**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