

Georgia DBHDD Bed Capacity Study and Strategic Plan

August 2023





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Executive Summary



Background

Alvarez and Marsal (A&M) was engaged by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) to develop a model that would identify future needed bed capacity for Georgia's behavioral health crisis and forensic system and support evaluation of responses to that forecasted bed demand. This model would form the basis of a Study and Strategic Plan (hereafter "Study" for brevity) that would articulate where beds are needed, of what type, and when over a ten-year period.

The model and Study focus on a specific and critical part of the broader system managed by DBHDD. They include crisis stabilization and inpatient facilities funded by DBHDD that serve two discrete populations:

- 1. Uninsured adults and children and adolescents (C&A) receiving behavioral health crisis services; and
- 2. Adults involved in the criminal justice system receiving forensic behavioral health services.

The model was developed using numerous historical and current data sources provided by DBHDD and input from DBHHD personnel across divisions and diverse subject matter expertise to help the model reflect the current operating reality of the system. The Study is based on outputs from this model.

While this Study focuses on behavioral health crisis and forensic beds, it is not meant to suggest that DBHDD should invest only in this level of care, or at this level of care at the expense of other services. DBHDD supports a broad statewide system in which behavioral health crisis and forensic beds are one component of various inter-related services.

Recommendations Overview

Georgia has an acute near-term need for additional community-based behavioral health crisis beds for adults.

The model projects that Georgia will need five new facilities (i.e., BHCCs) by 2025 to meet near-term demand. Georgia will need an additional facility by 2027 and two more by 2032, for a total of eight new facilities over a ten-year period. These projections assume that additional capacity will be built only in the form of BHCCs; it assumes no additional state hospital beds will be added. The projected near-term need may be mitigated by diversion measures that allow individuals in crisis to be stabilized without admission to a facility, such as via GCAL or Mobile Crisis.

This projection assumes that Georgia will staff its existing facilities in such a way that they attain optimal occupancy rates (i.e., make the most efficient use of their existing bed capacity). Georgia will need to maximize its current bed capacity by addressing workforce challenges to meet the demand projected in the model.

Georgia also has an acute near- and long-term need for additional forensic state hospital beds, with a gap of 119 beds projected by 2025. This projected need is supported by the state's growing forensic waitlist. While this need can be met by building new facilities, it may also be mitigated by increasing resources to reevaluate individuals on the forensic admissions waitlist, expanding jail-based competency restoration programs, and / or increasing utilization of forensic step-down facilities, such as Community Integration Homes and Forensic Apartments.

While Georgia does not have an immediate need for other bed types considered in the model or Study, **DBHDD should revisit these projections as appropriate and as additional information becomes available** about DBHDD's broader environment or unmet need for DBHDD services.

Further Considerations

The limited scope and duration of this engagement did not allow for complete evaluation of the topics identified below. The recommendations support the need for further analysis and assessment.

- 1. <u>TempObs</u>: there is a need to improve the reporting of TempObs episodes to allow the model to better predict future demand and evaluate usage of existing capacity.
- 2. <u>Occupancy Rates</u>: there is a need to assess opportunities to address low occupancy rates in certain facilities where demand is high, some of which may be related to staffing (described below).
- 3. <u>Staffing</u>: there is a need to identify strategies to address gaps in staffing driven by 6.2% average inflation¹ and low unemployment.

1. Average annual change in Consumer Price Index for South Region (including Georgia), July 2020 – July 2023; reported by U.S. Bureau of Labor Statistics as of August 10, 2023.



Goals of the Study / Strategic Plan



DBHDD retained A&M to develop a behavioral health crisis and forensic bed projection model to assist DBHDD in determining where and when to make additional investments in bed capacity. This Study illustrates the outputs of that model.

Goals of the Study

- 1. Assess the **historical and current utilization** of the Georgia behavioral health crisis and forensic system.
- 2. Identify **future needed bed capacity**, where, of what type, and when over a 10-year period $(2023 2032)^1$;
- 3. Make **recommendations and identify constraints** that may have an impact on bed demand and needed capacity; and
- 4. Project **preliminary cost estimates** of investments associated with needed future bed capacity.

Populations considered in this Study

- 1. Uninsured adults and C&A receiving behavioral health crisis services; and
- 2. Adults involved in the criminal justice system receiving forensic behavioral health services.





This Study illustrates the potential future trajectory of bed need in the Georgia behavioral health crisis and forensic system. This illustration is not done within a vacuum, however, and is best understood in its unique historical context.

Context for the Study

A range of environmental factors impact, and will continue to affect, Georgia's behavioral health crisis and forensic system. In turn, these factors influence the contours and outputs of this Study. These include but are not limited to:

- 1. The **impact of the COVID-19 pandemic**, which increased the prevalence of behavioral health diagnoses while simultaneously limiting crisis service utilization and exacerbating workforce shortages;
- 2. The **national rollout of the 988 Suicide and Crisis Lifeline**, which is expected to increase demand for behavioral health crisis services;
- 3. The **receding but still inflationary environment of the broader economy**, which increases provider costs and constrains their ability to hire staff in a period of historically low unemployment. Together these factors limit providers' ability to utilize all available beds.

This Study illustrates the potential future trajectory of bed need in the Georgia behavioral health crisis and forensic system. This illustration should be understood and used in specific ways, as described below.

Using this Study

This Study should be understood and used in the following ways:

- 1. This Study shows a baseline projection of needed beds based on a) historical utilization of Georgia's behavioral health crisis and forensic system from 2018-2022 and b) future population growth. In other words, **it shows the future trajectory of the system absent any material changes**.
- 2. This projection **provides a solid quantitative foundation for DBHDD to build upon** as it considers investment, programmatic, and policy changes in the future.
- 3. While this Study focuses on behavioral health crisis and forensic beds, it is not meant to suggest that DBHDD should invest only in this level of care, or at this level of care at the expense of other services. DBHDD supports a broad statewide system in which behavioral health crisis and forensic beds are one component of various inter-related services.
- 4. Cost estimates are **illustrative and meant to serve as a starting point for further discussion**; they do not represent a specific appropriations request by DBHDD.



DBHDD System Background



DBHDD System Background | Behavioral Health Crisis

The behavioral health crisis system of Georgia comprises community-based services to assist an individual in crisis, facility-based treatment to stabilize an individual in crisis, and outpatient services to help an individual return to the community.



Population Served

Individuals generally at or below 200% of the Federal Poverty Level (FPL) without private insurance, Medicaid, or Medicare.

1. This is an illustrative, not exhaustive, depiction of DBHDD behavioral health crisis services.

DBHDD System Background | Forensic

The behavioral health forensic system of Georgia comprises pre-admission services to evaluate an individual's psychological condition, facility-based treatment to treat an individual deemed incompetent to stand trial or not guilty by reason of insanity, and outpatient services to help an individual return to the community.



Population Served

Adults involved in the criminal justice system requiring forensic behavioral health services, either in the form of restoration to competency to stand trial (IST) or due to a jury verdict of not guilty by reason of insanity (NGRI).

1. This is an illustrative, not exhaustive, depiction of DBHDD behavioral health forensic services.

While services under Georgia's system are expansive, the core of that system is state-funded facilities that stabilize and treat individuals and prepare them for return to the community. Facilities not explicitly included below, or services that are paid for by private insurance or Medicaid or Medicare, are not included in the Study.

Populations and Facilities Included in this Study

Population	Facilities	Rationale
Behavioral Health	 Crisis Stabilization Units (CSU) Behavioral Health Crisis Centers (BHCC) Crisis Stabilization Unit Temporary Observation (TempObs) Walk-In State Hospitals (AMH) State-Contracted Private Hospitals 	 Community facilities (CSUs and BHCCs) and the state's five psychiatric hospitals are the primary sites of crisis stabilization services in Georgia. Community-based crisis response services, like MCTS, may alleviate but will not eliminate demand for crisis beds at crisis stabilization facilities. State-contracted private hospitals are used as overflow for community-based crisis beds and are relevant to the Study only in that context.
Forensic	 State Hospitals Community Integration Homes (CIH) Forensic Apartments (FA) 	 State hospitals are the only facilities in Georgia with dedicated forensic beds for those incompetent to stand trial (IST) or found not guilty by reason of insanity (NGRI). While Community Integration Homes and Forensic Apartments are step-down services, they are also dedicated facilities funded by DBHDD and have material impact on successful reintegration of an individual into their community.

DBHDD System Background | Region and Service Area Map

The model relied on the following map of Georgia counties and DBHDD service areas and regions, provided by DBHDD.



#	Service Area Name			
1	Lookout Mountain			
2	Highland Rivers			
3	Avita Community Partners			
5	Douglas			
6	Fulton County			
7	Clayton CSB			
8	DeKalb CSB			
9	View Point Health (GRN CSB)			
10	Advantage Behavioral Health			
11	Serenity Behavioral Health			
12	River Edge CSB			
13	Oconee CSB			
15	Pathways			
16	McIntosh Trail			
17	New Horizons CSB			
18	Middle Flint			
20	Aspire Behavioral Health (Albany Area CSB)			
21	Georgia Pines			
22	Behavioral Health Services of So. GA			
23A	CSB of Middle Georgia			
23B	CSB of Middle Georgia (Ogeechee)			
24	Pineland Area CSB			
25	Unison Behavioral Health (Satilla CSB)			
26	Gateway CSB			

DBHDD System Background | Illustrative Behavioral Health Pathway

The process flow below illustrates many of the multiple pathways that could result in a crisis bed placement for individuals with a behavioral health crisis. This flow forms the conceptual framework for bed projections.



Individuals begin in upper left and flow through the system >>>

Disclaimer: This patient pathway is meant for use as a supplemental resource to the DBHDD crisis bed capacity model developed by A&M. It should not be considered a final or comprehensive depiction of all possible options and outcomes.

DBHDD System Background | Illustrative Forensic Pathway

The process flow below illustrates many of the multiple pathways that could result in a bed placement for individuals with behavioral health conditions and involved with the justice system. This flow forms the conceptual framework for bed projections.



