

**GEORGIA STATE HEALTH PLAN
COMPONENT PLAN**

**Inpatient Psychiatric and
Substance Abuse**

Issue Date: March 2007

HEALTH STRATEGIES COUNCIL
& GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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*Developed by the Psychiatric and Substance Abuse
Technical Advisory Committee of the Health Strategies Council*

Adopted by the HEALTH STRATEGIES COUNCIL on March 9, 2007
Rules adopted by the BOARD of COMMUNITY HEALTH in December 2006

PREFACE

This Component Plan, a product of the Health Strategies Council and the Georgia Department of Community Health (the "Department"), identifies and addresses issues related to psychiatric and substance abuse services and recommends goals, objectives and system changes to ensure a statewide system of cost-effective and efficient care. The Plan is designed to achieve official state health initiatives relating to access to quality care and cost containment. The Plan provides a rational basis for the continued development of needed psychiatric and substance abuse services for Georgians.

This plan has been produced through an open, public participatory process developed and monitored by the Health Strategies Council. The plan is effective upon approval by the Council and the Board of Community Health, and supersedes all related sections of previous editions of this component of the State Health Plan.

For purposes of the administration and implementation of the Georgia Certificate of Need ("CON") Program, this component plan is intended to provide general background and rationales for the criteria and standards set forth in Rule 111-2-2-.26. The Department's rules shall constitute the final authority for all Certificate of Need review decisions.

Any questions or comments on this Component Plan should be directed to the

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Introduction

Statement of Public Policy

The Department of Community Health, through its Division of Health Planning, is responsible for managing the state's health planning program and establishing standards and criteria for the granting of Certificates of Need. Two of the Department's primary missions are to contain health care costs by avoiding unnecessary duplication of services and to establish and enforce quality-of-care standards. In addition, the Department is committed to ensuring that providers assume a share of the responsibility for the health care needs of low-income citizens and under-served or at-risk members of their local community. Financial access, clinical proficiency and community outreach are cornerstones of the Department's mission.

The Health Strategies Council, a 27-member board appointed by the Governor, is responsible for developing the components of Georgia's State Health Plan and addressing policy issues concerning access to health care services. This component plan, and the associated rules, have been approved by the Health Strategies Council and are consistent with the overall goals of the CON program.

Planning Process

Georgia's former Psychiatric and Substance Abuse Component Plan and its corresponding rules related to inpatient psychiatric services were adopted in 1990. In 2006, the Department, with the assistance of the Technical Advisory Committee ("TAC") appointed by the Health Strategies Council, undertook the task of updating these rules and the component plan. The TAC met numerous times and studied trends and other data related to the status of mental health services in the State and throughout the country, and the utilization and distribution of such services throughout Georgia's planning regions. The TAC was charged with, among other things, determining the best method to evaluate the need for new or expanded inpatient psychiatric and substance abuse services in the State, as well as considering other standards that would maximize the accessibility and quality of such services.

In particular, the TAC found that as a result of the evolution in mental health services over the past 20 years, the previous component plan and rules needed significant revision in order to better reflect current health care practices, and to respond more adequately to the needs of consumers and purchasers. The TAC and the Department also expressed concern that the method of planning for psychiatric health services embraced by the previous plan and rules did not allow state regulators to adequately factor industry changes into the decision-making process. For example, the trend towards deinstitutionalization, the growth in community services, and changes in reimbursement and treatment patterns have dramatically changed the landscape of mental health services and must be taken into account when adopting and implementing policies that aim to determine the need for such services.

The TAC specifically considered the following factors during its deliberations and adoption of the new rules for inpatient psychiatric and substance abuse services:

- 1) Variations in treatment approaches
- 2) Inpatient services as part of an integrated mental health system
- 3) Definition/designation of planning areas for services
- 4) Existing and future roles of the private and public sectors
- 5) Historical utilization of existing services
- 6) Effect of reimbursement practices and payment mechanisms
- 7) Provision of indigent care.

This component plan is the result of the careful study of the mental health services delivery system in Georgia by the TAC and the Department and the development of new rules governing the establishment of new and expanded inpatient psychiatric and substance abuse services in the State.

Overview

National Trends

Over the past several decades, the mental health system has been transformed, from one in which the decisions relating to the treatment of people with mental disorders were made centrally by state and federal agencies, to one in which decision-making is decentralized and primarily within the purview of private organizations. The types of providers, treatments, and modalities available to *patients* of old seem modest measured by today's standard, where *consumers* face a wide array of choices with respect to treatment for their mental health needs.

According to National Institute of Mental Health (NIMH) estimates, approximately 26.2 percent of adults in the United States have symptomatic mental disorders, (e.g. major depression).¹ When applied to the 2004 U.S. Census residential population estimate for ages 18 and older, this translates to 57.7 million people.² Despite the effectiveness of treatment and the many paths to obtaining a treatment of choice, only 25 percent of persons with a mental disorder obtain help for their illness in the health care system. In comparison, 60 to 80 percent of persons with heart disease, for example, seek and receive care.³ Issues relating to financial and physical access, and societal stigmas contribute to the reluctance to seek care. Mental health disorders impact the pediatric population as well, with an estimated one in ten U.S. children and adolescents suffering from mental illness severe enough to cause some level of impairment. The Center for Mental Health Services (CMHS), estimates that two thirds of these young people are not getting the help they need. Substance abuse disorders involving alcohol and drugs are among the most common mental disorders and are found in 8.1 percent of Americans, according to the Substance Abuse

¹ Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.

² U.S. Census Bureau Population Estimates by Demographic Characteristics. Table 2: Annual Estimates of the Population by Selected Age Groups and Sex for the United States: April 1, 2000 to July 1, 2004 (NC-EST2004-02) Source: Population Division, U.S. Census Bureau Release Date: June 9, 2005.
<http://www.census.gov/popest/national/asrh/>

³ National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC). *Prevalence of Chronic Circulatory Conditions: Vital and Health Statistics*, Series No. 10(94). DHEW Pub. No. NRA 75-1521. Hyattsville, MD: National Center for Health Statistics, 1992.

and Mental Health Services Administration (“SAMHSA”): 2005 National Survey on Drug Use and Health.⁴

Psychiatric catastrophic illnesses are among the top leading catastrophic illnesses, comprising over 40 percent of the total costs of mental health care per year.⁵ Health planners expect that these costs will rise as our population ages and the number of people with chronic disorders and organic syndromes increases. In addition, the need for mental health services increases in areas where the level of environmental risk factors, such as poverty, exist.

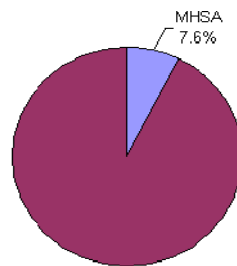
National recognition of mental illness and its costs to society have increased. Consequently, spending and insurance coverage for mental health services have dramatically increased, although the majority of funds are directed at hospitalization. The direct costs of diagnosing and treating mental disorders totaled approximately \$69 billion in 1996, nearly 70 percent of which was for the services of mental health specialty providers; with most of the remainder for general medical services providers. The majority (53 percent) of mental health treatment was paid for by public sector sources, including state and local governments, as well as Medicaid, Medicare, and other federal programs. 47 percent of mental health expenditures were paid by private sources. Of expenditures from private sources, almost 60 percent were from private insurance. The remainder came from out-of-pocket payments, including insurance co-payments. By 2001, national spending on mental health and substance abuse services rose to \$104 billion. To put this number in perspective, it is useful to compare it to national spending on health care for all types of conditions. Total national health services and supplies expenditures were \$1,373 billion in 2001, of which mental health and substance abuse spending made up 7.6 percent (Figure 1). Of total mental health and substance abuse spending, \$85 billion (82 percent) was directed toward mental health (“MH”) and \$18 billion (18 percent) was for substance abuse (“SA”) in 2001. Of total national health care spending, MH comprised 6.2 percent of such spending in 2001, while SA constituted 1.3 percent.⁶

⁴ Substance Abuse and Mental Health Services Administration. (2006). *Results from the 2005 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD.

⁵ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration and National Institutes of Health. *Mental Health: A Report of the Surgeon General*, 1999.

⁶ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration and National Institutes of Health. *Mental Health: A Report of the Surgeon General*, 1999.

**Figure 1. Mental Health Expenditures as a Percent of
Total National Health Care Expenditures, 2001**



All Health = \$1,372.5 billion

Source: National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001, Chapter2, Substance Abuse and Mental Health Service Administration

Due to the complex biological, social, and psychological etiologies of mental illness and the range of disabilities, treatment approaches vary greatly. Planning for mental health services should include a range of interrelated services that provide a continuum of care for individuals in a variety of settings. Inpatient psychiatric and substance abuse hospital care is viewed as one important component of the mental health care system and is one of the most restrictive, highly developed, and resource intensive parts of the continuum. Outpatient therapy, day or night treatment programs, community mental health centers, halfway houses, group homes, residential treatment centers, and partial hospitalization are other components of the mental health system that are less costly and can be made available at the community level.

When assessing the need for psychiatric and substance abuse inpatient hospital care, the range of services provided by the mental health system in an area must first be evaluated. If there is a limited availability of one type of service, other related services may be over-utilized. The availability and utilization of mental health services is also influenced by factors such as government funding, reimbursement, economic status, and unemployment. Fiscal policies at the national and state levels have, for example, limited the resources available for preventive mental health programs.

In the past 30 years, states have dramatically reduced the number of public inpatient psychiatric hospital beds. SAMHSA data show that, in 1970, there were about 525,000 psychiatric hospital beds nationwide. By the year 2000, that number had dropped to 215,000, a 50% decrease. For those persons still being treated in these facilities, the stays are considerably shorter. In the past, those who went to the hospital for mental health treatment often stayed for several months, even years. Now, the average length of stay for adults receiving inpatient care for mental disorders is less than a week.

Another important concern is that mental illness in the population age 65 years and older is growing. An estimated 20 percent of persons age 55 and older experience specific mental disorders such as depression, anxiety, substance abuse, and dementia, which are not classified as part of “normal” aging. Alzheimer’s disease strikes 8 to 15 percent of people over age 65, with the number of cases in the population doubling every 5 years after age 60. Alzheimer’s

disease is thought to be responsible for 60 to 70 percent of all cases of dementia and is one of the leading causes of nursing home placements.^{7 8}

Table 1: National Prevalence Rates, Ages 55 and Up, 1999

Any Anxiety Disorder	11.4%
Simple Phobia	7.3%
Social Phobia	1.0%
Agoraphobia	4.1%
Panic Disorder	0.5%
Obsessive Compulsive	1.5%
Any Mood Disorder	4.4%
Major Depressive Episode	3.8%
Unipolar major Depression	3.7%
Dysthymia	1.6%
Bipolar I	0.2%
Bipolar II	0.1%
Depressive Symptoms	8-20%
Schizophrenia	0.6%
Any Disorder	19.8%
Alzheimer's Disease*	8-15%

* Rates of prevalence increase greatly for residents of nursing homes.

Too often issues of late-life depression and other mental illnesses go unrecognized by primary care physicians, and thus individuals are not referred to appropriate services. The public mental health system provides very few specialized programs for these older persons; much of the current service array focuses on interventions or other support forms that do not interest individuals who are older and have retired.

