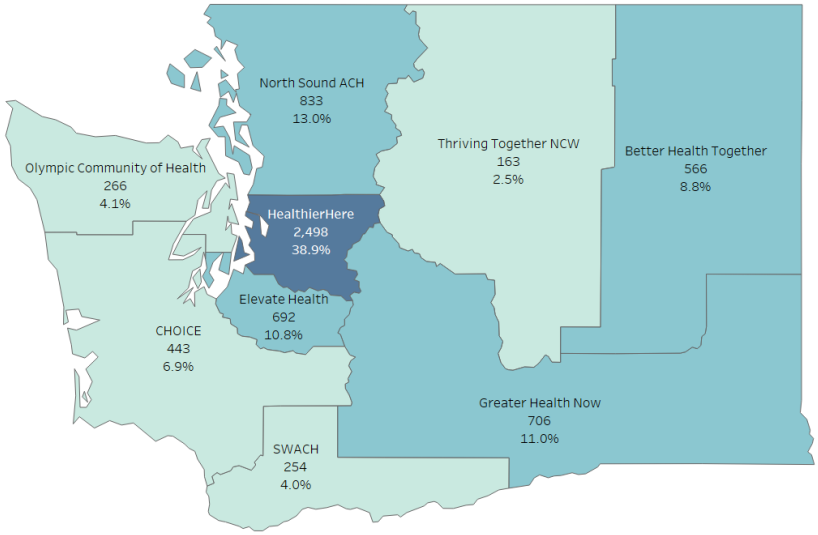
Figure 13. Share of state total ARNP supply in provider networks: ACHs, 2021–23
(sorted by 2021 distribution)
See Table 5 in the appendix for an accessible version of this data.



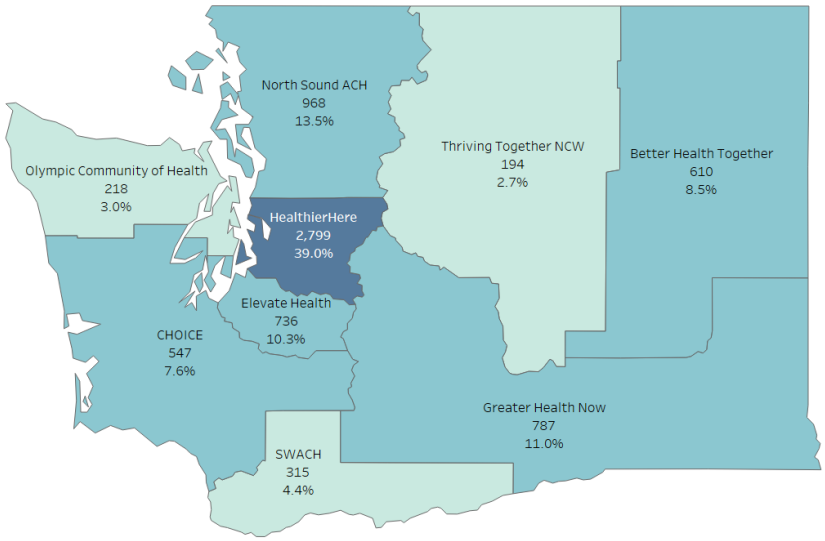
Map 7. Number and percent of ARNPs in provider networks: ACHs, 2021–23
See Table 5 in the appendix for an accessible version of this data.



2021



2022



2023

ACHs: Number of overall ARNPs per 100,000 population

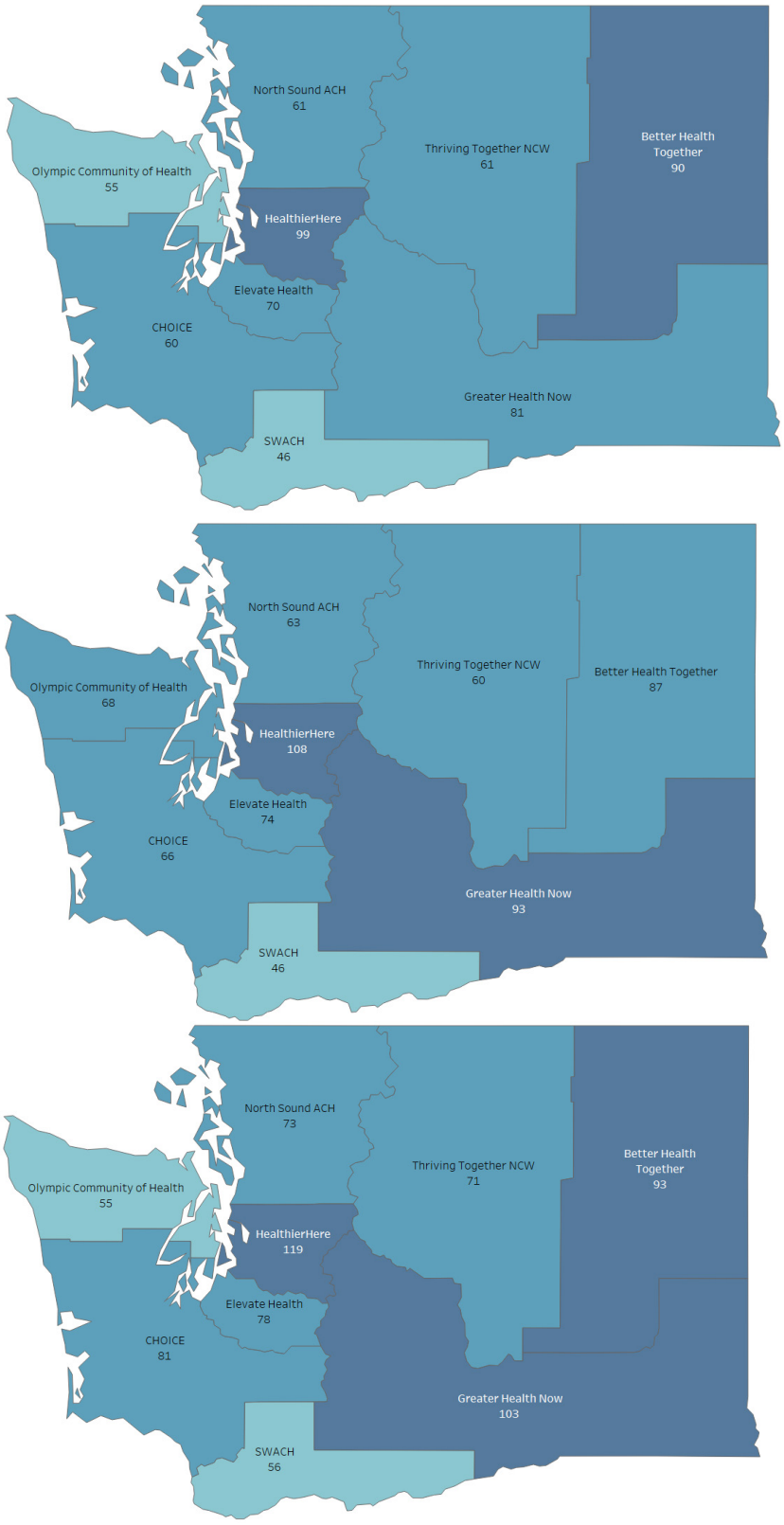
All ACHs except one had higher overall ARNP rates in 2023 compared to their respective rates in 2021. The exception was the Olympic Community of Health, which maintained a rate of 55 ARNPs per 100,000 population in both 2021 and 2023 despite a higher rate of 68 per 100,000 in 2022.

