Agenda

May 30, 2024 at 9:00 a.m.
Board Room 3, Perimeter Center
9960 Mayland Drive, Henrico, VA 23233

1. Call to Order and Welcome – Dr. Thomas Eppes, Jr., Chair
2. Roll Call – Allyson Flinn, Policy Analyst
3. Review of Task Force Mandate (Chapter 423 of the 2024 Acts of Assembly) – Allyson Flinn
4. Review of Agenda – Joseph Hilbert, Deputy Commissioner of Governmental & Regulatory Affairs
5. Approval of Meeting Minutes from March 8 Meeting – Dr. Thomas Eppes, Jr.
6. Adoption of Updated Remote Participation Policy – Allyson Flinn
7. Presentation – Nelson Smith, Commissioner, Virginia Department of Behavioral Health & Developmental Services

Break

8. Review of Meeting Materials – Allyson Flinn & Val Hornsby, Policy Analyst
9. Public Comment Period
10. Psychiatric Beds and Services & Expedited Review
    a. Staff Presentation – Allyson Flinn & Val Hornsby
    b. Breakout Session*

Break

    c. Group Discussion and Adoption of Recommendations – Dr. Thomas Eppes, Jr.
11. Wrap-Up and Next Steps – Dr. Thomas Eppes, Jr.
12. Meeting Adjournment

* The Task Force will form into three smaller groups for the breakout session; the breakout sessions are open to the public and the discussion of each group will be included in the meeting minutes.

State Health Services Plan Task Force
March 8th, 2024
Time 9:00 a.m.
Perimeter Center, Board Room 4
9960 Mayland Drive
Henrico, VA 23233

Task Force Members in Attendance – Entire Meeting (alphabetical by last name): Jeannie Adams; Dr. Kathy Baker; Dr. Keith E. Berger; Karen Cameron; Carrie Davis; Michael Desjadon; Paul Dreyer; Amanda Dulin; Kyle Elliott; Dr. Thomas Eppes, Jr.; Paul Hedrick; Shaila Camile Menees; Rufus Phillips; Tom Orsini; Dr. Marilyn West.

Staff in Attendance (alphabetical by last name): – Rebekah E. Allen, Senior Policy Analyst, Virginia Department of Health (VDH) Office of Licensure and Certification (OLC); Kimberly F. Beazley, Director, VDH OLC; Erik O. Bodin, COPN Director, VDH OLC; Allyson Flinn, Policy Analyst, VDH OLC; Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs, VDH; Val Hornsby, Policy Analyst, VDH OLC; Vanessa MacLeod, Adjudication Officer, VDH; Dr. Karen Shelton, State Health Commissioner, VDH.

1. **Call to Order and Welcome**

   Dr. Thomas Eppes, Jr. called the meeting to order at 9:03 a.m.

2. **Review of Agenda**

   Rebekah E. Allen reviewed the agenda.

3. **Staff Presentation: COPN Program**

   Ms. Allen presented an educational PowerPoint to the Task Force regarding the Certificate of Public Need (COPN) process in Virginia. The presentation covered what COPN is applicable to in Virginia, project types, and the application processes.

   While discussing current project types, Mr. Desjadon inquired about the $15 million threshold for capital expenditures and how this threshold had been established. Erik O. Bodin explained the history of the capital expenditure threshold and how inflation contributes to the increase of that threshold.

   Thomas Orsini asked Mr. Bodin if increasing the number of batch cycles available for each project type would increase the timeliness of the COPN process by reducing the amount of time needed to reach a decision. Mr. Bodin determined that while it may marginally decrease the time needed for review, the 190-day review period would still exist. Mr. Orsini then clarified that the “hang up” for the process is not the batch cycles, but the 190 days set forth for review, to which Mr. Bodin agreed.

Rufus Phillips inquired about the triggers for an IFFC, to which Ms. Allen explained that competing applications and third-party claims for good cause would trigger an IFFC. Ms. Allen deferred to Mr. Bodin, who stated that recommendations for denial would also trigger an IFFC for a project.

Ms. Allen informed the group that the Health Systems Agency of Northern Virginia is the only regional health planning agency currently in operation. Ms. Cameron then clarified for the group that the lack of a regional health planning agency does not change the review timeline for the Virginia Department of Health (VDH), to which Ms. Allen confirmed. Ms. Cameron then inquired if the applicant could continue to add and adjust the application throughout the process, to which Mr. Bodin explained that a recent law change stopped applicants from being able to submit "shell applications" and continuously build up the application throughout the review process.

Kyle Elliott inquired whether there was a burden on an applicant to justify the approval of their application, and if there were any assumptions by the adjudication officer on reasons to approve or deny an application. Mr. Bodin explained that the burden is on the applicant due to the fact that the adjudication officer is firewalled from the process until the IFFC occurs.

As Ms. Allen explained the expedited review process, Jeannie Adams asked how the public would be informed if an expedited review application were filed under the current process. Mr. Bodin explained that while there currently is no mechanism in place, VDH would post it to its website as a way to notify the public. Ms. Allen then clarified that the Code of Virginia requires an expedited process, but that the timelines and requirements of that process are not dictated by the Code. Ms. Allen continued, explaining that the project types allowable for expedited review cannot be changed by the regulations, but that the expedited process can be.

Dr. Marilyn West inquired about the earlier discussion regarding application responses and what constitutes a satisfactory response. Mr. Bodin explained that the applicant needs to have provided a response to each application question, and that it is up to the applicant to decide what kind of response will be given, as that response will be used for the remainder of the application review process.

Shaila Camile Menees reminded the group that an application for expedited review can be filed at any time, and that the Task Force needs to keep this in mind while making recommendations for the expedited review process. Dr. Eppes inquired whether the group could use the specific recommendations discussed in the 2021 COPN report as the recommendations of the Task Force, to which Ms. Allen replied in the affirmative, stating that some recommendations would require legislation, while others from that report may use regulations as a mechanism for change.

Dr. West discussed the role of the State Board of Health (Board) as it relates to the regulatory process and expressed concern that the Board was under no obligation to accept the recommendations made by the Task Force for regulatory changes. Dr. Karen Shelton told the Task Force that all efforts would be made to ensure that the recommendations of the Task Force go to the Board and that the Task Force meeting and making recommendations would be an ongoing process.

Dr. Eppes called for a brief break. The Task Force then resumed its meeting a 10:00 a.m.

4. Roll Call

Dr. Eppes led the roll call of the Task Force at 10:04 a.m. All Task Force members were present with the exception of Steve Gravely.

5. Approval of Prior Meeting Minutes

The minutes from the February 9, 2024 meeting were reviewed. Ms. Cameron made a motion to amend the minutes by:

- On Page 2, Item 3, first paragraph, first sentence, adding that Ms.Cameron's nomination for Vice-Chair was seconded by Mr. Desjadon;
- On Page 2, Item 7, third paragraph, last sentence, replacing "additional data" with "timeline";
- On Page 4, Item 7, first paragraph, last sentence, replacing "3" with "2"; and
- On Page 4, Item 7, last paragraph, second-to-last sentence, replacing "due to controversy" with "due to their critical nature and/or volume dependence, such as cardiac surgery for neonatal intensive care."