Individuals begin in upper left and flow through the system >>>

Disclaimer: This patient pathway is meant for use as a supplemental resource to the DBHDD crisis bed capacity model developed by A&M. It should not be considered a final or comprehensive depiction of all possible options and outcomes.



Methodology and Limiting Factors



The bed projection model aggregates a range of data sources from DBHDD and uses them to create the following inputs. These inputs then form the basis of the "model logic" (i.e., calculations) that drive projections.

Key Terms and Definitions

Term	Definition				
Available Beds	The number of existing and available beds for a selected calendar year. For future years this includes beds currently under development and expected to be operational at a later date.				
Average Daily Census (ADC)	The average number of patients occupying a bed at a facility on any given day, also known as Average Client Load (ACL).				
Facility Type The classification of facilities overseen by DBHDD used for bed projections. Facility types that are included for behavioral health are private contract hospital, BHCC, CSU, Crisis Inpatient, and State Hospital (AMH). Facility types that are included for forensics are C State Hospital, Forensic Apt.					
Patient Days	The total number of days all admitted patients spent at a facility for a given period (also known as length of stay). Same day admissions and discharges are counted as one day. The model considers patient days between 2018 and 2022.				
Patient Pathway The organization of care processes for a well-defined group of patients. The two pathways included in this model, as already an are behavioral health crisis and forensics.					
Occupancy Rate A measure of how often available beds at a given facility have been occupied by patients, calculated as the number of patient by (365 * the number of available beds).					
Occupancy Rate (Alternative)	The "optimal" occupancy rate for a given facility type (e.g., 85% for community-based crisis facilities like BHCCs; 95% for State Hospitals). This is different from Occupancy Rate, which is a measure of <i>historical</i> occupancy. Optimal rates were provided by DBHDD leadership.				
Use Rate	The number of days of bed care provided per capita for a target population, expressed as [Patient Days/Target Population]. The target population denominator in use rate varies based on patient pathway, age category, and geography.				
Target Population	The group of individuals that can potentially be served by Georgia's behavioral health crisis and forensic system. Each patient pathway uses a different target population. The behavioral health pathway uses 200% FPL as the target population, and the forensics pathway uses the general population as the target population.				

Using the inputs defined above, the model generates a variety of outputs that illustrate the forecasted number of beds the DBHDD behavioral health crisis and forensic system may need over the coming 10-year period.

Key Terms and Definitions

Term	Definition
Future ADC 🔹	The number of forecasted beds based solely on use rate (i.e., the forecasted number of beds in use by patients in future years). This output does not factor in occupancy rate.
Forecasted Bed Need • The total number of forecasted beds based on use rate and occupancy rate. This output assumes historical occupancy rate constant for the selected calendar year.	
Forecasted Gap	The number of beds needed to meet the gap between Available Beds and Forecasted Bed Need for any given future year.
Forecasted Bed Need Alternative •	The total number of forecasted beds based on use rate <i>and</i> occupancy rate. This output assumes an <i>"optimal"</i> occupancy rate for the selected calendar year, rather than using the historical occupancy rate. This optimal rate will vary by pathway and facility type.
Forecasted Gap Alternative	The number of beds needed to meet the gap between Available Beds and Forecasted Bed Need Alternative for any given future year.
Forecasted Gap Alternative + State Hospital Excess ("SH Excess")	The Forecasted Gap Alternative for behavioral health adult community projections, plus the number of projected "excess" or "spillover" beds from state hospitals. This represents the total projected need for behavioral heath adult community beds, assuming optimal occupancy rates.

The model projects future bed need for the behavioral health and forensic pathways by applying historical utilization ("use rate") to future population projections. This methodology is slightly tailored to each pathway but generally follows the outline below.

General Model Logic Overview

= model outputs

Step	Formula	Purpose	
1. Calculate historical patient days	Average of (patient days in the historical period) ¹	Quantifies historical utilization, which allows development of a "use rate" to project future bed need.	
2. Calculate historical use rate	Average historical patient days Average historical target population ²	Generates a "use rate", based on historical trends, that is applied to future projected populations.	
3. Calculate future patient days	Population projections * average historical use rate	Converts future projected populations to patient days so those patient days can be converted to a projection of needed beds.	
4. Calculate future average daily census (ADC)	Future patient days 365 days	Converts future patient days into a projected number of beds. This is <i>not</i> the final forecasted bed need; it is further adjusted by occupancy rates.	
5. Calculate historical occupancy rate	Historical patient days Historical number of available bed days ³	An intermediary step that calculates the historical occupancy rate for a facility, which is then applied to future ADC.	
6a. Calculate forecasted bed need	Future ADC Historical occupancy rate	Adjusts future ADC by historical occupancy rates, creating a forecasted bed need that factors in both historical utilization and the efficiency of existing bed use.	
6b. Calculate forecasted bed need alternative	Future ADC Optimal occupancy rate	Adjusts future ADC by an <i>optimal</i> occupancy, which varies by pathway and facility, creating a final forecasted bed need.	

^{1.} The historical period used varies by pathway and facility type. For example, the behavioral health pathway excludes 2020 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pathway excludes 2020-2022 to avoid including data skewed by the COVID-19 pandemic, while the use rate for state hospitals in the forensic pat

^{2.} The target population for each pathway varies. The behavioral health pathway uses 200% FPL as the target population; the forensics pathway uses the general population as the target population. See the Key Considerations slide for more detail.

^{3.} Available Bed Days is defined as total available beds across a given year multiplied by 365 days.

Some of the details of the model logic vary slightly by pathway and facility type, as described below.

Pathway Facilities, Utilization Periods, and Target Populations

The two pathways included in the model encompass different facility types and leverage different historical periods of utilization data. Different periods were used to "normalize" the trends for each pathway or subpathway, i.e., to compensate for various distortions in the data, such as those caused by the COVID-19 pandemic or idiosyncratic workforce issues.

Pathway	Subpathway	Facilities	Historical Period Used	Target Population
	State Hospital AMH	State Hospital AMH	2018, 2019, 2021, 2022	200% FPL Adults
Behavioral Health Crisis	Adult Behavioral Health	BHCC Crisis Inpatient CSU Private Contract Hospital	2018, 2019, 2021, 2022	200% FPL Adults
	C&A Behavioral Health	CSU Private Contract Hospital	2018, 2019, 2021, 2022	200% FPL C&A
Behavioral Health Forensic	State Hospital Forensic	State Hospital Forensic	2018, 2019	Adult General Population
	Community Integration Home (CIH)	• CIH	2018-2022 Adult General Popula	
	Forensic Apartment (FA)	Forensic Apartment	2018-2022	Adult General Population

Data and Data Transformations

Data that fed the model included:

- 1. Episodic, facility, and geography assignment data provided by DBHDD; and
- 2. Population data obtained from publicly available sources (U.S. Census, GA Office of Planning and Budget, etc.).

Episodic and facility data were transformed to address DBHDD input and preferences.

Not every service area or region contains at least one facility of each type, so **populations in certain geographies were reallocated to another geography with a facility** to ensure that use rate calculations do not disregard populations residing in service areas or regions without facilities.

• These reallocations were made based on historical episodic data to identify where individuals from counties *without* facilities ultimately received service.

Pathway	Populations From	Reallocated To
State Hospital	Region 1	Region 2, 3, 5
AMH	Region 4	Region 3, 5, 6
State Hospital Forensic	Region 1, 4	Region 2, 3, 5, 6
	Service Area 1, 5	Service Area 2
Adult Benavioral	Service Area 13	Service Area 12
Tieaith	Service Area 23B	Service 23A
	Service Area 7	Service Area 8
C&A Behavioral	Service Area 13, 18	Service Area 12
Health	Service Area 3, 5, 17	Service Area 15
	Service Area 21, 23A, 23B, 24, 25, 26	Service Area 26
CIH and FA	Statewide Population	N/A

The trends of certain inputs, such as population and patient days (i.e., utilization), are critical drivers of the model's bed projections. The historical trends in patient days required a measure of "normalization" to ensure accurate projections.

Population Trends

The Georgia Office of Planning and Budget's (OPB) projections are used from 2022 onwards.



Georgia's total population increased steadily between 2018 and 2022. 200% FPL projections from 2022 and onwards are assumed to be a percentage of OPB total population projections, based on the average 2018-2021 ratio of 200% FPL population to total population.¹

OPB projects the state population to increase at a steady rate from 2022 on. Since adult and C&A 200% FPL projections are a fixed percentage of the total population, they too are projected to grow at a similar rate.

Patient Day Trends (Adult Behavioral Health Example)

The average of historical adult behavioral health patient days is applied to projected population growth to project future adult behavioral health patient days.



The trends in historical patient days vary by pathway and facility type, though there is at least one common theme: the impact of COVID-19. As the chart above shows, the utilization of Georgia's adult behavioral health crisis facilities dropped materially in 2020 due to the pandemic.

To compensate for the effect of this idiosyncratic event, the model employs different periods of time between 2018 and 2022, depending on the pathway and type of facility (as described in the "Key Considerations" slide). For adult behavioral health, this meant excluding 2020 from the use rate calculations.

* Region 2's anomalous increase during COVID is attributable to new beds coming online just before and during the pandemic.

^{1. 2018-2021} population figures are derived from the U.S. Census Bureau.

This model and Study include input from key DBHHD personnel across divisions with diverse subject matter expertise. Their understanding of and experience managing Georgia's crisis system added critical detail and nuance to this Study.

Engagement Process

Engagement with "key informants" was a critical part of this Study, as they provide a level of insight into the Georgia system's history, processes, and idiosyncrasies that quantitative data may not reveal on its own. Key informant engagement followed the procedure below for the Study:

- **1. Identify target populations** for inclusion in Study (i.e., behavioral health adult and C&A crisis; behavioral health forensic);
- 2. Identify DBHDD divisions and personnel that serve or facilitate service of these target populations;
- Organize key informant group discussions by division and / or populations served. As needed, organize additional "breakout" discussions¹ with smaller groups, focused on specific topics;
- **4. Document all key informant input** from discussions for use in the model and Study, and for DBHDD review; and
- 5. Produce critical outputs, including:
 - Summaries of key informant meeting notes;
 - Patient pathways (as shown above); and
 - This Study and its supporting bed projection model.

