DESERTCOM Committee
Agenda

July 23rd, 2026, at 1:00 p.m.

Perimeter Center, Training Room 2

9960 Mayland Drive, Henrico, VA 23233

1. Call to Order and Welcome
2. Roll Call
3. Public Comment Period
4. Review Meeting Minutes from May 15, 2026 (page 2-8)
5. Review Materials
    - NEW Updated Maps
    - Expedited Review Process (pages 9-11)
    - Definitions and Preference Language (page 12)
6. Next Steps and Wrap Up
7. Meeting Adjournment

Meeting Minutes
SHSP TF – DESERT Committee
May 15, 2026, 10:00 a.m.
Virtual

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

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 10:02 a.m.

Ms. Miller called the roll.

Quorum was established.

Ms. Cameron reviewed the agenda.

The committee reviewed the meeting minutes from the previous meeting, April 20, 2026. Ms. Davis motioned to approve the minutes, Mr. Stone seconded the motion, and the committee approved the minutes unanimously.

Ms. Cameron called for public comment. The committee received public comment via email earlier in that morning from VHHA (forwarded by Ms. Miller). Ms. Coley from VHHA was present. The committee acknowledged the written public comment.

Ms. Cameron led the discussion to the review of the maps and methodology produced by the social-epi team at Virginia Department of Health ‘s Office of Health Equity. The committee discussed each slide.

Slide 2. The Primary Care Provider

The definition as provided to include:

- Certified Nurse Midwife
- Family Practice
- General Practitioner

- Internal Medicine
- Obstetrics & Gynecology
- Pediatrics

Slide 3. 15-mile Radius Buffer Around Census Tract with Population density > 1,500 per square mile (SQM) (.05 FTE equates to two hours of service per week)

The committee shared confusion about what this map represents.

Mr. Honaker opined that this map is based on population density rather than a lack of providers.

Slide 4. 30-mile Radius Buffer Around Census Tract with Population density < 1,500 per SQM

Ms. Cameron stated that the map does show a good distribution. She stated the western edge does not seem to show many providers.

Slide 5. Physician – Population Ratio of Less Than One Physician per 3,500 Population

Ms. Cameron welcomed observations from the committee.

Mr. Jacobs stated the Northern Neck does not have any physicians nearby. It's a 45- minute drive from Fredericksburg to Colonial Beach. Additionally, Westmoreland County and Kilmarnock are also lacking physicians. The closest hospital to King George and Westmoreland is in Fredericksburg. Anywhere further south would need to travel to Tappahannock, where there is a VCU facility.

Mr. Rufus advised there is a Bon Secours facility near Kilmarnock.

Slide 7. Percent Population Below 200% Federal Poverty Level

Ms. Cameron stated the map shown in this slide shows the four variables outlined in the original bill.

Mr. Garner stated that SHSP TF was advised to consider from the Acts of Assembly 2025 areas that have an annual poverty rate of at least 20% according to the latest data provided by the US Census Bureau. This map shows areas below 200% of the FPL.

Ms. Cameron asked to confirm if this original legislative ask was to look into areas of poverty at 100 or 200%.
Mr. Garner reiterated that the original task from the legislature was to look at the areas where at least 20% of the population are impoverished.

Ms. Cameron asked if there is another map at 100%.

Mr. Garner stated that there is not a map at 100%. While this map is helpful, it is not exactly what legislature wanted the SHSP TF to consider.

Ms. Cameron asked the staff to ask for an additional map at 100% to be created.

Slide 8. Physician (FTEs) to Population Ratio

Ms. Cameron asked to provide an explanation for the map on this slide.

Mr. Garner stated the task of the legislature is to look at areas that do not have a hospital or health care provider. By health care provider, from the map, the committee is interpreting this to mean PCP within a 30 mi radius of the population density is less than 1,500 residents per SQM, or within a 15 mi radius of the population density is more than 1500 residents per SQM. There is a separate element to consider whether there is less than one primary care physician per 3,500 residents.

Mr. Beckner asked to clarify that this is physician only vs what is provided in the previous slide definition. He asked if this map includes those non physicians listed on the second slide or is this physician only.

Mr. Stone pointed out the PCP definition on slide two is the HRSA definition.

Ms. Miller advised she can ask for clarification if where "physician" is stated in the slides, if that means "physician" or does that mean those PCPs listed in slide 2. (If they mean physician, what does "physician" mean?)