HealthierHere ACH consistently had the highest overall ARNP rates across all three years, with rates increasing from 99 in 2021, to 108 in 2022, and to 119 in 2023. SWACH had the lowest rates each year, remaining at 46 in both 2021 and 2022, and rising to 56 in 2023. Two other ACHs, Better Health Together and Greater Health Now, had overall rates between 80 and 100 per 100,000 population. The remaining five ACHs had overall rates ranging between 50 and 80 (see Figure 14).

The rates in SWACH present a unique case. This ACH covers the southwest corner of the state, bordering the greater Portland area. Some residents in this region receive medical services across the border in Oregon. Health providers practicing in Oregon are not included in our analysis. As a result, the demand for providers to practice in this region is lower than it otherwise would be.

Figure 14. Number of overall ARNPs in provider networks per 100,000 population: ACHs, 2021–23
See Table 6 in the appendix for an accessible version of this data.

Map 8. Number of overall ARNPs in provider networks per 100,000 population: ACHs, 2021–23
See Table 6 in the appendix for an accessible version of this data

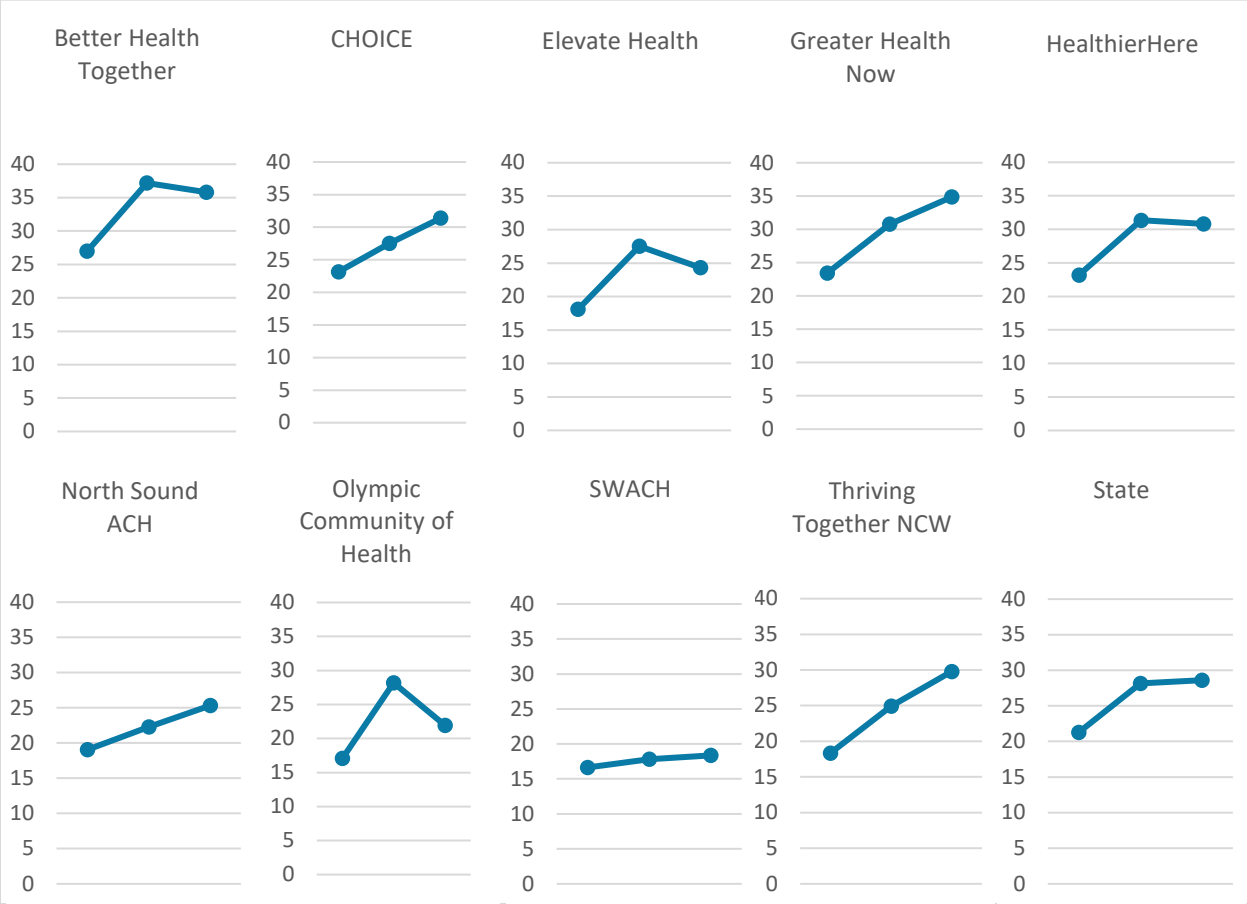


ACHs: Number of primary care ARNPs per 100,000 population

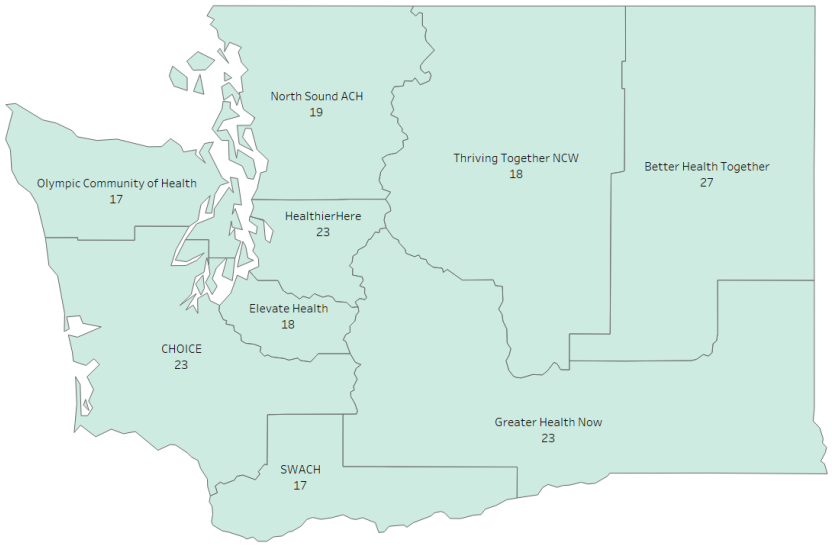
The primary care ARNP rates for all nine ACHs were higher in 2023 than their respective rates in 2021. However, for three ACHs — Better Health Together, Elevate Health, and Olympic Community of Health — the year with the highest rate was 2022. Better Health Together ACH had the highest rates of all ACHs in all three years, increasing from 27 per 100,000 population in 2021 to 37 in 2022, and then slightly decreasing to 36 in 2023. SWACH had the lowest rates among the ACHs each year, changing from 17 per 100,000 in 2021 to 18 in both 2022 and 2023. The remaining seven ACHs had rates for primary care ARNPs ranging between 17 and 35 per 100,000 population (see Figure 15).