1. These included confirmatory discussions with DBHDD personnel on decisions related to model inputs, logic, and outputs.

Contributing DBHDD Divisions

Division / Organization
Office of the Commissioner
Office of the Chief Financial Officer
Office of the Chief Information Officer
Division of Strategy, Technology, and Performance
DBHDD Information Management
Division of Behavioral Health
Division of Hospital Services
Hospital Operations
Office of Crisis and Transition Services
Office of Crisis Coordination
Office of Adult Mental Health
Office of Children, Young Adults & Families
Office of Medicaid Coordination & Health System Innovation

Personnel from other divisions were included in key informant engagement as well; this list represents the primary points of contact. The bed projection model, like any model, is limited in its focus and constrained by various factors beyond the present control of A&M and DBHDD. These are important considerations when drawing conclusions based on model outputs.

Model Limitations and Constraints

- 1. The bed projection model is **focused on behavioral health crisis and forensic beds**. It does not include or address the broader behavioral health continuum i.e., outpatient or community-based services, crisis or otherwise nor does it model bed need for any other discrete population served by DBHDD.
- 2. The model is **based on specific inputs and calculations** (as described in the "Model Logic" slide above). These inputs limit the outputs and recommendations that the model can generate. For example, the model does not attempt to project "unknown demand" for behavioral health crisis services (i.e., individuals that need crisis services but are not served by DBHDD) because there is no available data to quantify that demand.
- 3. Data availability, quality, and structure **limit the model's ability to make projections**. A lack of data prevented incorporation of some variables into the model; limits on quality and structure required cleaning and transforming the data to enable useful projections.
- 4. The collection, cleaning, and transformation of data is a time-consuming effort. This model was developed under a limited timeline in order to support DBHDD's consideration of and planning for FY2025 budget requests related to behavioral health crisis and forensic bed needs.



Bed Projections



The following foundational concepts are used in the bed projection model and are critical to understanding both model outputs and potential responses to forecasted demand as well as potential gaps in existing capacity.

Concepts Related to Methodology

Grouping of Service Areas

- 1. Not every service area contains at least one facility of each facility type; for example, service area 1 does not contain a community behavioral health facility for adults (e.g., BHCC / CSU), so adults in crisis typically travel to service area 2 for a bed.
- 2. To ensure that use rate (i.e., patient days / target population) calculations do not disregard the populations residing in service areas without facilities, populations in certain service areas were reallocated to another service area with a facility.
- 3. Such reallocations were determined by studying historical episodic data to identify where individuals from service areas without facilities ultimately received service, and mapping population to that service area for modeling purposes.

Occupancy Rate

- 1. Calculated as the number of patient days reported by each facility in CY 2022 divided by available bed days (i.e., 365 * the number of known beds in a facility) in CY 2022; this is a measure of how often available beds at a given facility are occupied by patients.
- 2. The model must account for this factor when projecting required beds based on anticipated occupancy rates to reflect inefficiencies in room assignment and placement processes that result from gender mismatch and / or identified safety risks.
- 3. Inadequate staffing is a further driver of occupancy rates, but one that can be controlled for in the projections model (see definition of "Forecasted Bed Need or Gap Alternative" at right).

Concepts Related to Bed Types and Labels

Term	Definition
Available Beds 🌘	The number of existing and available beds for a selected calendar year. For future years this includes beds currently under development and expected to be operational at a later date.
Community Beds	Beds in Behavioral Health Crisis Centers (BHCCs), free-standing Crisis Stabilization Units (CSUs), and state-contracted private hospitals (SCB).
Excess State Hospital Demand	Bed need resulting from reallocation of growth in demand for state hospital beds to BHCCs / CSUs, pro-rated by service area population across the state. Also called "SH Excess," "Add'l Beds," and "Spillover."
Forecasted Bed Need or Gap	Number of beds needed to meet the gap between available beds and future bed demand assuming current occupancy rates remain steady.
Forecasted Bed Need or Gap Alternative ●	Number of beds needed to meet the gap between available beds and future bed demand assuming an optimal occupancy rate (i.e., 85% for adult behavioral health).
Future ADC 🔵	The number of forecasted beds based solely on use rate (i.e., the forecasted number of beds in use by patients in future years). This output does not factor in occupancy rate.
Net Regional Gap	Sum of gaps projected for individual service areas within a region, where spare capacity in one service area (gap < 0) is assumed to offset shortfalls (gap > 0) in another service area.
State Contracted Bed (SCB) Equivalent	Number of permanent beds it would take, assuming 100% occupancy (i.e., ADC), to replace all state-contracted private hospital beds utilized on an <i>ad hoc</i> basis in a region.

The examples below illustrate a key concept in subsequent bed projections: "optimal" occupancy rates can impact the projected bed need for a given area. The size of impact depends on factors such as available beds, demand, and current occupancy.



Region 6: Optimize Occupancy to Meet Demand



● Future ADC ● Available Beds ● Forecasted Bed Need ● Forecasted Bed Need Alternative

Explanation of Examples

The examples at left (taken from their respective sections below) illustrate two different scenarios:

- Region 6: in 2025, Forecasted Bed Need is greater than Available Beds by 49 beds. This 49-bed gap is almost completely removed if Region 6 facilities achieve optimal occupancy rates of 85% (illustrated by the Forecasted Bed Need Alternative line). Region 6 facilities should seek to meet the optimal occupancy rate.
- Region 4: in 2025, Forecasted Bed Need is greater than Available Beds by 7 beds. Unlike Region 6, however, this 7-bed gap is expanded to a 9-bed gap by meeting an 85% occupancy rate; two facilities in Region 4 have occupancy rates greater than 85%. Reducing these rates would *increase* the need for beds. **Region 4 should** maintain its current occupancy rates.

Adult behavioral health bed need is greatest in the northwest corner of Georgia, concentrated in Regions 1, 2, and 3. These regions, along with Regions 4 and 6, will need a total of eight additional facilities by 2032 to meet demand.





Region #	2025 Alt. Gap + SH Excess	2025 Potential Net-New Facility Need	2027 Alt. Gap + SH Excess	2027 Potential Net-New Facility Need	2032 Alt. Gap + SH Excess	2032 Potential Net-New Facility Need
1	14	1	19	0	27	0
2	21	1	24	0	30	0
3	72	3	76	0	87	1
4	10	0	12	1	13	0
5	2	0	1	0	4	0
6	6	0	8	0	13	1
Totals	125	5	140	1	174	2

Any decreases in gaps between periods are attributable to new capacity coming online

Assessment

The model suggests that Georgia will need **an additional eight facilities** (BHCCs with 24 CSU beds and 16 TempObs chairs) over the next 10-year period in order to meet growing demand for crisis beds. The timing and location of these new facilities will vary depending on region and service area:

- **Region 1:** 1 new facility by 2025
- Region 2: 1 new facility by 2025
- **Region 3:** 3 new facilities by 2025 and 1 additional facility by 2032
- Region 4: 1 new facility by 2027
- Region 5: no new facilities needed
- Region 6: 1 new facility by 2032

The model also suggests there is a material near-term need for most of these additional facilities: **five of the eight facilities are needed before 2025**.

This projected need assumes that Georgia is able to meet optimal occupancy for all of its existing facilities; **if this is not achieved**, **the number of needed additional beds and facilities will be greater**.

While creation of new BHCCs can reduce the use of state-contracted private hospital beds by 2025, Georgia will need to address temporary gaps before new facilities come online by continuing to use state-contracted private hospital beds in the short term. This also assumes that adjacent service areas with spare capacity can take on volume from service areas with an anticipated gap within the same region.

A region-by-region breakdown is presented in subsequent slides.

A new facility is assumed to be needed when a region's projected bed need is 50% or more of the bed capacity of a BHCC (i.e., 12 out of 24 beds).



Bed Projections | Adult Behavioral Health | Region 1 Overview

The need for additional beds in Region 1 varies significantly by service area: the Highland Rivers area has a consistently higher need for beds than Avita Community Partners, regardless of forecast (i.e., with or without "optimal" occupancy of 85%).

Gap for Region 1: Community Beds



● Future ADC ● Available Beds ● Forecasted Bed Need ● Forecasted Bed Need Alternative

SA #	SA Name	2025 Gap	2025 Alt. Gap	2027 Gap	2027 Alt. Gap	2032 Gap	2032 Alt. Gap
1	Lookout Mountain	Service area doesn't have any community beds; grouped w/ SA #2			′ SA #2		
2	Highland Rivers	41	15	43	17	49	21
3	Avita Community Partners	7	-6	8	-5	10	-4
5 Douglas		Service	e area doesn'	t have any co	mmunity bed	s; grouped w/	′ SA #2
Net Regional Gap		48	9	51	12	59	17

Gap for Region 1: Community + Excess State Hospital





SA #	SA Name	2025 Alt. Gap + SH Excess	2027 Alt. Gap + SH Excess	2032 Alt. Gap + SH Excess	
1	Lookout Mountain	Service area doesn't have any community		s; grouped w/ SA #2	
2	Highland Rivers	19 (+4 add'l beds)	22 (+5 add'l beds)	28 (+7 add'l beds)	
3	Avita Community Partners	-5 (+1 add'l bed)	-3 (+2 add'l beds)	-1 (+3 add'l beds)	
5 Douglas		Service area doesn'	t have any community bed	s; grouped w/ SA #2	
Net Regional Gap		14 (+5 add'l beds) 19 (+7 add'l beds)		27 (+10 add'l beds)	
= explore BHCC addition = new BHCC needed = no ne					

ALVAREZ & MARSAL

Bed Projections | Adult Behavioral Health | Region 1 Detail

Population growth, low occupancy rates, the need to reduce the use of state-contracted beds, and reallocated demand from state hospitals all impact bed need in Region 1. Even while staffing for optimal occupancy, a new facility will be needed by 2025.

