

SUMMARY MEETING MINUTES

January 18-20, 2011

The Negotiated Rulemaking Committee (hereafter the “Committee”) was convened for its fourth meeting at 9:44 A.M. on January 18, 2011 at the Radisson Hotel, Arlington, Virginia. The meeting was facilitated by Lynn Sylvester and Dan LeClair of the Federal Mediation and Conciliation Service.

Committee members present:

Marc Babitz
Andrea Brassard†
Roy Brooks*
Jose Camacho
Kathleen Clanon*
Beth Giesting
David Goodman*†
Daniel Hawkins*
Sherry Hirota
Steve Holloway
Barbara Kornblau
Tess Kuenning
Alice Larson
Nicole Lamoureux†
Tim McBride
Lolita McDavid
Alan Morgan
Ron Nelson†
Charles Owens
Robert Phillips
Alice Rarig
Patrick Rock
Edward Salsberg
William Scanlon
Sally Smith
John Supplitt
Don Taylor
Elisabeth Wilson

* Represented by a designated alternate for all or parts of the meeting

† Participation via teleconference for all or parts of the meeting

GENERAL ADMINISTRATIVE MATTERS

Ms. Sylvester welcomed the Committee to the Radisson Hotel, a new meeting place for the Committee. She reminded every Committee member to sign in each day. In addition, there was a reminder for members of the public to sign in and identify any request to address the Committee.

APPROVAL OF SUMMARY MINUTES

Prior to this meeting, the Committee reviewed the draft minutes from November's meeting. A Committee member suggested adding "public housing residents" to the list of subpopulations discussed on page six. Some Committee members noted their concern about the disparity of substance in the minutes among topics. Because it is difficult for the notetakers to record every point made by a Committee member, the Committee will direct notetakers to include the key points of each discussion. In addition, the following sentence will be added to the "Sub-Population Discussion" on page six of the minutes: "A rich discussion took place with many committee members voicing their concerns about the needs of the various special populations."

Other typographical and grammatical corrections were made to the minutes from November's meeting in order to be consistent with minutes from past meetings.

The November meeting minutes were approved as modified.

OVERVIEW OF WHERE WE'VE BEEN: FRAMEWORK AND ROADMAP

Mr. Salsberg gave a presentation entitled, "Overview of Where We've Been: Framework and Roadmap," (Attachment 1) which outlined a monthly timeframe for the Committee, including topics to be discussed at each meeting. He also thanked the subcommittees for all the hard work they have done thus far.

SUBPOPULATIONS SUBCOMMITTEE – SUMMARY REPORT

Dr. Wilson reported on the work of the Subpopulations Subcommittee. The Subcommittee met (via conference call) three times for a total of six hours. The Subcommittee agreed on four objectives: (1) to be more inclusive of underserved groups, (2) to build in room for new/emerging populations, (3) to decrease work and expense for local communities/state agencies, and (4) to allow local communities to make a case for local needs. Dr. Wilson provided a table that summarized the Subcommittee's work and discussions (Attachment 2). There were seven issues, listed below, that the Subcommittee discussed and seven questions that the Subcommittee is seeking more input on from the full Committee.

1. Consensus among the Subcommittee to use the well-established criteria for MUPs (in Section 330 of the Public Health Service Act) as a starting point.
2. Consensus among the Subcommittee to pre-identify and name some populations in the rule. Still undecided on the details of what those populations would have to prove in addition to the Section 330 criteria (which they presumably meet)
3. Consensus among the Subcommittee that populations not pre-identified would have to document that they meet the identified criteria.
4. Discussion on whether MUP designation would equal an automatic Special Population HPSA designation. No consensus for the issue among the Subcommittee but issue will be revisited when the full Committee adopts population-to-provider ratios for the geographic designations.
5. Discussion on Special Population HPSAs, specifically whether the current criteria and regulations should be used. No consensus for the issue as it seeks more information on the current criteria.
6. Consensus among the Subcommittee there should be a Governor's Exception for MUPs and Special Population HPSAs.
7. Discussion on facility designation and whether to use established criteria. Did not fully address the issue yet, thus undecided.