As with the previous discussion of the low overall ARNP rate in SWACH, the same explanation applies to its low rate of primary care ARNPs.

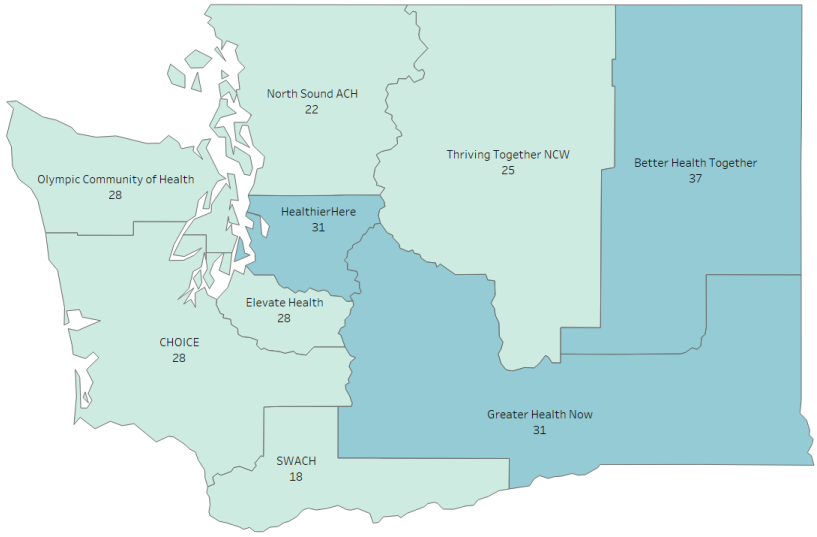
Figure 15. Number of primary care ARNPs in provider networks per 100,000 population: ACHs, 2021–23
See Table 6 in the appendix for an accessible version of this data



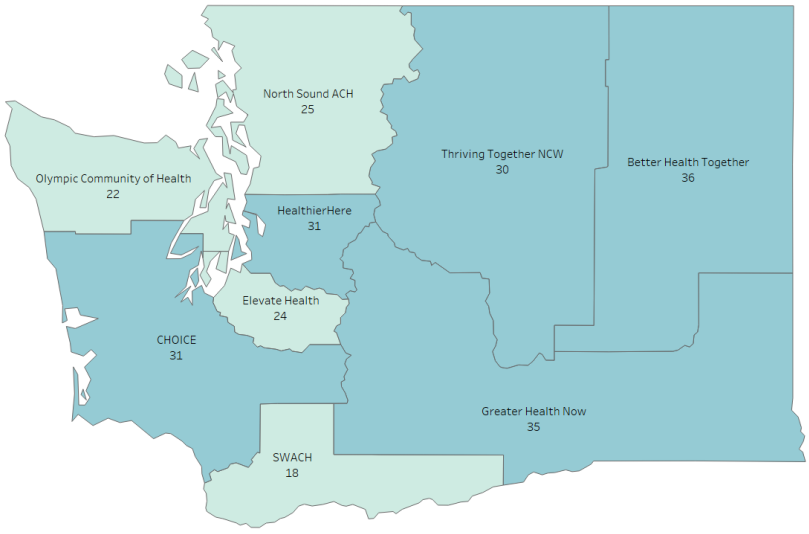
Map 9. Number of primary care ARNPs in provider networks per 100,000 population: ACHs, 2021–23
See Table 6 in the appendix for an accessible version of this data.