Mr. Desjadon seconded the amendments and the motion passed unanimously by voice vote. The meeting minutes as amended were approved without objection.

6. Public Comment Period

One member of the public signed up to give public comment. Bill Ellwood, representing Universal Health Services (UHS), discussed the current standard review process in Virginia, stating that the process worked well and that expediting this process would not fix the problems present. Mr. Ellwood asked that if the Task Force chooses to expedite this process, that they ensure it is robust and that conditions and enforcements are put in place to protect Virginians.

Mr. Desjadon inquired if there have been any competing applications for psychiatric services in the past 10 years, to which Mr. Bodin replied in the affirmative. Dr. Eppes inquired about where the UHS facilities were located, and how many Temporary Detention Orders, if any, did their facilities accept. Mr. Orsini inquired whether UHS has experienced any occupancy issues related to their psychiatric beds. Mr. Dreyer asked Mr. Ellwood if UHS had any psychiatric beds in the western part of the state, to which Mr. Ellwood responded in the negative.

Mr. Desjadon then inquired if the UHS facilities participated in the Patriot Program, to which Mr. Ellwood responded that he was not sure.

7. Psychiatric Beds and Services & Expedited Review

7.1. Staff Presentation

Allyson Flinn presented the Task Force with an overview of the directive found in SB 277, data trends for psychiatric beds and services in the state, past legislative efforts related to psychiatric beds and services, and applicable reports of interest to the group. While presenting an overview of COPN denials since SFY13, Dr. Eppes inquired with Ms. Flinn about the two denials, to which Ms. Flinn answered that the 2 were from a competing application pool in planning district (PD) 8.

Ms. Menees inquired with Ms. Flinn about obtaining data for the total counts of psychiatric beds and a list of the facilities where these beds exist. Mr. Desjadon requested VDH provide the bed numbers by planning district and per 100,000 using both the state and national average. Ms. Dulin inquired about the free-standing psychiatric facility located in far southwest Virginia, and the area that this facility serviced. Dr. Shelton replied that while it may serve some residents of Tennessee and North Carolina, the facility could not accept patients under temporary detention orders (TDOs) from other states, as they are unable to cross state lines.

Dr. Baker requested the average census of the psychiatric facilities as it was unclear whether the problem is capacity or staffed beds, to which Ms. Flinn confirmed that VDH could provide the number of staffed beds. Mr. Bodin recommended that the denominator of licensed beds should be used for staffing calculations, to which Ms. Cameron agreed. Dr. Baker then requested the data regarding TDOs and the length of time in which it takes for those to be placed, to which Mr. Bodin responded that VDH does not have that data on hand. Heidi Dix informed VDH staff that the Department of Behavioral Health and Disability Services (DBHDS) can provide the average wait times for TDO placement but will not be able to provide that data by planning district.

While discussing past legislative efforts, Ms. Cameron inquired about whether a facility could convert a psychiatric bed to a medical-surgical bed without a COPN, to which Dr. Shelton answered in the negative, stating that she did not believe beds could be freely converted. Mr. Phillips inquired about the ability to convert beds during COVID-19, to which Ms. Flinn responded in the affirmative. Ms. Allen clarified that it was the addition of beds under an executive order, not the conversion of beds. Mr. Desjadon then inquired about receiving a history of past legislative efforts and why the bills had been unsuccessful in the past. Ms. Flinn confirmed that VDH could provide this data, and Ms. Allen further explained that VDH can only provide the public conversations that surrounded the bills.

Val Hornsby then presented a jurisdictional comparison on COPN and psychiatric services and beds in different states to the Task Force. Ms. Dulin inquired about

the combination of psychiatric beds and substance use disorder beds and whether or not this has changed the landscape of the bed need in Virginia. Ms. Allen responded to Ms. Dulin, stating that VDH would try to acquire this data. Ms. Cameron then discussed that substance use disorder patients cannot be placed in a psychiatric bed unless that patient has a psychiatric co-morbidity or dual diagnosis, to which Dr. Shelton confirmed. Ms. Allen then clarified that Ms. Cameron is correct in saying that psychiatric beds require a primary psychiatric diagnosis.

Dr. Eppes requested that VDH provide data regarding states that do not have a COPN equivalent, specifically how these states handle charity care and TDOs. Ms. Cameron requested that VDH create a comparison of Virginia and a state without COPN that is similar in terms of economics, population, and geography. Dr. West requested data from the states that do not have a COPN equivalent and the external landscape that exists that ties in this process. Dr. Berger seconded that request, stating that he would like to know how states operate without a COPN equivalent. Mr. Phillips requested information on how the states without COPN assure that quality is upheld without the COPN guardrails in place. Carrie Davis requested information about TDO discharges, and if there is anything relating to those discharges that is currently contingent on COPN or the conditions imposed.

7.2. Breakout Sessions

Dr. Eppes announced that the Task Force members would be breaking into three smaller groups for breakout sessions. Ms. Allen explained that Task Force members would go across the hall to Training Room 1, which had been partitioned into 3 smaller rooms, according to which group they had been randomly assigned. Ms. Allen also explained that these breakout sessions were open to the public, that seating was available in each partitioned room for the public, and that a member of staff would be in each room to minute the discussions. Dr. Eppes then announced the membership of each group.

Group 1 – Training Room 1A

Group 1 consisted of Dr. Berger, Ms. Davis, Mr. Desjadon, Ms. Dulin, and Mr. Philips.

Mr. Desjadon initiated the discussion by asking what information the Task Force had and what it would need in order to make recommendations. Dr. Berger spoke about his experience applying for a COPN without sucess; he also spoke about other jurisdictions like South Carolina that had repealed or were in the process of repealing COPN requirements and what information those jurisdictions may be about to provide about increases in quality and decreases in cost that resulted from COPN deregulation. Mr. Philips and Mr. Desajadon agreed that more information from non-COPN jurisdictions would be valuable, with Mr. Desjadon specificaly pointing to data about quality, access, and costs. Mr. Philips stated it was important to compare Virginia to jurisdictions with similar demographics. Ms. Davis

questioned what the group meant by access, to which Mr. Desjadon responded it meant people getting what they wanted. Ms. Davis emphasized that access should be leveled across income levels and Mr. Desjadon agreed and further stated that it should be level across geographic location as well.

The group received comments from Curtis Byrd with Chesapeake Regional Healthcare, who stated that certain service lines are not profit centers. Mr. Byrd further stated that there needed to be a mechanism for equitable bed distrubtion because reimbursement is not keeping pace with costs and there are differing levels of investment needed to put beds into service. Mr. Desjadon asked what the overall psychiatric need in Virginia was and how to determine it. Dr. Berger responded that the market should determine need.

Ms. Dulin spoke about the JLARC report's highlights about the different discharge experiences between state and non-state psychiatric hospitals. The group received comments from Bill Elwood of Elwood Consulting, LLC, who stated that already-approved psychiatric inpatient beds are not the issue. Ms. Davis stated that COPN may not be the issue for inpatient psychiatric care and that removing COPN could leave Virginia in the same place as it is today, but that at least that barrier would no longer be present. Mr. Desjadon reiterated his point about what the overall psychiatric need was in Virginia and Ms. Dulin questioned whether Virginia had the resources to treat psychiatric conditions before it became an inpatient issue. Mr. Desjadon asked what has moved the needle for psychiatric care and Dr. Berger responded that perhaps the Task Force should hear from providers. Mr. Philips reminded the group of the narrow assignment that the Task Force has, and Mr. Desjadon read aloud the text of SB277. Ms. Davis questioned whether fulfilling that assignment would move the needle.

