State Health Services Plan Task Force

December 13, 2024

Time 9:00 a.m.

VIA WEBEX

Task Force Members in Attendance (alphabetical by last name): Dr. Baker; Karen Cameron; Michael Desjadon; Paul Dreyer; Amanda Dulin; Dr. Thomas Eppes, Jr.; Paul Hedrick; Mr. Orsini; Dr. Marilyn West.

Staff in Attendance (alphabetical by last name): – Erik O. Bodin, COPN Director, VDH OLC; Val Hornsby, Policy Analyst, VDH OLC; Dr. Karen Shelton, State Health Commissioner, VDH.

1. Call to Order and Welcome

Dr. Thomas Eppes, Jr. called the meeting to order at 9:01 a.m.

2. Roll Call

Val Hornsby called the roll of the Task Force members. Mr. Hornsby noted that Ms. Adams, Dr. Berger, Ms. Davis, Mr. Elliott, Ms. Menees, and Mr. Phillips were absent from the meeting.

3. Review of § 32.1-102.2:1 of the Code of Virginia

Dr. Eppes waived the review of § 32.1-102.2:1.

4. Review of Agenda

Mr. Hornsby reviewed the agenda with the Task Force members. There was discussion regarding the official recommendations and the status of the Commissioner's report of the Task Force, the establishment of guiding principles for the State Health Services Plan (SHSP), the presentation of data observations by VDH staff, and the regulatory and legislative process presentation to be delivered by staff.

5. Review of Meeting Materials

Mr. Hornsby reviewed the meeting materials with the Task Force members upon which no task force members had questions.

The Task Force members requested clarification of the acronyms for the State Health Services Plan (SHSP) and the Administrative Process Act (APA).

Mr. Hornsby specified the exemption in the Code of Virginia from the APA for the SHSP and the regulatory process the Task Force would adhere to.

6. Approval of Prior Meeting Minutes

The Task Force members approved the meeting minutes from the November 18th meeting of the SHSP Task Force without objection. The minutes were motioned by Dr. West and seconded by Dr. Eppes.

7. Public Comment Period

Mr. Clark Barrineau spoke on behalf of the Medical Society of Virginia (MSV). Mr. Barrineau expressed concern regarding the distribution of voting items a few days in advance of the Task Force meeting. Mr. Barrineau suggested VDH lay out a comprehensive plan for 2025 in voting items and meeting dates. Mr. Barrineau stated that the guiding principles should reflect concerns of patient care and costs and that MSV believes guiding principle 6 should be included.

8. The State Health Services Plan

a. Presentation of feedback on the establishment of Guiding Principles for the SHSP

Mr. Hornsby presented the current guiding principles and the feedback on guiding principles provided by the SHSP Task Force members.

Ms. Adams asked if the feedback provided by the Task Force members was provided between the previous meeting and the current one.

Ms. Cameron stated that much of these were her suggestions.

Ms. Adams stated that she hasn't had time to review these and that she agrees with Mr. Barrineau's comments.

Dr. West asked if health care resources is defined whereas medical care facilities is already defined in the Code of Virginia.

Ms. Cameron gave the background of her suggestion of health care resources and underutilization and appropriateness of that language.

Dr. West reiterated her concerns.

Ms. Cameron stated that these are suggestions and that she was hoping for more feedback from the Task Force members.

Mr. Orsini stated that the Code of Virginia sets up the structure and the guiding principles dictate how the SHSP Task Force operates.

Dr. Eppes expressed concern that healthcare resources could extend to physician's offices which are not regulated by COPN.

Mr. Desjadon expressed that for guiding principle 1, the Task Force members want to keep it broad so it's not too prescriptive, but not so broad that it is all-encompassing. Mr. Desjadon stated that the language of desire of appropriate distribution for health care resources is the goal of COPN and considered incorporating guiding principles 1 and 2 together.

Ms. Adams stated that the guiding principles 1-5 as written are fine and that the Task Force may want to consider additional guiding principles based on what the 2018 State Medical Facilities Plan (SMFP) Work Group proposed.

Ms. Cameron asked why the SMFP was changed to the SHSP.

Mr. Dreyer stated that the General Assembly changed that.

Ms. Cameron said that the current guiding principles reflect the SMFP, but not the SHSP.