Following Dr. Wilson's report, other members of the Subcommittee and Committee provided their input on the work done thus far. Subcommittee members stressed that they wanted certain established subpopulations pre-identified and one member added the linguistically isolated population to the list. Members discussed how some subpopulations are currently statutorily identified but would also meet the criteria under the second issued discussed by the Subcommittee. The legality of this particular point will be reviewed by HRSA; it is important to sort out what is statutory and what is regulatory. Questions also arose as to the legality of creating a facility MUP designation and whether the over 65 years of age criterion was going to be kept. There were also comments approving the Subcommittee's proposed use of Healthy People 2020 to expand the health status factors for consideration in MUPs, using the list from Healthy People 2020. Additional comments included: a concern that MUPs and HPSAs address different needs and should be kept separate – the "right tool for the right job"; and a concern that Healthy People 2020 was not a good tool for rural areas and may need more discussion by the committee depending on what develops.

HEALTH STATUS/OUTCOMES ANALYSIS AND OPTIONS

Eric Turer of John Snow, Incorporated (JSI) gave a presentation entitled, "Concepts Related to Assessing Health Status/Outcome Measures," (Attachment 3) which discussed the applicability of assessing health status in a community overall as a direct indicator of need independent of the adequacy of provider supply. The goal in making a decision on health status/outcome is to decide

what measures to use and how to measure them. The health status/outcome measures in the current designations were briefly described and discussed. Mr. Turer described what factors should be considered in selecting measures and potential data sources. In addition, he provided one possible conceptual framework for health status indicators, providing examples for each category in the framework. Mr. Turer then described and discussed in detail what factors should be considered when applying health statistic measures. JSI also provided a handout which included a literature review of research studies which have examined the relationship between various health statistics and primary care, including the measures examined and pros and cons associated with their use.

Following Mr. Turer's presentation, the Committee discussed their questions and concerns. There were concerns about the use of infant mortality rate as an indicator, specifically with using the national average rate. There were also concerns about the exclusion of insurance status as an indicator, though it was explained that it has been treated, thus far, as a barrier to care rather than a health status measure. Finally, Committee members discussed access to data, specifically collecting data in rural areas and receiving data from the Federal government. There was discussion of the RWJ County rankings and the data used, a suggestion that the BPHC Resource Guide might be a useful document to review and a brief discussion of the use of proxies for areas where good data are not available (such as the Social Deprivation Index being developed by the Graham Center). One option would be to include a combination of direct and indirect measures.

There was concern about the data collection burden, particularly in rural areas, and the need to assure the accuracy and validity of any data submitted.

DATA TECHNICAL SUBCOMMITTEE – SUMMARY REPORT

Dr. Rarig reported on the work of the Data Technical Subcommittee. The Subcommittee met (via conference call) five times for a total of nine hours. The Subcommittee understood their charge to be twofold: (1) review data sources available on demand/need and supply, and (2) consider possible methods for weighting to get at the best population to provider measures. Dr. Rarig provided a document that summarized the Subcommittee's work and discussions (Attachment 4). There were two overall issues that the Subcommittee discussed with many underlying questions/issues that arose. The Subcommittee discussed the issue of counting and weighting providers with substantial agreement on provider types for inclusion; however, the Subcommittee needs more discussion on data availability and accounting for the mix of providers. The Subcommittee also discussed the issue of counting and weighting populations with agreement that it would be desirable to generally continue with the current criteria. The Subcommittee also discussed possible adjustments for weighting populations but did not come to a consensus on any particular method. The Subcommittee has a

few outstanding issues to consider including, methodology, marketing and impact testing.