Ms. Dulin stated that inpatient beds can freely be exchanged between different use types (e.g., medical-surgical, psychiatric, etc.) without a COPN. The group received comments from Mr. Bodin, who clarified that psychiatric inpatient beds could be converted to a non-psychiatric inpatient beds without a COPN, but that the reverse would require a COPN. Ms. Dulin expressed her concerns about the higher level of care and patient needs in the psychiatric population. Mr. Bodin explained concerns about completely removing psychiatric inpatient beds from COPN without appropriate guardrails on their use or future conversion could become a back-door way for hospitals to increase medical-surgical beds without going through COPN. Ms. Dulin stated that she did not understand the distinction between inpatient psychiatric beds and substance abuse inpatient beds. Mr. Bodin stated that COPN does not apply to beds in residential substance abuse facilities or in intermediate care facilities for individuals with substance abuse.

Ms. Dulin stated that care for TDO patients was paid for by the Commonwealth and Mr. Desjadon noted that it appeared that state hospitals were overburdened with TDO patients. The group received comment from Mr. Elwood, who reminded

everyone of the financial incentive recommendations that JLARC had included in its report regarding TDO patients. Ms. Dulin asked what the effect was of having psychiatric inpatient beds 'attached' to hospital emergency departments. THe group received comment from Sara Heisler from Sentara Healthcare, who stated that patients are often boarded in the emergency department for lack of staffed psychiatric inpatient beds. Ms. Heisler further stated that until the Commonwealth puts more resources towards community service boards, there would be no fix for behavioral health care. Mr. Desjadon agreed that there was a need for community resources before behavioral health issues become acute.

The group received a comment from Mr. Elwood, who questioned what the fix was if overcrowding in state hospitals was an issue. The group also received a comment from Ms. Heisler, who questioned what the state was doing for staffing. Mr. Elwood also reminded the group that SB 277 included the Task Force making recommendations on what could be moved to expedited review. Ms. Dulin stated she thought that psychiatric inpatient beds could be moved to expedited review. Dr. Berger reiterated his desire to see information from jurisdictions without COPN and see what is working for those areas.

The group then wrote down their major questions that they felt needed additional data from staff prior to making recommendations. The group then end its breakout session and returned to Board Room 4.

Group 2 – Training Room 1B

Group 2 consisted of Ms. Adams, Dr. Baker, Mr. Elliott, Dr. Eppes, Ms. Menees, and Ms. Ramos.

Ms. Adams began the conversation inquiring about what the Task Force was able to recommend, and whether or not this was restricted only to expedited review. Dr. Baker discussed the need for the Task Force to be thoughtful of the recommendations made. Dr. Eppes then discussed that a timeline for reevaluation should be set for this process, recommending a reevaluation in approximately 5-10 years. Dr. Baker then discussed the need to know and understand what the outcome of each recommendation may be.

Mr. Elliott then inquired about TDOs, and if a problem was non-compliance with accepting TDOs, why did this problem exist. Dr. Baker responded to Mr. Elliott, stating that the JLARC report was not explicit, but it was possible to make a leap that the level of care provided by a facility may not be appropriate for a TDO patient, and that most TDOs are not accepted because the safety of the staff cannot be maintained. Dr. Eppes then suggested that utilization may be too low, and that police departments do not want to transport a patient across the state for a TDO. Dr. Baker clarified that police are hesitant to remove a patient from their place of home.

Ms. Adams requested data on bed closures. Ms. Menees stated that the issue was not the number of beds in state, but instead the number of beds in the state that are staffed. Ms. Menees further explained that there is a shortage of appropriate workforce numbers, and that removing COPN will further exacerbate this issue by potentially increasing the number of beds that are not staffed.

Dr. Eppes then discussed the JLARC report, discussing the data regarding TDOs and bed utilization rates. Ms. Menees clarified that the issue is an insufficient number of staff, specialization, and equipment. Dr. Baker asked if this Task Force could recommend licensure requirements, including how hospitals manage seclusion and restraints. Ms. Menees discussed the directive of the Task Force, and how this focus is on how beds are allocated in the state.

Ms. Menees then reviewed the questions for consideration. Ms. Ramos stated that the Task Force did not have enough data to answer question one of the questions for consideration. Dr. Eppes agreed, stating that the Task Force needed information about states that have repealed COPN, as well as information about the current psychiatric workforce. Dr. Baker then suggested the group set up a process if the standard COPN process is not used. Ms. Menees responded, stating that the group should focus on utilizing expedited review for facilities that already offer psychiatric services and have reached capacity. Ms. Menees further stated that the group needed to be mindful of applications that may negatively impact providers who already provide services in that area, explaining that the group needs to consider different process for projects that add services and beds in an existing facility versus a project that creates new facilities and services.

Ms. Menees inquired about how the group could devise a recommendation on the two project types mentioned above, stating that removing COPN entirely will remove the ability to require facilities to adhere to charity care conditions. Dr. Eppes discussed the JLARC report and the information regarding the underutilization of private hospitals and whether this was a staffing issue. Ms. Menees responded, stating that it was a staffing issue. Dr. Baker inquired with the group about what data they would need and requested information on COPN conditions and facility adherence to those conditions, bed utilization, and workforce challenges faced by the facilities. Ms. Menees requested data regarding state level psychiatric workforce challenges. Dr. Eppes requested data regarding the operational and licensed bed numbers in private hospitals, to which Ms. Menees requested state hospital data as well in order for the Task Force know the entire bed utilization landscape.

Dr. Eppes requested information on the reality of COPN in Virginia. Ms. Menees inquired about what the problem is if it is not a volume issue, to which Mr. Elliott further inquired whether the problem is staffing or volume. Dr. Eppes then stated that it may be a bed issue, asking if the available beds were really available, to which Ms. Menees answered that the issue is not beds, but that the approved beds

are not readily available to the people who need them. Ms. Menees further stated that the COPN process would not fix this, and that the ask should be how the Task Force can approach the review of additional beds.

Dr. Baker and Dr. Eppes both agreed that if the recommendation was to get rid of COPN, the Task Force would need data from other states without COPN in order to see how these states handle health care facility regulation. Dr. Baker further stated that the Task Force would need to know how other states that have repealed COPN handle their forensic bed inventory. Ms. Menees then stated that no applications for psychiatric beds have really been denied in recent years and that this may indicate that the issue is not that beds cannot be added. Ms. Ramos then suggested that COPN may be potentially keeping businesses out of the state.

Ms. Menees then suggested the group separate the expedited recommendation into two buckets, with one bucket for existing facilities and another for new facilities. The group then debated if this bifurcation is necessary, whether or not conditions should be required for expedited review certificates, and if there should be certain "triggers" that will pull a project out of expedited review and put it into standard. The group the concluded that more data would be necessary before any recommendations could be made.