Summary of Trends in Georgia

The following section presents an overview of the existing inpatient psychiatric and substance abuse services in Georgia. These inpatient services are classified as either acute or extended care programs. In the first section, definitions of acute and extended care programs is provided, and in the second section, the types of facilities providing such care is described. Utilization of such services is then examined, first for acute care and then extended care. Although the utilization and availability of inpatient hospital care is affected by other types of mental health programs, the other types of care are not directly covered in this section.

⁷ U.S. Department of Health and Human Services. *A Report of the Surgeon General (1999)*, p. 336.

⁸ Lebowitz, B.D.; Pearson, J.L.; and Cohen, G.D. Clinical geriatric psychopharmacology. Baltimore, MD: Williams & Wilkins, 1998.

Program Definitions

A “psychiatric or substance abuse inpatient program” is defined in the Rules as an organized entity with specific plan and intent to serve a special population via designated staff in designated beds in a licensed hospital, and provides services on a 24-hour, seven days per week basis.

The Rules define an “acute care psychiatric or substance abuse inpatient program” as a psychiatric or substance abuse program that provides acute and/or emergency stabilization and other treatment for acute episodes. An acute care program provides medically oriented evaluation, diagnosis, stabilization and short-term treatment using individual and/or group therapies, as well as other treatment activities. Two programs are defined: adult psychiatric and/or substance abuse, and pediatric psychiatric and/or substance abuse.

An “extended care psychiatric or substance abuse inpatient program” is defined as a psychiatric or substance abuse program that focuses on self-help basic living skills to enhance the patient's ability to perform successfully in society upon discharge by emphasizing psycho-social, vocational/prevocational and educational components in its treatment plan. This care is based on a psychiatrically and medically oriented treatment model rather than the predominately custodial nursing care provided in licensed nursing homes and personal care homes for mentally disabled. The program is designed to treat people who do not require acute care and who usually have already had at least 1 acute care admission. Due to this design of more therapeutic, education, and social activities, the staffing levels of extended care programs consist of proportionately fewer nurses and physicians. Two programs are defined: adult psychiatric and/or substance abuse, and pediatric psychiatric and/or substance abuse.

Adult programs serve patients age 18 years and older, while pediatric programs serve patients age 0 to 17 years. Substance abuse programs include alcohol and chemical dependencies, and a combination of detoxification and rehabilitative treatment.

Facilities Providing Inpatient Psychiatric and Substance Abuse Care

There are three types of facilities providing inpatient psychiatric and substance abuse services in Georgia:

- a) Public freestanding hospitals (the state regional hospitals)
- b) Private freestanding hospitals
- c) General or other specialty hospitals with psychiatric and/or substance abuse programs

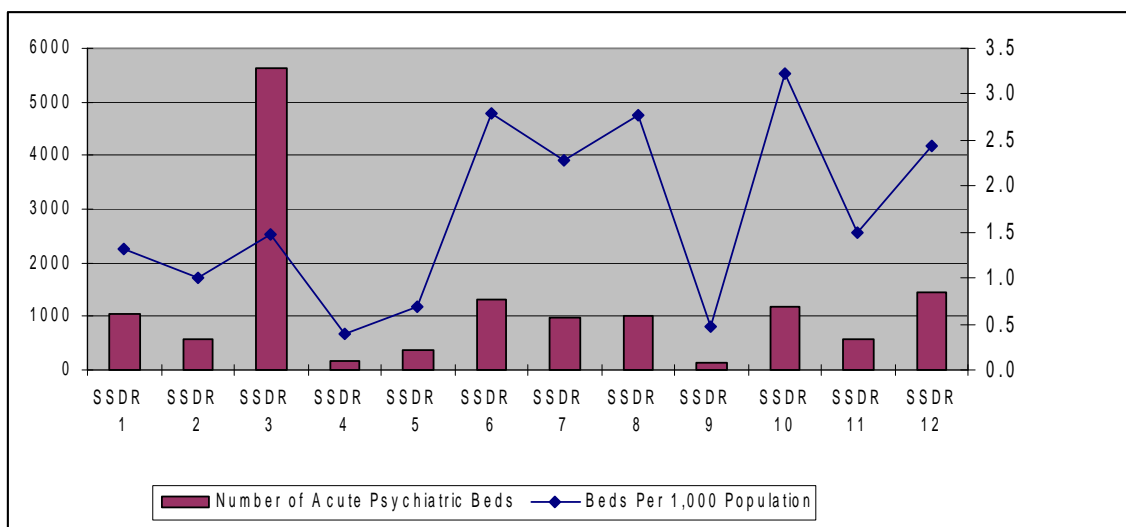
For the purposes of this plan, state regional hospitals are referred to as public sector hospitals. All freestanding hospitals providing inpatient psychiatric and substance abuse care that are not public sector hospitals are referred to as private freestanding hospitals. The private freestanding facilities and other hospitals, including general hospitals and specialty hospitals with psychiatric or substance abuse programs, are referred to as private sector hospitals. The locations and distribution of these facilities throughout Georgia are provided in Appendix B.

As of January 2007, 50 facilities statewide provide psychiatric and substance abuse services. A current list of facilities providing psychiatric and/or substance abuse services appears in Appendix B. Table 2 below presents a summary of the number of acute care psychiatric and substance abuse bed capacity by hospital type. Figure 3 illustrates the distribution of acute psychiatric and/or substance abuse beds in 2005 by State Service Delivery Region ("SSDR"). A map of the state's service delivery regions appear as Appendix A. SSDR 3, encompassing the metro-Atlanta area, is the most populous region of the state. Metro-Atlanta has a lower number of available beds per population (1.5 per 1,000) when compared to other less populous regions of the State. Area 10 has the largest number of available beds in the state (3.2 per 1,000) when compared to other regions in the state.

Table 2. Psychiatric and Substance Abuse Beds By Hospital Type, 2005

Psychiatric and Substance Abuse Beds by Ownership				
Hospital Type	Adult Psych	Adult SA	Pediatric Psych	Pediatric SA
Private	1,013	442	309	52
Public	884	8	154	0
Total	1,897	450	463	52

**Figure 2. Distribution of Acute Psychiatric Beds in Georgia
By State Service Delivery Region, 2005**



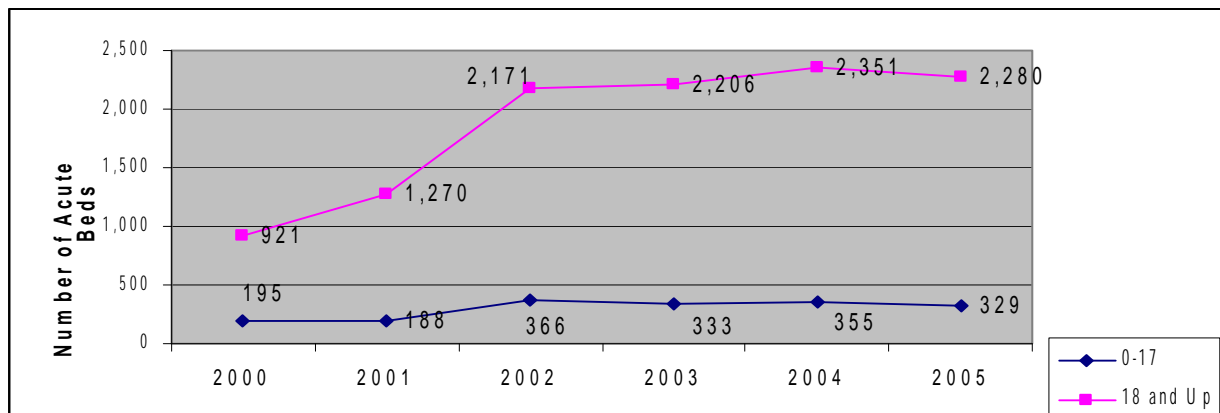
Source: 2000-2005 Annual Hospital Questionnaire, Psychiatric and Substance Abuse Addendum,
Division of Health Planning

Over the past 5 years, there has been a slight decrease in the number of hospitals that provide inpatient psychiatric and substance abuse care. The number of beds, however, has more than doubled, increasing by approximately 133%, as reflected in Figure 3. The number of beds in acute care programs that are set up and staffed each year is based on utilization from the past year, budget considerations, and program changes. This variation may account for the fluctuation in the number of available pediatric beds each year. Access to such care has

Inpatient Psychiatric & Substance Abuse Component Plan

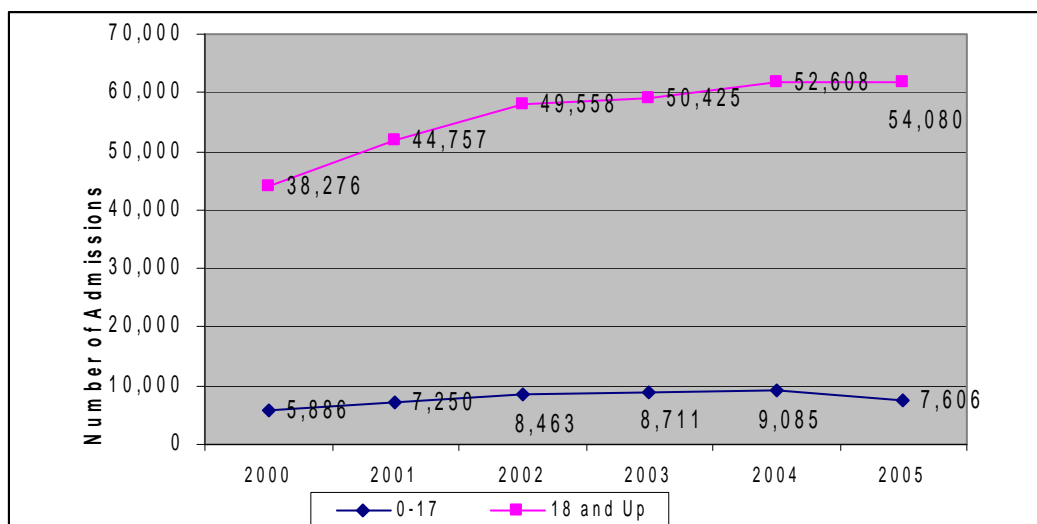
improved since many of the new psychiatric and substance abuse programs have been established in hospitals outside the metropolitan Atlanta area.

Figure 3. Number of Acute Psychiatric and/or Substance Abuse Beds in Georgia, 2000-2005



Source: 2000-2005 Annual Hospital Questionnaire, Psychiatric and Substance Abuse Addendum, Division of Health Planning

Figure 4. Number of Acute Psychiatric and/or Substance Abuse Admissions, 2000-2005



Source: 2000-2005 Annual Hospital Questionnaire, Psychiatric and Substance Abuse Addendum, Division of Health Planning

In the past, many hospitals offered programs for adults only. The number of beds available for treatment of pediatrics has continuously increased. Currently there are pediatric programs in the majority of the major urban areas of Georgia.

With respect to reimbursements, the range of third party coverage for mental health services includes no coverage (indigents and medically indigents), Medicaid-eligible, under-insured, Medicare eligible and fully insured. The availability of care for the uninsured or underinsured is limited, and there are restrictions concerning Medicaid and Medicare coverage. Historically, private insurance coverage for mental health services was limited when compared to coverage

for other types of illness. The Mental Health Parity Act, enacted in 1996, prohibits different dollar limits for mental health services and general health care.