Mr. Garner stated one of the elements to consider from legislature is whether there is at least one PCP per 3,500 residents.

Slide 9. Average Drive-Time to the Closest Outpatient Facility

Ms. Cameron asked if outpatient surgery on this slide is diagnostic imagining, ambulatory, physicians.
Ms. Miller confirmed it is Outpatient Surgical Hospitals (OSH).

Slide 12. Medial Desert Index Based on Four Criteria

Mr. Beckner commented that this does not include FQHCs or free clinics.

Ms. Davis provided the outline of the map request discussed on April 20, 2026. The committee had asked for specifically 200% of the FPL, one map with IH (a colored dot), second map with OSH (a separate-colored dot), third map of PCP (in a colored dot not already used), and a fourth map showing the combined results. There is not a map showing those combined, overlaid results.

Ms. Cameron stated that the committee erred in asking for 200% rather than 100%, making point that the 200% came from the charity care conditioning language.

Mr. Stone added that 200% also applies to FQHC.

Ms. Davis asked if the committee should go back and have the maps meet the definition of the legislation.

Ms. Cameron stated that based on what Mr. Garner stated, the first legislation criteria, is just really a ballpark.

Mr. Garner advised that 2025 legislature articulated and clearly defined that these areas would meet at least two of the three criteria. In 2026, they added a need to consider the unique geographic, socio economic, cultural transportation, and other barriers. He asked to consider whether the committee and the task force would be comfortable providing explanation to the legislature, commissioner and the Board of Health that while the legislature asked for one solution, the committee decided to modify that solution with what the committee thinks is a better solution. He asked if the committee should focus on applying 100% to the original task at hand.

Ms. Cameron stated this is an issue that the task force has been struggling with for over a year.

Mr. Phillips pointed out that the maps do not include safety net facilities or rural health centers.

The committee discussed which representatives should be included in a conversation to explain what the committee is recommending outside of the original charge

Slide 14. Spatial Distribution of Inpatient Hospitals by Location

Ms. Cameron stated that this map is a good representation of distribution.

Slide 15. Spatial Distribution of Outpatient Hospitals by Location

No comments from the committee.

Slide 16. Spatial Distribution of Inpatient Hospitals and Outpatient Hospitals by Location

Ms. Cameron asked if the committee could ask if this map could have an overlay of free clinics, rural health centers and FQHC.

Mr. Garner advised we need to have the FPL shown at 100% on the map on slide 12, Medical Desert Index Based on Four Criteria, 20% of the population at or below the poverty

level. He requested a different color schematic. The hospitals superimposed on top would get us closer to the 2025 mandate from the general assembly.

Ms. Miller reiterated the request to the committee for confirmation.

On slide 12, the committee would like to see:

- 20% of the population at 100% FPL
- Change of color from green scale to make it easier for visual consumption
- Input the impatient hospitals with black dots

On slide 16, the committee would like to see:

- free clinics, rural health centers, and FQHC overlay on top

Ms. Miller advised she will share the draft with the committee for feedback prior to sending it to Rex and will include Rex at the next meeting to explain those maps.

Ms. Miller presented the maps created by COPN.

Ms. Miller presented the maps created by VHHA.

Ms. Cameron stated a recommendation could be made for staff to have access to specific mapping tools to look for gaps when reviewing a new project.

Ms. Honaker advised that this is already one of eight required considerations. Each staff report does have a map that shows the area 30 minutes from a site within the planning district where the project is located. The Commissioner reviews this each time.

Mr. Garner gave the timelines for the upcoming deadlines.

- June 11th Board of Health meeting
- June 12th is the next SHSP TF meeting (virtual)
- August 28th is the SHSP TF meeting (in person)
- September 17th is the Board of Health meeting
- October 1st is the deadline to report back to the Senate Committee on Education and Health

Ms. Cameron asked if they could have the final recommendations for the August 28th meeting and discussed the agenda for the June 12th meeting.

Mr. Garner stated it would be beneficial to go back to the legislative mandate and update the regulations to implement an expedited application and review process. There is a vast difference between an expedited review process and a preference.

Ms. Cameron stated that this was already discussed last year and the task force encompassed everything in that. She asked if there was anything outstanding from that discussion. She opined that the expedited review is not the issue preventing these people from accessing service.