Dr. Phillips then discussed the Social Deprivation Index and presented a document prepared by him, Dr. Taylor, Dr. Goodman, Dr. McBride and Stephen Petterson (works with the Graham Center) (Attachment 5). Regarding the identification of MUAs, the group reached three decision points. The first decision point is the widespread use of social deprivation measures to identify areas in need of additional health resources. This approach uses widely available demographic data to form an index correlated with poor health outcomes, health status, costs and unnecessary hospitalizations. The second decision point is measuring actual outcomes against the risks. This could identify the potential for social deprivation measures to do a better job in some parts of the country than others. The third decision point is to introduce the measure of workforce. In addition there are other decisions and possibilities to be discussed with the full Committee, including combining measures into one index, how to weight measures, flexibility provided to local areas and flexibility regarding data sources. Dr. Phillips explained that the following measures were predictive indicators: percent Black, percent single mothers, percent below poverty, percent with no high school diploma, percent unemployed, percent with no car ownership and percent uninsured. Not as predictive were: percent Hispanic, percent renter occupied, percent linguistically isolated, percent overcrowding, percent foreign born and percent high need.

Following Dr. Rarig's and Dr. Phillips' presentations, the Committee discussed their questions and concerns. It was noted that the Social Deprivation Index is only one proposal and has yet to get consensus from the Data Technical Subcommittee. The Subcommittee has discussed at least three different approaches but it was a broad ranging discussion for systems that might be relevant. Committee members asked questions about factors reducing the effects of social deprivation, whether there was a follow up on "percent Hispanic" not being a good indicator and whether this index works for all populations, including native Hawaiians and Pacific Islanders. Overall, the Committee appreciated the creativity being applied in the area of data by the Subcommittee.

There were some questions about alternatives: can we get more information about how RWJ decided which variables to include and how to weight them? Can their measures work at the sub-county level – not all are primary care related – are they direct measures? Could we include some of their measures combined with some SDI measures and other socio-economic factors? This discussion will continue in the Subcommittees with a goal of presenting some more concrete options at the next meeting.

INTRODUCTION TO RATIONAL SERVICE AREAS

Mr. Turer gave a presentation entitled, “Concepts for Defining Rational Service Areas for Primary Care Access” (Attachment 6) which described the current rules and approach for rational service areas. Mr. Turer also discussed the approach to Rational Service Areas (RSAs) under NPRM-2. The current goal for the Committee, as he described, is to establish rules for defining service areas that reasonably reflect effective primary care access patterns. There are three considerations for meeting the goal: (1) geographic units, (2) distance/travel time and (3) boundary/contiguous area issues. In addition, options for impact testing were also discussed.

Following Mr. Turer’s presentation, the Committee discussed their questions and concerns. A concern arose about states with predefined RSAs and whether the Committee’s process would affect those. It was determined that the Committee can make the decision whether to affect those states with predefined RSAs. Note: there are currently 5 states with predefined RSAs. One Committee member thought a broader discussion of current patterns of access to primary care not empirically determined would be interesting. Questions also arose as to the history of why RSAs were applied to HPSAs and not MUAs. It was mentioned that RSAs are applied to MUA/Ps even though they are not mentioned in the statute or regulations for MUA/Ps. [Note: the MUP statute refers to the population of an area designated, and the MUA/P regulations refer to “natural neighborhoods” or “homogeneity of a neighborhood . . . may constitute more natural areas for designation.”] There was also a discussion of whether overlapping service areas should be allowed, which is a change from the current approach.

INTRODUCTION TO PRIMARY CARE SERVICE AREAS

Dr. Goodman gave a presentation entitled, “Primary Care Service Areas” (Attachment 7). Dr. Goodman noted that Primary Care Service Areas (PCSAs) were redefined in 1999 but have not be redefined since. A PCSA is the smallest geographic area that can be considered a discrete service area for primary care. A PCSA includes a Zip Code Tabulation Area (ZCTA). Dr. Goodman explained the reasons for using Medicare data to define PCSAs and discussed the current areas for HPSA and MUA designations. Finally, Dr. Goodman discussed the advantages and disadvantages for using PCSAs for evaluating primary care.