2021



2022



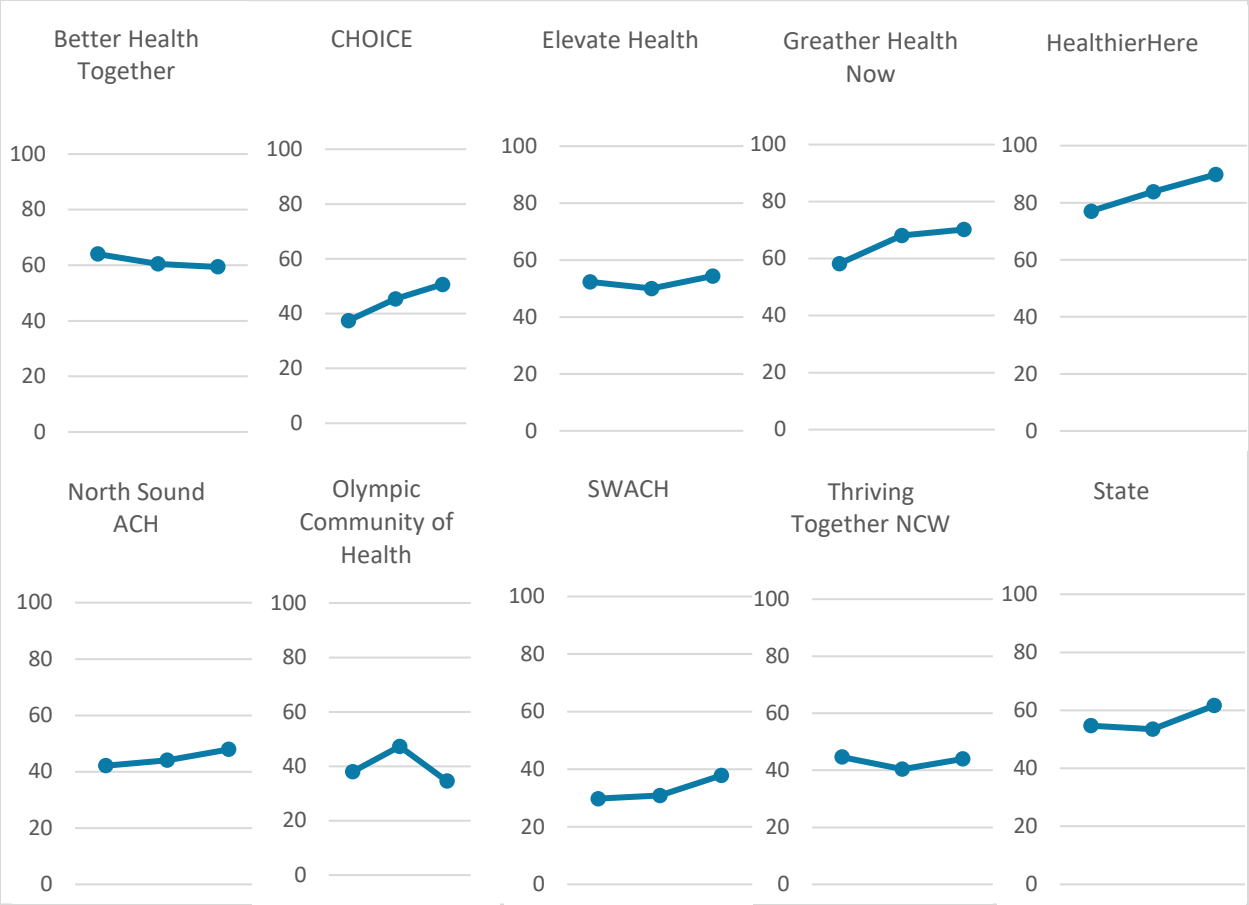
2023

ACHs: Number of specialist care ARNPs per 100,000 population

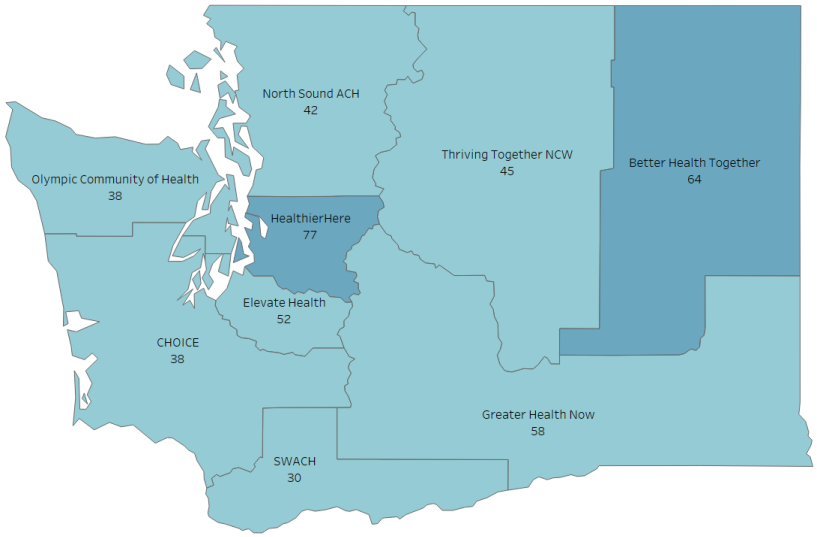
In 2023, only three of the nine ACHs had lower specialist care ARNP rates per 100,000 population compared to 2021. These ACHs were Better Health Together, Olympic Community of Health, and Thriving Together NCW. HealthierHere ACH consistently had the highest rates across all three years, increasing from 77 ARNPs per 100,000 in 2021 to 84 in 2022, and reaching 90 in 2023. SWACH had the lowest rates in 2021 and 2022, at 30 and 31 respectively. However, its rate increased to 38 per 100,000 in 2023, surpassing the lowest rate of 35 that year in the Olympic Community of Health. The remaining ACHs had specialist care ARNP rates between 40 and 70 per 100,000 population (see Figure 16).

As with the previous discussion of the low overall ARNP rates in SWACH, the same explanation applies to its low rate of specialist care ARNPs.

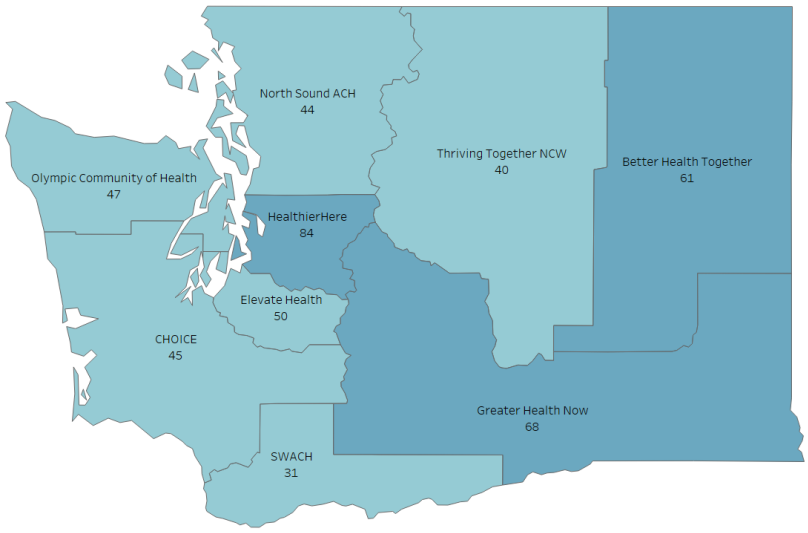
Figure 16. Number of specialist care ARNPs in provider networks per 100,000 population: ACHs, 2021–23
See Table 6 in the appendix for an accessible version of this data.



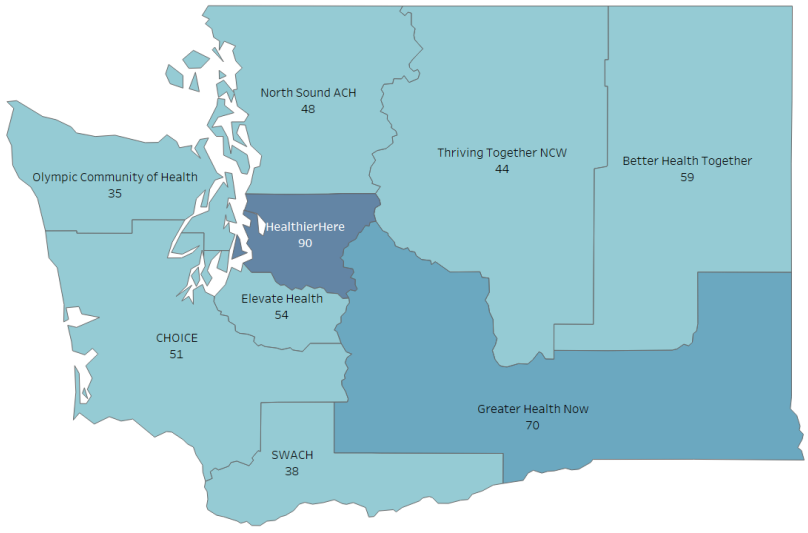
Map 10. Number of specialist care ARNPs in provider networks per 100,000 population: ACHs, 2021–23
See Table 6 in the appendix for an accessible version of this data