Gap for Region 1: Community + Excess State Hospital



Net Regional Gap

14 (+5 add'l beds) 19 (+7 add'l beds) 27 (+10 add'l beds)

= explore BHCC addition = new BHCC needed

= no new BHCC needed

Assessment

Key Observations

Crisis bed need in Region 1 has three primary drivers:

- 1. Population growth (i.e., "demand" for crisis beds)
 - Region 1's 200% FPL adult population compound annual growth rate (CAGR) of 0.80% is higher than that of the state overall.
 - Statewide Georgia 200% FPL adult population CAGR: 0.68%.
- 2. Capacity-based factors (i.e., the "supply" of beds)
 - Current occupancy rates for each service area:
 - Avita Community Partners: 55%
 - Highland Rivers: 69%
 - These service areas contract for **the equivalent of 13 private hospital beds as of 2023**, a gap which is assumed to be addressed in the community going forward.
- 3. Excess demand from State Hospitals
 - Accounts for 5 beds in 2025; 7 beds in 2027; 10 beds in 2032.

Recommendations

Optimize staffing at facilities within these service areas to achieve optimal occupancy rates (85%) and decrease needed beds over the next 10-year period.

Immediate gaps in demand can be mitigated by addressing staffing issues, but the model suggests that an additional facility is still needed by 2025. This assumes that available capacity at Avita, or at state-contracted hospitals, can address the need in Highland Rivers in the interim.

A new BHCC facility built by 2025 **could be located in Highland Rivers**, potentially nearer to Atlanta to support possible spillover from that region; **or in Lookout Mountain or Douglas,** which currently have no crisis bed facilities.

A new facility is assumed to be needed when a region's projected bed need is 50% or more of the bed capacity of a BHCC (i.e., 12 out of 24 beds).

Bed Projections | Adult Behavioral Health | Region 2 Overview

The need for additional beds in Region 2 is concentrated primarily in the Advantage Behavioral Health service area, regardless of forecast (i.e., with or without "optimal" occupancy of 85%). Other areas have little to no immediate need.



Gap for Region 2: Community Beds

● Future ADC ● Available Beds ● Forecasted Bed Need ● Forecasted Bed Need Alternative

SA #	SA Name	2025 Gap	2025 Alt. Gap	2025 Alt. 2027 Gap 2 Gap G		2032 Gap	2032 Alt. Gap
10	Advantage Behavioral Health	70	70 35 72 37 78		78	41	
11	Serenity Behavioral Health	-7	-10	-7	-10	-7	-10
12	River Edge CSB	1	-7	1	-7	1	-7
13	Oconee CSB	Service	area doesn't	have any cor	nmunity beds	; grouped w/S	SA #23A
23B	CSB of Middle GA (Ogeechee)	Service area doesn't have any community beds; grouped w/SA #23A					
	Net Regional Gap	64 18 66 20 72 24					24

Gap for Region 2: Community + Excess State Hospital



SA #	SA Name	2025 Alt. Gap + SH Excess	2027 Alt. Gap + SH Excess	2032 Alt. Gap + SH Excess	
10	Advantage Behavioral Health	36 (+1 add'l beds)	39 (+2 add'l beds)	43 (+2 add'l beds)	
11	Serenity Behavioral Health	-9 (+1 add'l beds)	-9 (+1 add'l beds)	-8 (+2 add'l beds)	
12	River Edge CSB	-6 (+1 add'l beds)	-6 (+1 add'l beds)	-5 (+2 add'l beds)	
13	Oconee CSB	Service area doesn't	have any community beds,	grouped w/SA #23A	
23B	CSB of Middle GA (Ogeechee)	Service area doesn't have any community beds; grouped w/SA #			
Net Regional Gap		21 (+3 add'l beds)	24 (+4 add'l beds)	30 (+6 add'l beds)	
		= explore BHCC add	ition = new BHCC needed	= no new BHCC needed	

= explore BHCC addition

= no new BHCC needed

Bed Projections | Adult Behavioral Health | Region 2 Detail

Low occupancy rates and the need to reduce use of state-contracted beds, especially in the Advantage Behavioral Health area, are drivers of the capacity gap in Region 2. Even if occupancy is optimized, the model suggests a new facility will be needed by 2025.

Gap for Region 2: Community + Excess State Hospital



SA #	SA Name	2025 Alt. Gap + SH Excess	2027 Alt. Gap + SH Excess	2032 Alt. Gap + SH Excess	
10	Advantage Behavioral Health	36 (+1 add'l beds)	39 (+2 add'l beds)	43 (+2 add'l beds)	
11	Serenity Behavioral Health	-9 (+1 add'l beds)	-9 (+1 add'l beds)	-8 (+2 add'l beds)	
12	River Edge CSB	-6 (+1 add'l beds)	-6 (+1 add'l beds)	-5 (+2 add'l beds)	
13	Oconee CSB	Service area doesn't	have any community beds,	; grouped w/SA #23A	
23B	CSB of Middle GA (Ogeechee)	Service area doesn't	have any community beds,	; grouped w/SA #23A	
Net Regional Gap		21 (+3 add'l beds)	24 (+4 add'l beds)	30 (+6 add'l beds)	
		= explore BHCC addit	tion = new BHCC needed	= no new BHCC needed	

Assessment

Key Observations

Crisis bed need in Region 2 has three primary drivers:

- Population growth (i.e., "demand" for crisis beds)
 - Region 2's 200% FPL adult population compound annual growth rate (CAGR) of 0.62% is slightly lower than that of the state overall.
 - Statewide Georgia 200% FPL adult population CAGR: 0.68%.
- 2. Capacity-based factors (i.e., the "supply" of beds)
 - Current occupancy rates for each service area:
 - Advantage Behavioral Health: 55%
 - Serenity Behavioral Health: 69%
 - River Edge CSB: 63%
 - These service areas contract for **the equivalent of 37 private hospital beds as of 2023**, a gap which is assumed to be addressed in the community going forward.
- 3. Excess demand from State Hospitals
 - Accounts for 3 beds in 2025; 4 beds in 2027; 6 beds in 2032.

Recommendations

Optimize staffing at facilities within these service areas to achieve optimal occupancy rates (85%) and decrease needed beds over the next 10-year period.

Immediate gaps in demand can be mitigated by addressing staffing issues, but the model suggests that an additional facility is still needed by 2025. This assumes that available capacity at Serenity, River Edge, or at state-contracted hospitals can address the need in Advantage in the interim.

A new BHCC facility built by 2025 **could be located in Advantage**, potentially nearer to Atlanta to support possible spillover from that region; **or in Oconee or Middle GA (Ogeechee)**, which currently have no crisis bed facilities.

A new facility is assumed to be needed when a region's projected bed need is 50% or more of the bed capacity of a BHCC (i.e., 12 out of 24 beds).



Bed Projections | Adult Behavioral Health | Region 3 Overview

The need for additional beds is widespread across Region 3, with the greatest need in the DeKalb area. Fulton is significantly over capacity and should be returned to sustainable levels. Only the Clayton area has a moderate need for additional beds.



Gap for Region 3: Community Beds

● Future ADC ● Available Beds ● Forecasted Bed Need ● Forecasted Bed Need Alternative

SA #	SA Name	2025 Gap	2025 Alt. Gap	2027 Gap 2027 Alt. Gap		2032 Gap	2032 Alt. Gap
6	Fulton County	-3	17	-2	18	0	21
7	Clayton CSB	9	9	9	9	10	10
8	DeKalb CSB	60	33	61	34	64	36
9	View Point Health (GRN CSB)	23	6	24	6	26	8
	Net Regional Gap	89	65	92	67	100	75

Gap for Region 3: Community + Excess State Hospital



SA #	SA Name	2025 Alt. Gap + SH Excess	2027 Alt. Gap + SH Excess	2032 Alt. Gap + SH Excess	
6	Fulton County	19 (+2 add'l beds)	21 (+3 add'l beds)	25 (+4 add'l beds)	
7	Clayton CSB	10 (+1 add'l beds)	10 (+1 add'l beds)	11 (+1 add'l beds)	
8	DeKalb CSB	35 (+2 add'l beds)	36 (+2 add'l beds)	39 (+3 add'l beds)	
9	View Point Health (GRN CSB)	8 (+2 add'l beds)	9 (+3 add'l beds)	12 (+4 add'l beds)	
Ne	t Regional Gap	72 (+7 add'l beds)	76 (+9 add'l beds)	87 (+12 add'l beds)	
		= explore BHCC addit	ion = new BHCC needed	= no new BHCC needed	

Bed Projections | Adult Behavioral Health | Region 3 Detail

The need for additional beds in Region 3 is acute. Occupancy rates, the need to reduce use of state-contracted beds, and the growing Atlanta population are major drivers. Staffing to allow for optimal occupancy will mitigate the number of new beds needed.

Gap for Region 3: Community + Excess State Hospital



SA #	SA Name	2025 Alt. Gap + SH Excess		2027 Alt. Gap + SH Excess		2032 Alt. Gap + SH Excess		
6	Fulton County	19 (+2 add'l beds)		21 (+3 add'l beds)		25 (+4 add'l beds)		
7	Clayton CSB	10 (+1 a	dd'l beds)	10 (+1 add'l beds)		11 (+1 add'l beds)		
8	DeKalb CSB	35 (+2 a	35 (+2 add'l beds)		36 (+2 add'l beds)		(+3 add'l beds)	
9	View Point Health (GRN CSB)	8 (+2 ad	8 (+2 add'l beds)		9 (+3 add'l beds)		(+4 add'l beds)	
Net Regional Gap 72 (+7		72 (+7 a	7 add'l beds) 76		76 (+9 add'l beds)		87 (+12 add'l beds)	
			= explore BHCC add	dition	= new BHCC needed		= no new BHCC needed	

Assessment

Key Observations

Crisis bed need in Region 3 has three primary drivers:

- Population growth (i.e., "demand" for crisis beds)
 - Region 3's 200% FPL adult population compound annual growth rate (CAGR) of 0.87% is higher than that of the state overall.
 - Statewide Georgia 200% FPL adult population CAGR: 0.68%.
- 2. Capacity-based factors (i.e., the "supply" of beds)
 - Current occupancy rates for each service area:
 - Fulton County: 133% (Fulton's optimal occupancy rate may be >85% but still <100%)
 - Clayton CSB: N/A (Clayton does not have non-SCB facilities)
 - DeKalb CSB: 61%
 - View Point Health (GRN CSB): 53%
 - These service areas contract for **the equivalent of 62 private hospital beds as of 2023**, a gap which is assumed to be addressed in the community going forward.
- 3. Excess demand from State Hospitals
 - Accounts for 7 beds in 2025; 9 beds in 2027; 12 beds in 2032.