The group then wrote down their major questions that they felt needed additional data from staff prior to making recommendations. The group then end its breakout session and returned to Board Room 4.

Group 3 – Training Room 1C

Group 3 consisted of Ms. Cameron, Mr. Dreyer, Mr. Hedrick, and Mr. Orsini, Dr. West.

Ms. Cameron stated that the first issue to address would be the need for psychiatric beds and queried about whether part of the demand for beds was that community-based services were not readily available across the Commonwealth, inquiring that if more psychiatric beds are available through the COPN process, would that change the other issues faced by psychiatric facilities, especially workforce issues. Ms. Cameron further stated that there are unseen issues relating to these topics.

Mr. Dreyer reiterated the findings of the JLARC report and the need for more staff in state psychiatric facilities. Mr. Dreyer further stated that the JLARC report emphasized that state psychiatric hospitals take any individual as is their requirement.

Dr. West asked what in the external landscape of psychiatric services is driving the need and what the demographics were of individuals receiving those services. Mr. Hedrick reiterated the need for more information to answer more questions and discussed what substance abuse or residential treatment would look like regarding expanded psychiatric service access.

Ms. Cameron stated that with Medicaid expansion in Virginia, more people have access and queried about whether the issue is that the problem is bigger or more people have access to care which means the volume of people with access to those facilities is larger, further stating that if the Commonwealth can do a good job in community-based care, expanded psychiatric bed capacity would not be as necessary in the future. Mr. Dreyer stated that inpatient psychiatric services would still be a necessity and queried about why bills surrounding COPN were not passing.

Mr. Orsini discussed that when Medicaid was expanded, some providers chose not to take it, to which Ms. Cameron stated this was for the purpose of reaping a profit and not provide charity care and that substance abuse rehabilitation options were more popular and covered more often by insurance in the 1980's. Mr. Orsini then asked if opening more facilities to participate in Medicaid would require more staff.

Dr. West asked what segment of the population we would talking about when we look at psychiatric services and about the adequacy of community-based programs. She further inquired about data on states without a COPN program.

Mr. Dreyer recapped what was written on the groups flipchart thus far which was the necessity for more data, continuum of care, and recognition of health disparities in low-income communities. Ms. Cameron emphasized the value of the public process which cannot be fully deregulated and would require stepwise changes to be made if there are to be changes.

Mr. Orsini stated that if you were to take COPN completely away, there would not be inpatient psychiatric facility in low-income facilities and that the COPN process is still the way to go in Virginia. He further inquired about whether VDH has the staff for the expedited review process. Mr. Hedrick stated that going through the standard review process can be expensive if a lawyer is needed. Dr. West emphasized that low-income populations may be adversely affected and that there may be health disparity issues with changes with COPN.

Ms. Cameron further discussed considerations for rural communities and conditioning issues. Mr. Orsini asked if some level of review would require including charity care and TDOs, to which Ms. Cameron stated that if you get rid of the process, you have no ability to have conditioning.

Ms. Cameron stated that psychiatric beds could be a part of expedited review and that there needs to be some off ramp for addressing concerns and further discussed expedited review for expansion of services. Dr. West then asked if there were psychiatric beds in nursing homes.

Ms. Cameron stated that Medicaid has the data from psychiatric services, and Mr. Hedrick said that VHI has some of the data they need for making

recommendations. Ms. Cameron in reference to expedited review stated that making the process simpler may not be beneficial.

The group then wrote down their major questions that they felt needed additional data from staff prior to making recommendations. The group then end its breakout session and returned to Board Room 4.

7.3. Group Discussion

Dr. Eppes called the Task Force back for a group discussion to review what each breakout group had to recommend. Ms. Cameron then had a clarification about the conversion of psychiatric beds to non-psychiatric beds, deferring to Mr. Bodin, who then explained that you need a certificate to increase the number of psychiatric beds in a facility and that nothing bars you from converting those beds into medical-surgical beds, with one small exception being the RFA process.

Dr. Eppes then requested that group 1 share their recommendations first. Mr. Desjadon presented for group 1, stating that the group consensus was to have more data in order to make a decision. For this data, the group requested information on how states without COPN look like in terms of healthcare quality, cost, and access, information about what the real need or problem is, the relationship between the high-volume emergency departments and the facilities, and information regarding past legislation. The Task Force had no questions for Mr. Desjadon or group 1 at the conclusion of their summary presentation.

Ms. Menees from group 2 then presented the group's summary, stating that they had similar data requests. Group 2 also requested data about operational beds and licensed beds due to the discussions the group had about workforce, and data regarding past COPN projects and whether or not those projects have met the projected occupancy rates. Ms. Menees then concluded with a summary of the bifurcated expedited process, placing emphasis on ensuring conditions and triggers are put in place for these project types. The Task Force had no questions for Ms. Menees or group 2 at the conclusion of their summary presentation.

Mr. Dreyer then presented for group 3, stating that they too had similar data requests. Similarly to group 2, group 3 also placed emphasis on needing conditions. Mr. Dreyer discussed group 3's interest in the unseen issues, stating that the continuum of behavioral health services, staffing limitations, and community resources are all factors of this greater issue. Mr. Dreyer concluded the presentation with the group's data requests, such as the demographic data of psychiatric patients, and information regarding the growth of Medicaid and how this affects the COPN process.

8. Wrap-Up and Next Steps

Dr. Eppes requested that the Task Force utilize the breakout groups during the next meeting in order to continue the current discussions. Dr. Eppes also requested that the Task Force members reach out to him if they have any ideas or recommendations to share before the next meeting on May 17th. Mr. Phillips

inquired whether or not he was able to join remotely next meeting due to his travel schedule, to which Ms. Allen responded that he may, but to keep in mind that he may not be able to participate in the breakout sessions due to the technology being unavailable.

Dr. Shelton then suggested to the group that they request a presentation from the DBHDS in order to gain insight and knowledge about the Right Help, Right Now initiative, as it may apply to some of the questions and data inquiries that the Task Force discussed today. Dr. Eppes requested that VDH staff reach out to DBHDS in order to request a presentation to the Task Force, to which VDH staff confirmed in the positive.

9. Meeting Adjournment

The meeting adjourned at 12:10 a.m.

GROUP 1

QUESTIONS

1. QUALITY: CON vs. NON CON
2. COST: CON vs. NON CON
3. ACCESS: CON vs. NON CON

* BROKEN BY - SDOH, DEMOGRAPHICS, GEOGRAPHY, PAYER

4. WHAT IS NEED?
   - BEDS?
   - STAFF?
   - REIMBURSEMENT?
5. WHAT HAS MOVED NEEDLE?

SPECIFIC TO SB

- WHERE IS REAL PRESSURE POINT?
  - TREND
  - TYPE (PATIENT / CONDITION)

- RELATIONSHIP OF HIGH VOLUME ED'S TO INPATIENT ADMISSIONS?