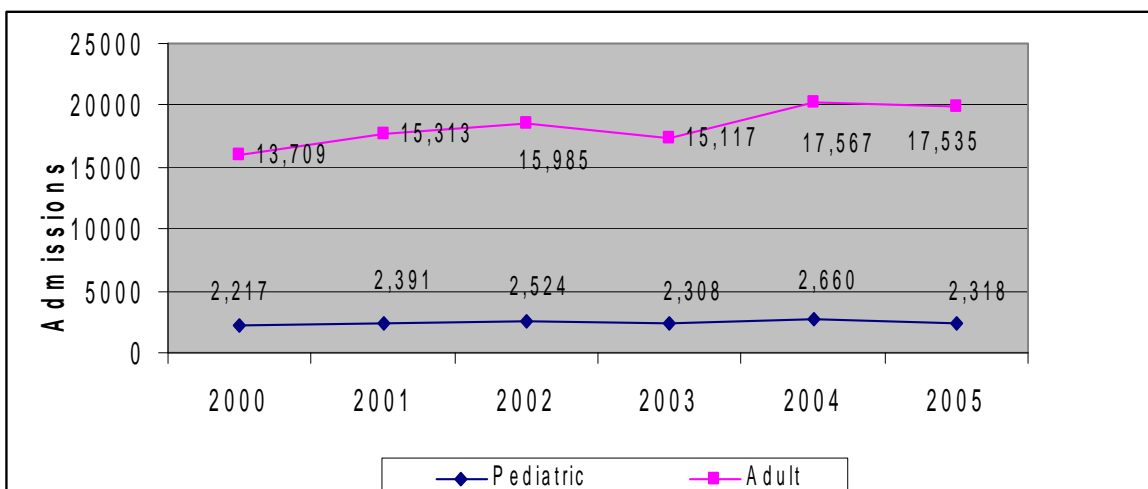
Prepaid health plans, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) experience higher utilization rates for outpatient mental health services than traditional insurance plans. Such plans usually offer coverage for a range of services, while emphasizing the use of less costly preventive services that encourage the use of early treatment and avoid hospitalization.

a) Public/State Regional Hospitals

There are 7 state regional hospitals in Georgia that provide acute care. See Appendix B for a listing of these hospitals. State hospitals account for 1,345 acute care beds and 205 extended care beds. Approximately 6.7% of acute care beds are allocated to programs for pediatrics.

Utilization of state psychiatric hospitals has fluctuated over the past several years due to deinstitutionalization policies, funding limitations, and the growth of the private sector, as well as increased possibilities for treatment of certain disorders. In Georgia, state programs currently stress a community-oriented approach that includes residential treatment facilities. For some individuals, these facilities provide a less costly and a more effective form of treatment than inpatient hospital care. However, reimbursement issues often dictate what type of treatment an individual may receive, and where that care may be provided. Reimbursement, therefore, determines what types of services are offered. Although reimbursement for mental health services generally has increased, the focus is still on inpatient hospital services. Figure 5 below demonstrates the utilization of state-operated psychiatric and substance abuse programs. These hospitals experience high occupancy rates, thus limiting the number of beds available for new admissions.

Figure 5. Utilization of Public/State Psychiatric Hospitals in Georgia, 2000-2005

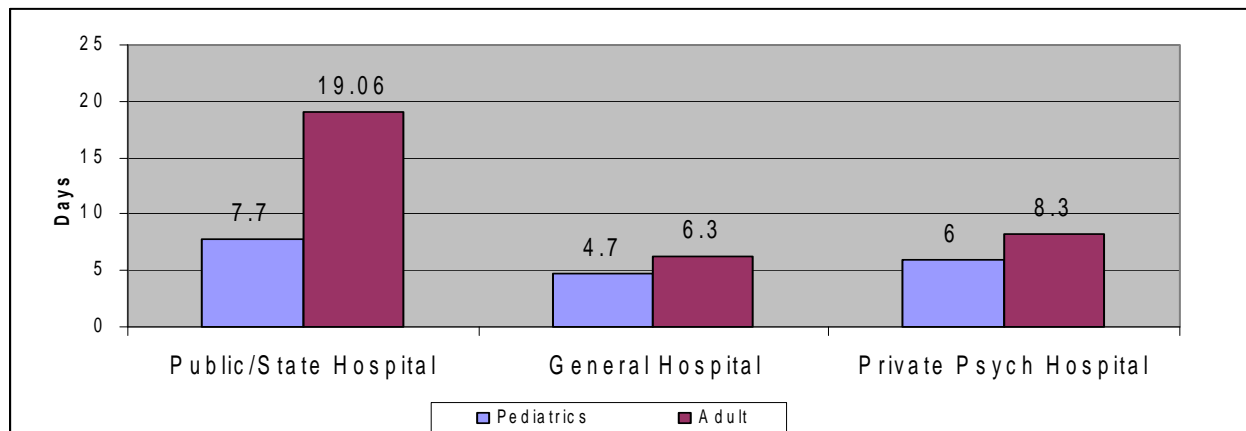


Source: 2000-2005 Annual Hospital Questionnaire, Division of Health Planning

The major source of revenue for public sector hospitals are state-funded grants, Medicaid, and other federally matched programs. Private freestanding psychiatric hospitals are not reimbursed by Medicaid in Georgia, limiting the availability of such care to Medicaid patients.

Consequently, state facilities typically experience greater utilization than their private counterparts (see Figure 6).

Figure 6. Acute Psychiatric and Substance Abuse Care Average Length of Stay By Hospital Type, 2005



Source: Annual Hospital Questionnaire and Psychiatric and Substance Abuse Addendum, 2005

Note: Average Length of Stay was calculated from the total admissions and patient days of programs for which program specific data were available.

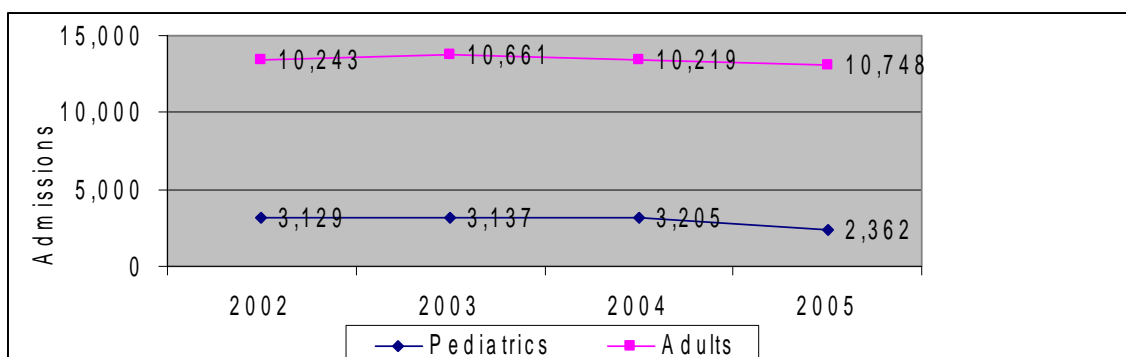
The Department of Human Resources/Division of Mental Health, Developmental Diseases and Addictive Diseases (“DHR”), established 8 mental health regions in Georgia, as referenced in Appendix B. A state regional hospital is designated to serve each region and state residents are generally admitted to the hospital assigned to their mental health region. Access to hospital care is through community intake and assessment to ensure that people are referred to the hospital only when they need that level of care. Some inpatient care that was traditionally provided in the state regional hospitals is now being provided by general hospitals, private freestanding hospitals, and residential treatment centers. Contracting with general and private freestanding hospitals for inpatient hospital care will increase the availability of residential treatment programs for individuals, as an alternative to inpatient care for psychiatric and substance abuse treatment. Patients may then seek short-term care at general or private freestanding hospitals, or seek treatment in residential treatment centers that are closer to home and allow better planning by DHR for follow-up services.

b) Private Freestanding Hospitals

Currently, there are 9 private freestanding psychiatric and substance abuse hospitals in Georgia that primarily provide acute care (Appendix B). The private freestanding hospitals account for 998 beds. 32 percent, or 129, of these beds are designated for pediatric services. These hospitals are licensed as specialty hospitals, and include all freestanding psychiatric and substance abuse hospitals that are not owned and operated by DHR. The development of new private freestanding hospitals may be explained by many factors including the broadening of private third party insurance coverage, and community awareness of mental illness and substance abuse and their respective treatment programs and the increase in marketing of such programs and services. The cost of establishing psychiatric and substance abuse services is generally lower than the costs of establishing other hospitals.

Data from the Annual Hospital Questionnaire and Psychiatric and Substance Abuse Addendum indicate a 50 percent decline in the number of freestanding psychiatric hospitals since 2000. This decline has been largely due to facility closures from inactivity or mergers with larger organizations. Utilization of freestanding psychiatric hospitals has been relatively consistent throughout the last few years (see Figure 7).

Figure 7. Utilization of Freestanding Psychiatric Hospitals, 2002-2005



Source: 2000-200, Annual Hospital Questionnaire, Psychiatric and Substance Abuse Addendum, Division of Health Planning

Most private freestanding hospitals receive the majority of their patient revenues from third party payors other than Medicare and Medicaid. These hospitals are not eligible for Medicaid reimbursement. Limitations on Medicare and Medicaid coverage in conjunction with the trend away from institutionalized psychiatric care to more community-based services may also have impacted the viability of freestanding psychiatric hospitals.

c) Acute General and Specialty Hospitals

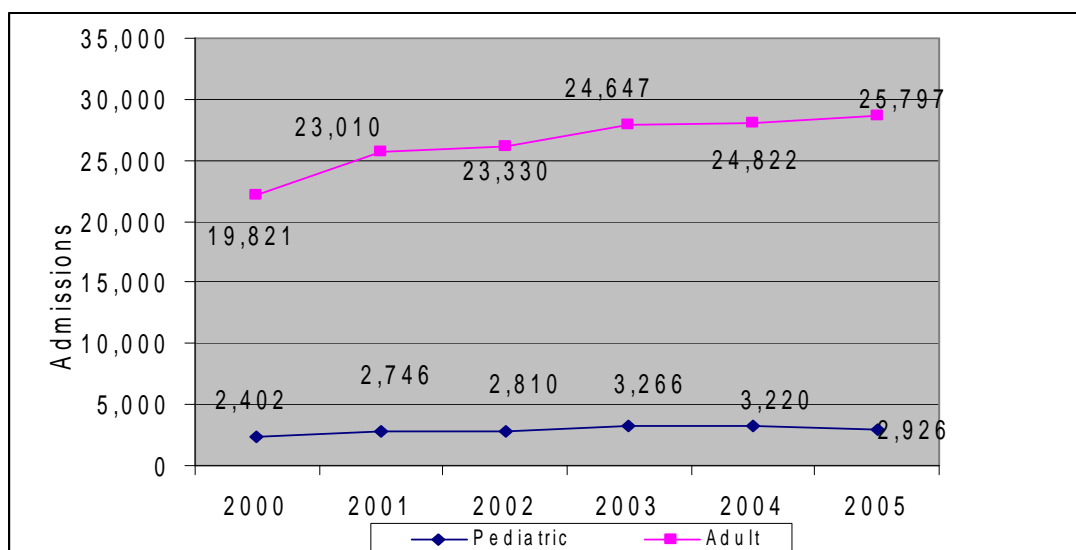
General hospitals often seek methods of service diversification in order to increase utilization and to better meet the needs of the community. Establishment of psychiatric and substance abuse programs is one form of service diversification. It is generally less costly to convert existing hospital beds that are under-utilized to psychiatric or substance abuse beds than to build new facilities. There are other factors, including program intensity and size, that require consideration when planning to meet community needs for such care. Conversion may not always be an appropriate alternative. The size of programs in general hospitals varies; some programs have fewer than 10 beds, while others have over 45 beds. The private freestanding hospitals tend to have larger programs than the programs in general hospitals. General hospitals with a large number of beds dedicated to psychiatric and/or substance abuse programs have hospital staff and treatment plans that are similar to the private freestanding hospitals.

