

DESERTCOM Committee
Agenda

May 15, 2026, at 10:00 a.m.

Virtual

1. Call to Order and Welcome
2. Roll Call
3. Review of Meeting Minutes of April 20, 2026
4. Public Comment Period
5. Review and Discussion of Maps
6. Next Steps and Wrap Up
7. Meeting Adjournment

Meeting Minutes
SHSP TF – DESERT Committee

Meeting Minutes
SHSP TF – DESERT Committee
April 20, 2026, 2:00 p.m.
9960 Mayland Drive, Training Room 1
Henrico, Virginia 23233

Task Force Members in Attendance (alphabetical by last name): Mr. Jim Beckner; Ms. Karen Cameron (chair); Ms. Carrie Davis; Mr. Deepak Madala (conflict); Mr. Rufus Philips; Mr. Stone (dialed in virtually)

Staff in Attendance (alphabetical by last name): Mr. Antwon Jacobs, COPN Supervisor; Mr. Geoff Garner, Senior Policy Analyst; Ms. Casey Miller, Policy Analyst

Ms. Cameron welcomed the committee and called the meeting to order at 2:06 pm.

Ms. Miller called the roll.

Quorum was established.

Ms. Cameron reviewed the agenda.

The committee reviewed the meeting minutes from the previous meeting, April 7, 2026. In the first paragraph on page two after the public comment section there were two typographical errors. In the second paragraph on page four the word, “presented”, was replaced with the word, “requested”. With no other corrections to be made, the committee approved the minutes unanimously.

Ms. Cameron called for public comment. There was none in the room; however, the committee received public comment earlier in the day from VHHA (forwarded by Ms. Miller). The committee acknowledged the written public comment.

Ms. Cameron advised the committee that the maps discussed in the last meeting were not ready to be presented. She asked if the staff could ask the State Health Commissioner’s Office to move this as a higher priority due to these materials being critical to the committee’s recommendations and meeting the deadline set by the General Assembly.

The committee reviewed and discussed the COPN Expedited Review Project.

The committee kicked off a conversation pertaining to definitions and preferences for COPN services.

Ms. Cameron mentioned that when reviewing the need for comprehensive inpatient services, patient follow-up care could include providing services like telehealth, as well as working with FQHCS, and free clinics in those areas to provide specialist appointments.

For example, regarding provision of services, preference could be given to those providing complimentary telehealth services to persons who reside in medical deserts.

The committee agreed the recommended preferences should apply to the following services serving populations in medical deserts but not necessarily located in medical deserts (since the economies of scale and workforce may not be present in those areas to support these higher cost services):

- Diagnostic Imaging
- General Hospital
- Neonatal Care
- Open Heart, Transplants, and Cardiac Catheterization
- Outpatient Surgical Hospital and OR Additions
- Substance Abuse Tx., ICF/IIDs, and Medical Rehab Beds
- Radiation Therapy Services
- Nursing Homes and Beds

The committee defined:

“Support Team” means person(s) who provide non-medical support to patients (i.e., caregiver)

“Medical desert” means designated areas with unique geographic socio economic, cultural, transportation and other barriers to access to healthcare.

The committee drafted the preference language:

- Preferences to those who have demonstrated or have actionable plans to provide and/or facilitate access, including transportation services, to primary and specialty care to persons and their support team who live in medical deserts
- The committee discussed implementation of similar language below (previously written for psych beds):

“To ensure the appropriate levels of patient care, providers of acute psychiatric and acute substance use treatment must show evidence of providing or the commitment to provide a continuum of ambulatory services, aligned to their acute care patient population. The continuum may be accomplished through formal relationships with community-based providers.”

- Finally, the committee identified preference language for providers who have demonstrated specific health literacy improvement efforts and actionable plans to expand those efforts within medical deserts.

To be included as the language for continuum of care for the following:

- General Hospital
- Neonatal Care
- Open Heart, Transplants, and Cardiac Catheterization
- Outpatient Surgical Hospital and OR Additions
- Substance Abuse Tx., ICF/IIDs, and Medical Rehab Beds
- Radiation Therapy Services

The committee added an alternate placeholder for May 15, 2026, from 10 am-12 pm to meet virtually in case the maps are not yet complete on May 11, 2026.

Mr. Phillips motioned to adjourn.

Mr. Stone seconded the motion.

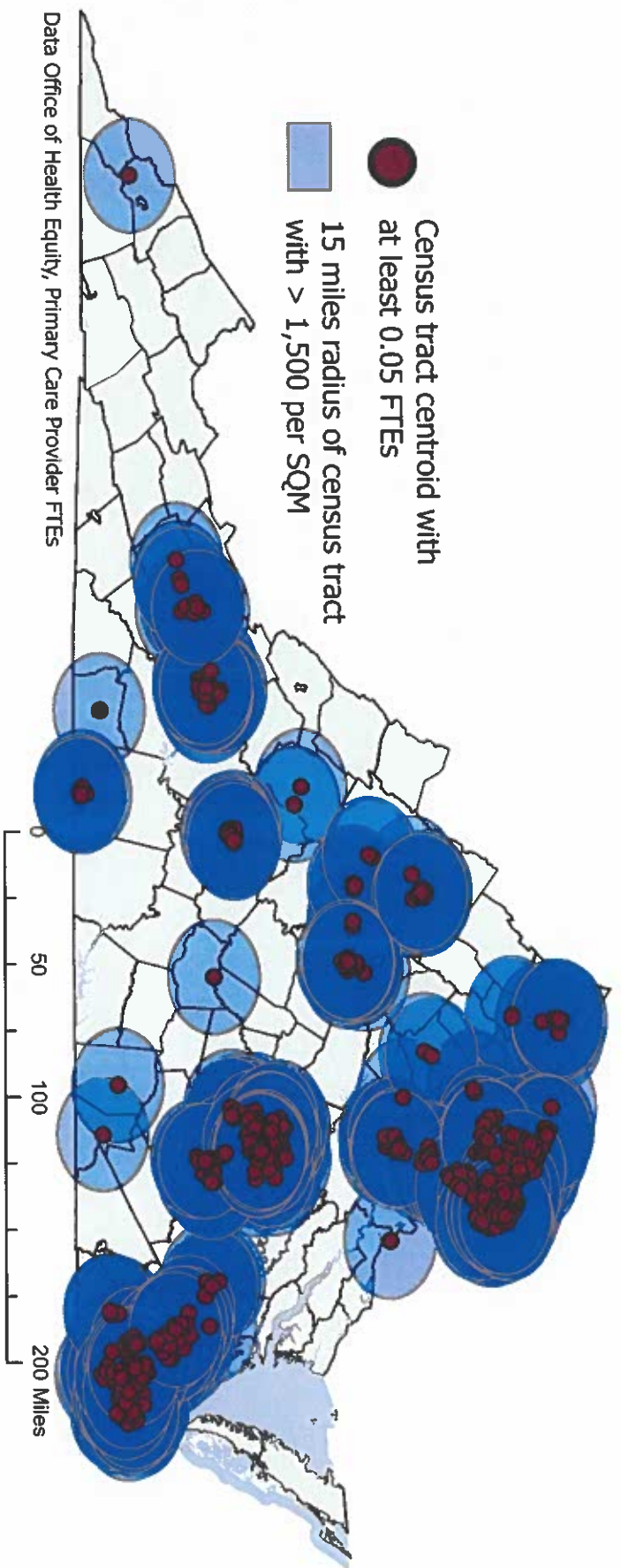
The committee adjourned at 3:47 pm.