- RESOURCES TOWARDS ACUTE vs INPATIENT
  - Comments
    - → DOES COPN HELP
    - → IS IT BEDS + COMMUNITY + STAFFING

Needs:

- Private + State + 3 operational vs. licensed Beds
- Success for states w/ NO COPN — How has it gone, what's been outcome? Process
- Approved Projects Projected vs. actual occupancy — Did They / Do They meet projections

(A) Existing Facility

- Expedited Process / OR NO COPN
- Same conditions Required
- If Issues / concerns move back to standard

(B) New Facility or New Service at Existing Facility

→ Expedited unless contested

→ TBD, More Data, More Discussion needed

Unseen Issues/Impacts:

1) Continuum of Behavioral Services – Community Based Programs lacking
2) Staffing is a limitation
3) Value of a public process
4) Segmentation of populations – who serves underserved
5) Health Disparities ⇒ Conditioning process

Level of Review:

⇒ Some Level of Review should be required
↳ should include charity + TDO conditions
→ Expedited Review for expansion of existing services
↳ with an "off-ramp" to full review if opposed/incomplete

* DCOPN Needs personnel + resources *
↳ should use same review criteria

What we need to know:

1) what is driving psych services need?
2) what are demographics of psych patients?
3) Private vs. Public need / Psych vs. Substance Abuse
4) Growth of Medicaid with expansion

Meeting Materials – Summary

Table of Contents

1.0 Tableau Dashboard

The Tableau dashboard was created specifically for the State Health Services Plan Task Force to share and display relevant data in an interactive way. The purpose of this deliverable is to showcase data that will allow the Task Force to make data-driven recommendations. Please review this deliverable prior to the meeting due to the large volume of information; however, it will be available on the SHSP portion of VDH's website for use during the meeting. The following data can be found within the dashboard:

1. ***The number of beds by facility***
   This dashboard allows the user to view the number of beds a facility has by bed type, as well as by licensed beds and staff beds.
2. ***The number of beds by Planning District***
   This dashboard allows the user to view the number of beds a planning district has by bed type, as well as by licensed beds and staffed beds. This dashboard also contains the rates for licensed beds and staffed beds by 100,000 population. Please note that the applicable bed types have been age adjusted to create a more accurate picture of the bed supply in each planning district.
3. ***Psychiatric Facility types and locations***
   This dashboard allows the user to select a psychiatric facility type in order to see the location of that facility, and the planning district that the facility is within. This dashboard also allows the used to view a scatterplot comparison of the adult and pediatric licensed and staffed bed ratios by planning district, or by facility type. Please note that the applicable bed types have been age adjusted to create a more accurate picture of the bed supply in each planning district.
4. ***COPN data regarding decisions, median application fees, and median estimated capital expenditures by batch group***
   This dashboard allows the viewer to view "C" cycle COPN data by planning district. The user will be able to view the number of decisions made, the median application fee, and the median requested capital expenditure. The user is also able to filter the results by year as well.
5. ***Psychiatric quality data by state – Map & Graph***

This dashboard contains data from the Centers for Medicare and Medicaid Services' Five Star Rating System for hospitals, specifically those with psychiatric units. The user will be able to select a quality measure to view the results in each state, as well as the national average of that measure. This dashboard contains a data dictionary that can be found by clicking the text at the bottom of the page.

6. ***Planning District demographics***
   This dashboard allows the user to select a planning district and view the percent of the population with an income below 200% FPL, the population by sex, the population by race, and the population by age.
7. ***Metric comparison data by Planning District***
   This dashboard contains specific health-related metrics from VDH's Community Health Data Portal. The user will be able to select a metric to view the outcome in each planning district in Virginia. The dashboard also has the functionality to allow the user to filter the planning districts viewed, if applicable.
8. ***COPN bill trends***
   This dashboard allows the user to view past legislation related to psychiatric services and facilities and COPN by result and by year. The legislation included in this dashboard consist of every bill that contained provisions for psychiatric facilities and services. Please note that not every bill included on this visualization was solely focused on psychiatric facilities and services; some bills contain provisions for numerous areas affected by COPN.
9. ***Psychiatric Admission Demographics***
   This dashboard allows the user to view the population demographics for all hospital admissions with a primary psychiatric diagnosis (F00-F99) by planning district. The user will also be able to manipulate the visualizations by selecting any of the demographic metrics to view the corresponding demographics for those metrics.
10. ***Diagnosis Codes***
    This dashboard allows the user to view the number of admissions by primary diagnosis code with the ability to adjust the visualization by age, sex, and race.
11. ***Time Trends – Psychiatric Admissions***
    This dashboard allows the user to view the time trends for various demographics of interest to create a comparable time trend.

2.0 Past Legislative Efforts

Information regarding past legislative efforts related to psychiatric services and expedited review has been collected and condensed into a one-page write-up and an excel spreadsheet. The purpose of this information is to inform the Task Force on what past legislation has been filed, and the results of that legislation.

3.0 State Comparison Data

The following are descriptions of the data collected on structures of COPN or licensure in states other than Virginia. The purpose of this data is to provide insight into how other states regulate the development of health care facilities.

1. ***COPN non-psychiatric data***
   This data centers on states which have COPN programs, but which do not regulate psychiatric services through said COPN program. There are 8 such states. This data outlines the regulatory structure these states use for psychiatric services; whether they have state hospitals; what limitations are placed on facilities to ensure they provide quality, access, and care; and whether these states have bed utilization or designation requirements and data collection.
2. ***Non-COPN psychiatric data***
   This data focuses on states which do not have a COPN program and what methods they use to regulate psychiatric services. There are 15 such states. Like the COPN non-Psych data, this data outlines the regulatory structure these states use for psychiatric services; whether they have state hospitals; what limitations are placed on facilities to ensure they provide quality, access, and care; and whether these states have bed utilization or designation requirements and data collection.
3. ***Temporary Detention Order (TDO) Data***
   These data show whether other states have the equivalent to Virginia's TDOs. This data comprises all 50 states and DC. Other states call them involuntary admissions, emergency detentions, etc. The main elements this data shows are whether other states have an equivalent to TDOs; if a state has a COPN program; if they regulate TDOs through COPN; if they regulate TDOs through licensure; and whether there are any penalties in law for not accepting TDOs through COPN or through licensure.
4. ***Virginia Comparison Data***
   This data compares Virginia to Pennsylvania, Maryland, and North Carolina along the above data measures as well as others such as expansion of Medicaid eligibility. The purpose of this data is to compare Virginia to these states and their CON programs, and in the case of Pennsylvania, a state which does not have a CON program, and to compare each states regulatory framework, quality of services, and access to psychiatric services.

4.0 Process Change Analysis

The purpose of this document is to provide the Task Force with brief analyses of potential options available to them regarding expedited review and psychiatric services and facilities. Each policy option contains a brief analysis on how it currently works, and how the process would work if a change was made.

5.0 Department of Behavioral Health and Developmental Services Presentation

TBD.

6.0 Analysis on the Impacts of Medicaid Expansion on Psychiatric Services

The purpose of this document is to provide the Task Force with an analysis of the impact Medicaid expansion has had on psychiatric services. This document briefly covers background regarding Medicaid expansion in Virginia and delves into specific research regarding the effects of Medicaid expansion on psychiatric services.

