

SUMMARY MEETING MINUTES

February 16-18, 2011

The Negotiated Rulemaking Committee (hereafter the “Committee”) was convened for its fifth meeting at 1:07 P.M. on February 16, 2011 at the Legacy Hotel, Rockville, Maryland. 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
Kathleen Clanon
Beth Giesting
David Goodman*
Daniel Hawkins
Sherry Hirota
Steve Holloway
Barbara Kornblau
Tess Kuenning
Alice Larson*†
Tim McBride
Lolita McDavid
Alan Morgan
Ron Nelson*
Charles Owens
Robert Phillips
Alice Rarig
Edward Salsberg
William Scanlon
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 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. Ms. Sylvester gave each Committee

member a list of twelve question for the Committee to answer (based on the Federal Register Notice of Intent for the Committee) in order to track the Committee's progress (Attachment 1).

APPROVAL OF SUMMARY MINUTES

Prior to this meeting, the Committee reviewed the draft minutes from January's meeting. A Committee member suggested changing "health statistic" to "health status measure" in the first full paragraph on page 4.

The January meeting minutes were approved as revised.

SUBCOMMITTEE REPORTS

The Subcommittees and their respective workgroups were each permitted 30 minutes to report to the Committee on their progress.

Data Technical Subcommittee Reports

Dr. Rarig indicated that the workgroups of the Data Technical Subcommittee were charged with examining and vetting the available data sources.

Workforce Workgroup

Ms. Kuenning reported on the progress of the Workforce Workgroup. The Workgroup, which met three times via phone, was charged with looking at provider types and making recommendations regarding specialty/subspecialty, weighting factors and inclusion. The Workgroup put together a spreadsheet with their recommendations to reflect the empirical data (Attachment 2). The Workgroup made the following recommendations regarding what provider types to count:

Medical Doctors

- General Practitioners: INCLUDE
- Family Medicine: INCLUDE
- Internal Medicine (no subspecialty): INCLUDE
- Internal Medicine (subspecialty): EXCLUDE
- Internal Medicine (other - % of time in primary care): EXCLUDE
- Pediatrics (no subspecialty): INCLUDE
- Pediatrics (subspecialty): EXCLUDE
- Ob/Gyn: INCLUDE – use 0.25 weight for impact testing
- Hospitalists: EXCLUDE
- Geriatricians: INCLUDE
- Adolescent Medicine: INCLUDE
- General Surgeons: EXCLUDE
- Residents: EXCLUDE

- Urgent Care Providers: EXCLUDE

Physician Assistants* – USE 0.75 WEIGHT FOR IMPACT TESTING

- Family Practice/Primary Care: INCLUDE
- Other Specialties: EXCLUDE
- Urgent Care Providers: EXCLUDE

Nurse Practitioners: USE 0.75 WEIGHT FOR IMPACT TESTING

- Family Practice: INCLUDE
- Pediatric or Adult Care: INCLUDE
- Other Acute Care: EXCLUDE
- Geriatric (primarily in institutions): INCLUDE
- Urgent Care Providers (and Retail Clinics): EXCLUDE
- Women's Health: INCLUDE – weight same as Ob/Gyns

Certified Nurse Midwives: INCLUDE – weight same as Ob/Gyns

Others

- Community Health Aides: EXCLUDE
- Alternative/Holistic/Naturopathic: EXCLUDE
- Locum Tenens: EXCLUDE
- Ready Responders: EXCLUDE

**For Physician Assistants and Nurse Practitioners, the specialty of the supervising physician determines the PA/NP specialty, unless they are practicing independently, in which case the specialty of the practitioner will be used.*

Ms. Kuenning also indicated that there are three outstanding issues for the Workgroup: (1) back out providers (NHSC, J1, IHS, etc.); (2) definition of primary care; and (3) assuring that the methodology recommended for capacity will ensure that providers see the underserved.