Medical Desert Index

Based on four Variables

Primary Care Provider Definition by HRSA

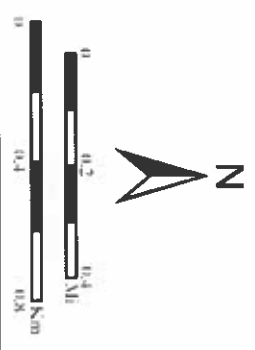
- 1. Certified Nurse Midwife
- 2. Family Practice
- 3. General Practitioner
- 4. Internal Medicine
- 5. Obstetrics & Gynecology
- 6. Pediatrics

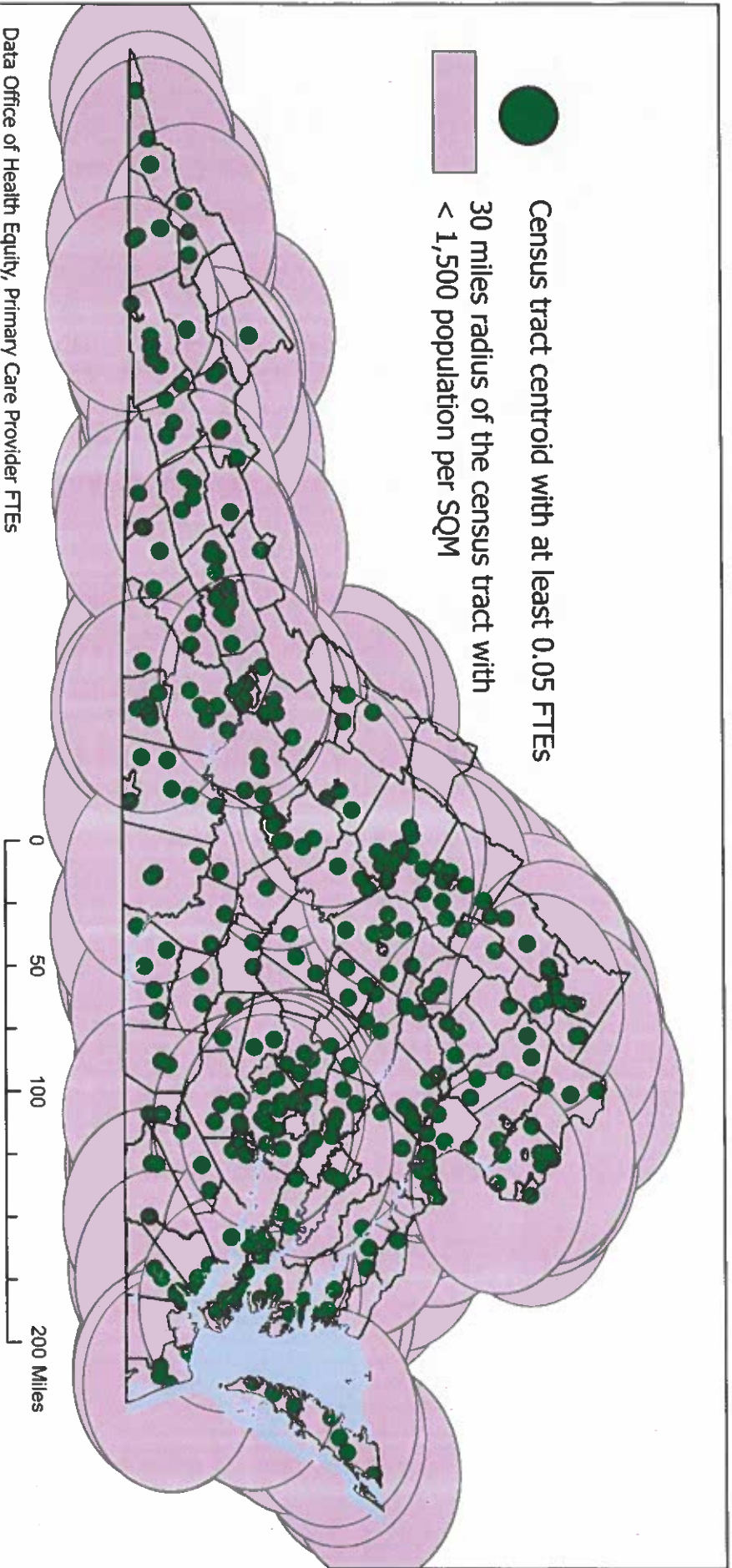


The Primary Care Providers' FTEs were aggregated by census tract, and a 15-mile radius was drawn around the census tract if the tract had a population density of greater than 1,500 persons per square miles

15-mile Radius Buffer Around Census Tract with Population Density >1,500 per SQM

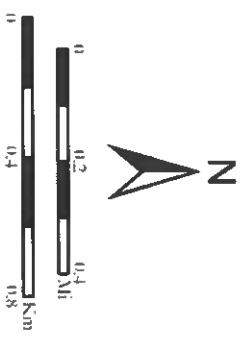
Each Census Tract has at least 0.05 FTEs