Currently there are 28 general hospitals with acute psychiatric and/or substance abuse programs (Appendix B). These hospitals account for 864 psychiatric beds, 14 percent of which are used as pediatric beds. The data for a geriatric specialty hospital, with an acute psychiatric program, is listed under the acute general hospital heading as well. Many general hospitals without established programs provide some psychiatric and substance abuse care. In these hospitals, the average length of stay is much shorter than in hospitals with dedicated programs. It is believed that the majority of admissions to such hospitals are only for medical stabilization

or detoxification, and that if other treatment is required, patients are transferred to hospitals with established programs. Nationwide, it has been estimated that 40 percent of total treatment episodes for mental disorders occur in general hospitals without psychiatric units. In Georgia, only 0.1 percent of reported psychiatric admissions were in general hospitals without programs.

Data from the Annual Hospital Questionnaire and Psychiatric and Substance Abuse Addendum indicate that there was a 30 percent increase in the number of general hospital psychiatric or substance abuse beds since 2000, which is indicative of the movement towards more diversified services. Utilization of psychiatric and substance abuse programs at these hospitals has been relatively consistent throughout the last few years (see Figure 8).

Figure 8. Utilization of Psychiatric and Substance Abuse Programs in General Hospitals, 2000-2005



Source: 2000-2005 Annual Hospital Questionnaire, Psychiatric and Substance Abuse Addendum, Division of Health Planning

d) Facilities Providing Extended Inpatient Care

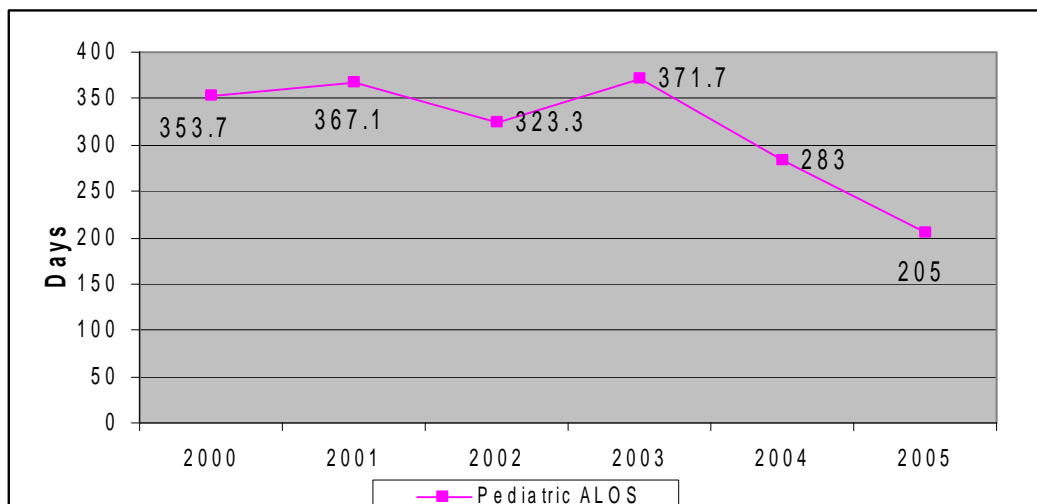
Extended Care is designed to enhance psycho-social skills and provide vocational/prevocational and educational programs for individuals requiring long term hospital psychiatric or substance abuse care. There are 2 types of patients treated in extended care programs - those whose average length of stay is 1-to-2 years, and those whose stay in the hospital is for longer periods of time. Treatment and program activities may differ for the different types of patients. For example, the patients who are expected to be discharged in 1 to 2 years may receive more educational/vocational training.

In Georgia, extended care programs for adults are provided in state regional hospitals while private sector hospitals provide the majority of extended care for pediatrics. There are approximately 489 beds for adult extended care programs in 6 of the 7 state hospitals. The majority of these beds are located at Central State Hospital (see Appendix B for the location of these programs).

There are currently 2 state regional hospitals and 7 private freestanding hospitals that provide extended care programs for pediatrics. The majority of beds are located in the metropolitan Atlanta area at facilities that only provide extended care programs. These hospitals are licensed as specialty hospitals/intensive residential treatment facilities. A small number of pediatric extended care beds are located in private freestanding hospitals licensed primarily for the provision of acute care.

In 2005, there were approximately 862 admissions to pediatric extended care programs. The average annual lengths of stay vary from approximately 150 days to over 600 days, with an average of approximately 205 days statewide for 2005. Currently, there are 4 hospitals, all in the Atlanta area, with operational programs. The occupancy rates of 2 of the 4 hospitals are very high. There are 4 private hospitals in other parts of the state.

**Figure 9. Utilization of Pediatric Extended Care Psychiatric and/or Substance Abuse
Average Length of Stay, 2000-2005**



SOURCE: Annual Hospital Questionnaire and Psychiatric and Substance Abuse Addendum, 2005

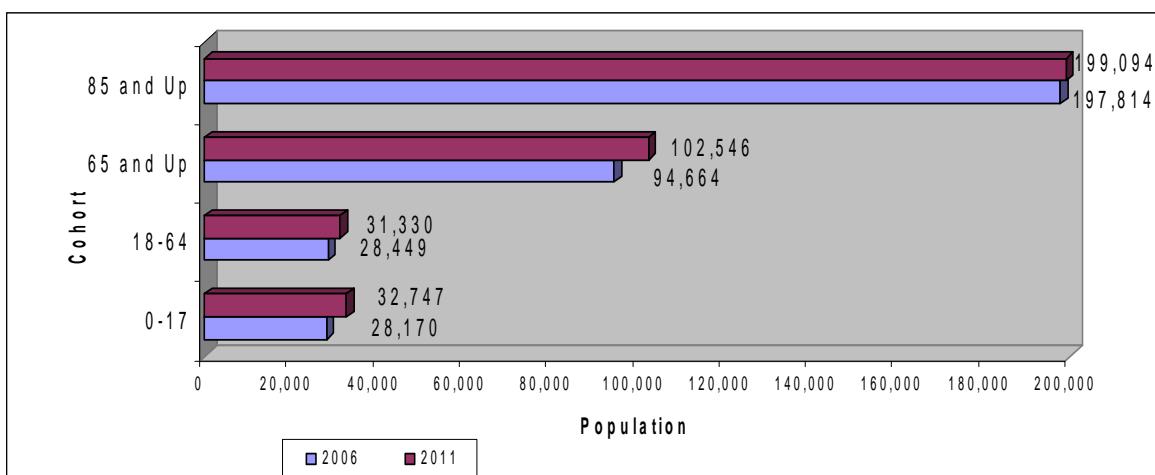
NOTE: Average Length of Stay was calculated from the total admissions and patient days of programs for which program specific data were available

As previously mentioned, the only facilities that currently provide adult extended care are the state regional hospitals. There are no privately-owned adult extended care facilities in Georgia, although such facilities exist in other states. There are many factors influencing the availability of such care. One factor is that the market for extended care in hospitals is very limited, as insurance coverage for such care is very limited. Some community programs are designed with an array of services that include alternatives to hospitalization. Another factor is that many people that require such care may be placed in nursing homes, with or without psychiatric programs. Other people who experience a degree of mental illness requiring such care receive it at home or comprise part of the homeless population.. According to a 2003 study performed by the Urban Institute, approximately 46 percent of Georgia's homeless are chronically mentally ill, a portion of which would require extended hospital care.⁹

⁹ Cunningham, M., Henry, Meghan.: National Alliance to End Homelessness, January 2007, p. 3.

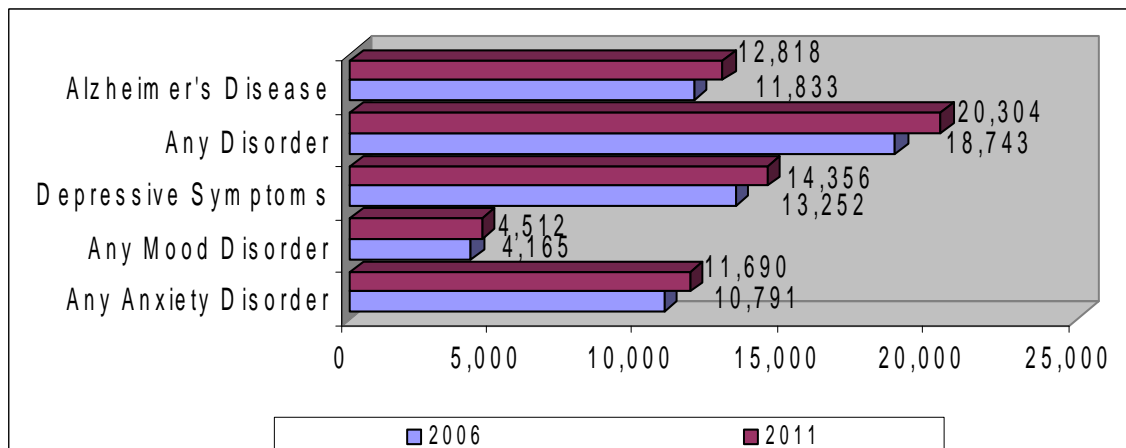
Many chronically mentally ill patients are cared for in nursing homes. For approximately 20 percent of all nursing home residents in the United States, mental illness is their primary disability, and 58 percent of all nursing home residents experience some form of chronic mental illness.¹⁰ According to the Department's data, statewide statistics mirror those of the nation, as persons with mental illness constitute more than 15 percent of general nursing home residents, and individuals with Alzheimer's Disease make up about 20 percent of the patient population. At this time, there are not many reliable studies that quantify the mental health needs of older adults in Georgia. As a result, the Department has made a projection of the number of cases based upon national prevalence rates and 2011 state population projections, as shown in Figures 10 and 11 below (no adjustments have been made in consideration of factors particular to Georgia and its population characteristics).

Figure 10. Population Projections by Age Cohort for 2011



Source: Governor's Office of Planning and Budget

Figure 11-Projected Incidence of Mental Health Disorder in Georgia, 2006 and 2011



Source: Division of Health Planning

¹⁰ Issacs, Mareasa R., The Use of Nursing Homes as long-term Care Facilities for the Mentally 111, Alpha Center, February 1982.

With the projected rates of mental health disorders in the state, psychiatric programs will be challenged to provide a range of appropriate services to reach this particular group. DHR's Division of Aging Services ("DAS") indicates that this group is seriously under-represented in receiving services. DAS provides a number of social and health services for this population, but access to mental health services is limited due to several factors, including the unwillingness of some elderly persons to seek mental health care due to the stigma associated with mental health services. Developing psychiatric units within geriatric hospitals or a program targeting the specific needs of this group has been a recent trend in the state.