2021



2022



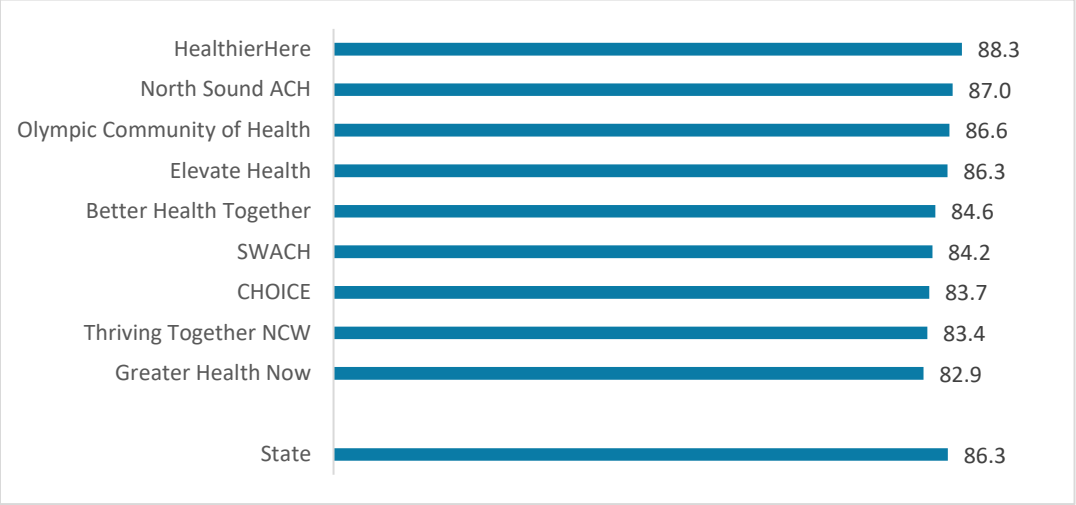
2023

ACHs: Percentage of female ARNPs

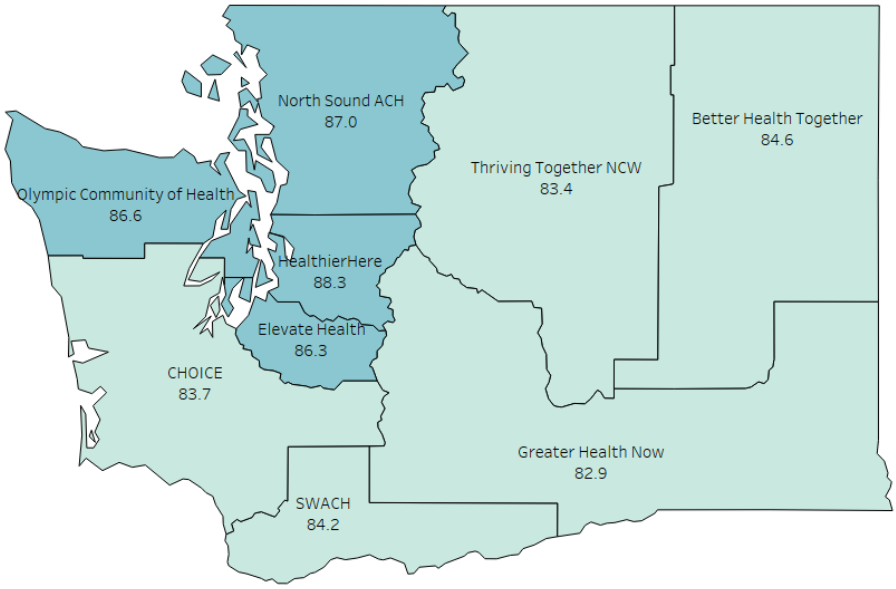
The three-year average percentages of female ARNPs for 2021–2023 among the ACHs showed little variation. The shares in the ACHs ranged from 82.9% (Greater Health Now) to 88.3% (HealthierHere), while the state's three-year average was 86.3%. Besides HealthierHere, three other ACHs — North Sound ACH, Olympic Community of Health, and Elevate Health — had shares at or above the state's average. All four of these ACHs are located around Puget Sound (see Figure 17).

Table 7 in the appendix shows that the share of female ARNPs decreased in eight of the nine ACHs from 2021 to 2023. Thriving Together NCW was the only ACH with an increase, by 4 percentage points from 80.9% in 2021 to 84.9% in 2023.

Figure 17. Three-year average percentage of female ARNPs in provider networks: ACHs, 2021–23



Map 11. Three-year average percentage of female ARNPs in provider networks: ACHs, 2021–23
See Table 7 in the appendix for an accessible version of this data

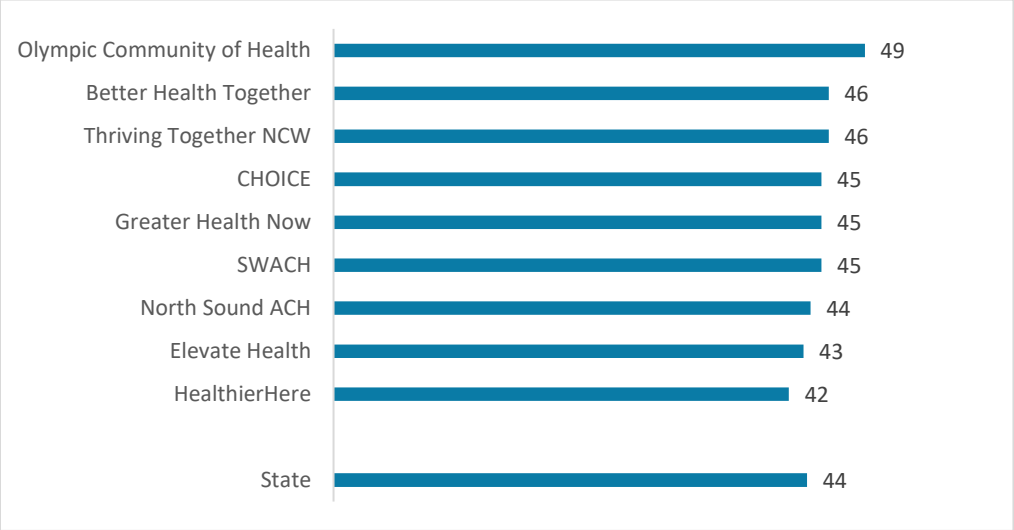


ACHs: Median age of ARNPs

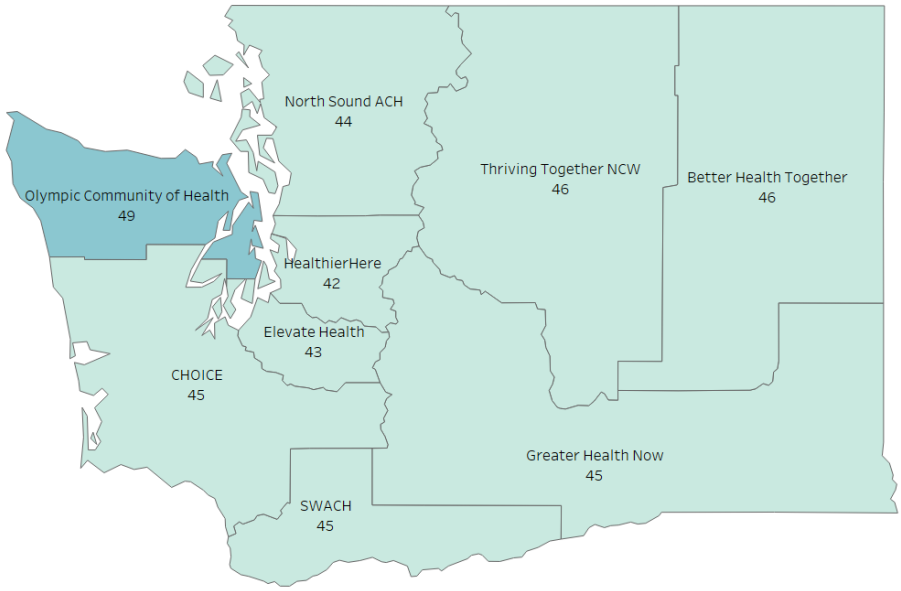
The three-year average median age of the ARNPs in the ACHs had a difference of seven years from 42 years in HealthierHere to 49 years in Olympic Community of Health. There were three ACHs that had a median at or lower than the state median of 44 years. These three ACHs are located along the I-5 corridor next to Puget Sound: North Sound ACH, HealthierHere, and Elevate Health (see Figure 18).

Table 7 in the appendix shows that these three were also among the four ACHs in which the ARNP median age dropped (the fourth ACH was Thriving Together NCW). SWACH was the only ACH with an increase in its ARNP median age, from 44 years in 2021 to 45 years in 2023. In the remaining four ACHs, there was no change in the ARNP median age from 2021 to 2023.