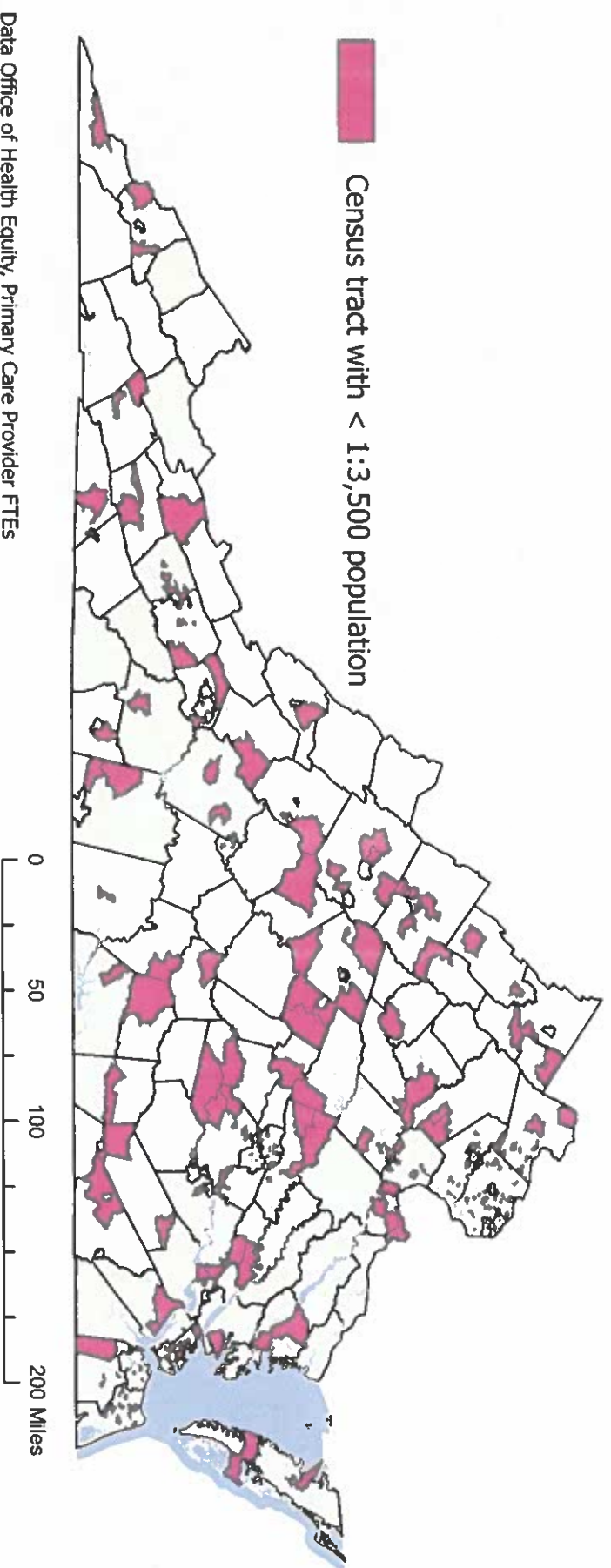




30-mile Radius Buffer Around Census Tract with Population Density <1,500 per SQM

Each Census Tract has at least 0.05 FTEs



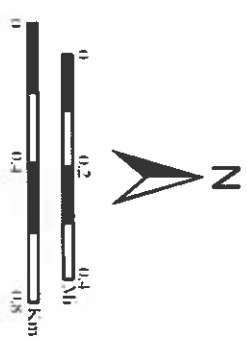


The Primary Care Providers' FTEs are based on patient interaction (time spent on patients). The Physician-Population Ratio was calculated by dividing the population in the census tract by the total number of physician FTEs. The map shows census tract with less than one physician FTE per 3,500 population

2026

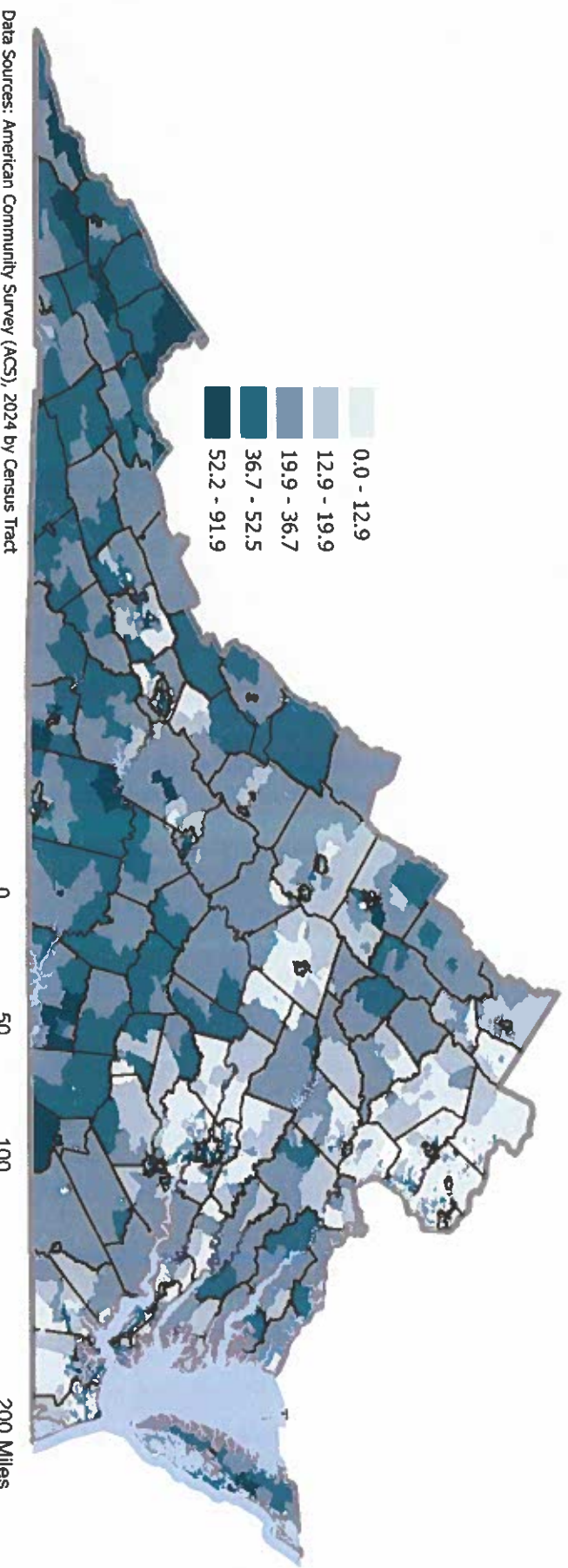
Physician-Population Ratio of Less Than One Physician per 3,500 Population