As with acute care, the number of beds in the extended care programs of the state regional hospitals that are set up and staffed each year is based upon utilization from the past year, budget considerations, and program changes. The occupancy rates are very high and the programs are often not able to meet increasing demands. DHR is focused on increasing community-based programs for the chronically mentally ill, which in turn will reduce the need for both acute and extended care at the state regional hospitals. These programs will be based upon 4 components: residential care, available crisis intervention through outpatient treatment or at a local hospital, development of daytime programs to develop psycho-social, educational, and vocational skills, and case management. As the availability of these community-based programs increases, admissions to extended care programs at state facilities should decrease.

Specific Review Considerations and Rationales

Standard: Applicability

111-2-2-.26(1) Applicability.

(a) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing acute care adult psychiatric and/or substance abuse inpatient program. An application for Certificate of Need for a new or expanded acute care adult psychiatric and/or substance abuse inpatient program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule. For purposes of these rules, a service, facility, or program approved as an acute care adult psychiatric and/or substance abuse inpatient program may offer both acute care psychiatric and acute care substance abuse inpatient care, acute care substance abuse inpatient care alone, or acute care psychiatric inpatient care alone. A facility approved to offer acute care adult psychiatric and/or substance abuse inpatient services may not offer an acute care pediatric psychiatric and/or substance abuse inpatient program, nor any type of extended care psychiatric and/or substance abuse program without first obtaining a certificate of need.

(b) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing acute care pediatric psychiatric and/or substance abuse inpatient program. An application for Certificate of Need for a new or expanded acute care pediatric psychiatric and/or substance abuse inpatient program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule. For purposes of these rules, a service, facility, or

program approved as an acute care pediatric psychiatric and/or substance abuse inpatient program may offer both acute care psychiatric and acute care substance abuse inpatient care, acute care substance abuse inpatient care alone, or acute care psychiatric inpatient care alone. A facility approved to offer acute care pediatric psychiatric and/or substance abuse inpatient services may not offer an acute care adult psychiatric and/or substance abuse inpatient program, nor any type of extended care psychiatric and/or substance abuse program without first obtaining a certificate of need.

(c) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing extended care adult psychiatric and/or substance abuse inpatient program. An application for Certificate of Need for a new or expanded extended care adult psychiatric and/or substance abuse inpatient program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule. For purposes of these rules, a service, facility, or program approved as an extended care adult psychiatric and/or substance abuse inpatient program may offer both extended care psychiatric and extended care substance abuse inpatient care, extended care substance abuse inpatient care alone, or extended care psychiatric inpatient care alone. A facility approved to offer extended care adult psychiatric and/or substance abuse inpatient services may not offer an extended care pediatric psychiatric and/or substance abuse inpatient program, nor any type of acute care psychiatric and/or substance abuse program without first obtaining a certificate of need.

(d) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing extended care pediatric psychiatric and/or substance abuse inpatient program. An application for Certificate of Need for a new or expanded extended care pediatric psychiatric and/or substance abuse inpatient program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule. For purposes of these rules, a service, facility, or program approved as an extended care pediatric psychiatric and/or substance abuse inpatient program may offer both extended care psychiatric and extended care substance abuse inpatient care, extended care substance abuse inpatient care alone, or extended care psychiatric inpatient care alone. A facility approved to offer extended care pediatric psychiatric and/or substance abuse inpatient services may not offer an extended care adult psychiatric and/or substance abuse inpatient program, nor any type of acute care psychiatric and/or substance abuse program without first obtaining a certificate of need.

Rationale: Applicability

The applicability standards delineate four separate types of inpatient psychiatric and substance abuse programs:

1. Acute Care Adult Psychiatric and/or Substance Abuse
2. Acute Care Pediatric Psychiatric and/or Substance Abuse
3. Extended Care Adult Psychiatric and/or Substance Abuse
4. Extended Care Pediatric Psychiatric and/or Substance Abuse

The TAC believed that psychiatric and substance abuse services are complementary and interchangeable. Previous component plans required separate CONs for psychiatric and substance abuse services. In addition, the TAC felt it appropriate to join child and adolescent programs into a separate pediatric program category.

Standard: Need

111-2-2-.26(3)

- (a) *An application for a new or expanded psychiatric and/or substance abuse inpatient program(s) shall provide sufficient documentation of the need for such program(s) in the planning area. In the case of an application for an expanded psychiatric and/or substance abuse inpatient program, the applicant shall justify the need for the expansion by, at a minimum, documenting that the expansion program has achieved an occupancy rate of 80 percent for an adult program or an occupancy rate of 70 percent for a pediatric program for the most recent 12 months prior to submitting an application, except that a pediatric program which has obtained an occupancy rate of 65 percent may be permitted to expand if such program demonstrates clinical reasons why 70 percent occupancy is not attainable.*
- (b) *An application for a new or expanded psychiatric and/or substance abuse inpatient program(s) in an existing hospital involving an increase in the maximum evaluated bed capacity of the hospital shall not be approved unless the applicant provides sufficient documentation that it is not appropriate to convert existing hospital beds to beds designated for the proposed program(s) or to close existing hospital beds.*
- (c) *An application for a new acute psychiatric and/or substance abuse program(s) in a proposed or Certificate-of-Need approved new hospital shall not be approved unless the total number of beds in the hospital is determined as needed by application of the Department's appropriate bed need methodology for new hospitals unless the hospital commits that the beds to be added in excess of the appropriate bed need as calculated by the short stay bed need methodology will be utilized solely for one of the types of programs identified in 111-2-2-.26(2)(a) and (2)(d). Such beds added in excess of the appropriate bed need shall not be used for any other service or program. Should a hospital cease to offer inpatient psychiatric and/or substance abuse program(s), any and all beds obtained by this provision shall be relinquished and deducted from the hospital's CON-authorized and licensed bed capacities.*

Rationale: Need

Under the original Psychiatric and Substance Abuse Component Plan and Rules numeric need methodologies were defined for both acute inpatient psychiatric and substance abuse programs and extended care psychiatric programs. For acute inpatient psychiatric and/or substance abuse programs two separate numerical need methodologies were defined; one specific to

private-sector programs and one specific to public-sector (state-owned) programs. The numeric need methodology defined for extended care psychiatric programs accounts for both private-sector and public-sector providers in the same methodology. The TAC concluded that the methodology defined for extended care psychiatric programs in the old plan and rules continued to address the needs for extended care psychiatric services. The TAC recommended that the methodology defined in the old plan and rules for psychiatric and substance abuse programs be removed from the standards.

Any methodology that evaluates the need for new or expanded psychiatric and substance abuse programs should be responsive to current industry changes, including demographic trends, technological and treatment advances, financing strategies, and clinical and other operating realities. Critical components that should be considered include: mechanisms to determine demand for services currently and in the planning horizon year, establishing the most appropriate optimal occupancy rates by type of service, the existing supply of services, and specific needs of the target service area populations.

The TAC recommended that the numeric need projection methodology requirement for a new or expanded psychiatric and/or substance abuse program from the old rules be removed from the requirements. This recommendation was based on their findings in two critical areas of consideration. Major components of the model outlined in the old plan and rules were no longer considered valid and alternatives were not able to be identified. Also, it was agreed that the declines in the number of payers for acute psychiatric and substance abuse services and reductions in the levels of reimbursement for the remaining payers had made it impossible to accurately measure demand for these services using conventional measurements of utilization and occupancy. Moreover, these forces may also have mitigated the efficacy of such a requirement.

The 1990 Component Plan and Rules specified that applicants for new or expanded psychiatric and/or substance abuse services be reviewed against a demand-based methodology that relied on national projection trends for physicians in psychiatry as a baseline for determining the number of potential acute psychiatric or substance abuse patients in an area. The Graduate Medical Education National Advisory Committee (GMENAC) published physician rates per capita by specialty area in 1981 (See 'Physician Requirements for 1990 for Psychiatry'). Rates were published for adult psychiatric, adult substance abuse, and child and adolescent psychiatric and substance abuse types of service and were adopted as a major component of the demand-based model adopted in the rules. The GMENAC rates have been widely criticized for overestimating the number of physicians actually needed by projecting surpluses in physician workforce rather than shortages. A modified approach was adopted by the Council on Graduate Medical Education (COGME) and these rates also overestimated the need for physicians. (See Richard A. Cooper, MD, 'There's a Shortage of Specialist. Is Anyone Listening?' *Academic Medicine*, Vol. 77, No. 8, August, 2002; Richard A. Cooper, MD, 'Adjusted Needs: Modeling the Specialty Physician Workforce', *AANS Bulletin*, Spring 2000; Kevin Grumbach, 'Fighting Hand to Hand Over Physician Workforce Policy', *Health Affairs*, Vol. 21, No.5, 2002). The TAC was unable to identify a more acceptable or valid model for projecting physician workforce needs.

The demand-based need projection model recommended by the previous TAC also included an expected average length of stay for each type of service. The lengths of stay were derived from actual utilization at the time, but the TAC found them to be significantly out of step with more recent utilization patterns. Also, the previously adopted demand-based formula assumed that 55% of the demand would be treated by private-sector (non State of Georgia) providers.

However, recent utilization patterns indicate that up to 70% of psychiatric and substance abuse utilization in Georgia has been provided by private-sector programs. These findings underscore the general consensus of the TAC that the nature of acute psychiatric and substance abuse treatment has seen significant change since the previous TAC made its recommendations.

The TAC considered the actual utilization of acute psychiatric and substance abuse in Georgia. Data from the Division of Health Planning's Annual Hospital Questionnaire indicates a wide variation in rates of occupancy for existing acute psychiatric or substance abuse providers with some programs at or near capacity and others remaining under utilized. The TAC agreed that actual demand for acute psychiatric and substance abuse may not be able to be determined using utilization because of a variety of factors including cuts in reimbursement or coverage for services among payers, the growth of managed care plans among payers, and the nature of existing programs' physical arrangements with many having multi or double bed rooms. This conclusion is supported by much of the literature regarding mental health treatment and the nature of the acute psychiatric and substance abuse continuum of healthcare (See Ronald C. Kessler, Ph.D., Olga Demler, M.A., et al., 'Prevalence and Treatment of Mental Disorders, 1990 to 2003', The New England Journal of Medicine, June 16, 2005; Richard A. Sherer, 'Increased Demand, Restrictions, and Less Pay: Is This the Future of Psychiatry?', Psychiatric Times, January 2003).

Optimal occupancy rates should be established for all new or expanded psychiatric and substance abuse programs in order to ensure that beds are optimally utilized within the planning area before any new programs are established. National and state guidelines and standards recommend 80 to 85 percent as a desired occupancy rate for hospitals. That level of occupancy should provide enough beds for expected variations in admissions throughout the year, yet also ensure that the beds will not be under-utilized, which would raise costs. The size of the facility should have no impact on occupancy targets, but differences exist based on program type. For adult programs, need for expansion must be justified through documentation that the expansion program has achieved an occupancy rate that meets or exceeds 80 percent. Pediatric programs are so specialized in nature that they are more likely to have greater swings in occupancy, but potentially less routine occupancy. Optimal occupancy for pediatric programs should be set at 70 percent of available beds, unless a pediatric program which has obtained 65 percent occupancy can demonstrate clinical reasons why 70 percent occupancy cannot be attained. A lower occupancy standard was recommended for the adolescent and child programs than for the adult programs because such programs usually have a higher variability of admission patterns, a longer length of stay, and a smaller number of beds dedicated to their use. Occupancy targets promote operational efficiency and responsiveness to future community demand by focusing planning and development.