Figure 18. Three-year average median age of ARNPs in provider network: ACHs, 2021–23



Map 12. Three-year average median age of ARNPs in provider network: ACHs, 2021–23
See Table 7 in the appendix for an accessible version of this data



Data sources and method

Data Sources

Network Access Report. Health insurance companies conducting business in Washington must file a monthly Network Access Report (NAR) to the Office of the Insurance Commissioner. The purpose of these reports is for an insurer to demonstrate that it has an adequate supply of health care providers in its network(s) for the intended services. The report contains records of health care providers under contract with an insurance company's provider network. The information on individual providers includes name, credential, specialty, and practice location(s). Starting in 2017, Washington state's NARs discontinued the previous provider specialty categories and replaced them with Health Care Provider Taxonomy code set issued by the National Uniform Claim Committee. The NARs are publicly available on OIC's website. This study used the public NARs.

National Provider Identifier Registry. The National Provider Identifier (NPI) registry is a database in the National Plan & Provider Enumeration System (NPPES), created by the federal Centers for Medicare and Medicaid Services (CMS). The NPI is a 10-digit unique number assigned to an individual or organizational provider in the U.S. Part of the NPI database is publicly available. The public information for individual NPIs includes a provider's name, NPI number, taxonomy, and practice location. We used the public NPI data for this study.

Provider License Database. Health care providers must obtain a provider license with the Washington State Department of Health (DOH) to practice in the state. After initial licensing, providers must renew their licenses at certain intervals depending on the professions. For advanced registered nurse practitioners (ARNPs), renewal is every two years. The provider license database includes information on the provider's name, age, sex, credential type, license start date, most recent renewal date and expiration date. A subset of the provider license information can be searched as public information on the department's website. However, for this study, we used an extract file from the license database.

Method

a. Processing the June Network Access Reports for 2021–23

The NARs for June 2021–23 were downloaded from OIC's website. Once all insurance companies' reports were collected, the reports were combined by year, with each year's data processed separately. The NARs are structured in such a way that there are five blocks of rows of data. Depending on the block, the column name and purpose may be different. For example, a column in the block for individual provider information may be the individual NPI number, but in the block for organization contract information it may be the organization NPI number. That's why the next step was to "rectangularize" the data records by transforming the blocks of data rows into blocks of data columns so that each row is a record for an individual provider. The final step was to remove non-ARNP records and retain only ARNP records.

b. Matching ARNP records from the Network Access Reports with records in the National Provider Identifier registry and the DOH provider license database

We then matched processed ARNP records from the Network Access Reports with the National Provider Identifier registry on the NPI numbers. The NPI is a unique identifier issued to health care providers. It is required for Medicare services, but health insurance carriers also use it for all health services they provide. We only retained records that matched NPIs between the two files.

Next, the matched NAR-NPI records were matched with the DOH license database on the ARNP's credential number. In this step, we only retained matched records with non-expired licenses as of June of the selected year.

c. Provider specialty (primary care/specialist care)

Unlike the taxonomy used for physicians, the taxonomy for ARNP in the NARs did not identify the provider's specialty area. Instead, the prevailing taxonomy codes for ARNPs were 363LF0000X or 363L00000X ("Nurse Practitioners"). That's why we did not include "ARNP specialty" in this report. This report does, however, contain estimates for primary care ARNPs and specialist care ARNPs. The primary/specialist care status was assigned by the health insurance carriers in their NARs. The designation of primary/specialist care ARNPs in this report differs from the designation we used in our report for physician supply, where we used physicians' taxonomy codes to determine primary care and specialist care statuses.

d. Final record selection

There are numerous duplicate records due to cross-carrier reporting and/or cross-plan reporting within a carrier's report. In the final record selection process, only one record was retained from the data field combination of NPI, practice geo-coordinates and practice name. In addition, a small number of records that had missing data on the state of the practice location, ARNP's last name, or NPI were excluded from the final selection.

e. Constructing ARNP record weights

The processed NAR data included multiple records for some ARNPs who had multiple practice locations. ARNP supply analyses in this study required counting each ARNP as no more than one person. To meet this requirement while remembering that an ARNP may practice at multiple locations, we constructed data weights and applied the weights to the ARNP records. Below is a description of the weight construction.

Initial weight. Each ARNP was assigned the weight of 1 initially.

ZIP Code-level weight. After the construction of initial weights, the next step was to redistribute initial weights to an ARNP's records for different ZIP Codes. To construct the ZIP Code-level weight, we first counted the number of ZIP Codes associated with an ARNP. We then summed up the populations of the associated ZIP Codes.[7] Then we calculated each ZIP Code's fraction of the total population from all associated ZIP Codes. We used these fractions to distribute the initial weight into ZIP Codes associated with an ARNP.

For example, suppose an ARNP was associated with three ZIP Codes that accounted for 70%, 20% and 10% of the total population of the three combined ZIP Codes. The ZIP Code with 70% of the population would receive 0.7 of the initial weight, the 20% ZIP Code would receive a weight of 0.2, and the 10-percent ZIP would receive a weight of 0.1.

[7] Some ZIP Codes in the original Network Access Reports do not have associated population data. These are either institution ZIP Codes (e.g., campus ZIP code for universities) or mailbox ZIP Codes. Online ZIP Code maps were used to choose a substitute ZIP Code. The substitute ZIP Code is one that either encircles or shares the longest borderline with the ZIP Code in question.

In some cases, an ARNP was associated with multiple locations within a ZIP Code area. In that case, each location would receive an even share of the ZIP Code-level weight that we previously assigned. Extending the ARNP example above, suppose the ARNP was associated with three locations in the 70% ZIP Code area. Then the final weight for each location record for this ZIP Code associated with this physician would be 0.2333 (0.7/3).

From this process, the sum of weights of all records associated with an ARNP should equal 1 and the sum of weights of all ARNPs should equal the unique count of ARNPs without the weights. The ZIP Code-level weights can be used for analyses involving a single ZIP Code, clusters of ZIP Codes and the state.

County level weight. For county-level analyses, we needed an additional step to further distribute the ARNP record weight at the ZIP Code-level for ZIP Codes that cross county boundaries. We decided to use a county's fraction of that ZIP Code's population as the county's fraction of the weight for that ZIP Code.

Using the same ARNP example from above, suppose the 20% ZIP Code is associated with two counties, and County A's population fraction of the ZIP Code's total population is 70% and County B's fraction is 30%. Then the ZIP Code-level ARNP record weight of 0.2 is redistributed into 0.14 (0.2*0.7) to County A and 0.06 (0.2*0.3) to County B. For ZIP Codes whose areas are within the boundary of a single county, the ZIP Code-level weights were then copied over to the county-level weight.

From this process, the sum of weights of all records associated with an ARNP should sum to 1 and the sum of weights of all ARNPs should equal the unique count of ARNPs without weights. The county-level weights can be used for analyses for counties, regions consisting of counties, and the state.

f. Definitions

ARNP count: The weighting of ARNP records takes into consideration that an ARNP may practice at multiple locations. This weighting essentially assumes each ARNP identified in the NARs as working 100% full time equivalency (FTE). The ARNP's "FTE" is distributed into practice locations in different ZIP Code areas and into different counties when a ZIP Code area crosses county boundaries. Therefore, one ARNP FTE in a specific area can sometimes mean several ARNPs each contributing a fraction to the FTE. The ARNP count then is a sum of the total fractions.