Following, Ms. Kuenning's presentation, the Committee discussed their questions and concerns. Clarification was sought on why urgent care was recommended to be excluded. Ms. Kuenning explained that the reasoning to exclude urgent care providers was that they do not consider themselves to be practicing primary care and that urgent care providers are very transient. In addition, the Workgroup did not make a distinction between urgent care and retail clinics because they felt both provided only acute care rather than continuing comprehensive care. Also, it was noted that there is no data at the national/state level for urgent care and retail clinics.

A Committee member asked the Workgroup to correct their spreadsheet to reflect that geriatrics providers are not primarily in institutions.

The Workgroup was asked if they gave any consideration to residents working in clinic settings doing primary care. Mr. Salsberg explained that there was a lengthy discussion that included the possibility of weighting those residents at 0.1. Ultimately, including them was not worth the 0.1 weight so the Workgroup recommended excluding them.

The Workgroup also explained, in response to a question from the Committee, that they did not consider language access because they were only exploring who should be included for geographic designations at this point.

Following the Committee's discussion, Ms. Kuenning introduced a diagram that portrays the relationship of the components the Committee is considering (Attachment 3). She explained that there are two sides to the diagram: (1) health status/health outcomes/need; and (2) provider supply/population need/demand. The left side of the diagram is comprised of (a) social determinants of health, (b) direct measures of health and (c) barriers. The right side of the diagram (providers/population) encompasses the patient-to-provider ratios.

Health Status/Socio-economic Indicators Workgroup

Dr. Taylor gave a presentation on the progress of the Health Status/Socio-economic Indicators Workgroup (Attachment 4). The Workgroup was charged with further investigating the social determinants of health. He explained that the Workgroup has developed a four variable Social Deprivation Index (SDI) and related it to direct health status measures. The four variables for SDI are percent of population below 100% poverty, unemployment rate, % persons with less than high school diploma and % households with a single parent; the results of this four-variable SDI are highly correlated with those of the original nine-variable SDI. While there is no final recommendation yet, the Workgroup is moving toward SDI plus a direct measure of health. The analysis done shows a consistent relationship between the revised SDI and direct health status measures, but the correlation is imperfect, so there is a need to incorporate direct measures of health status as well. The data for the four SDI variables are available at a more local level than some health status measures, so the indirect measures can help identify areas at risk of poor health where the health status data are unavailable.

The health status measures used in the analysis of SDI were Standardized Mortality Rate, %Fair/Poor Health, Life Expectancy at Birth, Unhealthy Days, and Low Birth Weight.

There was agreement that this model might be a good place to start but needed further discussion, with questions remaining about weights, scaling, where to draw the line, etc. There were questions asked about validating the model and

determining which kinds of resources might change the patterns, as well as what was eliminated from the original model and why.

Following Dr. Taylor's presentation, Eric Turer of John Snow Incorporated (JSI) presented a few charts which showed the correlation between the four -variable SDI and health status (Attachment 5).

Ability to Pay Workgroup

Dr. McBride gave a presentation on the progress of the Ability to Pay Workgroup (Attachment 6). The Workgroup discussed three topical areas: poverty/income, uninsured and unemployment. He noted the early stage of some of their discussions and that they were exploring complicated issues. The Workgroup discussed data sources, measures and thresholds relating to poverty, but do not have recommendations for the Committee yet. The Workgroup also considered issues with ACS data related to larger confidence intervals for smaller geographic areas. No conclusions were reached. Similarly, as yet there are no recommendations for the Committee relating to measures of the uninsured or unemployment; however, the Workgroup's discussions are ongoing. There were comments about the need to allow flexibility for incorporation of measures that are not available now but may be in the future, as well as how to account for Cost of Living variations across the country and whether 100% or 200% of poverty is the more appropriate measure of access barriers.