In the past, the Department utilized an aggregate occupancy rate in the determination of need for new or expanding psychiatric and/or substance abuse programs. To prevent 1 program, which may be operating at low occupancy for a variety of reasons, from precluding other programs from being established in the planning area, the Department would consider variance from the standard when the Department determined that highly unusual circumstances existed that justified such action. The TAC recommended that applications for new or expanding psychiatric and/or substance abuse programs should now be reviewed on an institutional specific basis using optimal occupancy rate standards.

Bed capacity should be determined through the use of those beds that were approved or authorized beds during the CON process; only CON bed capacity should be used in any of the hospital bed need calculations. Licensed or set-up-and-staffed beds may represent something

less than the total available capacity (i.e., CON approved beds). As a general rule, before any new beds are added, the state should consider the use of available beds.

Applicants for new psychiatric and/or substance abuse program beds in a proposed new hospital should meet the standards set forth in the existing short stay hospital rules in terms of the numeric bed need projection. The formula for new hospitals utilizes a demand-based projection model determines the beds needed using actual utilization within a target area.

Standard: Adverse Impact

111-2-2-.26(3)(d) An applicant for a new or expanded psychiatric and/or substance abuse inpatient program(s) shall document that the establishment or expansion of its program(s) will not have an adverse impact on similar existing and approved programs in its planning region. State-owned and -operated psychiatric and substance abuse regional hospitals shall not be required to document this standard.

- 1. Accounting for market share and future population growth, an applicant for a new or expanded adult psychiatric and/or substance abuse inpatient program(s) shall have an adverse impact on similar existing and approved programs if it will:
 - (i) decrease annual utilization of a similar existing program, whose current utilization is at or above 85%, to a projected annual utilization of less than 75% within the first twenty-four months following the acceptance of the applicant's first patient; or*
 - (ii) decrease annual utilization of a similar existing program, whose current utilization is below 85%, by 10 percent over the twenty-four months following the acceptance of the applicant's first patient.**
- 2. Accounting for market share and future population growth, an applicant for a new or expanded pediatric psychiatric and/or substance abuse inpatient program(s) shall have an adverse impact on similar existing and approved programs if it will:
 - (i) decrease annual utilization of a similar existing program, whose current utilization is at or above 85%, to a projected annual utilization of less than 80% within the first twenty-four months following the acceptance of the applicant's first patient; or*
 - (ii) decrease annual utilization of a similar existing program, whose current utilization is below 85%, by 5 percent over the twenty-four months following the acceptance of the applicant's first patient.**

Rationale: Adverse Impact

All applicants seeking new or expanded program should address the impact of any proposed program on existing programs within the target service area. Because cost, quality, and access

to care are areas of critical importance to the Department, all applicants should address how any new or expanded program would specifically impact existing facilities in the target service area population. The burden to substantiate this impact is placed on the applicant. Both positive and negative impacts should be clearly delineated in the application.

State-owned and operated programs within the planning area of an applicant hospital should be afforded some stipulated protection. State programs typically provide higher than routine rates of indigent and charity care, and higher than routine rates of service to Medicaid and PeachCare populations. Because of their impact on these underserved populations, state programs are not required to document this standard. All other applicants should present analyses detailing projected changes in market share and payor mix for the applicant and similar existing program. Impact on an existing adult program shall be determined to be adverse if, based on the utilization projected by the applicant, any existing psychiatric and/or substance abuse program, whose current utilization is at or above 85 percent, would have a total decrease to a projected utilization of less than 75 percent within the first twenty-four months of implementation. Furthermore, any decrease in annual utilization of a program whose current utilization is below 85 percent by 10 percent within the first twenty-four months following implementation data would be considered an adverse impact. For new or expanded pediatric programs, a decrease in annual utilization of a similar existing program, with a current utilization at or above 85 percent to a projected utilization of less than 80 percent within the first twenty-four months of implementation would be considered an adverse impact. Likewise, a decrease in any existing pediatric program whose current utilization is below 85 percent by 5 percent within the same time period shall be considered to be an adverse impact.

Standard: Minimum Bed Size

111-2-2-.26(3)(e) A new psychiatric and/or substance abuse inpatient program(s) shall have the following minimum bed sizes based on type of program offered:

- 1. The minimum bed size of a new acute psychiatric and/or substance abuse program is eight beds.*
- 2. The minimum bed size of a new extended care psychiatric and substance abuse inpatient program is eight beds.*
- 3. The minimum bed size of a new freestanding psychiatric and/or substance abuse hospital primarily providing acute*

Rationale: Minimum Bed Size

Minimum recommended bed size for a new psychiatric and/or substance abuse inpatient program based on the type of program offered should be 8 beds for acute and/or extended programs. New freestanding psychiatric and/or substance abuse specialized hospitals must have a minimum of 50 beds. The minimum number of designated beds in aggregate of any and all acute and/or extended care program in a general hospital is ten beds. The general hospital may have 1 program with a minimum of 10 beds or 2 or more programs that together have 10 or more beds designated for this use. Unit facilities below this level are usually too small to be able to provide specialized staff and services at a reasonable cost and maintain program

integrity and quality. However, if bed standards are set at higher levels, the number of hospitals capable of supporting programs in some areas of the state would be limited. Furthermore, these minimum standards ensure that a sufficient number of beds in organized programs exist in all areas of the state. These thresholds only apply to new hospitals.

Standard: Accreditation

111-2-2-.26(3)(f) An applicant for a new psychiatric and/or substance abuse inpatient program(s) shall demonstrate the intent to meet the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) applicable to the type of program to be offered within 12 months of offering the new program. Extended care programs may demonstrate their intent to meet the standards of the Council on the Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA) in lieu of JCAHO.

111-2-2-.26(3)(g) An applicant for an expanded psychiatric and/or substance abuse inpatient program(s) shall be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for the type of program which the applicant seeks to expand prior to application. The applicant must provide proof of such accreditation. Extended care programs may be accredited by the Council on the Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA) in lieu of JCAHO.

Rationale: Accreditation

The TAC agreed that JCAHO accreditation should be required in order to ensure quality services. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) evaluates hospitals for JCAHO accreditation. If a general hospital, state regional hospital, or a specialty hospital, primarily providing acute care, is JCAHO accredited, it is deemed for licensure purposes and DHR, Office of Regulatory Service ("ORS") generally does not performed additional evaluations of the hospital for licensure. Under CON rules, therefore, the applicant is required to provide the date that the hospital was JCAHO accredited, if so accredited.

Standard: Licensure and Certification

111-2-2-.26(3)(h) An applicant for a new freestanding psychiatric hospital or intensive residential treatment facility shall demonstrate the intent to meet the licensure Rules of the Georgia Department of Human Resources for such facilities.

111-2-2-.26(3)(i) An applicant for an expanded freestanding psychiatric hospital or intensive residential treatment facility shall demonstrate a lack of uncorrected deficiencies as documented by letter from the Georgia Department of Human Resources.

111-2-2-.26(3)(j) An applicant for a new or expanded psychiatric and/or substance abuse inpatient program(s) shall provide documentation that the applicant has no uncorrected history of conditional level Medicare and Medicaid certification deficiencies in the past three years.

Rationale: Licensure and Certification

If a hospital is JCAHO accredited, the hospital is considered eligible for Medicare certification. If the hospital is not JCAHO accredited, ORS evaluates the hospital for Medicare certification. A freestanding psychiatric hospital, public or private, that is JCAHO accredited is deemed to meet Medicare certification except for 2 Medicare special conditions, which are evaluated each year by ORS or by the National Institute of Mental Health; these conditions relate to staffing and medical records. An applicant must provide information concerning any Medicare certification evaluations performed in the past 3 years, to document to the Department's satisfaction that the facility has not had a history of condition-level deficiencies. The documentation shall include, but not be limited to, any Medicare certification deficiency reports issued to the facility. If ORS performed an evaluation of the hospital, for any reason, in the past three years, the applicant shall provide any licensure deficiency reports issued. The Department shall review the licensure reports and determine if there were significant deficiencies which involved program quality or patient safety.

For purposes of CON review, a history of deficiencies, in the past 3 years, may be defined as 1 highly significant deficiency, several significant deficiencies, or documentation of a repeated significant deficiency. A CON should not be granted to any hospital with outstanding deficiencies or with a history of significant licensure and/or Medicare certification condition-level deficiencies.

Standard: Program Quality

111-2-2-.26(3)(k) An applicant for a new or expanded psychiatric and/or substance abuse inpatient program(s) shall provide sufficient documentation that the proposal is consistent with the following quality standards:

- 1. The program(s) shall maintain standards for the review and improvement of quality. To document such standards, the program(s) must submit quality improvement policies.*
- 2. The program(s) shall maintain standards to ensure the continuity of patient care. To document such standards, the program(s) must submit policies governing admissions and availability of adequate discharge planning.*

Rationale: Program Quality

The quality of a psychiatric or substance abuse program is a function of many interrelated variables, which include the program plan, admission policies and criteria, treatment protocols, discharge planning, and the institutional or program capacity to deliver services in an efficient and cost-effective manner, via physical plant arrangements and the provision of ancillary services. An applicant must address these variables in the program description of each proposed program and clearly differentiate how these variables will be addressed in each program.

Standard: Continuity of Care

111-2-2-.26(3)(l) An applicant for a new or expanded freestanding psychiatric and/or substance abuse inpatient program(s) shall document the existence of referral arrangements, including transfer agreements, with an acute-care hospital(s) within the planning region to provide emergency medical treatment to any patient who requires such care. If the nearest acute-care hospital is in an adjacent planning region, the applicant may document the existence of transfer agreements with that hospital in lieu of such agreements with a hospital located within the planning region.

Rationale: Continuity of Care

Acute inpatient psychiatric and substance abuse care is just one option in the range of mental health services that should be available to citizens. Individuals should be treated in the least restrictive and least costly setting which would meet his or her treatment needs most effectively. Inpatient care is often preceded and followed by less restrictive outpatient or residential care. It is important that facilities providing inpatient care have sufficient arrangements with, or knowledge of, other mental health providers to ensure that appropriate referrals are made to a facility so that continuity of care is achieved. Therefore, the Rules require that the applicant have referral arrangements with an acute care hospital(s) in the planning area. Acute and emergency medical treatment may then be received in an appropriate and timely manner, by any patient that requires such care.