Following Dr. Goodman’s presentation, the Committee discussed their questions and concerns. Clarification was sought on whether the Medicare data included people with disabilities in addition to the elderly. Dr. Goodman noted that the Medicare data only included the elderly. Dr. Goodman was asked how he envisions the use of PCSAs in the process. He gave three options: (1) PCSAs are considered the default RSA (as an option but not required) but could be used for impact testing initially, (2) start with PCSAs and then be able to depart from it in order to provide everyone with a level playing field, and (3) PCSAs are a

source of subcounty information. There were also some overall concerns with using PCSAs. Comments were made about PCSAs not being ideal.

DISCUSSION OF RELATIONSHIP OF HPSA AND MUA

Mr. Salsberg facilitated a discussion on the relationship of HPSAs and MUAs by creating two matrices. Each matrix had four boxes: HPSA (geography), HPSA (Population), MUA (geography) and MUA (population). The Committee helped to fill in the boxes of the first matrix based on what the current *statutes* require.

<p style="text-align: center;">HPSA (Geography)</p> P2P ratio; indicators of need for health services; percent of providers in area employed by hospitals and foreign graduates	<p style="text-align: center;">MUA (Geography)</p> P2P ratio; health status indicators; availability to pay; accessibility
<p style="text-align: center;">HPSA (Population)</p> Same as above	<p style="text-align: center;">MUA (Population)</p> Same as above

The second matrix was completed based on what the current *regulations* require.

<p style="text-align: center;">HPSA (Geography)</p> P2P ratio at 3500:1 OR P2P ratio at 3000:1 with high need factor	<p style="text-align: center;">MUA (Geography)</p> P2P ratio MDs per 1000; percent poverty; percent elderly; infant mortality rate
<p style="text-align: center;">HPSA (Population)</p> P2P ratio at 3000: 1 w/ high need factor	<p style="text-align: center;">MUA (Population)</p> P2P ratio based on subpopulation providers that serve them; percent poverty; percent elderly; infant mortality rate

After discussion and input from the Committee, Mr. Salsberg and HRSA are going to clean up the matrices and present them back to the Committee.

*******Day Two*******

Mr. Salsberg continued the discussion on the relationship of HPSAs and MUAs. He presented a revised matrix (Attachment 8) and made the clarification that the statute does not specify between MUA and MUP but does allow both. The Committee’s discussion centered on the simplicity of the matrix. Some thought it was too complex while others thought it was clear enough. There was a suggestion to have a list of things that the Committee can and cannot change during this process but the conclusion was that a list would not be helpful or attainable. There was continued agreement that there should be two separate designations to address different problems, though there may be similar components but different weights.

DISCUSSION ON SUPPLY – SUBCOMMITTEE REPORTS

Dr. Rarig presented a matrix prepared by the Data Technical Subcommittee entitled, “Draft Matrix Regarding Providers to Count – and Adjustment Options – with Comments” (Attachment 9). The Subcommittee spent between 30-60 minutes on the matrix. Dr. Rarig discussed the content of the matrix before the Committee voted on any provider inclusions. She noted that in general, military and VA providers should not be counted because they are not available to the general public. Concerns arose as to why cardiologists were singled out as an Internal Medicine specialty instead of lumping all Internal Medicine specialties together. The Committee decided that it was best to consider all Internal Medicine specialties together as one. A Committee member advised the other members to consider what primary care means when determining who is and is not counted: is it the provider or the type of services? Are primary care services provided by non-primary care providers the correct or most appropriate care we want to endorse? It is a measure of supply of services that is available and can help in comparing relative need between communities. The question was asked how the Subcommittee counted Nurse Practitioners and Physician Assistants. Dr. Rarig said the Subcommittee has not decided but would probably begin discussions with counting them as 0.5 FTEs as a starting point. The discussion then turned to whether states require NPs and PAs to be attached with a MD. It was said that 19 states have loosened the barriers for NPs and PAs and that there is not a justification for the 0.5 FTE coming out of limits/barriers in state practices.