ARNP rate: For this study, the ARNP rate is calculated as number of ARNPs per 100,000 population for the state, counties, or Accountable Communities of Health (each consisting of one or more counties).

g. Limitations

The Network Access Report is the main data source for ARNP supply estimates in this study, which means by default, the ARNPs included in this study are those who practice in provider networks. ARNPs who practice outside the provider networks are therefore not included. Often, those are providers who practice as solo practitioners, in small practice groups, or as public employees in federal or state institutions exclusively (e.g., VA hospitals, military hospitals, and state hospitals).

One possible error in the data may result in an overestimation of ARNPs in provider networks. This error occurs when insurance companies failed to promptly remove records from NARs for providers who no longer practice in Washington (due to retirement, moving to another state, or switching to a practice setting outside the provider networks, for example), although they maintain a Washington state license.

Another potential error is related to the weighting method we used. When constructing the ZIP Code-level weights for the records, if an ARNP had practice locations in multiple ZIP Code areas, we split the initial record weight based on each ZIP Code area's population fraction of the total population from all ZIP Code areas in question. Or, similarly, in constructing county-level weight, if an ARNP record had a ZIP Code area that crosses county boundaries, we assigned the county's fraction of the ZIP Code-level weight based on each county's population fraction of the ZIP Code area's total population. We believe these record weighting techniques offered a better geographic representation of the ARNPs than commonly used techniques of provider supply estimation that do not consider a provider's multiple practice locations. However, the degree of improvement in estimate precision from our weighting schemes remains unknown.

Another limitation, though not necessarily a source of error, is that this study's method does not consider ARNPs in bordering states who provide services to Washington residents. For example, Clark County sits across the Columbia River from the greater Portland area in Oregon. Some Clark residents use ARNP services in the Portland area. That means the actual ARNP supply in Washington's provider networks could have been larger than we estimated in this report if we had included the ARNPs in neighboring states that serve Washington residents.

Appendices – data tables

Table 1. Provider network ARNP supply and characteristics: Washington, 2021–23

	2021	2022	2023
Total Licenses	11,476	12,694	14,158
Number and Percent of ARNPs Providing Direct Care in Washington	5,902 (51.4%)	6,420 (50.6%)	7,174 (50.7%)
Number of ARNPs per 100,000 Population	76	82	90
Primary Care ARNPs			
Number	1652	2214	2275
Per 100,000 Population	21	28	29
Percent	28.0%	34.5%	31.7%
Specialist ARNPs			
Number	4,250	4,206	4,899
Per 100,000 Population	55	53	62
Percent	72%	66%	68%
Share of Women in			
Total ARNPs	87.0%	86.7%	85.3%
Primary Care ARNPs	87.6%	87.1%	87.3%
Specialist Care ARNPs	86.8%	86.5%	84.4%
Median Age			
Total ARNPs	44	44	43
Primary Care ARNPs	43	43	44
Specialist Care ARNPs	44	44	43
Median Age of Men			
Total ARNPs	43	43	43
Primary Care ARNPs	43	43	43
Specialist Care ARNPs	43	43	42
Median Age of Women			
Total ARNPs	44	44	43
Primary Care ARNPs	43	44	44
Specialist Care ARNPs	44	44	43

Table 2. Number and percentage of ARNPs in provider networks: counties, 2021–23

	Number of ARNPs			Percent of ARNPs		
County	2021	2022	2023	2021	2022	2023
Adams	10	4	8	0.2%	0.1%	0.1%
Asotin	27	15	31	0.5%	0.2%	0.4%
Benton	238	312	301	4.0%	4.9%	4.2%
Chelan	93	91	114	1.6%	1.4%	1.6%
Clallam	57	58	72	1.0%	0.9%	1.0%
Clark	241	247	307	4.1%	3.8%	4.3%
Columbia	3	2	2	0.0%	0.0%	0.0%
Cowlitz	77	76	92	1.3%	1.2%	1.3%
Douglas	6	8	8	0.1%	0.1%	0.1%
Ferry	5	7	8	0.1%	0.1%	0.1%
Franklin	34	45	55	0.6%	0.7%	0.8%
Garfield	1	2	0	0.0%	0.0%	0.0%
Grant	41	41	47	0.7%	0.6%	0.7%
Grays Harbor	36	37	63	0.6%	0.6%	0.9%
Island	28	29	36	0.5%	0.5%	0.5%
Jefferson	26	29	26	0.4%	0.5%	0.4%
King	2,275	2,498	2,799	38.5%	38.9%	39.0%
Kitsap	128	178	121	2.2%	2.8%	1.7%
Kittitas	27	27	51	0.5%	0.4%	0.7%
Klickitat	8	6	7	0.1%	0.1%	0.1%
Lewis	61	54	69	1.0%	0.8%	1.0%
Lincoln	10	7	9	0.2%	0.1%	0.1%
Mason	25	32	35	0.4%	0.5%	0.5%
Okanogan	26	22	26	0.4%	0.3%	0.4%
Pacific	7	9	8	0.1%	0.1%	0.1%
Pend Oreille	6	2	3	0.1%	0.0%	0.0%
Pierce	639	692	736	10.8%	10.8%	10.3%
San Juan	2	3	2	0.0%	0.0%	0.0%
Skagit	96	101	145	1.6%	1.6%	2.0%
Skamania	2	2	1	0.0%	0.0%	0.0%
Snohomish	534	536	612	9.1%	8.3%	8.5%
Spokane	515	528	563	8.7%	8.2%	7.8%
Stevens	16	18	19	0.3%	0.3%	0.3%
Thurston	188	234	278	3.2%	3.6%	3.9%
Wahkiakum	0	0	1	0.0%	0.0%	0.0%
Walla Walla	57	61	75	1.0%	1.0%	1.0%
Whatcom	132	164	173	2.2%	2.6%	2.4%
Whitman	28	53	39	0.5%	0.8%	0.5%
Yakima	194	190	233	3.3%	3.0%	3.2%
Total	5,903	6,420	7,174	100%	100%	100%

Table 3. Number of ARNPs per 100,000 population in provider networks – total, primary care, and specialist care: counties, 2021–23