Access Work Group

Dr. Rarig reported on the progress of the Access Workgroup (Attachment 7). The Workgroup met three times and discussed barriers to accessing primary care, including geographic, seasonal, economic, individual (disabilities) and cultural/linguistic. The Workgroup provided a number of suggestions to the Committee:

- Keep RSA definition as 30 minutes to care – with rural/frontier exception and ability to adapt for larger regional centers
- Consider “distance decay” and obstacles in adjusting estimates of capacity
- Consider which special populations can be assisted in having care provided through a designation process
- Consider cost of living, since cost of care varies with the cost of living and it varies significantly across different areas of the country.

In addition, Dr. Rarig briefly discussed some recommendations regarding data sources.

Subpopulations Subcommittee Reports

Dr. Wilson indicated that the Subcommittee formed three workgroups. She thanked each group for working hard the past few weeks.

Population Identification Workgroup

Dr. Clanon reported on the progress of the Population Identification Workgroup (Attachment 8). The Workgroup proposed naming certain population groups in the rule for automatic designation to simplify the process of identifying MUPs for these “special populations.” These would be population segments where sufficient national data showed they met need criteria in relation to health status, access barriers and ability to pay. The local jurisdictions serving those populations would only need to identify the population group size and demonstrate a lack of providers serving that population group. The Workgroup proposed four general criteria for identifying population groups eligible for streamlined MUP designation:

- Include Population groups already recognized in existing major federal health care service delivery legislation as experiencing health care access barriers and having more intense medical needs/health status issues
- Census data or other nationally recognized data base indicates >50% of people in this group are impacted by poverty
- Nationally accepted data indicate that >50% of people in the group have poor access to health care services
- Nationally accepted data indicate that >50% of people in this group have poor health status

Other population groups could qualify for MUP designation by presenting local data, but they would not be automatically designated.

The Committee asked if the Workgroup collapsed streamlined MUP and HPSA population group designations into one thing. Dr. Clanon explained that the Workgroup did not intend for the two to be joined but had not yet settled on a Special Population HPSA process. She requested that this be discussed further during the next day’s meeting. .

There were also concerns about the 50% threshold for the last three criteria being a high bar. Dr. Clanon indicated that the Workgroup was also concerned that this threshold may be too high; however, this 50% threshold could be used for a JSI test run.

Disparities/Access/Availability Workgroup

Ms. Hirota reported on the Disparities/Access/Availability Workgroup (Attachment 9). The Workgroup collected and reviewed the most notable publications on access and prepared a list of the most common groupings of “barriers to access” to primary care. The barriers fit into the following four categories: (1)

Socioeconomic Barriers, (2) Language and Cultural Barriers, (3) Geographic/ Environmental Barriers, and (4) Organizational/Logistic Barriers. Many issues are listed under each category. The Workgroup recommended that these four categories be included in the regulations as the framework for the access barriers and further discuss the inclusion of individual issues.

Community Health Profile Workgroup

Mr. Brooks reported on the progress of the Community Health Profile Workgroup. Their focus was on a locally driven model that could capture relevant data from the local level using a menu approach. This would empower the local communities.

Ms. Kornblau presented five screenshots of the potential website (Attachment 10). The website, for example, would allow a community to answer questions relating to population groups experiencing health care access barriers, community income relative to federal poverty level, access to care and health status indicators. In addition, a community would be able to upload supporting documentation/data directly through the website. Ms. Kornblau emphasized that the goal is to keep it simple. Mr. Brooks added that communities would be able to justify their claims by adding supporting documentation and information.

There were questions about how other population groups would apply; how the local model fits with the “streamlined” approach, how local data get included, etc. This may be at least a place to start at a national level. It was suggested to refer to this option as “streamlined” or “simplified” rather than “automatic,” since they would still be required to meet certain criteria.