Mr. Garner explained that he did not mean to imply that the task force cannot develop an appropriate language to provide preference. He pointed out that the preference was not part of the mandate. He explained that if the committee chooses to go beyond the scope, they are certainly welcome.

Ms. Cameron asked if the committee should have an expedited review of someone who will provide transportation services to an underserved area.

Ms. Davis explained the in the last meeting expedited review process was topic of discussion. The committee has charged each subcommittee to address that as they go through the full review. This committee is leaving it to the subcommittees to make recommendations for the full task force, and we will determine which categories would be appropriate for expedited review. The final recommendation would include the preferences overarching and the expedited process be individual by category.

The committee agreed upon the next meeting, in person on June 26th, from 9am-11am.

Ms. Cameron will have a call with Geoff and Joe Hilbert on an approach to engage communication with delegates and senators.

Ms. Davis motioned to adjourn.

Mr. Stone seconded the motion.

The committee adjourned at 11:30 am.

Expedited Review Process & Subcommittee Recommendation Summary

- *Proposed Recommendation on Expedited Review Process*

*******PLEASE NOTE this is proposed regulation currently under review*******

Project 8366 - Fast-Track

Fast Track Project - COPN Expedited Review Process

12VAC5-220-280. Applicability.

A. Capital expenditures as contained in subdivision 8 of "project" as defined in § 32.1-102.1 of the Code of Virginia or projects that involve relocation at the same site of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another, when the cost of such relocation is less than $5 million, shall be subject to an expedited review process.

B. The following projects shall also be subject to an expedited review process:

1. The establishment of a new medical care facility described in subdivision A 2 of § 32.1-102.1:3 by an existing medical care facility described in subdivision A 1 or 2 of § 32.1-102.1:3 that has an existing certificate to provide psychiatric services pursuant to subdivision B 6 of § 32.1-102.1:3, provided such new medical care facility is located in the same planning district as the existing medical care facility;

2. The addition of psychiatric beds at an existing medical care facility described in subdivision A 1 or 2 of § 32.1-102.1:3 that has an existing certificate to provide psychiatric services pursuant to subdivision B 5 of § 32.1-102.1:3, not to exceed 10 beds or 10 percent of all beds at the medical care facility, whichever is greater, and provided that the applicant has not been awarded a certificate for the addition of psychiatric beds pursuant to this provision in the previous two-year period;

3. The relocation of psychiatric beds to an existing medical care facility described in subdivision A 1 or 2 of § 32.1-102.1:3 that has had an existing certificate to introduce a psychiatric service for at least the previous 12 months pursuant to subdivision B 5 of § 32.1-102.1:3 and that is within the same planning district; and

4. Any capital expenditure of $15 million or more, not defined as reviewable in subdivisions 1 through 7 of § 32.1-102.1:3, by or on behalf of a medical care facility described in subsection A other than a general hospital.

12VAC5-220-285. Ninety-Day Review Cycle.

A. The department shall review completed applications which qualify for expedited review pursuant to 12VAC5-220-280 in accordance with the following 90-day scheduled expedited review cycles.

Batch Group	*Due Date for Complete Applications*	*Review Cycle*	
		Begins	*Ends*
A	*February 5*	*Feb. 10*	*May 10*
B	*May 7*	*May 12*	*Aug. 9*
C	*August 6*	*Aug. 11*	*Nov. 8*
D	*November 5*	*Nov. 10*	*Feb. 7*

12VAC5-220-290. Application forms.

A. Obtaining application forms. Application forms for an expedited review shall be available from the department upon the request of the applicant. The department shall transmit application forms to the applicant within seven days of receipt of such request.

B. Application fees. The department shall collect application fees for applications that request a certificate of public need under the expedited review process. No application will be reviewed until the required application fee is paid as provided in 12VAC5-220-180 B.

C. Filing application forms. Complete applications for review under the expedited review process must be received by the Department and the appropriate regional health planning agency by the close of business at least five days before the start of the batch review cycle. All requests for a certificate of public need in accordance with the expedited review process shall be reviewed by the department and the regional health planning agency which shall each forward a recommendation to the commissioner within 40 60 days from the start date of the relevant batch cycle, after the submitted application has been deemed complete. No application for expedited review shall be reviewed until the application form has been received by the department and the appropriate regional health planning agency, has been deemed complete, and the application fee has been paid to the department. The expedited review period shall begin on the first day of the applicable review cycle within which an application is determined to be complete, in accordance with scheduled batch review cycles described in 12VAC5-220-285. If the application is not determined to be complete for the applicable batch cycle within five calendar days from the date of submission, the application may be refiled in the next applicable batch cycle.