by Census Tract



Map of the four Variables

Continuous Scale

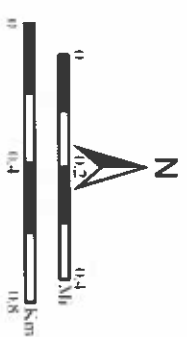


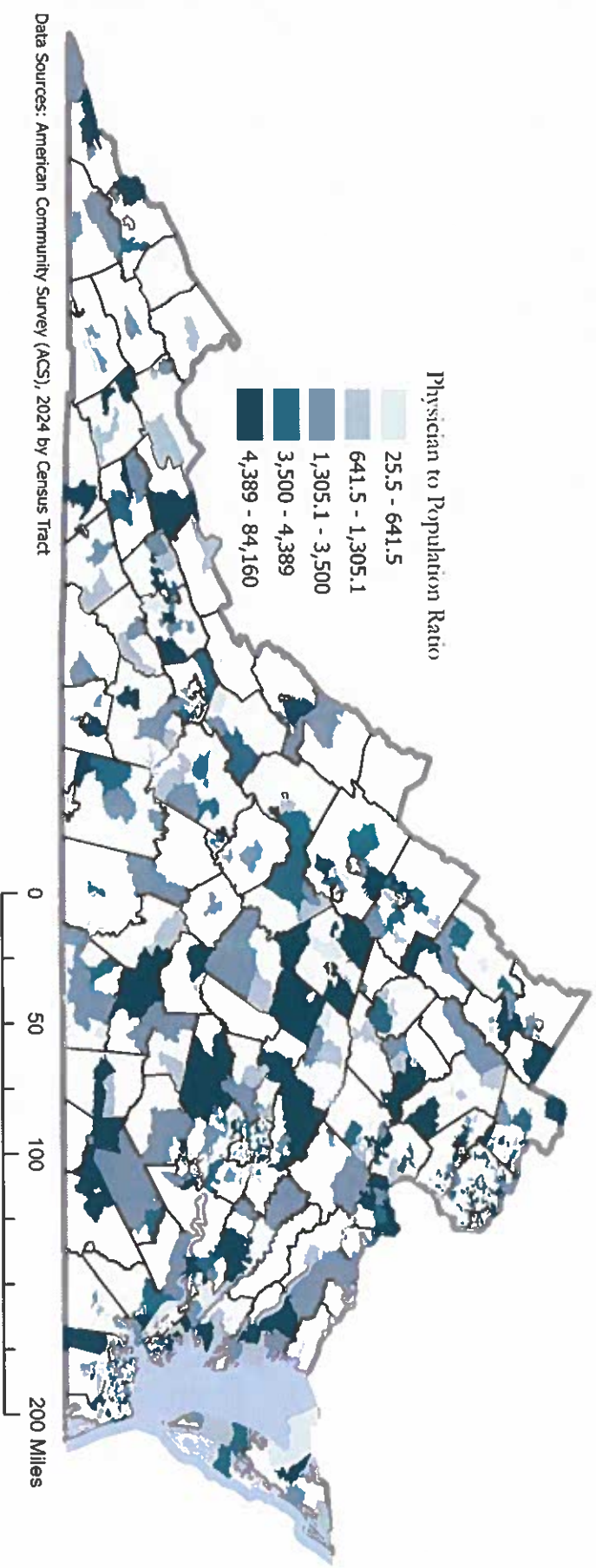
Poverty – We calculated the percentage of the population below 200% of the Federal Poverty Level by census tract using American Community Survey data. The percentage was calculated by dividing the number of individuals below 200% of the Federal Poverty Level by the total population for whom poverty status is determined in the census tract.

2026

Percent Population Below 200 % Federal Poverty Level

by Census Tract





Data Sources: American Community Survey (ACS), 2024 by Census Tract

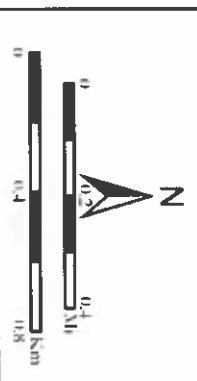
The Physician-Population Ratio was calculated by dividing the census tract population by the total number of physician FTEs. This Data was obtained from the VDH, Office of Health Equity.

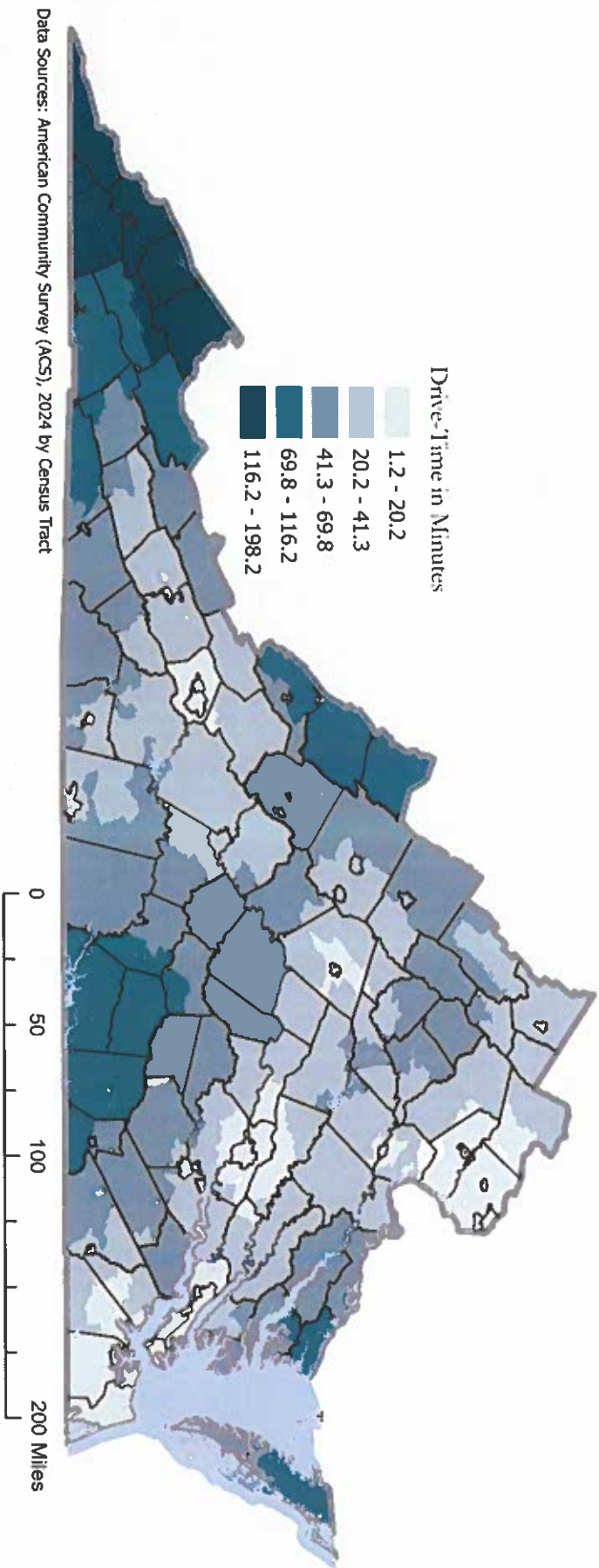
Note: Not every census tract has a Physician, as evidenced by the holes on the map.