CONSENSUS ON SUPPLY

Ms. Kuenning led the Committee’s discussion toward reaching a consensus on supply. The Committee was given two documents listing the provider types and recommendations of the Workforce Workgroup (Attachments 11 and 12). The Committee agreed to include (count) the following providers:

Medical Doctors

- General Practitioners
- Family Medicine
 - Need more info on “uncommon specialties”
 - Consider how to weight those who do significant amounts of Ob/Gyn
- Internal Medicine (no subspecialty)
- Pediatrics (no subspecialty)
- Ob/Gyn – weight at 0.25 for impact testing
- Geriatricians
- Adolescent Medicine

Physician Assistants* – USE 0.75 WEIGHT FOR IMPACT TESTING

- o Family Practice/Primary Care
- o Pediatrics/Adult Care

Nurse Practitioners*: USE 0.75 WEIGHT FOR IMPACT TESTING

- o Family Practice
- o Pediatric or Adult Care
- o Geriatric
- o Women’s Health – weight at 0.25 for impact testing

Certified Nurse Midwives– weight at 0.25 for impact testing

The Committee agreed that once they obtain a final copy of the proposed “supply” list, they will be able to discuss this list with their organizations and report back to the Committee with any changes.

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

FUTURE MEETING DATES

The Committee expressed concerns about a government shutdown possibly affecting the March meeting. Mr. Salsberg said that while HRSA does not expect a shutdown to happen, he will have to look into what effect a shutdown would have on the March meeting. Committee members wondered if they could still meet even if the Federal staff could not meet. Mr. Turer explained that JSI would be unable to cover travel expenses if the government shuts down.

The Committee confirmed the meeting times for the scheduled March and April meetings: day 1 begins at 9:30 a.m. and day 3 ends at 4 p.m. The Committee also decided to end at 3 p.m. on the last day of the current meeting.

COMMITTEE PROGRESS

The facilitators noted that the Committee has now answered two of the twelve questions originally posed to the Committee (in the Federal Register Notice): questions #1 and #4.

The Committee then broke into two small groups for further discussion. The first group, headed by Mr. Brooks and Dr. Taylor, was to discuss social determinants of health and direct measures of health. The second group, headed by Dr. Rarig and Ms. Hirota, was to discuss access barriers. The discussion topics were based on Ms. Kuenning’s diagram presented to the Committee earlier. The other members of the Committee were asked to select which group they want to participate in. Mr. LeClair asked the Committee members to do their best to cross-pollinate so that there are diverse interests on each group.

The Committee met in small groups for the rest of the morning.

DISCUSSION ON SMALL GROUPS REPORTS

Small Group 1 – Health Status Indicators and Direct Measures of Health

Dr. Taylor reported on the work of the first small group. The group discussed Social Determinants and Direct Measures each having a 50% weight. Within Direct Measures, standardized mortality ratio and direct health measures at the county or local level would each count for the other half of the total. Dr. Taylor discussed questions and issues that kept coming up:

- How to deal with actual or perceived double counting of poverty
- Decide whether to add the measures of race, ethnicity and linguistic isolation back into the SDI model
- Determine where local data is introduced
- Population designations

The small group also discussed the following direct measures of health and indicated whether the data was available at the local or county level:

- Standardized Mortality Rate - LOCAL
- Fair-poor health status - COUNTY
- Low birth weight - COUNTY
- Unhealthy (bed) days - COUNTY
- Activities of Daily Living limitations – LOCAL
- Years of potential life lost - COUNTY
- Mental health - COUNTY
- Chronic disease prevalence

The issue of race/ethnicity was raised related to use in the SDI. Data show it has an impact on health but do poverty and unemployment adequately capture that? Is it a barrier instead of a health status factor? There are some questions about the data related to Hispanics and health status.

The issue of a consistent approach for both geographic and population designation was raised; can we use the same basic factors and approach and estimate in some cases the information for the special populations if direct data are not available?

Small Group 2 – Barriers

Dr. McBride reported on the work of the second small group. The small group used the four categories of barriers that Ms. Hirota presented earlier and further

split each category. The results, listed below, were four barrier categories with groups of barriers within each category.