Recommendations

Optimize staffing at facilities within these service areas to achieve optimal occupancy rates (85%) and decrease needed beds over the next 10-year period.

Immediate gaps in demand can be mitigated by addressing staffing issues, but the model suggests that three additional facilities are still needed by 2025 and another by 2032. This assumes available capacity at state-contracted hospitals can address regional need in the interim.

All three BHCC facilities could be located in Fulton and DeKalb, in the metropolitan Atlanta area.

A new facility is assumed to be needed when a region's projected bed need is 50% or more of the bed capacity of a BHCC (i.e., 12 out of 24 beds).

Bed Projections | Adult Behavioral Health | Region 4 Overview

The need for additional crisis beds is relatively consistent across the three service areas of Region 4. No one service area has a significantly greater need than any other, through the region as a whole has a moderate need. Both Aspire Behavioral Health and Behavioral Health Svcs of So. GA are operating above the target occupancy of 85%.



Gap for Region 4: Community Beds

● Future ADC ● Available Beds ● Forecasted Bed Need ● Forecasted Bed Need Alternative

SA #	SA Name	2025 Gap	2025 Alt. Gap	2027 Gap 2027 Alt. Gap		2032 Gap	2032 Alt. Gap
20	Aspire Behavioral Health (Albany Area CSB)	0	1	0	1	0	1
21	Georgia Pines	3	2	3	2	3	2
22	Behavioral Health Svcs of So. GA	4	6	4	6	5	7
	Net Regional Gap	7	9	7	9	8	10

Gap for Region 4: Community + Excess State Hospital



SA#	SA Name	2025 Alt. Gap + SH Excess	2027 Alt. Gap + SH Excess	2032 Alt. Gap + SH Excess	
20	Aspire Behavioral Health (Albany Area CSB)	1 (+0 add'l beds)	2 (+1 add'l beds)	2 (+1 add'l beds)	
21	Georgia Pines	2 (+0 add'l beds)	3 (+1 add'l beds)	3 (+1 add'l beds)	
22	Behavioral Health Svcs of So. GA	7 (+1 add'l beds)	7 (+1 add'l beds)	8 (+1 add'l beds)	
Ne	t Regional Gap	10 (+1 add'l beds)	12 (+3 add'l beds)	13 (+3 add'l beds)	

= explore BHCC addition = new BHCC needed

= no new BHCC needed

There is no immediate need for additional bed capacity in Region 4. New capacity built in recent years, combined with relatively low population growth, has helped address demand. A new facility will likely be required by 2027, however.

Gap for Region 4: Community + Excess State Hospital





SA #	SA Name	2025 Alt. Gap + SH Excess	2027 Alt. Gap + SH Excess	2032 Alt. Gap + SH Excess	
20	Aspire Behavioral Health (Albany Area CSB)	1 (+0 add'l beds)	2 (+1 add'l beds)	2 (+1 add'l beds)	
21	Georgia Pines	2 (+0 add'l beds)	3 (+1 add'l beds)	3 (+1 add'l beds)	
22	Behavioral Health Svcs of So. GA	7 (+1 add'l beds)	7 (+1 add'l beds)	8 (+1 add'l beds)	
Net Regional Gap		10 (+1 add'l beds)	12 (+3 add'l beds)	13 (+3 add'l beds)	
= explore BHCC addition = new BHCC needed				= no new BHCC needed	

Assessment

Key Observations

Crisis bed need in Region 4 has three primary drivers:

- 1. Population growth (i.e., "demand" for crisis beds)
 - Region 4's 200% FPL adult population compound annual growth rate (CAGR) of 0.21% is lower than that of the state overall.
 - Statewide Georgia 200% FPL adult population CAGR: 0.68%.
- 2. Capacity-based factors (i.e., the "supply" of beds)
 - Current occupancy rates for each service area:
 - Aspire Behavioral Health (Albany Area CSB): 87%
 - Georgia Pines: 83%
 - Behavioral Health Svcs of So. GA: 91%
 - These service areas contract for **the equivalent of 4 private hospital beds as of 2023**, a gap which is assumed to be addressed in the community going forward.
- 3. Excess demand from State Hospitals
 - Accounts for 1 beds in 2025; 3 beds in 2027; 3 beds in 2032.

Recommendations

The model suggests that an additional facility is needed by 2027. Although projected bed need from any one service area in Region 4 is not acute enough within the next 10 years to require an additional facility, the total need across the region may justify an additional facility. Because occupancy rates in these service areas are already close to or above 85%, further optimizing staffing at facilities will likely not decrease the needed beds over the next 10-year period.

A new BHCC facility built by 2027 **could be located in any service area in Region 4**, potentially close to the center of the region to best service the entire region's population.

A new facility is assumed to be needed when a region's projected bed need is 50% or more of the bed capacity of a BHCC (i.e., 12 out of 24 beds).

Bed Projections | Adult Behavioral Health | Region 5 Overview

The need for additional crisis beds is relatively consistent across the four service areas of Region 5. With optimal occupancy (85%) and additional capacity coming online by 2026, no service area has a material need for additional beds.



Gap for Region 5: Community Beds

● Future ADC ● Available Beds ● Forecasted Bed Need ● Forecasted Bed Need Alternative

SA #	SA Name	2025 Gap	2025 Alt. Gap	2027 Gap	2027 Alt. Gap	2032 Gap	2032 Alt. Gap
23A	CSB of Middle GA	-1	-1	-5	-5	-5	-5
24	Pineland Area CSB	6	-1	6	-1	7	0
25	Unison Behavioral Health (Satilla CSB)	2	1	2	1	2	1
26	Gateway CSB	4	0	5	1	7	3
	Net Regional Gap	11	-1	8	-4	11	-1

Gap for Region 5: Community + Excess State Hospital







SA #	SA Name	2025 Alt. Gap + SH Excess	2027 Alt. Gap + SH Excess	2032 Alt. Gap + SH Excess
23A	CSB of Middle GA	0 (+1 add'l beds)	-4 (+1 add'l beds)	-4 (+1 add'l beds)
24	Pineland Area CSB	0 (+1 add'l beds)	0 (+1 add'l beds)	1 (+1 add'l beds)
25	Unison Behavioral Health (Satilla CSB)	1 (+0 add'l beds)	2 (+1 add'l beds)	2 (+1 add'l beds)
26	Gateway CSB	1 (+1 add'l beds)	3 (+2 add'l beds)	5 (+2 add'l beds)
Net Regional Gap		1 (+5 add'l beds)	4 (+5 add'l beds)	
		= explore BHCC addi	tion = new BHCC needed	= no new BHCC needed

There is no clear need for additional capacity in Region 5 over the next 10-year period, assuming need can be met by service areas with capacity or through state-contracted beds. Additional beds would reduce state-contracted bed use, however.

Gap for Region 5: Community + Excess State Hospital







SA #	SA Name	2025 Alt. Gap + SH Excess		2027 Alt. Gap + SH Excess		2032 Alt. Gap + SH Excess		
23A	CSB of Middle GA	0 (+1 add'l beds)		-4 (+1 add'l beds)		-4	(+1 add'l beds)	
24	Pineland Area CSB	0 (+1 add'	0 (+1 add'l beds)		0 (+1 add'l beds)		1 (+1 add'l beds)	
25	Unison Behavioral Health (Satilla CSB)	1 (+0 add'l	1 (+0 add'l beds)		2 (+1 add'l beds)		(+1 add'l beds)	
26	Gateway CSB	1 (+1 add'	l beds)	3 (+2 add'l beds)		5	(+2 add'l beds)	
Net Regional Gap		2 (+3 add'	l beds)	1 (+5 a	add'l beds)	4	(+5 add'l beds)	
= e		explore BHCC addition	on	= new BHCC needed		= no new BHCC needed		

Assessment

Key Observations

Crisis bed need in Region 5 has three primary drivers:

- 1. Population growth (i.e., "demand" for crisis beds)
 - Region 5's 200% FPL adult population compound annual growth rate (CAGR) of 0.49% is lower than that of the state overall.
 - Statewide Georgia 200% FPL adult population CAGR: 0.68%.
- 2. Capacity-based factors (i.e., the "supply" of beds)
 - Current occupancy rates for each service area:
 - CSB of Middle GA: 86%
 - Pineland Area CSB: 52%
 - Unison Behavioral Health (Satilla CSB): 81%
 - Gateway CSB: 79%
 - These service areas contract for **the equivalent of 6 private hospital beds as of 2023**, a gap which is assumed to be addressed in the community going forward.
- 3. Excess demand from State Hospitals
 - Accounts for 3 beds in 2025; 5 beds in 2027; 5 beds in 2032.

Recommendations

Optimize staffing at facilities within the Unison, Gateway, and Pineland service areas to achieve optimal occupancy rates (85%) and decrease needed beds over the next 10-year period. Optimizing Pineland may be particularly impactful as its current occupancy rate is well below 85%.

Immediate gaps in demand can be mitigated by addressing staffing issues, and the model suggests that no additional facility is needed through 2032. This assumes that Pineland, Unison, and Gateway can maintain an occupancy rate above 85% and that Middle GA, or state-contracted hospitals, can address need in the other service areas in the interim.