Ms. Dulin stated that guiding principle 4 addresses Ms. Cameron's concern, however indirectly. She further stated that any language changes would need to be defined and that the current language reflects the SHSP.

Mr. Desjadon concurred with Ms. Dulin.

Mr. Phillips motioned the adoption of guiding principles 1 through 5 as written in 12VAC5-230-30. Mr. Desjadon seconded that motion which was agreed upon unanimously by the SHSP Tak Force.

Mr. Hornsby reviewed the guiding principles proposed, but not adopted, by the SMFP Task Force in 2018 and the Task Force members feedback on these principles.

Mr. Dreyer asked about the definition of a non-institution-owned site of care.

Mr. Desjadon asked if the Task Force could view the 2018 SMFP Work Group guiding principles and redlined SHSP Task Force feedback side-by-side.

Ms. Cameron asked if the triple aim as provided by guiding principle 6 option 2 was already defined by the Institute for Health Care Improvement (IHI).

Dr. Eppes clarified his feedback regarding guiding principle 6 and the additions of education and physician burnout.

The Task Force members asked about the IHI and suggested that the language of "supporting the IHI "Triple Aim" be removed from guiding principle 6.

Mr. Phillips asked if provider burnout was a much larger concern in healthcare than what the SHSP Task Force is addressing.

Dr. Eppes further specified the difference between physician and providers, but that both should be included.

Ms. Dulin stated that the goals for healthcare are broader than what the SHSP Task Force can address and expressed concern about making the focus too broad regarding provider burnout and costs of healthcare.

Dr. Eppes described the specific example of costs of imaging in Lynchburg and further discussed inclusion of the education piece in the guiding principles.

Ms. Dulin stated that if the Task Force is going to add the information suggested by Dr. Eppes, that the language should be more specific. She further stated that she doesn't know how much the guiding principles should have the burden of fixing healthcare.

Mr. Phillips asked if the additions Dr. Eppes suggested would happen in effect of the higher order goals of the SHSP and stated that the only thing that wasn't included was the education piece.

Dr. Eppes discussed the section of the Code of Virginia where the SHSP states a goal of promoting the teaching missions of academic medical centers and private teaching hospitals.

Ms. Cameron stated the only addition to the existing guiding principles would be including language about workforce development.

Mr. Desjadon stated that he would add education and cost effectiveness.

Dr. Eppes reiterated that the guiding principles do not state anything specifically about patients.

Ms. Cameron stated that guiding principle 3 discusses a person's ability to pay.

Mr. Desjadon clarified the difference between respect of a person's ability and willingness to pay.

Ms. Dulin asked what the intent is for including patient copayment language.

Ms. Cameron further asked what the basis, whether systemic or sociodemographic, ability to pay should be considered on.

Mr. Desjadon suggested mirroring the language of guiding principle 1 to guiding principle 6 in regard to cost effectiveness.

Ms. Cameron reiterated that provider burnout is broader than what COPN deals with.

Ms. Adams concurred.

Dr. Eppes said that physician burnout could be removed, but that the education aim should continue to be included in guiding principle 6.

Ms. Dulin state that these can be a part of the considerations for specific projects and questioned if that is in the scope of the SHSP Task Force.

Dr. Eppes stated that his suggested additions are nebulous as opposed to being specific to project considerations.

Mr. Phillips asked about continuing to keep the education piece.

Mr. Bodin asked how the Task Force sees VDH implementing these guiding principles and stated that at present, the guiding principles in the SMFP inform the criteria that are in the SMFP for each service type. Mr. Bodin further stated that the guiding principles are not used in the application process or criteria and that the Task Force should consider how the guiding principles are going to be applied.

Dr. Eppes asked how the guiding principles in the SMFP are used in the application process.

Mr. Bodin replied that on very few occasions have the guiding principles been used in the application process and that those are cases with new technologies with no criteria.

Ms. Adams stated that when she was an attorney, she may have used the guiding principles as an argument in an informal fact-finding conference (IFFC).

Dr. Eppes suggested that this something that could be added, but rarely used in the application process. Dr. Eppes suggested that we vote on guiding principle 6 as written by the Task Force members.

Ms. Cameron stated that guiding principle 6 should be voted on at the next SHSP meeting.

Dr. Eppes concurred as chair of the SHSP Task Force.