12VAC5-220-300. Participation by other persons.

Any person directly affected by the review of a project under the expedited review process may submit written opinions, data and other information to the appropriate regional health planning agency and to the commissioner prior to their final action. Any member of the public may request a public hearing for an expedited application.

12VAC5-220-310. Action on application.

A. Decisions to approve any project under the expedited review process shall be rendered by the commissioner within 45 90 days of the start of the relevant batch review cycle. The commissioner may approve and issue a certificate for any project which is determined to meet the criteria for expedited review set forth in 12VAC5-220-280.

B. If the commissioner determines that a project does not meet the criteria for an expedited review set forth in 12VAC5-220-280, the applicant will be notified in writing of such determination within 45 90 days of the receipt of such request. In such cases, the department will forward the appropriate forms to the project applicant for use in filing an application for review of a project in the appropriate review cycle in accordance with Part V of this chapter.

C. Any project which does not qualify for an expedited review in accordance with 12VAC5-220-280, as determined by the commissioner, shall be exempted from the requirements of 12VAC5-220-180 A and B when such project is filed for consideration in accordance with Part V of this chapter.

The committee defined:

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

"**Medical desert**" means 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 to primary and specialty care to persons who live in medical deserts

The committee discussed implementation of similar language below (previously written for psych beds):

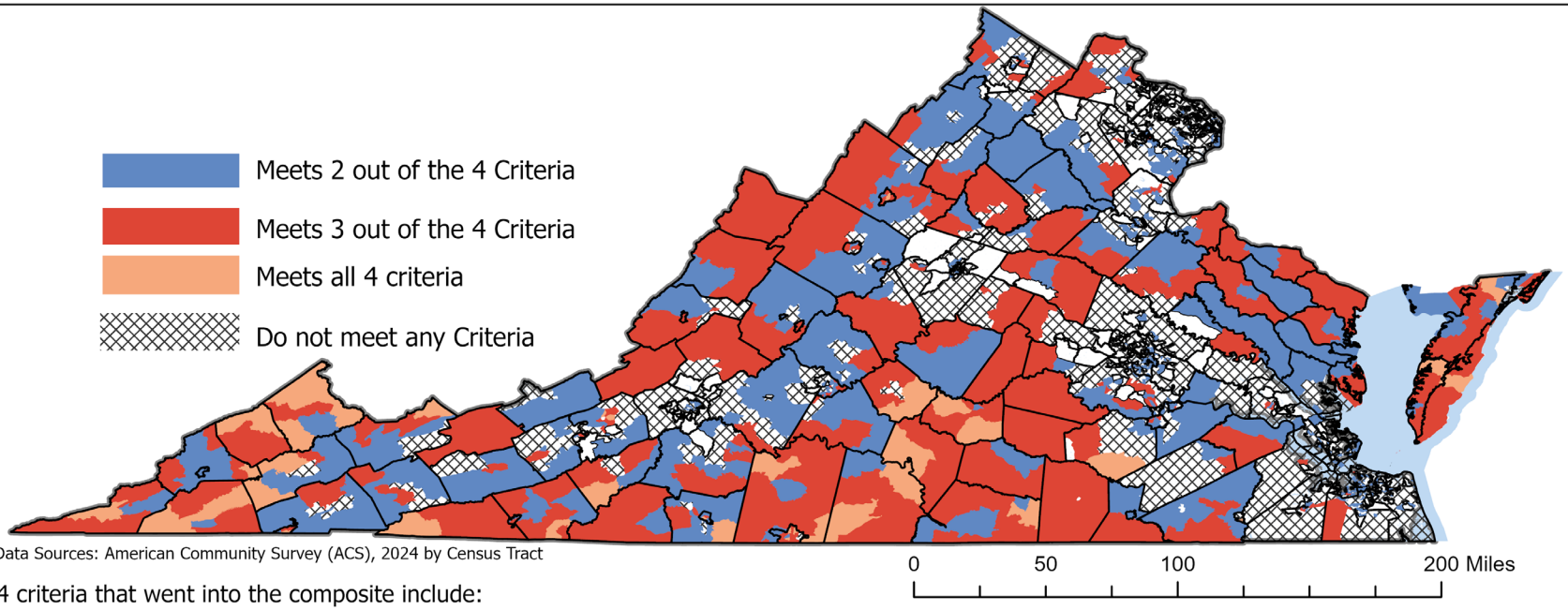
> "To ensure the appropriate levels of patient care, providers of acute psychiatric and acute substance use treatment must show evidence of providing or the commitment to provide a continuum of ambulatory services, aligned to their acute care patient population. The continuum may be accomplished through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