<p>GEOGRAPHIC/ENVIRONMENTAL</p> <ul style="list-style-type: none"> - Travel – “geo/seasonal” - Public Safety - Neighborhoods - Physical Barriers 	<p>SOCIOECONOMIC</p> <ul style="list-style-type: none"> - Coverage - Ability to Pay - Educational Attainment
<p>ORGANIZATIONAL</p> <ul style="list-style-type: none"> - Provider Capacity - Linguistic Competency - Cultural Competency - Quality/Medical Home Concept 	<p>LANGUAGE AND CULTURAL</p> <ul style="list-style-type: none"> - Discrimination - Linguistic Isolation/LEP - Immigration Status - Race/Ethnicity - Literacy

Dr. McBride indicated that some individual barriers were dropped off the list because they were related to health status instead of barriers to access. The small group also discussed the following: (1) that access should be one of the factors considered; (2) auto designation needs to be revisited; and (3) that facility designations need to be addressed as well.

Historically, for sub-populations, the group was identified based on a barrier and then the supply/lack of supply was addressed. If there are three options - geographic, population, and facility – how do various factors get included or not in each option?

The Committee raised some questions and concerns including why HIV was not listed. There was also a discussion of the issue of provider expertise for particular populations, given the multiple conditions that could apply, and the lack of a remedy that is linked to the rubric of medically underservice and provider shortages. It is a training issue of competency that these tools are not designed to address.

How do you address the stigma or refusal to serve certain groups? There was a suggestion that a small group should address the issues of competencies/discrimination/clinical expertise.

TESTING CONSENSUS ON HEALTH STATUS

The Committee took a preliminary vote on whether using the SDI (plus an outcome health status variable) is a promising starting point for impact testing. While the Committee voted to do such testing, they also decided to again break into two small groups in order to have further discussion on both health status and barriers.

SECOND DISCUSSION ON SMALL GROUP REPORTS

Small Group 2 – Barriers

Mr. Supplitt reported on the discussion of the second small group. Essentially what this small group did was pick one individual barrier from each of the four categories of access barriers identified above to use for discussion and initial testing. Their selections are listed below:

- Geographic/Environmental → 30 minutes travel
- Socioeconomic → % uninsured at a point in time
- Organizational → wait time
- Language and Cultural → linguistic isolation/LEP

The small group basically supported creating their own index, termed the Social Barriers Index (SBI). Their pitch is to ask JSI to model SBI at the geographic level for the four factors (barriers) above, for purposes of testing. The testing will hopefully show how each factor influences access to care. After clarification on ability to pay and whether LEP counts the deaf, Mr. Supplitt noted that the factors were chosen somewhat arbitrarily to reflect how SBI relates to access. The Committee voted for JSI to test the small group's model.

Small Group 1 – Health Status Indicators and Direct Measures of Health

Mr. Salsberg reported on the discussion of the first small group on health status. This small group decided on testing SDI plus standardized mortality rate. SDI would include four variables: (1) 100% poverty index, (2) percent of population without a high school diploma, (3) unemployment and (4) single family household. After testing SDI with standardized mortality rate, the small group wants to see how other direct measures correlate. This clarification addressed some concerns of the Committee. The small group also reiterated that most of the direct measures are available at the county level. A proposal was made to continue moving forward with testing SDI + SMR and the Committee voted for the proposal. Dr. Taylor noted that there is still the outlying question of where local data comes in. He suggested having a subgroup think about that question while the data is being tested.

There was discussion about what is the standard for testing – what are we measuring the results against? If it is only against existing designations and looking for limited change, why are we bothering to do this? If we do testing and it does not fit what we think are the needy areas, can we figure out why, what are we missing, etc.

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

MORNING AGENDA REVIEW

Mr. LeClair reviewed the agenda for the final day of the meeting, which included small group breakouts, reporting back, public comment and review of the roadmap.

The small groups each met to discuss whether to make adjustments to population counts.