Mr. Hornsby asked if the Task Force wanted to move guiding principle 7 to the next meeting as well.

Ms. Cameron expressed her concern about the innovative technologies' language in guiding principle 7, stating that it was not necessary to add this principle.

Mr. Phillips asked if guiding principle 7 was about the adoption of new technologies.

Mr. Dreyer stated that this was another way to address cost effectiveness.

Dr. Eppes stated that guiding principle 7 is broad enough to allow innovation and VDH would solicit comment on this principle before the Task Force votes on it at the next meeting.

Mr. Desjadon stated that by making guiding principle 7 explicit, that you may prevent what you are trying to promote.

Mr. Hornsby reviewed the map showing where inpatient psychiatric beds are within both a 60 minute and 30-minute drive in Virginia.

Task force members had concern with Farmville being outside of the 60-minute range when drive time from Lynchburg to Farmville is 1 hour.

b. Presentation of feedback on psychiatric services criteria

Mr. Hornsby reviewed the feedback the Task Force members provided on psychiatric services criteria.

Ms. Cameron reviews her proposed suggestions for travel time.

Mr. Dreyer stated that he has seen drive time used before and asked the DCOPN staff how they would assess improved distribution of services, citing that drive time is a quantifiable measure.

Ms. Cameron mentioned that time of day and weather conditions affect drive time and asked how many services have a drive time standard.

Mr. Bodin stated that all services have a drive time standard under normal conditions.

Mr. Phillips mentioned that if a planning district that is both rural and urban, drive time is a good measure.

Ms. Adams asked what the current drive time standard is for psychiatric services and stated that 60 minutes was too long.

Ms. Dulin mentioned that these are for inpatient psychiatric services, not for outpatient, and that most planning districts can cover 95% of the population in 60 minutes under normal conditions.

The Task Force members agreed to keep the drive time standard for inpatient psychiatric services as written in current regulation.

Ms. Cameron asked if DCOPN uses google maps.

Mr. Bodin stated that DCOPN is in the process of adopting ArcGIS for mapping drive time.

Ms. Dulin stated she has seen several different systems used as justification for drive time, and she mentioned that travel time is not necessarily drive time.

Ms. Cameron stated that we wouldn't need a motion to adopt this drive time to which Mr. Bodin reiterated that VDH is moving from the SMFP to the SHSP, and this would require a motion to adopt.

The Task force agreed to adopt the criteria as a block vote.

The Task Force members reviewed the criteria for continuity of inpatient psychiatric care.

Ms. Cameron described her suggested changes 12VAC5-850. C. regarding community partners and outpatient psychiatric services.

The Task Force members agreed upon Ms. Camerons suggestion.

Mr. Desjadon asked if there is a reason in the Code of Virginia for the current regulatory language in 12VAC5-850. C.

Mr. Bodin stated that there is not anything tat prevents or requires community-based partnerships regarding continuity of care.

Mr. Phillips asked if ownership, partnership, and contractual agreement were exhaustive for continuum of community-based support services.

The Task Force agreed to change the suggested language from "contractual" to "referral" agreement.

Mr. Bodin stated that you may be limiting to be so specific regarding community of care instead of something so innovative.

Ms. Adams stated that agreement clause was on the applicant to show their willingness to be a partner to community-based support services.

The Task Force agreed upon language for 12VAC5-230-850. C.

Ms. Cameron reinforced support for the current language for occupancy utilization requirements and described her suggestion that there not be a preference for geriatric patients.

Ms. Adams advocated for keeping the geriatric preference and requested the movement of voting on this item to the next meeting.

Ms. Cameron stated that removing the preference would lead to whatever population need is being considered over a geriatric preference.

Ms. Dulin stated that psychiatric services are the only services besides neonatal services that uses staffed and not licensed beds in its calculations for occupancy which changes the standard. Mr. Bodin stated that it presents an issue from a data standpoint and that the licensed beds is the gold standard. He further stated that the NICU beds are not licensed beds.

Ms. Dulin asked what VHI is collected and is the data being collected able to meet the standard and suggested that the SHSP Task Force lower the standard to 70% or 65% and remove the staffing nomenclature.

Mr. Dreyer discussed excess capacity concerns in regard to lowering the standard and asked if the Task Force wants to move from staffing to licensed nomenclature.