A new facility is assumed to be needed when a region's projected bed need is 50% or more of the bed capacity of a BHCC (i.e., 12 out of 24 beds).

Bed Projections | Adult Behavioral Health | Region 6 Overview

The need for additional beds in Region 6 is concentrated mostly in the Pathways and McIntosh Trail areas. Optimal occupancy rates (85%), however, would materially reduce the need for additional beds in all four service areas.



Gap for Region 6: Community Beds

● Future ADC ● Available Beds ● Forecasted Bed Need ● Forecasted Bed Need Alternative

SA #	SA Name	2025 Gap	2025 Alt. Gap	2027 Gap	2027 Alt. Gap	2032 Gap	2032 Alt. Gap
15	Pathways	25	18	26	19	28	21
16	McIntosh Trail	13	1	14	2	16	3
17	New Horizons CSB	6	-13	6	-13	7	-12
18	Middle Flint	5	-4	5	-4	6	-4
	Net Regional Gap	49	2	51	4	57	8

Gap for Region 6: Community + Excess State Hospital



SA #	SA Name	2025 Alt. Gap + SH Excess	2027 Alt. Gap + SH Excess	2032 Alt. Gap + SH Excess
15	Pathways	19 (+1 add'l beds)	20 (+1 add'l beds)	22 (+1 add'l beds)
16	McIntosh Trail	2 (+1 add'l beds)	3 (+1 add'l beds)	5 (+2 add'l beds)
17	New Horizons CSB	-12 (+1 add'l beds)	-12 (+1 add'l beds)	-11 (+1 add'l beds)
18	Middle Flint	-3 (+1 add'l beds)	-3 (+1 add'l beds)	-3 (+1 add'l beds)
Net Regional Gap 6 (+		6 (+4 add'l beds)	8 (+4 add'l beds)	13 (+5 add'l beds)
		= explore BHCC addit	tion = new BHCC needed	= no new BHCC needed

Low occupancy rates and the need to reduce use of state-contracted beds are the primary drivers of need in Region 6, especially within the Pathways service area. Optimizing occupancy rates would delay the need for an additional facility until closer to 2032.

Gap for Region 6: Community + Excess State Hospital







SA #	SA Name	2025 Alt. Gap + SH Excess Excess Excess		2032 Alt. Gap + SH Excess	
15	Pathways	19 (+1 add'l beds)	20 (+1 add'l beds)	22 (+1 add'l beds)	
16	McIntosh Trail	2 (+1 add'l beds)	3 (+1 add'l beds)	5 (+2 add'l beds)	
17	New Horizons CSB	-12 (+1 add'l beds) -12 (+1 add'l beds)		-11 (+1 add'l beds)	
18	Middle Flint	-3 (+1 add'l beds)	-3 (+1 add'l beds)	-3 (+1 add'l beds)	
Net Regional Gap 6 (+		6 (+4 add'l beds)	8 (+4 add'l beds)	13 (+5 add'l beds)	
		= explore BHCC ad	ldition = new BHCC needed	= no new BHCC needed	

Assessment

Key Observations

Crisis bed need in Region 6 has three primary drivers:

- 1. Population growth (i.e., "demand" for crisis beds)
 - Region 6's 200% FPL adult population compound annual growth rate (CAGR) of 0.58% is lower than that of the state overall.
 - Statewide Georgia 200% FPL adult population CAGR: 0.68%.
- 2. Capacity-based factors (i.e., the "supply" of beds)
 - Current occupancy rates for each service area:
 - Pathways: 74%
 - McIntosh Trail: 57%
 - New Horizons CSB: 48%
 - Middle Flint: 41%
 - These service areas contract for the equivalent of 20 private hospital beds as of 2023, a gap which is assumed to be addressed in the community going forward.
- 3. Excess demand from State Hospitals
 - Accounts for 4 beds in 2025; 4 beds in 2027; 5 beds in 2032.

Recommendations

Optimize staffing at facilities within these service areas to achieve optimal occupancy rates (85%) and decrease needed beds over the next 10-year period.

Immediate gaps in demand can be mitigated by addressing staffing issues, but the model suggests that an additional facility is still needed by 2032. This assumes that available capacity at New Horizons and Middle Flint, or at state-contracted hospitals, can address the need in Pathways and McIntosh in the interim. If not, an additional facility may be needed before 2032.

A new BHCC facility built by 2032 **could be located between Pathways and McIntosh**, which is close to the greater metropolitan Atlanta area.

A new facility is assumed to be needed when a region's projected bed need is 50% or more of the bed capacity of a BHCC (i.e., 12 out of 24 beds).



The distribution of TempObs chairs varies by region and the reporting of TempObs encounters is not complete. Current reported data shows TempObs chairs are underutilized but remain a critical diversionary / evaluation measure in Georgia's crisis system.

Statewide Gap: TempObs



● Future ADC ● Available Beds ● Forecasted Bed Need ● Forecasted Bed Need Alternative

Region #	2025 Gap	2025 Alt. Gap	2027 Gap	2027 Alt. Gap	2032 Gap	2032 Alt. Gap
1	1	-20	1	-20	2	-20
2	1	-16	1	-16	2	-16
3	-15	-30	-14	-30	-13	-29
4	1	-10	1	-10	2	-10
5	1	-16	1	-16	2	-16
6	1	-17	1	-17	2	-17
Net Statewide Gap	-10	-109	-9	-109	-3	-108
		= explo	re BHCC addition	= new BHCC r	needed = no	new BHCC needed

Assessment

Key Observations

TempObs chair need across the state has two primary drivers:

1. Population growth (i.e., "demand" for TempObs chairs) by region:

Region #	1	2	3	4	5	6
2023-2032 CAGR of 200% FPL Adults	0.80%	0.62%	0.88%	0.21%	0.49%	0.58%

- Statewide Georgia 200% FPL adult population CAGR: 0.68%.
- 2. Capacity-based factors (i.e., the "supply" of beds)
 - Current occupancy rates for each region :

Region	1	2	3	4	5	6
2022 Occupancy	0%	1%	40%	32%	5%	1%

Recommendations

Optimize staffing at TempObs facilities to achieve optimal occupancy (85%) and ensure current capacity meets forecast plus unidentified demand for TempObs chairs over the next 10-year period.

Based on current data, under optimal staffing conditions, the model does not suggest any shortage in capacity of TempObs chairs in the state. TempObs appears to be an underutilized resource, potentially driven by underreporting of episodes and staffing decisions to divert resources to CSU beds within BHCCs.

Measures should be taken to encourage and incentivize usage of TempObs chairs as a diversionary measure when patient level of need matches the TempObs level of care (i.e., lower acuity patients in crisis, including those currently served in state hospital TempObs beds). As free-standing CSUs continue to be converted to BHCCs and new BHCCs are developed in areas where capacity gaps are projected, TempObs should be leveraged for maximum diversionary impact.

A new facility is assumed to be needed when a region's projected TempObs need is 50% or more of the capacity of a BHCC (i.e., 8 out of 16 chairs).



Bed Projections | Child & Adolescent Behavioral Health

While there is no need for a new facility to be built when viewed on a statewide basis (assuming no unmet need), building one would minimize the use of state-contracted private hospitals and serve children and adolescents closer to where they live.

Statewide Gap: Child & Adolescent





Region #	2025 Gap	2025 Alt. Gap	2027 Gap	2027 Alt. Gap	2032 Gap	2032 Alt. Gap
1	1	1	1	1	1	1
2	16	-1	16	-1	17	-1
3	39	9	40	9	43	10
4	1	1	1	1	1	1
5	1	-2	2	-2	2	-1
6	0	-4	0	-4	1	-4
Net Statewide Gap	58	4	60	4	65	6

= explore CSU addition

```
= no new CSU needed
```

= new CSU needed

Assessment

Key Observations

Crisis bed need across the state has two primary drivers:

1. Population growth (i.e., "demand" for crisis beds) by region:

Region #	1	2	3	4	5	6
2023-2032 CAGR of 200% FPL C&A	0.74%	0.50%	0.87%	0.47%	0.35%	0.87%

Statewide Georgia 200% FPL C&A population CAGR: 0.68%.

2. Capacity-based factors (i.e., the "supply" of beds)

Current occupancy rates and SCB equivalents for each region and / or facility:

Region Facility	1 <i>N/A</i>	2 River Edge	3 DeKalb	4 N/A	5 Gateway	6 Pathways
2022 Occupancy	N/A ¹	39%	38%	N/A ¹	69%	62%
2023 SCB Equiv.	1	4	1	1	1	2

1. Regions 1 and 4 do not have non-SCB facilities, and thus no occupancy rate is available.

Recommendations

Optimize staffing at dedicated C&A facilities to achieve optimal occupancy rates (85%) and maximize the impact of current capacity over the next 10-year period.

Immediate gaps in demand can be mitigated by addressing staffing issues in every region aside from Region 3. This assumes that available capacity in Regions 2, 5, and 6, or at state-contracted private hospitals, can address the need from Regions 1, 3, and 4 in the interim.

The model suggests a **moderate need for a new C&A CSU facility to be built in Region 3**, particularly if the goal is to minimize use of state-contracted private hospitals and serve children and adolescents in crisis closer to where they live. Such a facility could be located closer to Region 1 in order to provide flexibility in serving the need from that region.

Alternatively, DBHDD could convert an existing CSU to a BHCC, which would also expand crisis bed capacity and services.

A new facility is assumed to be needed when a region's projected bed need is 50% or more of the bed capacity of a CSU (i.e., 8 out of 16 beds).



Bed Projections | Forensic | State Hospital

There is an immediate need for additional forensic state hospital beds at all facilities. This need would be mitigated by achieving optimal occupancy (95%), but it is still significant and suggests the opportunity to use other strategies to manage demand.