SMALL GROUP REPORTS

Small Group 1

Mr. Supplitt reported on the discussion of the first small group. Their proposal was to adjust resident civilian populations based on age and sex, with the understanding that as this is modeled, any significant outliers would trigger a provision to allow local adjustments.

Small Group 2

Dr. Taylor reported on the discussion of the second small group. Their proposal was also to include adjustment by age and sex; however, for places with high need, a lower designation for HPSA would be allowed.

The Committee reached consensus on using some age and sex adjustment.

In addition, the Committee reached consensus on taking into account special needs somewhere in the methodology.

DISCUSSION ON THRESHOLD

Committee members were given a document for the threshold discussion (Attachment 13). Andy Jordan, HRSA, explained that the Committee needs to make decisions on scales and thresholds. The Committee must first select the factors and measurement methods. Once those have been determined, the Committee will decide how to combine them into meaningful scales. Then, the Committee will decide where to establish the threshold on any given scale. Ms. Jordan offered the document as a generic concept to get the Committee thinking. The Committee expressed comments about the current population-to-practitioner standard being too stringent and setting any variable scale for threshold as being problematic. There was also a question on how to decide the threshold without first deciding whether to back out federally-funded and/or other obligated providers. There was an expressed desire to set thresholds in a way that they can be adjusted over time without a whole new rule being required; if they are set by percentiles or medians instead of an actual value they can be reset as the scale for a particular factor changes. The Committee decided to form a subcommittee to facilitate further discussion on threshold.

PARKING LOT

The Committee recapped the issues that were put in the parking lot during this meeting.

1. How to count/back out providers (Back out)
2. How to distinguish/count who will/will not see medical underserved
3. Threshold concept
4. Distinguishing factors in MUA/P vs. HPSA re: provider counts
5. How to count FTE
6. Facilities designation
7. Barriers

The Committee tasked three new subcommittees with these remaining issues. The Workforce and Threshold Subcommittee will tackle the first five issues. Members on this Subcommittee include Ms. Kuenning (Chair), Ms. Brassard, Dr. Goodman, Dr. Phillips, Mr. Holloway, Mr. Hawkins, Mr. Morgan and Ms. Kornblau. The Facilities Subcommittee will tackle the sixth issue as well as any “unknown unknowns.” Members on this Subcommittee include Dr. Clanon (Chair), Dr. McDavid, Ms. Kornblau, Dr. Rarig and Mr. Holloway. The Barriers Subcommittee will tackle the last issue and will be careful to avoid the provider side of the discussion. Members on this Subcommittee include Dr. Taylor (Co-Chair), Dr. Wilson (Co-Chair), Dr. Rarig, Mr. Brooks, Mr. Supplitt, Dr. Larson and Ms. Kornblau.

PUBLIC COMMENT

The Committee was provided with written comments from the following individuals:

- Kathy Lim Ko, President and CEO, Asian and Pacific Islander American Health Forum (Attachment 14)
- Kathy Wibberly, Director, Division of Primary Care and Rural Health, Virginia Department of Health (Attachment 15)
- Robert Restuccia, Executive Director, Community Catalyst (Attachment 16)

The Committee was also provided with a joint statement from 25 national, state and local organizations advancing the rights of low-income immigrant communities (Attachment 17).

Robert Zarr, from the American Academy of Pediatrics, asked the Committee consider children as a special population because of their unique health needs (Attachment 18). In addition, he stressed the importance of the health status indicators chosen by the Committee.

Dave Mason represents three nurse practitioner groups: American College of Nurse Practitioners, the National Association of Pediatric Nurse Practitioners and the National Organization of Nurse Practitioner Faculties. Mr. Mason discussed the important work of nurse practitioners and urged the Committee to include them in provider counts and weight them appropriately.

Lisa Summers, from the American Nurses Association, discussed the lack of data available at a detail level and that an accurate assessment of shortage would need to include nurse practitioners and certified nurse midwives. She also urged the Committee to count certified nurse midwives and Ob/Gyns in the same manner. In addition, Ms. Summers discussed the core competencies for nursing.