The Task Force decided to postpone the proposed changes to the psychiatric services criteria until the next meeting which will be voted on in a block vote.

Mr. Dreyer asked if pediatric and adult bed considerations should be looked at separately.

Mr. Bodin stated that breaking out those psychiatric bed areas of need would be helpful. He further stated that it would be cleaner to break that out, but that presently VDH can review the different psychiatric bed needs between pediatric, adult, and geriatric.

Mr. Dreyer stated that the difference is that with pediatric, you have to keep those patient populations separate from adults, but that this is not the case with geriatric.

Dr. Eppes asked if there is a need for a separate calculation for pediatric psychiatric patients.

Mr. Bodin replied that it would be more work, but that DCOPN is making recommendations to the Commissioner without the specificity of pediatric or adult psychiatric beds.

Break

Dr. Eppes requested that if anyone had not had their vote counted earlier in the meeting that VDH staff record that.

Mr. Hornsby affirmed that the previous role call vote was unanimously decided.

9. Wrap-Up and Next Steps

Mr. Hornsby discussed the CT current and straw regulations provided to the members.

Mr. Bodin described the map and data regarding CT services.

Mr. Hornsby clarified that the CT materials were not originally sent out to the members, but that VDH staff would provide that information to the Tasl Force members after the SHSP Task Force meeting.

Dr. Eppes asked what a justification for denial of a CT in an OR would be.

Mr. Bodin reiterated that the Code of Virginia stated that the addition of a CT regardless of use requires COPN and that he cannot recall if there have been any denials of a CT for OR use. He further stated that the SHSP Task Force can look at more specific criteria for a CT depending on its use.

Dr. Eppes said it would be helpful for the Task Force to see what applications for CT DCOPN is receiving and asked where the 7,400 SMFP average came from for CT scans.

Mr. Bodin stated it was the average throughput at the time the regulations were created.

Ms. Cameron stated that the scan was based off of the scans per day and scheduling and that 7,400 is a conservative number for capacity.

Mr. Dreyer said that CT is challenging because of the differences between outpatient and inpatient hospitals.

Ms. Dulin stated that the standard was not meant for applicants to request a new CT when they get to 100% utilization and recalled that the standard was 10,000. She also stated that it is the one COPN regulated aspect of freestanding EDs (FSEDs).

Dr. Eppes asked about the redlining for the straw regulations.

Mr. Bodin replied that some of the work came from the 2018 SMFP Work Group and some was from VDH staff and never adopted.

Ms. Cameron stated that the 2018 SMFP Work Group stopped meeting and took no action to which Mr. Bodin concurred.

Mr. Bodin stated that VDH staff was providing the straw regulations as a starting point for the SHSP Task Force. Mr. Bodin stated that some of the regulations were developed based on experiential information by the 2018 SMFP Work Group members.

Dr. Eppes stated that the VDH staff should give some guidance on how to proceed with regulations based on what is in the straw regulations.

Mr. Bodin stated that the member organizations of the SHSP Task Force can provide expertise in this area.

Ms. Dulin stated that the red line was confusing and if the Task Force can have data that breaks out mobile versus fixed, outpatient versus inpatient, and rural versus urban CT utilization and how CT data is collected by VHI per planning district.

Dr. Baker expressed concern about how FSED will skew the results.

Mr. Bodin stated that VDH does not currently have site-specific results for CT scans, but that VHI will collect that data moving forward.

Ms. Cameron suggested VHHA provide that information to VDH for the SHSP Task Force to use.

Ms. Dulin stated that 11 FSEDs are currently voluntarily providing CT scan data which is not all of the FSEDs in Virginia.

Dr. Eppes asked the Task Force members to ask their organizations to provide appropriate data for the Task Force to look at to make criteria decisions for CT services and MRI services.

Ms. Cameron suggested that the SHSP Task Force begin working on the data for therapeutic services for the SHSP.

Dr. Eppes discussed the complexity of the process and how the Task Force can keep it simple.

Dr. Baker asked about looking at models in other states for CON.

Ms. Cameron and Dr. Eppes reviewed the action items for the next meeting.

Ms. Cameron asked about states that have changed their CON laws in the past five years that are similar to Virginia and if the Task Force members or VDH staff could find data on that.

10. Meeting Adjournment

The meeting adjourned at 11:42 AM.