2026

Physician (FTEs) - to-Population Ratio

by Census Tract





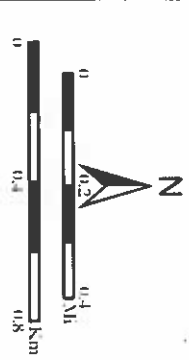
Data Sources: American Community Survey (ACS), 2024 by Census Tract

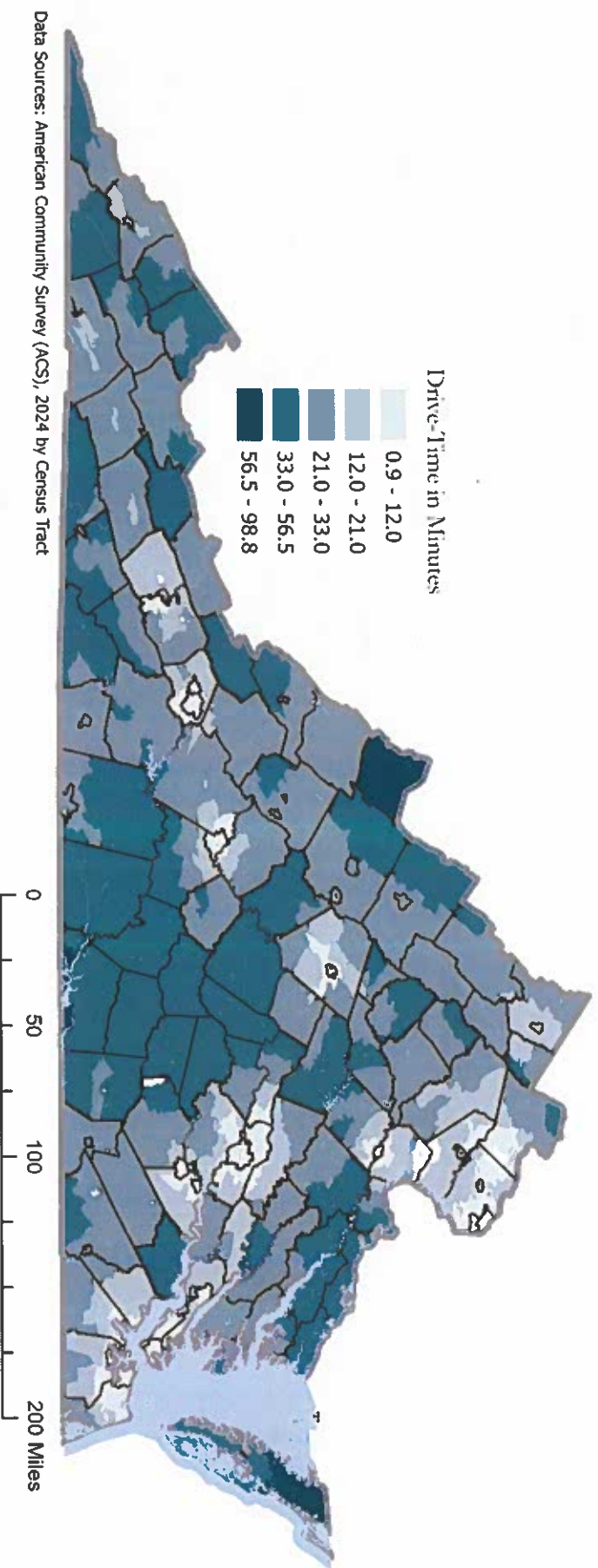
ARC GIS Network Analyst was used to calculate travel time in minutes from the population-weighted centroid of the census tracts to the outpatient facility. The calculation was based on travel times to the 3 nearest outpatient facilities and yielded the average drive time for each tract. Averaging the 3 nearest outpatient hospitals is more stable than using only the closest facility.

2026

Average Drive-Time to the Closest Outpatient Facility

by: Census Tract





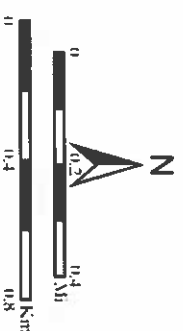
Data Sources: American Community Survey (ACS), 2024 by Census Tract

ARC GIS Network Analyst was used to calculate travel time in minutes from the population-weighted centroid of the census tracts to the Inpatient facility. The calculation was based on travel times to the 3 nearest Inpatient facilities and yielded the average drive time for each tract. Averaging the 3 nearest Inpatient hospitals is more stable than using only the closest facility.