Danielle Hawkes spoke on behalf of the National Asian Pacific American Women's Forum and National Latina Institute for Health (Attachment 19) who also issued a joint statement (Attachment 20). She discussed barriers to access related to medically underserved populations. She also discussed the importance of cultural and linguistic skills in health professional shortage areas.

Teresita Batayola, from the Association of Asian Pacific Community Health Organizations, urged the Committee to ensure that their final methodology is easily understandable and transparent (Attachment 21). In addition, she hoped the Committee's methodology would include direct measures that represent populations facing socio-economic, cultural and linguistic barriers to health access.

Bobbi Ryder (serving as Dr. Larson's alternate) asked the Committee to read a comment provided by the National Advisory Council on Migrant Health (Attachment 22).

REVIEW OF ROADMAP

Mr. Salsberg quickly reviewed the statutory deadlines for the Committee. By April 1, 2011, the Committee must submit a report to the HHS Secretary indicating whether the Committee is making sufficient progress to meet their assignment. By June 1, 2011, the Committee's final report is due to the HHS Secretary. By July 1, 2011, the interim final rule is to be published. Mr. Salsberg expressed his confidence in the Committee's progress thus far and believes the Committee is on track.

Mr. Salsberg updated the Committee with the information he had received on the logistics of a government shutdown. While he did not get a response back on a "Plan B," he was informed that if there is a government shutdown, government employees are not allowed to work – even if they volunteer. He will continue to seek information during the coming days.

The Committee agreed to schedule a meeting in May. The tentative dates are May 18-20, 2011 and the tentative location is the Legacy Hotel in Rockville. The dates and location will be confirmed by the next meeting.

DEVELOP AGENDA FOR NEXT MEETING

The Committee decided on the following topics for the next meeting:

- Workgroup Reports
 - Social Deprivation Index
 - Social Barrier Index
 - Population to Provider
 - Thresholds
 - Workforce
 - Facility Designation
- Discussion and Preliminary Consensus on Rational Service Areas
- Discussion and Preliminary Consensus on Subpopulations
- Preliminary Discussion and Consensus on Impact Testing Plan
- Review of and Consensus on Draft Status Letter to Secretary

The meeting adjourned on February 18, 2011 at 2:34 p.m.

**FEBRUARY 16-18, 2011 SUMMARY MEETING MINUTES
ATTACHMENTS**

1. Twelve Questions for the Committee
2. Workforce Workgroup Matrix Regarding Providers to Count – and Adjustment Options (Excel)
3. HPSA/MUA Components Diagram
4. Health Status Workgroup Report (PowerPoint)
5. PCSA/County SDI4 and Outcomes (PDF)
6. Ability to Pay Workgroup Report (PowerPoint)
7. Access Workgroup Report
8. Population Identification Workgroup Report
9. Disparities/Access/Availability Workgroup Report
10. Health Status Workgroup Community Profile Mockup (PowerPoint)
11. Workforce Workgroup Recommendations Table
12. Workforce Workgroup Recommendations List
13. Committee Decisions on Threshold (PowerPoint)
14. Written Comment from Kathy Lim Ko, President and CEO, Asian and Pacific Islander American Health Forum
15. Written comment from Kathy Wibberly, Director, Division of Primary Care and Rural Health, Virginia Department of Health
16. Written Comment from Robert Restuccia, Executive Director, Community Catalyst
17. Written Comment from 25 national, state and local organizations advancing the rights of low-income immigrant communities
18. Written Testimony from Robert Zarr, American Academy of Pediatrics
19. Written Testimony from Danielle Hawkes, Policy Analyst, National Latina Institute for Health

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

20. Written Comment from National Asian Pacific American Women's Forum and National Latina Institute for Health
21. Written Comment from Teresita Batayola, Board of Directors President, Asian Pacific Community Health Organizations
22. Written Comment from National Advisory Council on Migrant Health