7.0 Update to the Remote Participation and All-Virtual Meeting Policy

Chapter 56 of the 2024 Acts of Assembly amended § 2.2-3708.3 of the Code of Virginia, requiring an update to the Task Force's Remote Participation and All-Virtual Meeting Policy. The updates to conform to the mandate are as follows:

1. Inserted a provision on page 1 section 1.0 to require the Task Force to update its Remote Participation and All-Virtual Meeting Policy annually.
2. Inserted a provision on page 3 section 6.0 to make any member absent from any portion of the meeting during which visual communication with the member is voluntarily disconnected or otherwise fails or during which audio communication involuntarily fails, when audio-visual technology is available.
3. Amended the provision on page 4 section 7.1, changing the all-virtual meeting allowance from 25 percent to 50 percent of the meetings held per calendar year.

Certificate of Public Need Past Legislation Psychiatric Services and Expedited Review

- COPN bills relating to psychiatric services and process changes as a proportion of all COPN bills filed between 2000 and 2024.
  - 50.2% of all COPN bills filed dealt with process changes.
  - 10.3% of all COPN bills filed dealt with psychiatric services.
- 112 bills relating to COPN process changes and 23 bills relating to psychiatric services were filed between 2000 and 2024.
  - Of the 112 bills relating top COPN process changes, 29 House bills and 14 Senate bills passed.
  - Of the 23 bills with psychiatric services, 3 House bills and 2 Senate bills passed.
- COPN process change bills relating specifically to expedited review.
  - Of the process change bills that were filed, 52 sought to make changes to expedited review.
  - Of the 52 expedited review bills, 12 passed.
- Past legislation particularly relevant to psychiatric services and expedited review.
  - HB 1420 and SB 1141 from the 2017 session both proposed a permitting process for psychiatric services instead of COPN review.
  - SB 503 from the 2020 session proposed using planning region specific characteristics to determine need for psychiatric beds and other services.
  - SB 764 (Ch. 1271 2020 Acts of Assembly) made procedural changes to the SMFP to become the SHSP and direct the authority of the SHSP Task Force.
  - HB 743, SB 205, and SB 293 from the 2022 session proposed requiring TDO acceptance as a condition for the Commissioner to issue a COPN for psychiatric facilities.
  - HB 1600 and SB 953 from the 2023 session proposed including addition of or conversion of psychiatric beds into the expedited review process.
  - SB 277 (Ch.423 2024 Acts of Assembly) directs the SHSP Task Force to make recommendations for expedited review and psychiatric services.

Analysis on Potential Expedited and Psychiatric Process Changes

Legislative Mandate: Chapter 423 of the 2024 Acts of Assembly mandates the State Health Services Plan Task Force to develop recommendations on expedited review of project types subject to certificate of public need (COPN) requirements that are generally non contested and present limited health planning impacts. The Task Force shall also create recommendations regarding:

1. What facilities and projects listed in § 32.1-102.1:3 of the Code of Virginia should be added to the expedited review process;
2. Criteria that should apply to any project types subject to expedited review; and
3. A framework for the application and approval process of such projects.

Project types for consideration shall include:

1. Increases in inpatient psychiatric beds;
2. Relocation of inpatient psychiatric beds;
3. Introduction of psychiatric services into an existing medical care facility; and
4. Conversion of beds in an existing medical care facility to psychiatric inpatient beds.

Potential Expedited and Psychiatric Process Changes:

Option	How it works now	How it would change
1. Move psychiatric beds from full COPN review to expedited review*	Psychiatric beds are required to be requested using the full 190-day COPN process during the C application cycle.	Psychiatric beds could be requested at any time and would be reviewed during a 45-day review period.
2. Move the establishment of a psychiatric facility from full COPN review to expedited review*	In order to establish a psychiatric facility, a person is required to apply during the C application cycle for the full 190-day review process.	A person could apply for a COPN for a psychiatric facility at any time and would be reviewed during the 45-day review period.
3. Allow facilities that already provide psychiatric services to add beds using the expedited review process*	All facilities, whether they already have psychiatric beds or not, are required to submit an application using the full 190-day COPN process during the C application cycle.	Facilities with psychiatric beds would be able to request beds through the 45-day expedited process.
4. Allow facilities to relocate psychiatric beds through the expedited process*	All facilities are required to obtain a COPN through the full 190-day review cycle to relocate beds. If the bed relocation is 10 beds or 10%,	Facilities could obtain a COPN through the 45-day expedited review process to relocate any number of beds.

	whichever is less, and when the cost of relocation is less than $5 million, facilities may apply for a COPN through the 45-day expedited review process.	
5. Require facilities to request a COPN in order to convert beds from psychiatric beds to non-psychiatric beds*	Facilities are able to convert psychiatric beds to non-psychiatric beds freely (this does not apply to beds added through the RFA process).	Facilities would be required to request a COPN in order to convert beds from psychiatric beds to non-psychiatric beds.
6. Allow facilities that already provide psychiatric services to establish a new psychiatric facility through the expedited review process*	All projects involving a new psychiatric facility are required to obtain a COPN.	Facilities that already provide psychiatric services would be able to utilize the expedited process in order to establish a new psychiatric facility under its current hospital license.
7. Move the addition of psychiatric services from full COPN review to expedited review*	A facility is required to obtain a COPN in order to add new psychiatric services that have not been provided in the previous 12 months.	To add new psychiatric services, a facility would be able to apply at any time and the application would be reviewed during the 45-day review cycle.
8. Extend expedited review from 45 days to 90 days	Expedited review projects adhere to a 45-day review cycle that begins when an application is submitted and ends with a decision from the Commissioner by the 45th day.	Expedited review projects would adhere to a 90-day review cycle that begins when an application is submitted and ends with a decision from the Commissioner by the 90th day.
9. Require the Commissioner to condition expedited review applications on providing a specified level of charity care*	The Commissioner does not have the authority to condition expedited review projects.	The Commissioner would be required to condition all approved expedited project COPNs on providing a specified level of charity care.
10. Require the Commissioner to condition psychiatric projects on the acceptance of Temporary Detention Orders (TDOs)*	The Commissioner does not have the authority to condition COPNs on the acceptance of TDOs.	The Commissioner would be required to condition all approved psychiatric project COPNs on the acceptance of TDOs.

11. Require any project that is contested to be pulled from expedited review and placed into full review	There is no requirement regarding contested projects in the regulation.	Any project that is contested by a member of the public would be pulled out of expedited review and placed into full review.
12. Allow for members of the public to request a hearing for an expedited project	There is no public participation requirement in the regulation.	Members of the public would be able to request a public hearing for an expedited project to be held during the 45-day review cycle.
13. Add the following COPN projects to the expedited review process for existing medical care facilities that already provide the applicable existing service:* • Medical-surgical beds • Hospice beds • Psychiatric beds • Rehabilitation beds • Cardiac catheterization laboratories • Operating rooms • CT machines • MRI machines • PET machines • Linear accelerators	Any facility interested in adding any items from the list are required to obtain a COPN through the 190-day process.	Facilities that already provide the applicable services for the corresponding listed items may request a COPN through the expedited review process to add any of the projects listed.