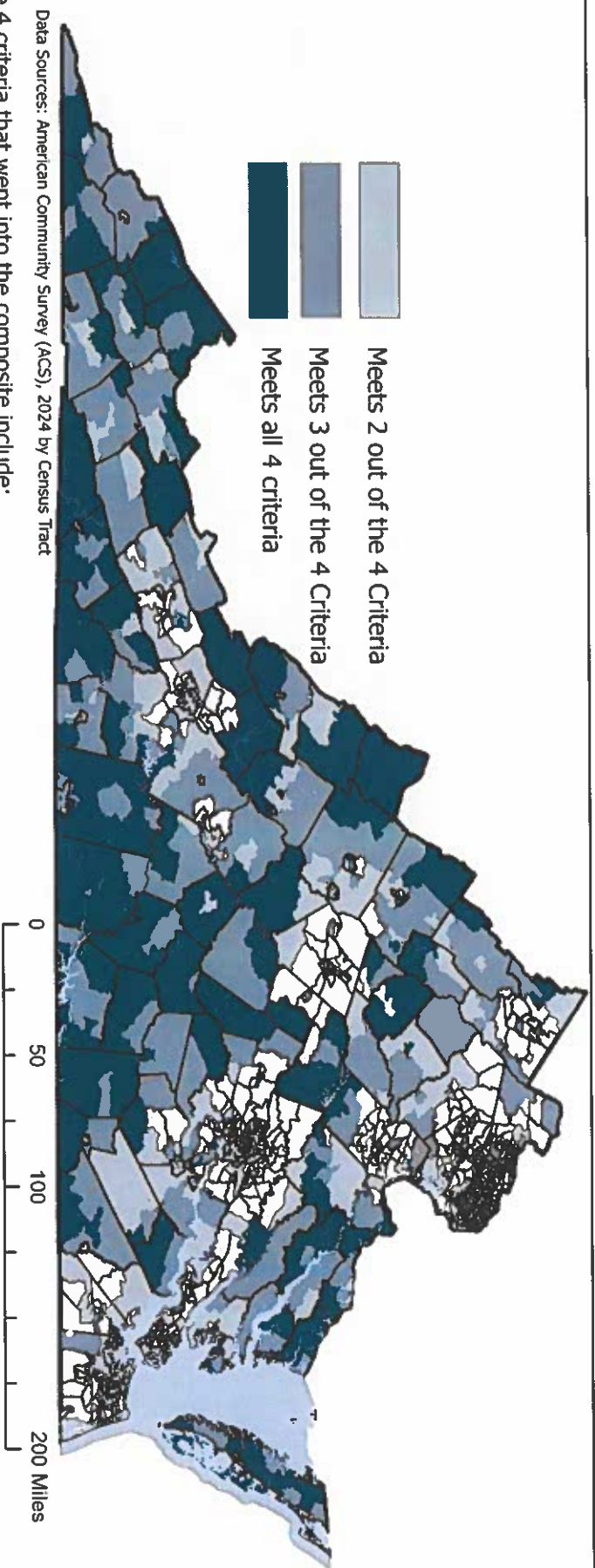
2026

Average Drive-Time to the Closest Inpatient Facility

by Census Tract



Composite Based on Binary



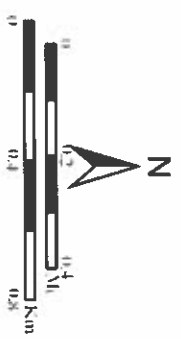
The 4 criteria that went into the composite include:

1. 200% FPL - Categorized Yes if the percent is above 19.9%, otherwise No
2. Outpatient Facility - Drive-Time from census tract with < 1,500 per SQM and >1,500 SQM to Outpatient facility. Flagged Yes if the drive time for <1,500 SQM is 30 minutes and 15 minutes for a tract with >1,500 SQM; otherwise No
3. Inpatient Facility - Drive-Time from census tract with < 1,500 per SQM and >1,500 SQM to Inpatient facility. Flagged Yes if the drive time for <1,500 SQM is 30 minutes and 15 minutes for a tract with >1,500 SQM; otherwise No
4. The Physician-Population Ratio - Census tracts with fewer than 1 FTE per 3,500 people and tracts without FTEs were flagged Yes; otherwise, No

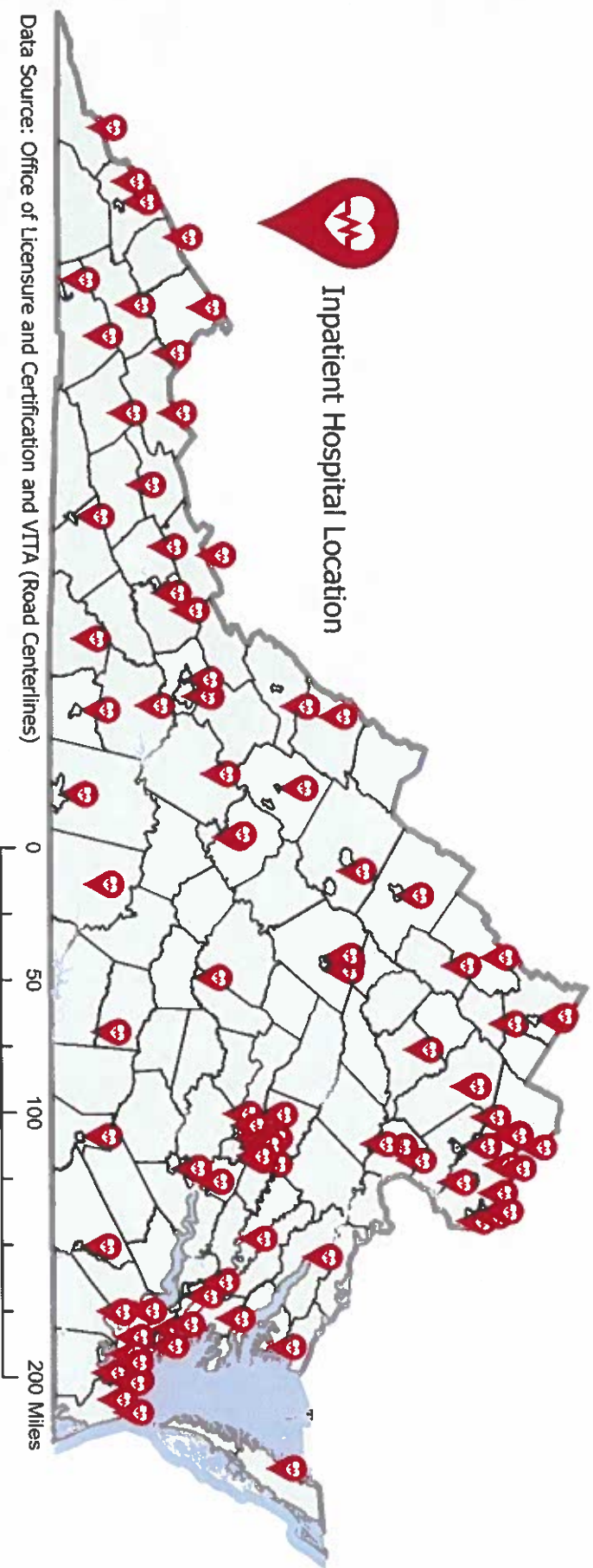
The COUNTIF function was used to count the number of Yes(s) in a row (per census tract). Any census tract with two or more Yes(s) was mapped **2026**