Statewide Gap: State Hospital Forensic



● Future ADC ● Available Beds ● Forecasted Bed Need ● Forecasted Bed Need Alternative

Region #	2025 Gap	2025 Alt. Gap	2027 Gap	2027 Alt. Gap	2032 Gap	2032 Alt. Gap		
1	R	Region doesn't have any state hospitals; distributed amongst Regions 2, 3, 5, 6						
2	44	31	50	36	62	48		
3	74	38	78	40	86	47		
4	R	egion doesn't have	any state hospitals	; distributed among	gst Regions 2, 3, 5,	6		
5	41	22	44	24	50	30		
6	33	28	37	32	45	40		
Net Statewide Gap	192	119	209	132	243	165		

Assessment

Key Observations

State hospital forensic bed need across the state has two primary drivers:

1. Population growth (i.e., "demand" for State Hospital forensic beds) by region:

Region #	1	2	3	4	5	6
2023-2032 CAGR of All Adults	N/A	0.76%	0.94%	N/A	0.50%	0.69%

- Statewide Georgia adult general population CAGR: 0.78%.
- 2. Capacity-based factors (i.e., the "supply" of beds)
 - Current occupancy rates for each region :

Region	1	2	3	4	5	6
2022 Occupancy	N/A	91%	77%	N/A	83%	92%

Recommendations

Optimize staffing at facilities across the state to achieve optimal occupancy rates (95%) and decrease the number of needed forensic beds over the next 10-year period.

Based on current trends (including a known waiting list that has been growing for several years), there is immediate need for additional forensic beds at all state hospitals, even if optimal staffing conditions (95% occupancy rate) are met. This bed shortage will only continue to grow in the next ten years if action is not taken to address it.

It is possible that as state hospital behavioral health patients are diverted to and served at community facilities, excess state hospital AMH beds may be converted to state hospital forensic beds. This would help meet state hospital forensic bed need without creating new beds. At the same time, increasing resources to reevaluate individuals on the waitlist and / or expanding jail-based competency restoration programs could also decrease demand for forensic beds. Increasing the utilization of forensic step-down facilities – i.e., Community Integration Homes and Forensic Apartments – may also decrease demand for forensic beds.

Bed Projections | Forensic | Community Integration Homes (CIH)

Existing CIH capacity is sufficient to address projected bed need over the next 10 years if optimal occupancy rates (95%) are achieved. Improving occupancy, especially in Region 6, would ensure there is a surplus rather than a shortage of capacity.

Statewide Gap: CIH



Region #	2025 Gap	2025 Alt. Gap	2027 Gap	2027 Alt. Gap	2032 Gap	2032 Alt. Gap
1	-5	-5	-4	-5	-4	-4
2	2	-1	3	-1	3	0
3	1	1	2	1	2	1
4	3	0	3	0	4	1
5	1	0	1	0	1	0
6	8	-2	8	-2	9	-2
Net Statewide Gap	10	-8	13	-7	15	-4
				= new CIH need	ied = no r	new CIH needed

Assessment

Key Observations

CIH need across the state has two primary drivers:

- 1. Population growth (i.e., "demand" for CIHs) by region¹:
 - Statewide Georgia adult general population CAGR: 0.78%.
- 2. Capacity-based factors (i.e., the "supply" of beds)
 - Current occupancy rates for each region :

Region	1	2	3	4	5	6
2022 Occupancy	94%	76%	83%	72%	80%	45%

Recommendations

Optimize staffing at facilities outside of Region 1 to achieve optimal occupancy rates (95%) and decrease needed CIH beds over the next 10-year period.

Based on current trends, under optimal staffing conditions the model does not suggest any shortage in capacity of CIHs in the state. This assumes that the capacity gap in Region 3 can be addressed by diverting individuals to other regions with spare capacity. At their current 2022 occupancy rates, Regions 2, 3, 4, 5, and especially 6 would all require additional capacity by 2025. However, except for Region 3 capacity in these regions would be sufficient at optimal occupancy.

Potential bed demand in Region 3 that exceeds current capacity may be addressed in Region 1 or Region 6, which would have excess capacity at a 95% occupancy rate.

A review and assessment of unused CIH beds (assuming optimal occupancy) may be merited. Increased use of CIH beds, when appropriate, may help to alleviate the demand on state hospital forensic beds.

A new facility is assumed to be needed when a region's projected CIH bed need is 1 or greater.

1. Population of interest for forensic stepdown is the total statewide adult general population and does not vary by region, unlike other pathways, e.g.: adult behavioral health, because of data limitations. Additionally, forensic stepdown patients can access these facilities across the state regardless of their originating location.



Bed Projections | Forensic | Forensic Apartments

Existing forensic apartment capacity is sufficient to address projected need over the next 10 years if occupancy rates (95%) are achieved. Improving operating efficiency in Regions 4 and 5 would ensure there is a surplus, rather than a shortage of capacity.

Statewide Gap: Forensic Apartments



Region #	2025 Gap	2025 Alt. Gap	2027 Gap	2027 Alt. Gap	2032 Gap	2032 Alt. Gap
1		Reg	ion does not have a	any forensic apartm	nents	
2	-2	-4	-2	-4	-1	-4
3	Region does not have any forensic apartments					
4	17	-7	18	-7	20	-6
5	2	-3	2	-3	3	-2
6		Region does not have any forensic apartments				
Net Statewide Gap	17	-14	18	-14	22	-12
				= new FA neede	ed = no r	new FA needed

Assessment

Key Observations

Forensic apartment need across the state has two primary drivers:

- Population growth (i.e., "demand" for forensic apartments) by region¹:
 Statewide Georgia adult general population CAGR: 0.78%.
- 2. Capacity-based factors (i.e., the "supply" of beds)
 - Current occupancy rates for each region :

Region	1	2	3	4	5	6
2022 Occupancy	N/A	83%	N/A	40%	68%	N/A

Recommendations

Optimize turnover (i.e., occupancy of forensic apartment units, which is generally independent of staffing levels) between residents at facilities across the state to achieve optimal occupancy rates (95%) and decrease needed beds over the next 10-year period.

Based on current trends, under optimal turnover conditions the model does not suggest any shortage in capacity of forensic apartments in the state. At their current 2022 occupancy rates, Regions 4 and 5 would require significant additional capacity by 2025. At optimal occupancy rates, there would be a comfortable excess in capacity in these regions.

A review and assessment of unused forensic apartment beds (assuming optimal occupancy) may be merited. Increased use of forensic apartment beds, when appropriate, may help to alleviate the demand on state hospital forensic beds.

A new facility is assumed to be needed when a region's projected FA bed need is 1 or greater.

1. Population of interest for forensic stepdown is the total statewide adult general population and does not vary by region, unlike other pathways, e.g.: adult behavioral health, because of data limitations. Additionally, forensic stepdown patients can access these facilities across the state regardless of their originating location.





Model Scenario Exploration



The bed projection model was deigned to offer flexibility that allows DBHDD to illustrate the evolution of demand for behavioral health crisis and forensic beds. These flexibilities impact bed projections and may produce different results from those above.

Model Flexibilities and Examples

Real-time Service Area or Region Adjustment of Demand

The visualizations for each pathway (i.e., charts, tables, and maps) offer the ability to adjust future demand up or down from the baseline established in the model (-50% to 50% in 5%-point increments). Adjusting demand may allow for illustration of several potential future scenarios, such as:

1. The use of 988 services allows DBHDD to better serve unmet need in the community, representing a potentially sizeable increase in demand for services. In each visualization within the model, a user could adjust the demand by up to 50% to look at the impact on future bed need. (See 988 example on the next page.)

New Facilities, New Utilization, New Population Data

Users of the model can add facilities as they come online, capture additional episodes of care, and refine the population-based projections with new information as it becomes available. New facilities can be added to the Facilities Table to increase the number of future available beds; new episodes of care can be added to the CrisisEpisodes Table to increase utilization and use rates; and new population projections can be used in place of the baseline data to refine the basis for future bed projections.

Detailed Facility Demand Adjustments

Users can also adjust demand on a facility-by-facility basis from the baseline established in the model. Adjusting demand in this fashion may allow for illustration of several potential future scenarios, such as:

1. A BHCC is projected to more effectively utilize its TempObs beds and divert more patients away from the crisis system. A user could adjust the facility-specific use rate multiplier, which sits in a data table that feeds the model, to account for the new diversion. Rather than its original use rate multiplier of 1x, the facility could have a use rate multiplier of 0.95x.

Detailed Facility Occupancy Adjustments

The defined occupancy targets (i.e., 85% for behavioral health community beds, etc.) may not be obtainable by all facilities. On a facility-by-facility basis, DBHDD could revise target occupancy based on the unique realities facing each facility. Adjusting occupancy in this fashion may allow for illustration of several potential future scenarios, such as:

- 1. A facility is currently at 55% occupancy. Based on efforts between the state and service providers, it is anticipated that the facility could reach 75% occupancy given workforce limitations. This lower occupancy target could be loaded into the model for this facility.
- 2. A facility has demonstrated a historical ability to maintain an occupancy rate of 90%; the alternative occupancy could be set to this level.

If the model is adjusted to reflect a hypothetical 50% increase in demand driven by 988, the model would project a 27-facility gap by 2025. Existing data does not suggest this scenario is likely; it is shown here only as an illustration of model capabilities.

Current Model Scenario



A 50% increase in future demand could increase the need for new facilities across every region and almost every service area. Under this scenario, the model suggests Georgia would need **an additional 29 facilities over the next 10-year period (with 27 of these needed by 2025)** compared to the model's baseline projections, which are more supported by existing data.

- Region 1: 5 new facilities by 2025 and 1 additional facility by 2032
- Region 2: 4 new facilities by 2025
- Region 3: 9 new facilities by 2025
- Region 4: 3 new facilities by 2025
- Region 5: 3 new facilities by 2025
- **Region 6:** 3 new facilities by 2032 and 1 additional facility by 2032

This scenario is hypothetical and demonstrates a dramatic increase in demand for illustrative purposes. Further study of 988's potential impact is recommended.