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

Updated Maps

- *Question: On slide 5, Physician – Population Ratio of Less Than One Physician per 3,500 Population and Slide 8, Physician (FTEs) to Population Ratio, what does "physician" mean? Is it PCP as defined on Slide 2, or does it have another meaning?*
- *Response: The physician means those providers who meet the criteria on slide 2 (Primary Care). We adhere to the HRSA definition as stated on slide 2*
- *Slide 8 shows the hours (FTEs) they (physicians) spend on patients. 40hrs = 1 FTE, 20hours = 0.5 FTEs. And we calculated the ratio based on the population in the area*



The 4 criteria that went into the composite include:

1. 100% 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

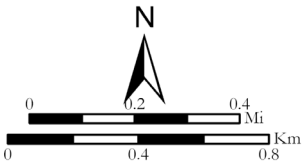
4. The Physician-Population Ratio - Census tracts with fewer than 1 FTE per 3,500 people and tracts without FTEs were flagged Yes; otherwise, No

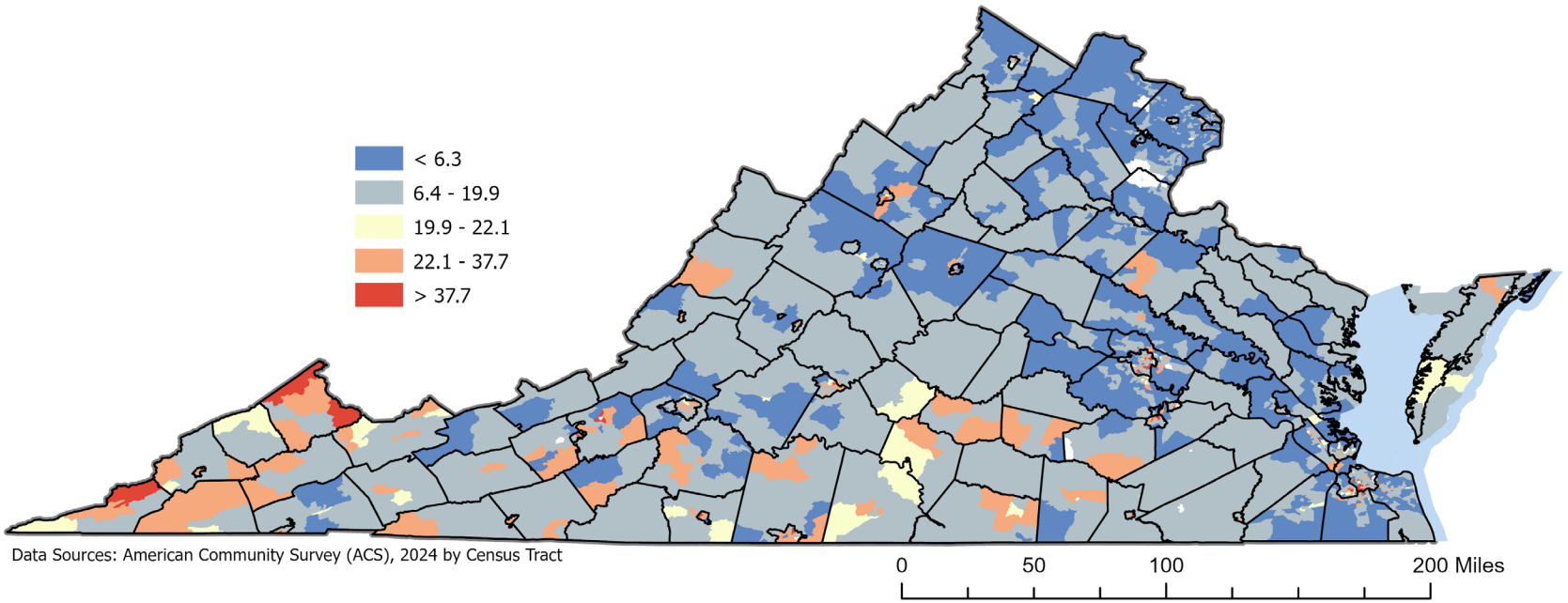
The COUNTIF function was used to count the number of Yes(s) in a row (per census tract). Any census tract with two or more Yes(s) was mapped