Medical Desert Index Based on Four Criteria

by: Census Tract



In & Outpatient Hospitals

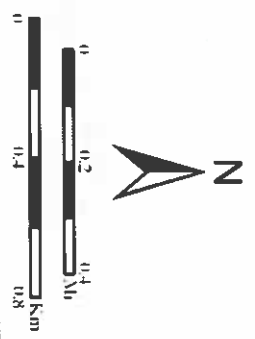


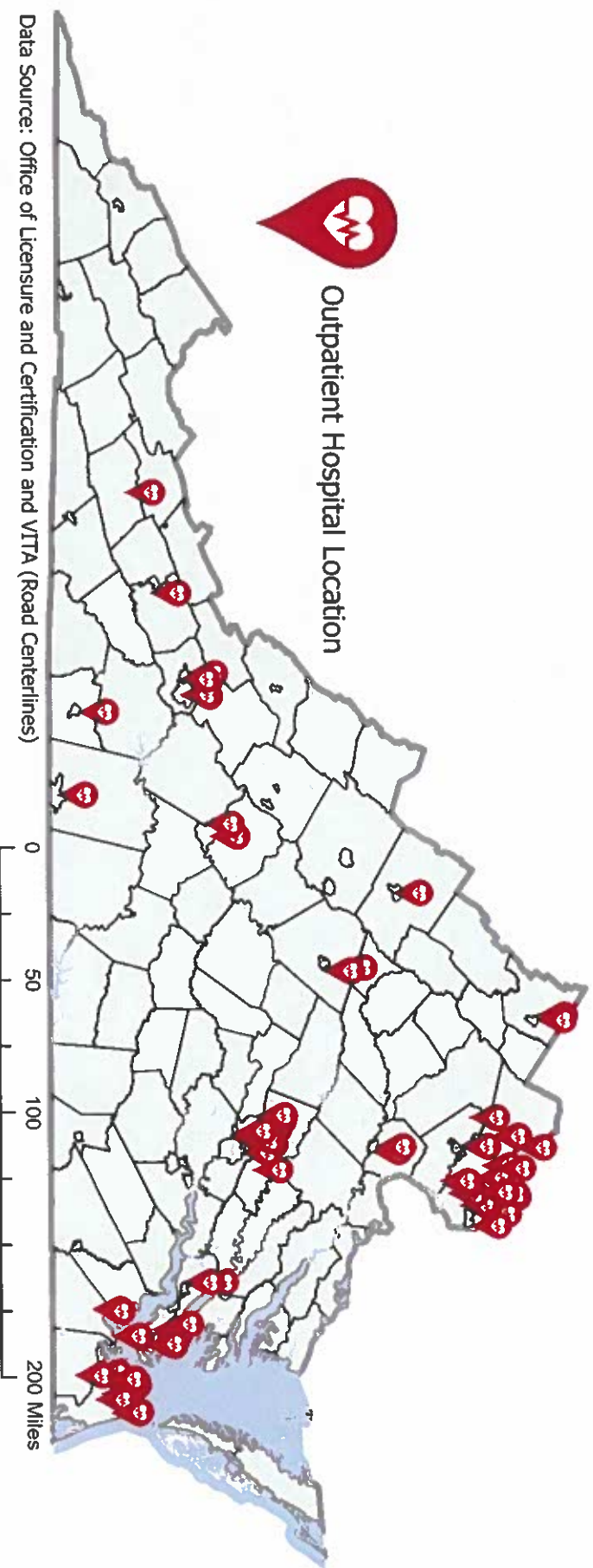
Data Source: Office of Licensure and Certification and VITA (Road Centerlines)

Methodology: The hospitals' addresses were georeferenced to their physical locations, and the ArcGIS Network Analyst tool was used to geocode the hospital addresses

2026

Spatial Distribution of Inpatient Hospitals by Location



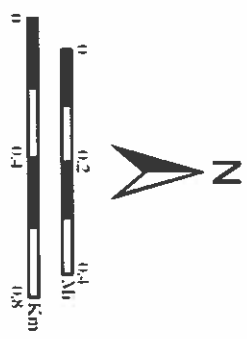


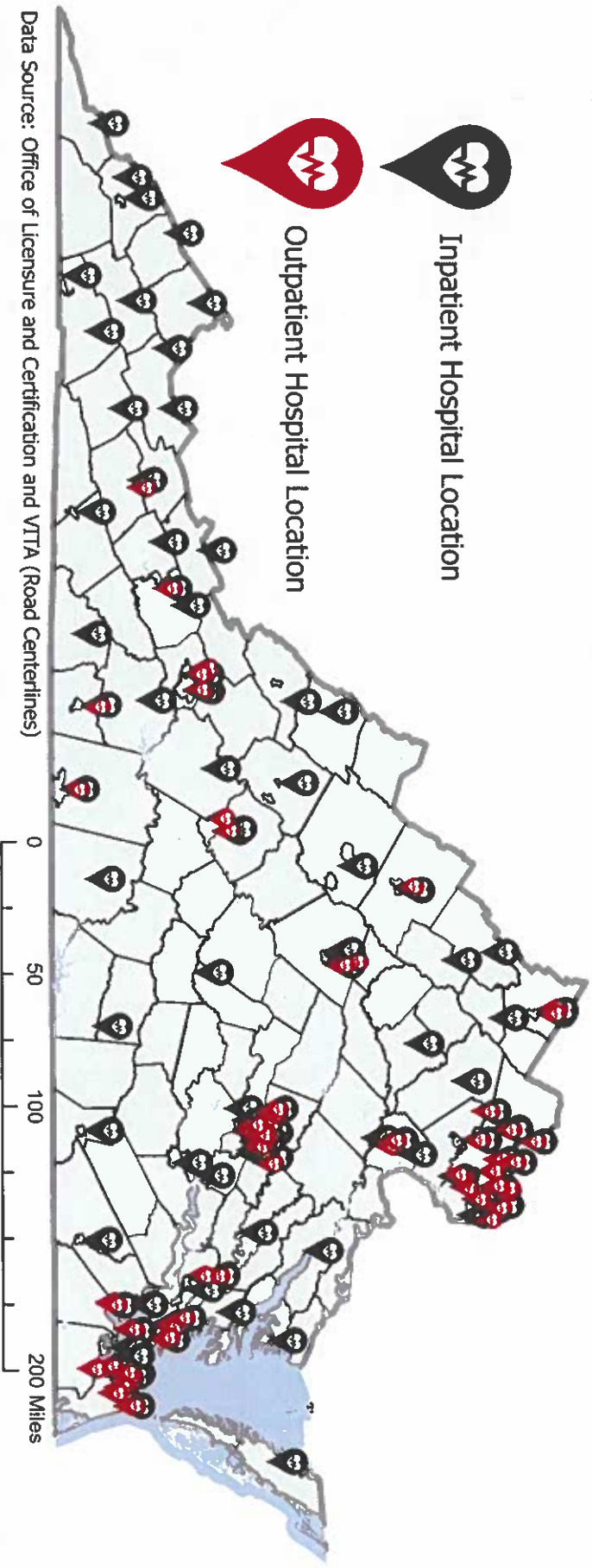
Data Source: Office of Licensure and Certification and VITA (Road Centerlines)