The Committee went through the matrix and voted on each provider listed:

Medical Doctors

- General Practitioners: Vote to include
- Family Practice: Vote to include
- Internal Medicine (no subspecialty): Vote to include
- Internal Medicine (subspecialty): Vote to exclude
- Pediatrics (no subspecialty): Vote to include
- Pediatrics (subspecialty): Vote to exclude
- Ob/Gyns: HOLD
- Hospitalists: Vote to exclude
- Geriatricians: Vote to include
- Adolescent Medicine: Vote to include

Physician Assistants

- Family Practice/Primary Care: HOLD (inclined to include; need further study on weights and impact)
- Other Specialties: HOLD (need further study)

Nurse Practitioners

- Family Practice: HOLD (inclined to include; need further study on weights and impact)
- Pediatric or Adult Care: HOLD (inclined to include; need further study on weights and impact)
- Certified Nurse Midwife: HOLD (need further study)
- Other Acute Care: HOLD (need further study)
- Geriatric (primarily in institutions): HOLD (need further study)

There was a request for additional information regarding the subspecialist issue from two committee members; the subcommittee will revisit these issues in their deliberations and report back.

DISCUSSION ON POPULATION COUNTS – SUBCOMMITTEE REPORTS

Dr. Rarig presented a matrix prepared by the Data Technical Subcommittee entitled, “Draft Matrix for Population Counts for NRM Data/Technical Subcommittee Background and/or Discussion” (Attachment 9). First, Dr. Rarig discussed the suggestions for populations to count and then she discussed adjustments based on population characteristics. The Committee made the following decisions on populations to count:

- Resident Population
 - National: Vote to include
 - State: Vote to include
- Exceptions
 - Military Barracks: Vote to exclude
 - Prison Populations: Vote to (probably) exclude
- Long Term Care Populations: HOLD
- Migrant Workers and Seasonal Populations (adjusted for time in area)
 - Migrant Workers: Vote to include
 - Seasonal Workers: Vote to include (clarify non-resident seasonal workers)
 - Seasonal Residents (non-workers): Vote to include
- Tourists: Vote to include (adjusted for time in area)

Dr. Rarig explained that adjustments can be made based on age, sex, race and language. The Committee discussed age/gender adjustments helping to reflect more appropriate level of need, population counts versus visits, and alternatives being weighting factors such as elderly and youth dependency ratios. Could the presence of a large disabled population be a high need indicator? Will MEPS continue as a source of data? Use of relative versus normative factors-means/percentiles, etc. are options to consider. Or does an SDI approach work better in addressing a local community? Barriers and health status issues will need to be addressed, but it may not be in the population count portion of a model. There was some discussion about a version of the barrier-free approach could be used to make the age/gender adjustment for a population’s relative

need for care. The Committee did not make any decisions on any populations characteristic adjustments.

DISCUSSION ON INDICATORS – SUBCOMMITTEE REPORTS

Mr. Holloway presented a matrix prepared by the Data Technical Subcommittee entitled, “Draft Matrix for Health Status Measures for NRMC Data/Technical Subcommittee Background and/or Discussion” (Attachment 9). He discussed ten health status measures, including the sources of each measure, the pros and cons of using each measure and how each measure would be used in a MUA or HPSA. Mr. Holloway noted that the first four measures – standardized mortality ratio, infant mortality rate, post-neonatal mortality rate, and low birth weight – are readily available in all states from vital statistics. One Committee member noted that vital statistics are not the most accurate data because, for example, some races/ethnicities head to their home countries to die and are not reported in their state’s death statistics. The next four measures – percent fair/poor self-assessed health status, hypertension prevalence, diabetes prevalence and disability prevalence – are gathered from survey data. The final two measures – ambulatory care sensitive conditions and social deprivation index – received the most debate from the Committee. There was extensive discussion about data sources (ACS, BRFSS, etc), their reliability, their continued support over time. The subcommittees will continue to explore these issues and report back. The Committee requested to have a presentation on the Social Deprivation Index. There was also a suggestion to consider a broader list of potential measures based on the literature review.