Standard: Financial Accessibility

111-2-2-.26(3)(m) An applicant for a new or expanded acute or extended care psychiatric and/or substance abuse program(s) shall document that the program(s) will be financially accessible by:

- 1. providing sufficient documentation that unreimbursed services for indigent and charity patients in a new or expanded program(s) will be offered at a standard which meets or exceeds three percent of annual gross revenues for the program after provisions have been made for bad debt, and Medicaid and Medicare contractual adjustments have been deducted. If an applicant, or any facility in Georgia owned or operated by the applicant's parent organization, received a Certificate-of-Need for a hospital program(s) or service(s) or a total facility and the CON included an expectation that a certain level of unreimbursed indigent and/or charity care would be provided in the program(s), service(s), or hospital(s), the applicant shall provide sufficient documentation of the facility's(ies') provision of such care. An applicant's history, or the history of any facility in Georgia owned or operated by the applicant's parent organization, of not following through with a specific CON expectation of providing indigent and/or charity care at or above the expected level will constitute sufficient justification to deny an application; and*
- 2. agreeing to participate in the Medicare and Medicaid programs, whenever these programs are available to the facility.*

Rationale: Financial Accessibility

The provision of services on a nondiscriminatory basis particularly to the indigent and uninsured or underinsured population has become a growing concern in the state. Many indigent and uninsured or underinsured individuals cannot afford to purchase psychiatric and/or substance abuse services. The purpose of this standard is to ensure that equity exists in the provision of psychiatric and/or substance abuse services to those individuals who cannot afford such care.

In addition to the requirements of 111-2-2-.26(3)(m), an applicant for an expanded psychiatric and/or substance abuse inpatient program(s) shall document that it has met or exceeded all previous commitments to indigent and charity care. If the applicant has not provided the level of indigent and charity care services sufficient to meet such commitments, the applicant may satisfy this requirement by paying a fine equal to the difference in the amount of services provided and the commitment made. In the case of a competitive or joined review, the Department shall favor an applicant that has actually provided the committed level of service to indigent and charity care patients over an applicant that has met this burden through the payment of a fine.

Furthermore, the Department shall require all applicants to document that unreimbursed services for indigent and charity patients will be offered at or above the stated level. Additional services that document a commitment to another form of accessibility include arrangements with community mental health centers or other providers of care to the public sector, including state agencies. The documentation should include financial projections that acknowledge the costs of providing such care, while still showing financial feasibility. The Department recognizes that facilities may experience financial losses due to Medicaid and Medicare reimbursement and bad debt. Facilities may offer services for reduced charges to individuals and/or organizations with special contracts, such as preferred provider organizations. These financial losses are not, however, classified as losses due to the provision of unreimbursed indigent and/or charity care.

The applicant's history, and the history of any facility in Georgia owned or operated by the applicant's parent organization, concerning the provision of indigent and charity care, shall be evaluated. If a previous CON, for a hospital program(s) or services(s) or for the total facility, was granted through CON Rules that included a standard for the provision of unreimbursed indigent and/or charity care, the applicant shall document to the Department's satisfaction that the facility(ies) provided such care. If a previous CON was granted for an application with a specific expectation that the facility would provide a certain level of unreimbursed indigent and/or charity care, the applicant shall document to the Department's satisfaction that that level of care was provided. An applicant's history, or the history of any facility in Georgia owned or operated by the applicant's parent organization of not providing unreimbursed indigent and/or charity care at or above the level specified, will constitute sufficient justification to deny an application.

In the past, the Department has accepted applicant requests to be assessed by the total facility, within the same parent company, regarding the provision of indigent and charity care. However, when reviewing applications for CON compliance with the standard, the Department will evaluate the provision of unreimbursed indigent and/or charity care provided in the CON approved program(s) and/or services(s). Therefore, the Department will use program specific data for that facility through the whole report period.

The Department shall review annual data concerning the provision of unreimbursed indigent and/or charity care from the time a program, service, or facility with the CON expectation began operation and each year thereafter.

In addition to providing unreimbursed indigent and/or charity care, an applicant for a new or expanded program must agree to participate in the Medicare and Medicaid programs, whenever these programs are available to the facility. Currently in Georgia, private freestanding psychiatric and/or substance hospitals are not eligible for Medicaid reimbursement. Assessment of the facility's provision of services to Medicare and Medicaid patients is another form of accessibility analysis.

Standard: Provision of Data

111-2-2-.26(3)(o) An applicant for a new or expanded psychiatric and/or substance abuse inpatient program(s) shall agree to provide the Department with requested information and statistical data related to the operation of such a program(s) on a yearly basis, or as needed, and in a format requested by the Department.

Rationale: Provision of Data

Uniform data is essential to assess the changing patterns and projected service needs relevant to the provision of this service. As additional emphasis is placed on quality, cost, and efficiency indicators, the collection of data will allow more precise assessment of these factors as well as others which are important to health planning. Applicants will be required to provide requested information and statistical data related to the operation and provision of psychiatric and/or substance abuse programs to the Department of Community Health by the requested time.

APPENDIX A

PSYCHIATRIC AND SUBSTANCE ABUSE INPATIENT SERVICES TECHNICAL ADVISORY COMMITTEE

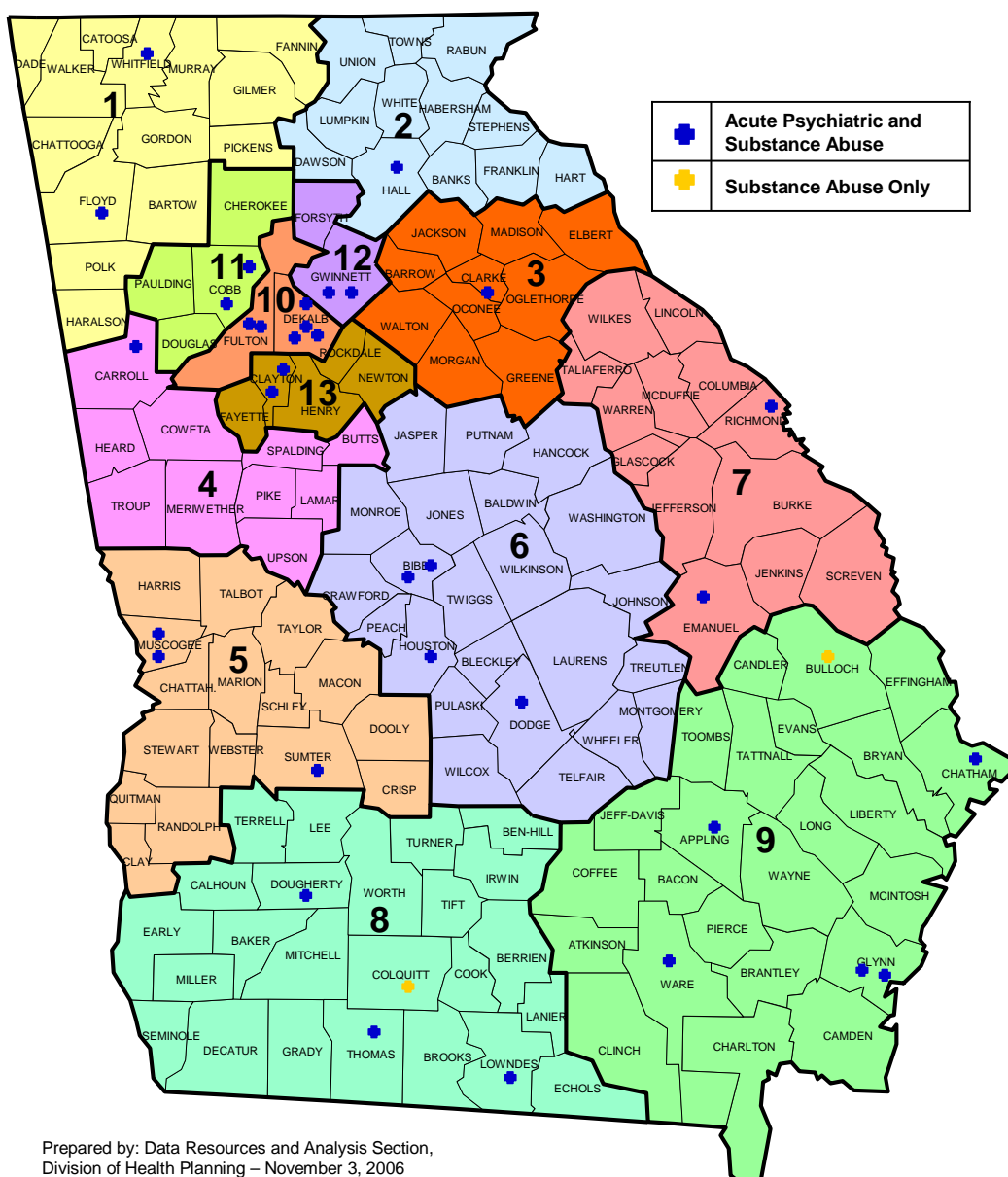
- Joel Axler, MD
- Paul Hackman
- Ray Heckerman
- Gary Howard
- Roslind Hudson
- Doris Patillo
- Mary Lou Rahn, B.S.N.
- Brenda Reid
- Robin Robinson
- Mark Scott
- Wayne Senfeld, ED.S, L.P.C
- Sandra Sexson, MD
- Mary Ann Smith, RN
- Pat Strode
- Carol Zafaritos

APPENDIX B

PSYCHIATRIC PROGRAM LOCATIONS AND PLANNING AREAS

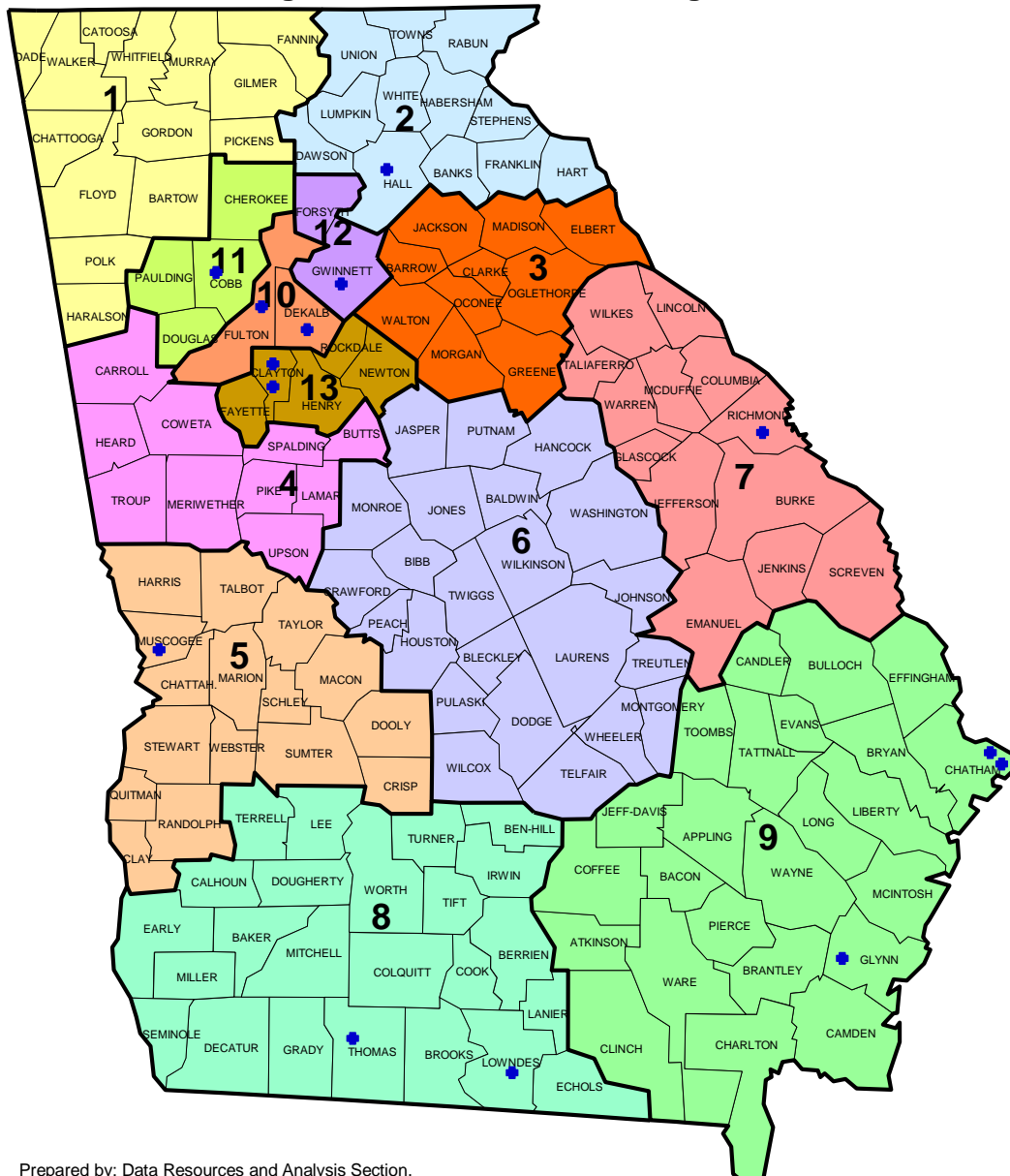
LOCATION OF HOSPITALS PROVIDING ADULT ACUTE PSYCHIATRIC AND/OR SUBSTANCE ABUSE PROGRAMS B-1