Methodology: The hospitals' addresses were georeferenced to their physical locations, and the ArcGIS Network Analyst tool was used to geocode the hospital addresses

2026

Spatial Distribution of Outpatient Hospitals by Location



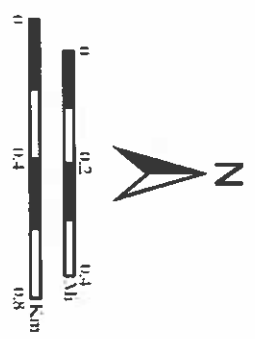


Data Source: Office of Licensure and Certification and VITA (Road Centerlines)

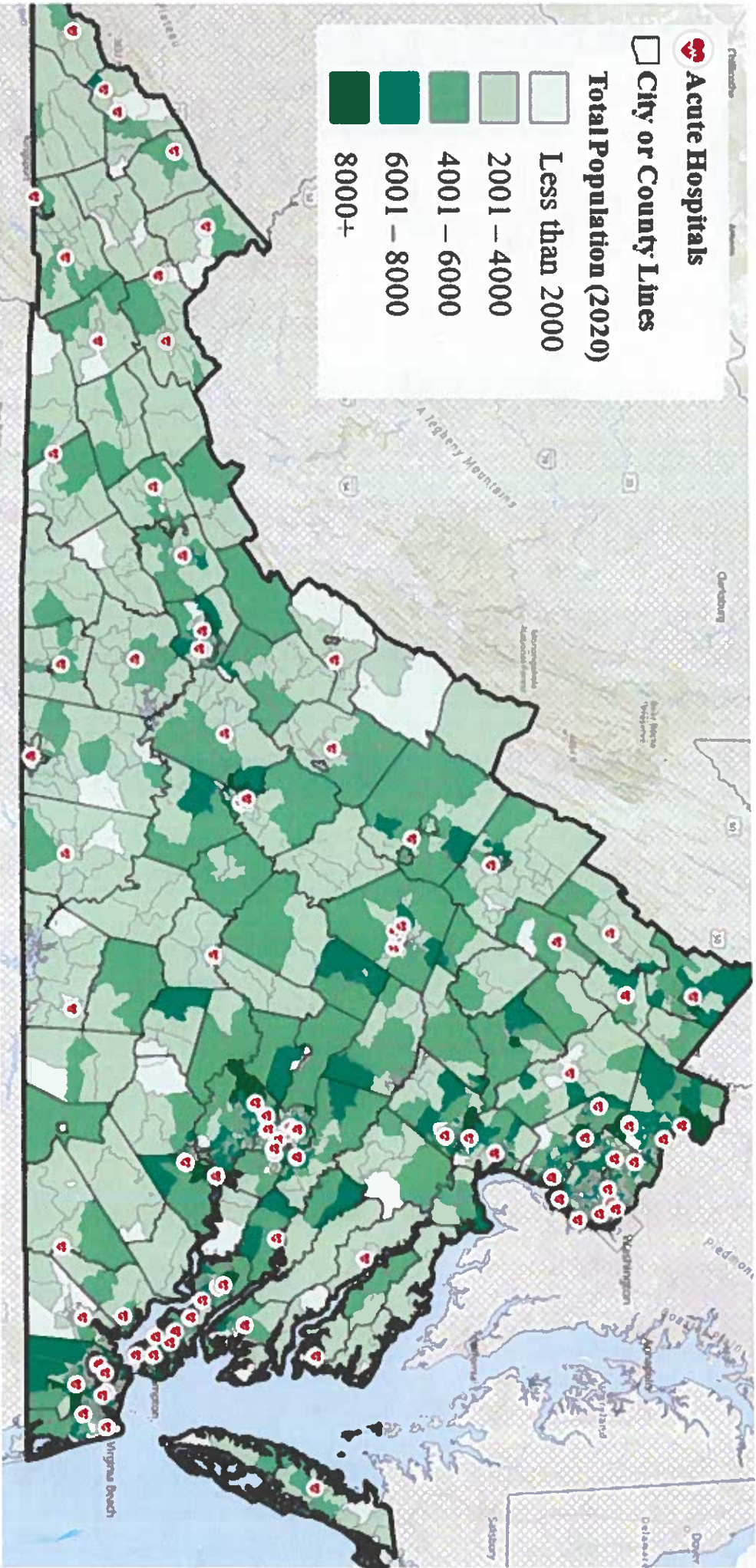
Methodology: The hospitals' addresses were georeferenced to their physical locations, and the ArcGIS Network Analyst tool was used to geocode the hospital addresses

2026

Spatial Distribution of Inpatient & Outpatient Hospitals by Location



Map: Acute Care Hospitals and Population by Census Tract (Virginia)



Source: 2020 Census, DCOPN Inventory (2026), ArcGIS