*****Day Three*****

SUBCOMMITTEE REPORTS – NEXT STEPS – FOLLOW UP

Dr. Wilson briefly discussed the next tasks of the Subpopulations Subcommittee. The Subcommittee is going to use the current statutory criteria but they need to discuss how to define those groups that will be pre-identified and those that will not be. The Subcommittee is going to take ownership of health status measures to ensure that population issues are included, including a review of Healthy People 2020. They will also address disparities, accessibility and availability of providers, ways to include local data and the HPSA/MUA overlap issue. The two subcommittees will collaborate in areas where their charges overlap.

Dr. Taylor discussed the next actions of the Data Technical Subcommittee with a presentation entitled, “Proposed Actions of Data Technical Subcommittee for Feb. 2011 Meeting” (Attachment 10). They have organized further into four subgroups: (1) Workforce; (2) Accessibility-distance, Barriers; (3) Ability to Pay; and (4) Health Status/Socio-Economic Indicators. They do not understand their task to be impact testing but rather using empirical data to flush out decisions. Impact testing will come further down the road. The Subcommittee will have

three general tasks. They will demonstrate the distribution of primary care across the country. They will also provide judgment and recommendation on relative merit of data sources. Finally, they will consider ways to combine direct health and the social deprivation approach to MUA. Each task involves greater detail specified in Dr. Taylor's presentation.

HEALTHY PEOPLE 2020 PRESENTATION

Ms. Geri Tebo from the Office of Disease Prevention and Health Promotion at the U.S. Department of Health and Human Services gave a presentation entitled, "Healthy People 2020: Preparing for a New Decade" (Attachment 11). She noted that Healthy People 2020 launched on December 1, 2010 and is a national agenda for improving the populations' health. Healthy People has been around since Jimmy Carter was President and has had a quick evolution. Healthy People creates a strategic framework and tracks data-driven outcomes. Multiple stakeholders are involved and engaged at all levels. Some of the new topic areas for Healthy People 2020 include Genomics, Global Health, LGBT Health and Social Determinants of Health. A goal of Healthy People 2020 is to achieve health equity, eliminate health disparities and improve the health of all groups. Ms. Tebo discussed the disparities of particular races and genders, the LGBT population, people with disabilities and rural/urban residents. She also introduced features of the Health Indicators Warehouse which launches on January 21, 2011.

HPSA AND MUA PROCESS MAP PRESENTATION

Dr. Babitz gave a presentation entitled, "Map for HPSA and MUA" (Attachment 12). He outlined three goals in creating the map: (1) addressing areas and populations with the greatest health disparities, (2) adhering to statutory requirements, and (3) keeping it simple. Dr. Babitz's process map has a category each for HPSA and MUA/P. Underneath each category are process points. Ultimately, the process map requires the Committee to make five decisions: (1) define Rational Service Area, (2) select Population-to-Provider methodology, (3) select Health Status Needs methodology, (4) define "other factors for MUA/P," and (5) perform impact testing and revisit the previous decisions. The discussion following the presentation centered around pinning everything on income and education. Some members thought including access barriers, for example, would be useful. Overall, Committee members appreciated the simplicity of Dr. Babitz's map.

SOCIAL DEPRIVATION INDEX PRESENTATION

Dr. Phillips gave a presentation entitled, "Options for HPSA and MUA/MUP Designation" (Attachment 13). The question, framed by Dr. Phillips, was whether an index of underservice that predicts health outcomes and identifies communities of need can be created. The objective is to create a national

measure of social deprivation at the level of the primary care service area that is predictive of health care need and access. The primary method of the index is secondary data analysis. Once the data are available, the variables are converted to centiles and a factor analysis is completed. From this process, indices are created and then a pair-wise correlation is performed. Dr. Phillips displayed the findings in tables, charts and graphs. Questions arose about the use of this index in other countries and whether the information is peer-reviewed. Dr. Phillips indicated that the information is not peer-reviewed but that similar approaches have been utilized in places in Europe and Canada, some for 20 years, and has been improving outcomes. Other concerns were noted about the complexity of the index and not being able to explain it externally.