*Requires a legislative change

Effects of Medicaid Expansion on Psychiatric Services

Medicaid Expansion and Psychiatric Services

- Background Information
    - In 2019, Medicaid coverage in Virginia rose from 1 million to 1.4 million low-income residents, primarily nonelderly adults.[1]
    - Medicaid expansion between 2015 and 2019 laid the groundwork for data sharing, cross-county coordination, and shared planning across stakeholders and levels of government in Virginia, including county mental health clinics, community health clinics, and health plans.[2]
    - Federal regulations (42 CFR 435.1009) prohibit federal financial participation in Medicaid services provided to individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD) unless they are under age 22 and are receiving inpatient psychiatric services. Therefore, services to persons aged 21 to 65 in mental hospitals are not covered by Medicaid, even after Medicaid expansions as determined by the Department of Medical Assistance Services (DMAS).[3]
    - Services for individuals below 21 and 65 and older are as follows: inpatient psychiatric services, medically managed intensive inpatient services in a general acute care hospital, inpatient services in freestanding psychiatric hospitals, and outpatient psychiatric services. [4]
- Effects
    - Medicaid expansion has been aimed primarily at community based and outpatient treatment.[5]
    - National trends show a direct link between Medicaid expansion and a reduction in the proportion of adults who had depression or screened positively for depression, possibly attributable to increased financial security.[6]
    - Other studies to consider:
        - One study, using data from 2005-2019, found that Medicaid expansion did not significantly affect overall mental health and substance use related inpatient visits. Compared with non-expansion states, Medicaid expansion was associated with a 23%

[1] Cuellar, A. & Havel, W. "Transforming Behavioral Health Care in Virginia." March 18, 2021. https://doi.org/10.1176/appi.ps.202000466
[2] Et. al
[3] Department of Medical Assistance Services. "Chapter 4: Covered Services and Limitations." Revised February 23, 2024. https://vamedicaid.dmas.virginia.gov/pdf_chapter/psychiatric-services#gsc.tab=0
[4] Et. al
[5] Cuellar, A. & Havel, W. "Transforming Behavioral Health Care in Virginia." March 18, 2021. https://doi.org/10.1176/appi.ps.202000466
[6] Dey, J., Rosenoff, E., & West, K. "Benefits of Medicaid Expansion for Behavioral Health." US Department of Health and Human Services. March 28, 2016. https://aspe.hhs.gov/reports/benefits-medicaid-expansion-behavioral-health#main-content

increase in the Medicaid share of those visits, an 18% reduction in the uninsured share of those visits, and a 4% decrease in the privately insured share of the visits.[7]

- Another study found that mental health and substance use related ED visits increased among the Medicaid and non-Medicare adult population in expansion vs. non-expansion states but was associated with reductions in mental health and substance use related ED visits among the uninsured and privately insured populations.[8]

[7] Jayawardhana, J. "The Impact of Medicaid Expansion on mental health and substance use related inpatient visits." International Journal of Drug Policy. September, 2023. https://www.sciencedirect.com/science/article/abs/pii/S0955395923001871?via%3Dihub[8] Jayawardhana, J. "Impact of Medicaid Expansion on Mental Health and Substance use Related Emergency Department Visits." January 1, 2022. https://doi.org/10.1080/08897077.2021.1941521

[8] Jayawardhana, J. "Impact of Medicaid Expansion on Mental Health and Substance use Related Emergency Department Visits." January 1, 2022. https://doi.org/10.1080/08897077.2021.1941521

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1.0 Purpose

This document was created to comply with the requirements of Code of Virginia §§ 2.2-3708.2 and 2.2-3708.3, which requires that any public body who wishes to allow its members to participate in public meetings through electronic means to adopt a written policy governing electronic participation on an annual basis.

2.0 Scope

This document applies to all members of the State Health Services Plan Task Force. This document supplements any agency-wide policy on electronic participation in public meetings and to the extent there is a conflict between an agency-wide policy and this policy, the agency-wide policy supersedes. If an exception to the

physical quorum requirement has been provided by the current appropriations act, the provisions of the appropriations act shall supersede this document.

3.0 Definitions

All-virtual meeting: A public meeting that has been approved as an all-virtual meeting pursuant to this policy. During an all-virtual meeting, all members, staff, and the public may participate through electronic communication. No more than two members may be assembled in one physical location that is not open to the public.

Electronic communication: The use of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities to transmit or receive information.

In-person meeting: A public meeting that has not been approved as an all-virtual meeting pursuant to this policy. All in-person meetings must have a quorum assembled in one physical location.

Member: A member of the Task Force.

Office of Licensure and Certification (OLC): An office within VDH that administers licensing programs for hospitals, outpatient surgical hospitals, nursing facilities, home care organizations, and hospice programs; administers certification and registration program for managed care health insurance plans and private review agents; administers the certificate of public need program; is the state survey agency for Medicare and Medicaid; and provides primary staffing support for the Task Force.

Public meeting: A meeting at which the public may be present.

Remote participation: Participation by an individual member of the Task Force by electronic communication means in an in-person meeting where a quorum of the Task FO is otherwise physically assembled.

State Health Services Plan Task Force (Task Force): A task force created pursuant to Code of Virginia § 32.1-102.2:1 that is composed of individuals appointed by the State Health Commissioner, who are broadly representative of the interests of all residents of the Commonwealth and of the various geographic regions.

Virginia Department of Health (VDH): An executive branch agency in the Commonwealth of Virginia that assists the State Board of Health and State Health Commissioner with administering and providing a comprehensive program of preventive, curative, restorative and environmental health services; educating the citizenry in health and environmental matters; developing and implementing health resource plans; collecting and preserving vital records and health statistics; assisting in research; and abating hazards and nuisances to the health and to the environment, both emergency and otherwise.

Virginia Freedom of Information Act (FOIA): State law (Code of Virginia § 2.2-3700 *et seq.*) that governs the release of public records and the procedures for public meetings.

4.0 Authorities

Code of Virginia §§ 2.2-3708.2 and 2.2-3708.3

5.0 Responsibilities

5.1 Task Force Chair

The Task Force Chair is the member duly elected or appointed to the position in accordance with the Task Force's bylaws. The Task Force Chair is responsible for receiving requests from Task Force members to remotely participate and for ensuring the approval of remote participation is sought as outlined in this document.

5.2 Task force members

The Task Force members have been appointed to the Task Force pursuant to Code of Virginia § 32.1-102.2:1. The Task Force members are responsible for timely contacting the Task Force Chair if they cannot attend a meeting and familiarizing themselves with this document.

5.3 VDH OLC staff

VDH OLC staff are responsible for receiving requests from Task Force members to remotely participate, for distribution of Task Force meeting materials to the public, and for creating and posting meeting notices and meeting minutes.

6.0 Policy on remote participation

Individual members may remotely participate in in-person meetings of the Task Force as permitted by Code of Virginia §§ 2.2-3708.2 and 2.2-3708.3. This policy shall apply to the entire membership and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting. A member will be considered absent from any portion of the meeting during which the visual communication with the member is voluntarily disconnected or otherwise fails or during which audio communication involuntarily fails.

Whenever an individual member is to remotely participate in an in-person meeting from a remote location, the following conditions must be present:

a. A quorum of the Task Force must be physically assembled at the primary or central meeting location.
b. There must be arrangements for the voice of the remote participant to be heard by all persons at the primary or central meeting location.
c. The reason that the member is unable to attend the meeting and the remote location from which the member participates must be recorded in the meeting minutes.