2026

Medical Desert Index Based on Four Criteria

by Census Tract





Poverty – We calculated the percentage of the population below 100% of the Federal Poverty Level by census tract using American Community Survey data. The percentage was calculated by dividing the number of individuals below 100% of the Federal Poverty Level by the total population in the census tract for whom poverty status is determined.

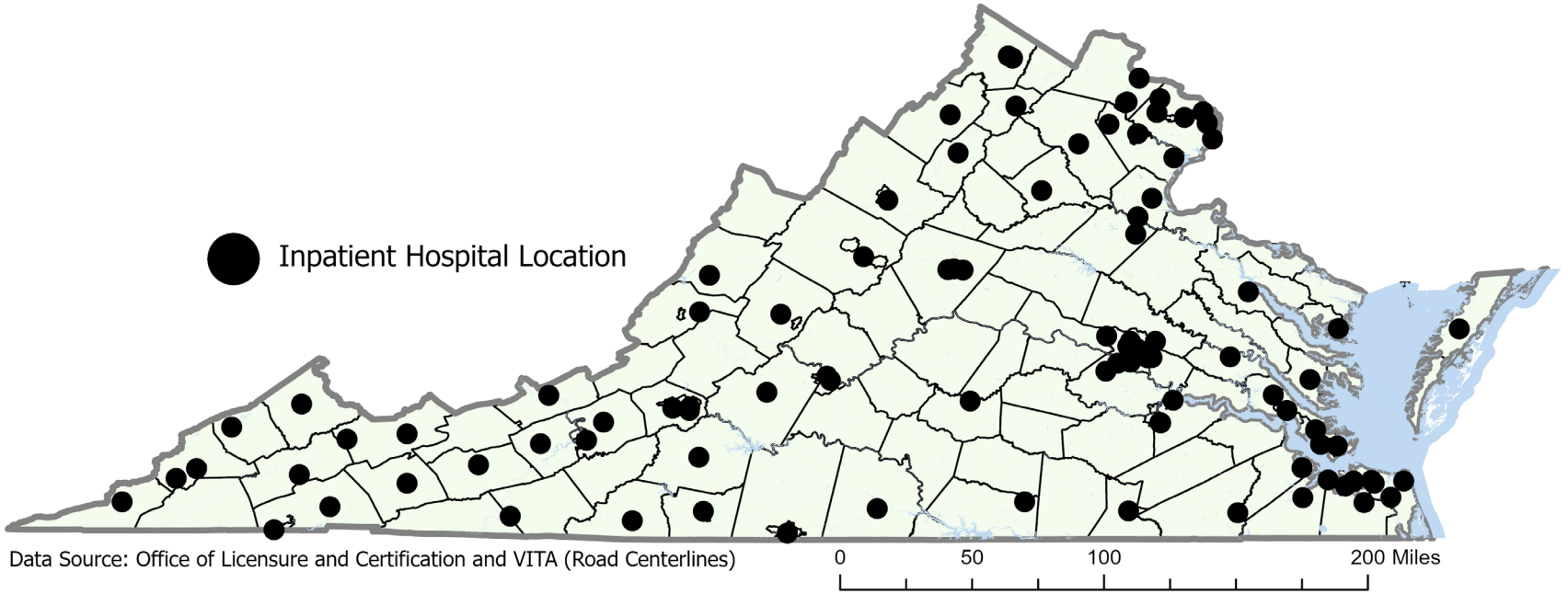
Percent Population Below 100% Federal Poverty Level

by Census Tract

N

2026

0 0.4 0.8 Km



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

0 50 100 200 Miles

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

N

0 0.2 0.4 Mi

0 0.4 0.8 Km