DEVELOP AGENDA FOR NEXT MEETING

The facilitators provided a draft agenda to the Committee which included the following topics:

- Continue to seek consensus on demand/need
- Seek consensus on supply
- Seek consensus on sub-populations
- Second discussion on health status and outcomes
- Second discussion on rational service areas
- First discussion on thresholds of underservice
- Impact testing analysis plan discussed
- Data Technical Subcommittee Report
- Subpopulations Subcommittee Report

A Committee member asked to have Access issues on the agenda also. The topic was delegated to the Accessibility-distance, Barriers subgroup of the Data Technical Subcommittee. In addition, the Committee decided to extend March and April meetings to three days. HRSA will work the Committee to finalize the exact dates of each meeting.

PUBLIC COMMENT

The Committee was provided with written comments from Louise Cohen, Deputy Commissioner, New York City Department of Health and Mental Hygiene (Attachment 14); O. Marion Burton, President, American Academy of Pediatrics (Attachment 15); Mikki Stier, Senior Vice President of Government and External Relations, Broadlawns Medical Center (Attachment 16); and Matthew Holder, Director, Underwood and Lee Clinic (Attachment 17).

Dana Thomas, from the National Family Planning and Reproductive Health Association, asked the Committee to clarify that access to Title X-supported obstetric and gynecologic services are evaluative criteria for MUA/HPSA designations (Attachment 18).

Tanya Armont, from Planned Parenthood, hoped that women's primary care access needs will be reflected in the Committee's works. She asked that the Committee include Ob/Gyns in the primary care provider count in order to reinforce the primary care role they have for women.

Susan Waisockie, from the National Association of Nurse Practitioners and Women's Health, enforced the two previous comments and stressed that Nurse Practitioners and Women's Health Nurse Practitioners are practicing primary care, especially disease prevention and treatment.

Mary Jo Goolsby, from the American Academy of Nurse Practitioners, also stressed the primary care role that 89% of nurse practitioners are prepared for (Attachment 19). Her organization supports the inclusion of Nurse Practitioners and wants them weighted accurately.

Tina Johnson, from the American College of Nurse Midwives, stressed the value of including certified nurse midwives and nurse practitioners in the provider count. She explained how certified nurse midwives become primary care providers to many patients. She also noted that there are about 12,000 certified nurse midwives in the country (Attachment 20).

The meeting adjourned on January 20, 2011 at 11:58 a.m.

**JANUARY 18-20, 2011 SUMMARY MEETING MINUTES
ATTACHMENTS**

1. Overview of Where We've Been: Framework and Roadmap (PowerPoint)
2. NRMC Special Populations Subcommittee Discussion Summary January 2011 (PDF)
3. Concepts Related to Assessing Health Status/Outcome Measures (PowerPoint)
4. Data Technical Subcommittee Draft Report to Negotiated Rulemaking Committee
5. Identifying MUAs – Three decision points
6. Concepts for Defining Rational Service Areas for Primary Care Access (PowerPoint)
7. Primary Care Service Areas (PowerPoint)
8. HPSA MUA Grid
9. Data Technical Subcommittee Matrices (Excel)
10. Proposed Actions of Data Technical Subcommittee for Feb. 2011 Meeting (PowerPoint)
11. Healthy People 2020: Preparing for a New Decade (PowerPoint)
12. Map for HPSA and MUA (Power Point)
13. Options for HPSA and MUA/MUP Designation (PowerPoint)
14. Written Comment from Louise Cohen, Deputy Commissioner, New York City Department of Health and Mental Hygiene
15. Written Comment from O. Marion Burton, President, American Academy of Pediatrics
16. Written Comment from Mikki Stier, Senior Vice President of Government and External Relations, Broadlawns Medical Center
17. Written Comment from Matthew Holder, Director, Underwood and Lee Clinic

Health Resources and Services Administration
Negotiated Rulemaking
Designation of Medically Underserved Areas/Populations & Health Professional Shortage Areas

18. Written Comment from Dana Thomas, Director of Policy and Advocacy, National Family Planning and Reproductive Health Association
19. Written Comment from Mary Jo Goolsby, Director of Research and Education, American Academy of Nurse Practitioners
20. Written Comment from Tina Johnson, Director of Professional Practice and Health Policy, American College of Nurse Midwives