50% Increase Scenario



Region #	2025 Alt. Gap + SH Excess	2025 Potential New Facility Need	2027 Alt. Gap + SH Excess	2027 Potential New Facility Need	2032 Alt. Gap + SH Excess	2032 Potential New Facility Need
1	14	1	19	0	27	0
2	21	1	24	0	30	0
3	72	3	76	0	87	1
4	10	0	12	1	13	0
5	2	0	1	0	4	0
6	6	0	8	0	13	1
Totals	125	5	140	1	174	2

Any decreases in gaps between periods are attributable to new capacity coming online

Region #	2025 Alt. Gap + SH Excess	2025 Potential New Facility Need	2027 Alt. Gap + SH Excess	2027 Potential New Facility Need	2032 Alt. Gap + SH Excess	2032 Potential New Facility Need
1	124	5	130	0	144	1
2	95	4	98	0	107	0
3	205	9	209	0	227	0
4	66	3	67	0	70	0
5	73	3	72	0	79	0
6	80	3	81	0	90	1
Totals	643	27	657	0	717	2



Peer State Comparison



The historical decline in state psychiatric hospital bed count, and a simultaneous increase in reliance on private psychiatric hospitals to meet demand, is a national trend and not unique to Georgia.

Trends

Large numbers of state psychiatric beds have been removed nationally since 1970. Since 2010, while the number of patients at state psychiatric hospitals has continued its downward trend, the number of private psychiatric hospital patients has doubled, reflecting a shift towards reliance on private hospitals to provide psychiatric care.

Sources

From table created by NRI (Table 6, p. 26), historical data from:

- 1970 to 1979 data from NIMH Surveys;
- 1983 to 2002 data from NIMH and SAMHSA Inventory of Mental Health Organization Surveys; and
- 2010 to 2020 from SAMHSA N-MHSS Surveys.

People are far less likely to be a patient in an inpatient or residential setting today than they were in 1970. Recent figures from 2018 show an inpatient census (excluding "other residential") that is 20% of what it was fifty years ago.

Source

Data from <u>table created by NRI</u> (Table 7, p. 27) using historical data from NIMH, SAMHSA, and SAMHSA N-MHSS.

By the Numbers



Rates per 100k Population, 1970 vs. 2018

■Other Residential ■General Hosp. ■Private Hosp. ■State Hosp.



Impact / Considerations

In recent decades states have focused on moving from state hospitals to community-based care and private hospitals. Despite an identified need for more inpatient capacity, policies have tended to focus on reducing risk of institutionalization (e.g., IMD exclusion policy restricting federal Medicaid reimbursement; HCBS settings final rule that tightens the definitions of restricted institutional practices). This general decrease in state psychiatric beds is often cited as a driver of increased homelessness and incarceration nationally.

State hospitals experienced the most significant decrease in patients per 100k population, in line with the general decrease in state hospital beds. To support ongoing demand for inpatient care, both general hospitals and private hospitals have increased the number of patients served. It is not clear in all cases that the increase in private capacity has been sufficient to fill the gap created by the loss of state hospital beds.

Peer State Comparison | Ohio, Pennsylvania, Virginia, and North Carolina

Compared to peer states – and national benchmarks – Georgia not only has fewer overall mental health beds but also fewer beds of each discrete type, including state hospital beds, community inpatient beds, and residential treatment beds.

Peer State Considerations

• States selected: OH, PA, VA, NC

- Selection based on factors, not services or quality:
 - Geography
 - Population
 - Number of State Operated Psychiatric Hospitals (between four and nine)
- 2022 MHA Rank: GA: 31, OH: 36, PA: 8, VA: 20, NC: 21
- Peer states are compared on the following metrics:
 - Total MH beds
 - MH beds per 100k population



Key Observations

- 1. Georgia's **population is growing faster than most states**, with only four states experiencing greater growth from 2020-22.
- 2. Despite its high population growth rate, Georgia **trails its peer states and the nation as a whole** in nearly every bed capacity figure outlined below.
- 3. In particular, residential treatment beds (i.e., not provided in a hospital) are offered in Georgia at a rate of 25-50% fewer per 100k than in most peer states and nationally.

Total 2022 Census Est. 2023 State Websites & Reports NMHSS 2018 Tables 4.7 and 4.8 **Total State** Orgs. with Inpatient Inp. Beds Per Res. Beds per Total Inpatient & Inpatient & Res. Est. Pop. State Hosp. Orgs. with Change 2020-22 Beds per 100k Hosp. Beds Inpatient Beds Beds 100k Res. Tx. Beds Res. Beds 100k beds per 100k Population Res. beds Georgia 10,912,876 200,939 939 8.6 2,076 19.0 1,282 3,358 37 21 11.7 30.8 8,683,619 2.749 31.7 52.3 Virginia -30.681 1,415 16.3 47 38 1.792 20.6 4.541 Pennsylvania 12,972,008 52,235 11.7 100 5,111 39.4 2,950 22.7 8,061 1,514 79 62.1 11,756,058 -43,316 1.085 9.2 72 3,108 26.4 62 1,923 16.4 Ohio 5.031 42.8 10.698.973 259,559 1.034 9.7 53 3.015 28.2 1.127 10.5 4.142 38.7 North Carolina 96 333,287,557 1,837,037 39,963 12.0 1.903 109.241 32.8 1.917 62,253 18.7 171,494 51.5 National

Georgia's Psychiatric Bed Capacity vs. Peer States

Source: National Mental Health Services Survey (N-MHSS): 2018 Data on Mental Health Treatment Facilities



Preliminary Cost Estimates

A&M received select cost data to couple bed projections with preliminary cost estimates. These estimates are focused on projected need for additional adult behavioral health crisis beds in the near-term (i.e., through 2025).

General Observations on Cost

- 1. Limited cost data were received as part of this analysis, including:
 - a. Budget template for 24/16 BHCCs (24 CSU beds, 16 TempObs chairs) for SFY23;
 - b. BHCC funding with SFY24 appropriations;
 - c. Expenditure reports for CIH and forensic apartments for SFY20-22; and
 - d. State Hospital cost report extracts for SFY22.
- 2. All figures reflect known costs at the time the estimate or report was prepared and do not reflect inflation factors that would need to be considered in an appropriations request.
- 3. These figures are not intended to be an appropriations request but may inform the inputs into such a request.
- 4. The cost of optimizing staffing has been estimated using the budget template for 24/16 BHCC facilities.
- 5. TempObs is not operated as a standalone program; the cost of building new TempObs capacity has been factored into the figures for developing new BHCCs.
- 6. C&A is currently operating below optimal occupancy rates, so the recommendation focuses on optimizing occupancy and matching demand with resulting spare capacity on a statewide basis. That cost has not been estimated as part of this analysis.
- 7. The cost of addressing demand for forensic state hospitals is not included here due to the variety of potential responses to the unmet demand for forensic beds and a lack of concrete cost data for building additional state hospital capacity.

Adult BHCC Cost Assumptions

- The recurring annual cost to operate a 24/16 BHCC was estimated at **\$13.3 million**, of which \$11.6 million was estimated to be staffing costs, as of SFY23. Based on discussions with leadership, this budgeted amount could be redirected toward start-up costs during the period of development for new BHCCs.
- The additional cost required to enhance staffing at an existing BHCC was estimated at \$96,000 per bed (including TempObs), or the per-bed difference between the new BHCC cost of \$13.3 million and the current approved BHCC cost of \$9.5 million.
- The cost to convert a 16-bed CSU into a 24-bed BHCC with 16 TempObs chairs and walk-in capacity was estimated at **\$10.8 million**, using SFY24 proposed budgets.

Based on the bed projections for adult behavioral health, DBHDD needs five additional facilities by 2025. DBHDD should consider additional steps – enhancing budgets for existing BHCCs and increasing workforce compensation – to help meet this future need.

Regional Facility Recommendations

DBHDD will need five new facilities by 2025. As the bed projection model shows above, these will be concentrated in Regions 1, 2 and 3, with Region 3 requiring a majority of the new facilities (three out of five). New BHCC facilities, rather than the conversion of existing CSUs, will more efficiently address emerging need across these regions given the distribution of demand.

Region 1 Recommendation: Build a new BHCC

- Two of the three CSUs in Highland Rivers already have capacity that exceeds a typical BHCC (Polk Residential Treatment Unit: 30; Whitefield Treatment Services: 28).
- Rather than converting Floyd Crisis Unit into a BHCC, which would only contribute 8 additional beds, a new BHCC should be built to fully cover the 14-bed gap in Region 1.

Region 2 Recommendation: Build a new BHCC

- A new BHCC would have the greatest impact in Advantage Behavioral Health, which has a 36-bed gap.
- Region 2's existing CSU is in a service area without a capacity gap.

Region 3 Recommendation: Build three new BHCCs

• Region 3 does not have any CSUs to convert to BHCCs.

Region 4 Recommendation: N/A – there is no capacity gap to fill by 2025

Region 5 Recommendation: N/A - there is no capacity gap to fill by 2025

Region 6 Recommendation: N/A - there is no capacity gap to fill by 2025

Est. SFY25 Cost of Implementing Recommendations

Region	Recommendation	Cost
Region 1	Build one new BHCC	\$13,300,000
Region 2	Build one new BHCC	\$13,300,000
Region 3	Build three new BHCCs	\$39,900,000
Region 4	N/A	N/A
Region 5	N/A	N/A
Region 6	N/A	N/A
Subtotal		\$66,500,000

Statewide	Enhance staffing at existing BHCCs ¹	\$51,600,000
Subtotal		\$51,600,000

Statewide	Increase staff compensation to maximize occupancy rates	TBD
Subtotal		TBD

Total* \$11	8,100,000
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* To be updated with staff compensation subtotal once quantified.

Georgia's existing BHCCs operate with different budgets based on their count of beds and TempObs chairs, per SFY24 appropriations. This enhanced staffing cost assumes a per-bed incremental cost of \$96,000, derived by dividing the difference in new and old BHCC operating costs (\$3.8 million) by the number of beds and TempObs chairs in a new 24/16 BHCC (40). This incremental cost is then multiplied by the existing number of beds and TempObs chairs at all existing BHCCs, yielding a total additional cost of \$51.6 million. The additional incremental cost per BHCC ranges between \$1.9 million and \$4.3 million.