Additionally, if three or more Task Force members are participating from a single remote location, that location is required to be open to the public.

6.1 Limits on remote participation

A member may not use remote participation due to personal matters more than two meetings of the Task Force per calendar year or 25% of the meetings held per calendar year rounded up to the next whole number, whichever is greater. There is no statutory limit on the number of meetings in which a Task Force member may participate electronically if the member's lack of physical attendance is due to a temporary or permanent disability or other medical condition; to a medical condition of a member of the member's family that requires the member to provide care; or to the member's principal residence being more than 60 miles from the primary or central meeting location.

7.0 Policy on all-virtual meetings generally

The Task Force may hold all-virtual meetings. If an all-virtual meeting is held, the Task Force must provide public access via electronic communication means. The electronic communication means used must allow the public to hear all Task Force members participating in the all-virtual meeting and, when audio-visual technology is available, to see Task Force members as well.

The Task Force must provide a phone number or other live contact information to enable the public to alert the Task Force if the audio or video transmission of the meeting fails. VDH OLC staff must monitor the designated means of communication during the meeting on behalf of the Task Force. If audio or video transmission of the meeting fails, the Task Force will take a recess until public access is restored. If a closed session is held during an all-virtual meeting, the Task Force must resume transmission of the all-virtual meeting to the public before the Task Force votes to certify the closed meeting as required by Code of Virginia § 2.2-3712(D).

VDH OLC staff, on behalf of the Task Force, will make available an electronic copy of the proposed agenda, all agenda packets and, unless exempt, all meeting materials furnished to the members at the same time that those materials are provided to members.

The Task Force will permit the public the opportunity to comment through electronic means, including by way of written comments, at all-virtual meetings when public comment is customarily received.

Additionally, if three or more Task Force members are participating from a single remote location, that location is required to be open to the public.

7.1 Limits on all-virtual meetings

The Task Force will not convene an all-virtual meeting more than two times per calendar year or 50% of the meetings held per calendar year rounded up to the next whole number, whichever is greater. The Task Force will not convene two consecutive all-virtual meetings.

8.0 Policy on all-virtual meetings during declared emergencies

The Task Force may meet by electronic communication means without a quorum physically assembled at one location when the Governor has declared a state of emergency in accordance with Code of Virginia § 44-146.17, provided that (i) the catastrophic nature of the declared emergency makes it impracticable or unsafe to

assemble a quorum in a single location and (ii) the purpose of the meeting is to provide for the continuity of operations of the Task Force or the discharge of its lawful purposes, duties, and responsibilities.

The Task Force shall:

a. Give public notice using the best available method given the nature of the emergency, which shall be given contemporaneously with the notice provided to Task Force members;
b. Make arrangements for public access to the all-virtual meetings through electronic communication means, including videoconferencing if already used by the Task Force; and
c. Provide the public with the opportunity to comment at all-virtual meetings when public comment is customarily received.

8.1 Limits on all-virtual meetings during declared emergencies

The provisions of Section 8.0 shall be applicable only for the duration of the emergency declared pursuant to Code of Virginia § 44-146.17.

9.0 Procedures

9.1 Remote participation due to disability or family medical condition

1. Each individual member shall file requests for remote participation with the Task Force Chair and VDH OLC staff, and include in the request:
    a. That the member is unable to attend the meeting because of a temporary or permanent disability or other medical condition that prevents their ability to physically attend such meeting; or
    b. That a medical condition of a family member of the member requires the member to provide care that prevents their physical attendance.
2. The member must make their request at least 5 business days before the meeting.
    a. The Task Force Chair may make exceptions to this deadline at their discretion.
3. At the beginning of the Task Force meeting after the determination of a quorum but prior to discussion of all other public business, the Task Force Chair shall identify:
    a. The member who wishes to remotely participate;
    b. The reason for their request; and
    c. The location from which the member is participating.
4. In the absence of a challenge, individual remote participation is approved unless such participation would violate this policy or the provisions of FOIA.
5. If remote participation is challenged, then the Task Force members at the primary or central meeting location shall vote whether to allow such participation.

9.2 Remote participation due to distance from primary residence

1. Each individual member shall file requests for remote participation with the Task Force Chair and VDH OLC staff, and include in the request that their principal residence is more than 60 miles from the primary or central location of the meeting.

2. The member must make their request at least 5 business days before the meeting.
    a. The Task Force Chair may make exceptions to this deadline at their discretion.
3. At the beginning of the Task Force meeting after the determination of a quorum but prior to discussion of all other public business, the Task Force Chair shall identify:
    a. The member who wishes to remotely participate;
    b. The reason for their request; and
    c. The location from which the member is participating.
4. In the absence of a challenge, individual remote participation is approved unless such participation would violate this policy or the provisions of FOIA.
5. If remote participation is challenged, then the Task Force members at the primary or central meeting location shall vote whether to allow such participation.

9.3 Remote participation due to personal matters

1. Each individual member shall file requests for remote participation with the Task Force Chair and VDH OLC staff, and include in the request:
    a. That the member is unable to attend the meeting due to a personal matter;
    b. Specifically identifies the nature of the personal matter.
2. The member must make their request at least 24 hours before the meeting.
    a. The Task Force Chair may make exceptions to this deadline at their discretion.
3. At the beginning of the Task Force meeting after the determination of a quorum but prior to discussion of all other public business, the Task Force Chair shall identify:
    a. The member who wishes to remotely participate;
    b. The reason for their request;
    c. The specific nature of the personal matter cited by the member; and
    d. The location from which the member is participating.
4. In the absence of a challenge, individual remote participation is approved unless such participation would violate this policy or the provisions of FOIA.
5. If remote participation is challenged, then the Task Force members at the primary or central meeting location shall vote whether to allow such participation.

9.4 Meeting notice

1. The Task Force and VDH OLC staff shall comply with the public meeting notice requirements in Code of Virginia § 2.2-3707.
2. The Task Force and VDH OLC staff shall include in every meeting notice:
    a. Whether the meeting will be an in-person or all-virtual public meeting; and
    b. A statement notifying the public that the method by which the Task Force chooses to meet shall not be changed unless the Task Force provides a new meeting notice in accordance with the provisions of Code of Virginia § 2.2-3707.

9.5 Meeting minutes

3. The Task Force and VDH OLC staff shall comply with the public meeting minutes requirements in Code of Virginia § 2.2-3707.
4. If a Task Force member is remotely participating, VDH OLC staff shall record the following information:
    a. If individual participation from a remote location is challenged, the vote on that challenge;
    b. Which members are remotely participating;
    c. The remote location from which the member participated;
    d. The reason why a member is remotely participating; and
    e. All votes in a roll-call fashion.
5. If a Task Force meeting is being held through electronic means due to a state of emergency, the VDH OLC staff shall record:
    a. The nature of the emergency;
    b. All votes in a roll-call fashion;
    c. That the meeting is being held by electronic communication means; and
    d. The type of electronic communications utilized.

10.0 Forms and Templates

None

11.0 References

None

12.0 History

Revision	Date	Author	Approver	Description
1.00.00	2/9/2024	Allen, Rebekah E.	State Health Services Task Force	Creation of policy
1.01.00	TBD	Flinn, Allyson B.		Revision