	Total ARNPs			Primary Care ARNPs			Specialist ARNPs		
County	2021	2022	2023	2021	2022	2023	2021	2022	2023
Adams	47	20	39	29	*	15	18	16	24
Asotin	119	65	138	35	19	52	84	47	86
Benton	114	147	140	22	31	30	92	116	109
Chelan	113	113	140	33	40	54	80	73	86
Clallam	73	75	92	28	38	37	45	38	55
Clark	47	47	58	17	18	19	30	29	39
Columbia	*	*	*	*	*	*	*	*	*
Cowlitz	69	68	82	30	28	32	39	40	50
Douglas	14	18	17	*	*	*	12	14	13
Ferry	66	90	115	51	67	77	*	*	*
Franklin	34	45	55	13	17	18	21	29	36
Garfield	*	*	*	*	*	*	*	*	*
Grant	40	41	45	12	21	21	28	20	24
Grays Harbor	47	49	82	27	21	41	20	28	41
Island	33	34	41	13	16	17	20	18	24
Jefferson	81	88	77	15	40	32	66	49	45
King	99	108	119	23	31	31	76	76	88
Kitsap	47	63	43	14	24	17	32	39	26
Kittitas	58	56	107	21	27	39	37	29	68
Klickitat	35	25	29	14	14	20	21	*	*
Lewis	75	65	82	31	30	34	44	35	48
Lincoln	91	65	83	57	45	42	34	*	41
Mason	38	48	52	12	24	20	27	24	32
Okanogan	60	52	59	22	29	31	38	23	28
Pacific	33	38	35	17	25	25	16	13	*
Pend Oreille	44	*	*	24	*	*	*	*	*
Pierce	70	74	78	18	28	24	52	46	53
San Juan	*	*	*	*	*	*	*	*	*
Skagit	73	77	110	28	33	50	45	44	59
Skamania	*	*	*	*	*	*	*	*	*
Snohomish	63	63	71	18	20	23	45	43	48
Spokane	98	96	101	27	40	38	71	56	64
Stevens	35	38	39	16	22	22	19	16	17
Thurston	64	78	92	21	30	31	43	48	60
Wahkiakum	*	*	*	*	*	*	*	*	*
Walla Walla	92	98	119	34	44	56	58	54	63
Whatcom	58	71	73	20	28	25	38	43	48
Whitman	58	110	81	19	44	20	38	66	60
Yakima	74	73	89	26	32	40	48	41	49
State	76	82	90	21	28	29	55	53	62

*The underlying number is too small for this calculation.

Table 4. Percentage of women and median age of ARNPs in provider networks: counties, 2021–23

	Percentage of Female ARNPs				Median Age			
County	2021	2022	2023	Three-year Average	2021	2022	2023	Three-year Average
Island	96.5	90.5	86.3	91.1	62	56	49	56
Mason	90.1	89.1	90.7	90.0	56	51	51	53
Kittitas	86.1	96.3	86.2	89.5	53	52	52	52
Skagit	90.4	91.1	86.9	89.5	49	62	45	52
Stevens	83.3	92.5	91.1	89.0	52	53	49	51
Clallam	93.0	88.3	85.2	88.8	48	53	50	50
Chelan	*	*	*	88.5	*	*	*	50
Whatcom	90.5	87.0	87.8	88.4	50	51	45	49
King	89.0	88.9	87.0	88.3	48	50	45	48
Franklin	90.5	87.4	85.1	87.7	49	46	48	48
Thurston	88.8	85.6	84.9	86.4	47	47	48	47
Pierce	*	*	*	86.3	*	*	*	47
Pacific	100.0	83.9	74.6	86.2	47	45	46	46
Snohomish	86.7	85.8	85.2	85.9	46	44	48	46
Kitsap	86.9	86.3	84.0	85.7	44	46	47	46
Jefferson	86.0	85.8	85.4	85.7	46	47	44	46
Spokane	86.3	85.3	83.3	85.0	41	47	49	46
Clark	85.0	83.2	84.2	84.2	46	47	44	46
Douglas	86.5	70.9	93.7	83.7	45	44	47	45
Yakima	85.7	82.1	83.1	83.6	46	45	45	45
Benton	80.5	83.2	82.7	82.1	47	45	43	45
Walla Walla	80.5	82.7	81.9	81.7	44	46	45	45
Whitman	87.2	85.6	72.2	81.7	45	45	45	45
Klickitat	78.4	80.6	85.0	81.3	46	45	44	45
Lewis	81.8	81.5	78.1	80.4	44	45	46	45
Okanogan	77.1	*	*	79.8	45	*	*	45
Grays Harbor	74.5	84.6	79.0	79.4	45	45	44	45
Cowlitz	*	*	*	78.2	*	*	*	44
Lincoln	89.9	69.9	66.0	75.2	45	44	43	44
Grant	*	*	*	74.1	*	*	*	43
Asotin	70.2	74.8	68.1	71.0	44	43	43	43
Ferry	72.5	59.5	70.8	67.6	44	44	41	43
Adams	89.6	41.7	61.5	64.2	42	42	42	42
Columbia	*	*	*	*	*	*	*	*
Garfield	*	*	*	*	*	*	*	*
Pend Oreille	80.7	*	*	*	52	*	*	*
San Juan	*	*	*	*	*	*	*	*
Skamania	*	*	*	*	*	*	*	*
Wahkiakum	*	*	*	*	*	*	*	*
State	87.0	86.7	85.2	86.3	44	44	43	44

*The underlying number is too small for this calculation.

Table 5. Number and percentage of ARNPs in provider networks: ACHs, 2021–23

	Number of ARNPs			Percentage of ARNPs		
ACH	2021	2022	2023	2021	2022	2023
HealthierHere	2,275	2,498	2,799	38.5%	38.9%	39.0%
North Sound ACH	792	833	968	13.4%	13.0%	13.5%
Elevate Health	639	692	736	10.8%	10.8%	10.3%
Greater Health Now	610	706	787	10.3%	11.0%	11.0%
Better Health Together	562	566	610	9.5%	8.8%	8.5%
CHOICE	395	443	547	6.7%	6.9%	7.6%
SWACH	251	254	315	4.3%	4.0%	4.4%
Olympic Community of Health	211	266	218	3.6%	4.1%	3.0%
Thriving Together NCW	166	163	194	2.8%	2.5%	2.7%
Total	5,903	6,420	7,174	100%	100%	100%

Table 6. Number of ARNPs per 100,000 population in provider networks – total, primary care, and specialist care: ACHs, 2021–23

	Total ARNPs			Primary Care ARNPs			Specialist ARNPs		
ACH	2021	2022	2023	2021	2022	2023	2021	2022	2023
Better Health Together	90	87	93	27	37	36	64	61	59
CHOICE	60	66	81	23	28	31	38	45	51
Elevate Health	70	74	78	18	28	24	52	50	54
Greater Health Now	81	93	103	23	31	35	58	68	70
HealthierHere	99	108	119	23	31	31	77	84	90
North Sound ACH	61	63	73	19	22	25	42	44	48
Olympic Community of Health	55	68	55	17	28	22	38	47	35
SWACH	46	46	56	17	18	18	30	31	38
Thriving Together NCW	61	60	71	18	25	30	45	40	44
State	76	82	90	21	28	29	55	53	62

Table 7. Percentage of women and median age of ARNPs in provider networks: ACHs, 2021–23

	Percentage of Female ARNPs				Median Age			
ACH	2021	2022	2023	Avg	2021	2022	2023	Avg
HealthierHere	89.0	88.9	87.0	88.3	50	48	49	49
North Sound ACH	88.2	86.9	86.0	87.0	47	45	45	46
Olympic Community of Health	88.4	86.7	84.6	86.6	46	45	46	46
Elevate Health	86.5	86.9	85.5	86.3	46	44	45	45
Better Health Together	86.2	84.6	82.9	84.6	45	45	45	45
SWACH	84.9	83.2	84.3	84.2	44	46	45	45
CHOICE	84.7	84.2	82.2	83.7	44	44	44	44
Thriving Together NCW	80.9	84.5	84.9	83.4	44	43	43	43
Greater Health Now	83.0	83.7	82.0	82.9	42	42	42	42
State	87.0	86.7	85.2	86.3	44	44	43	44