Adult Acute Psychiatric and Substance Abuse Program Locations and Planning Areas (Private Sector)



LOCATION OF HOSPITALS PROVIDING PEDIATRIC ACUTE PSYCHIATRIC AND/OR SUBSTANCE ABUSE PROGRAMS B-2

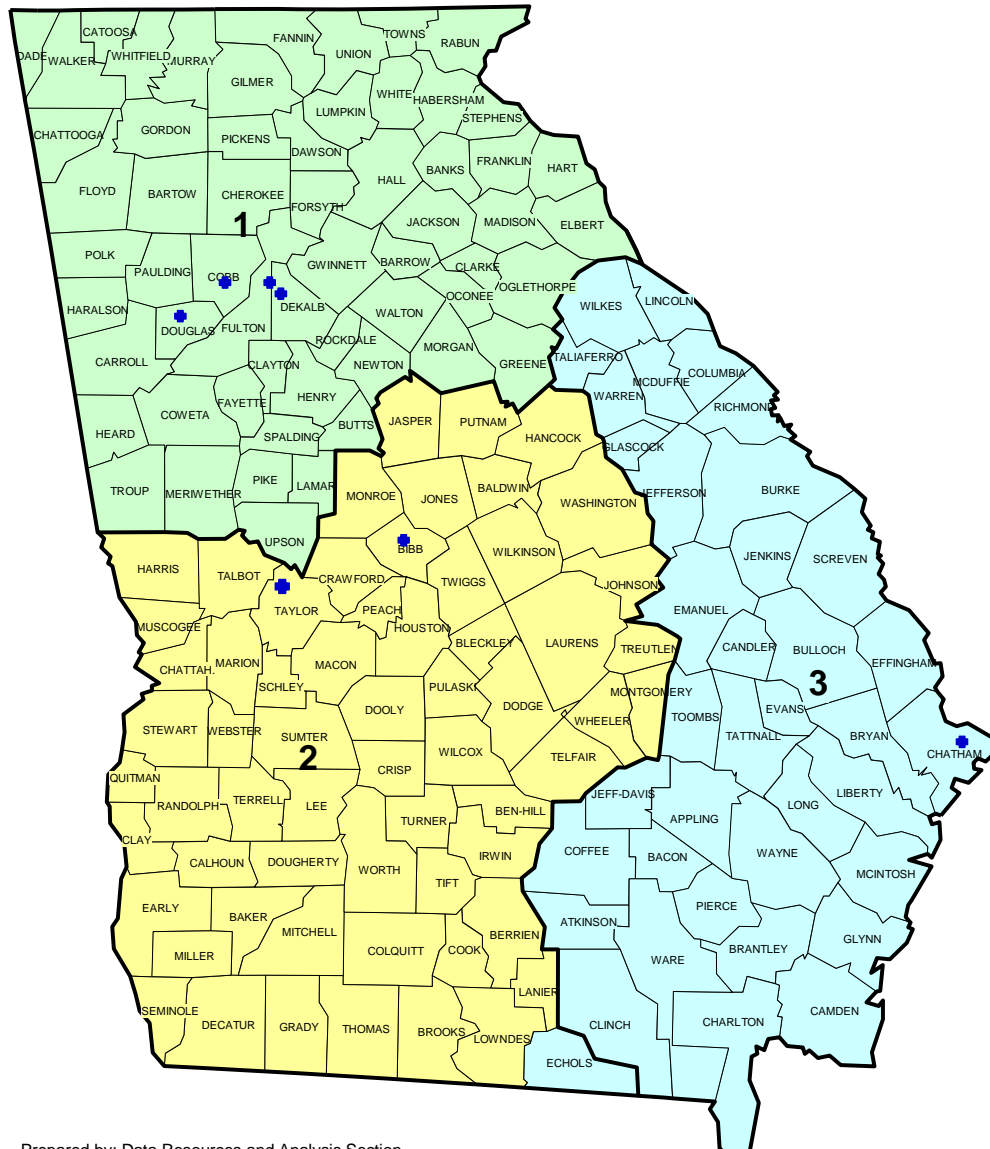
Private Sector Child and Adolescent Acute Psychiatric and Substance Abuse Program Locations and Planning Areas



Prepared by: Data Resources and Analysis Section,
Division of Health Planning – November 3, 2006

B-3

Child and Adolescent Extended Care Psychiatric Program Locations and Planning Areas (Private Sector)



Prepared by: Data Resources and Analysis Section,
Division of Health Planning – November 3, 2006

NEW PLANNING REGIONS

B-4

STATE SERVICE DELIVERY REGIONS

Amended Effective July 1, 2005



APPENDIX C

FACILITIES PROVIDING INPATIENT PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES BY TYPE

ACUTE CARE FACILITIES

PUBLIC/STATE Regional Hospital Listing

Baldwin	Central State Hospital* Broad Street Milledgeville, Georgia 31062 478-445-6644 website: http://www.centralstatehospital.org
Richmond	East Central Regional Hospital - Augusta Campus* 3405 Mike Padgett Highway Augusta, Georgia 30906 706-792-7000 website: http://www.augustareg.dhr.state.ga.us
DeKalb	Georgia Regional Hospital/Atlanta 3073 Panthersville Road Decatur, Georgia 30034 404-243-2100 website: http://www.atlantareg.dhr.state.ga.us
Chatham	Georgia Regional Hospital/Savannah*¹¹ 11915 Eishenhower Drive Savannah, Georgia 31406 912-356-2011
Floyd	Northwest Georgia Regional Hospital* Redmond Circle, N.W Rome, Georgia 30161 706-295-6011
Thomas	Southwestern State Hospital* 400 South Pinetree Boulevard P.O. Box 1378 Thomasville, Georgia 31799 229-227-3010 website: http://www.swsh.org/
Muscogee	West Central Georgia Regional Hospital*¹¹ 3000 Schatulga Road Columbus, Georgia 31907706-568-5000 website: http://www.wcgrh.org Source: DCH/DHP Inventory as of January 2007

*Also, provides extended psychiatric and substance abuse programs

¹¹ Also, provides extended pediatric psychiatric services

PRIVATE

Bibb	Coliseum Psychiatric Center
Bulloch	Willingway Hospital
Chatham	Coastal Harbor Treatment Center
Clayton	Anchor Hospital
Cobb	Ridgeview Institute
Colquitt	Turning Point Hospital
DeKalb	Peachford Behavioral Health System of Atlanta
Glynn	Focus By the Sea
Muscogee	The Bradley Center of Saint Francis

GENERAL

Appling	Appling Hospital
Bibb	Medical Center of Central Georgia
Carroll	Tanner Medical Center/Carrollton
Chatham	Memorial Health University Medical Center
Clarke	Athens Regional Medical Center
Clayton	Southern Regional Medical Center
Cobb	WellStar Cobb Hospital
DeKalb	DeKalb Medical Center
DeKalb	Emory University Hospital
DeKalb	Wesley Woods Geriatric Hospital
Dodge	Dodge County Hospital
Dougherty	Phoebe Putney Memorial Hospital

Floyd	Floyd Medical Center
Fulton	Atlanta Medical Center
Fulton	Grady Memorial Hospital
Fulton	Hughes Spalding Children's Hospital
Glynn	Southeast Georgia Regional Medical Center
Gwinnett	Emory Eastside Medical Center
Gwinnett	Gwinnett Medical Center
Hall	Northeast Georgia Medical Center
Houston	Houston Medical Center
Lowndes	South Georgia Medical Center
Muscogee	The Medical Center
Richmond	Medical College of Georgia Hospitals and Clinics
Sumter	Sumter Regional Hospital, Inc.
Thomas	John D. Archbold Memorial Hospital
Ware	Satilla Regional Medical Center
Whitfield	Hamilton Medical Center

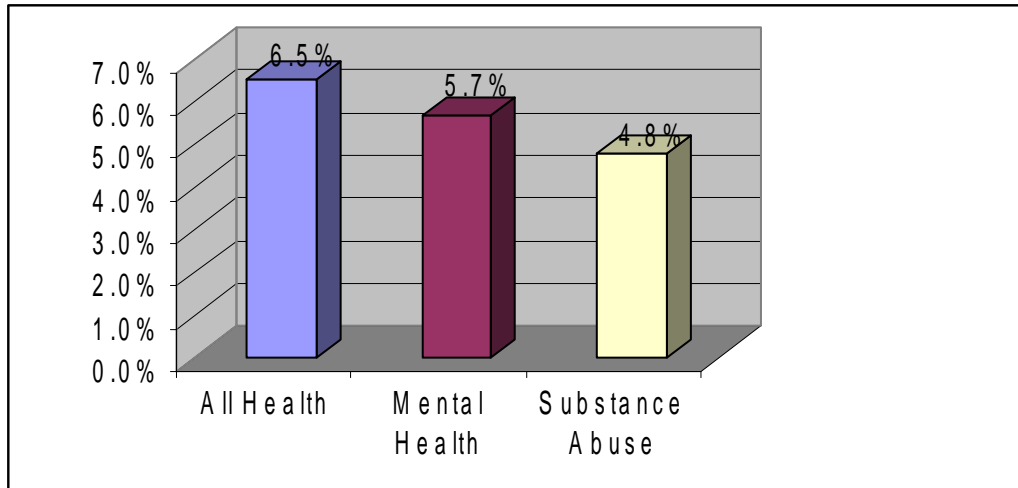
EXTENDED CARE PROGRAMS

Bibb	Behavioral Health System
Cobb	Devereaux Georgia Treatment Network
DeKalb	Laurel Heights Hospital
Douglas	Inner Harbour Hospital
Fulton	Hillside Hospital
Taylor	Georgia Center for Youth

APPENDIX D

PSYCHIATRIC AND SUBSTANCE ABUSE INPATIENT SERVICES ADDITIONAL DATA

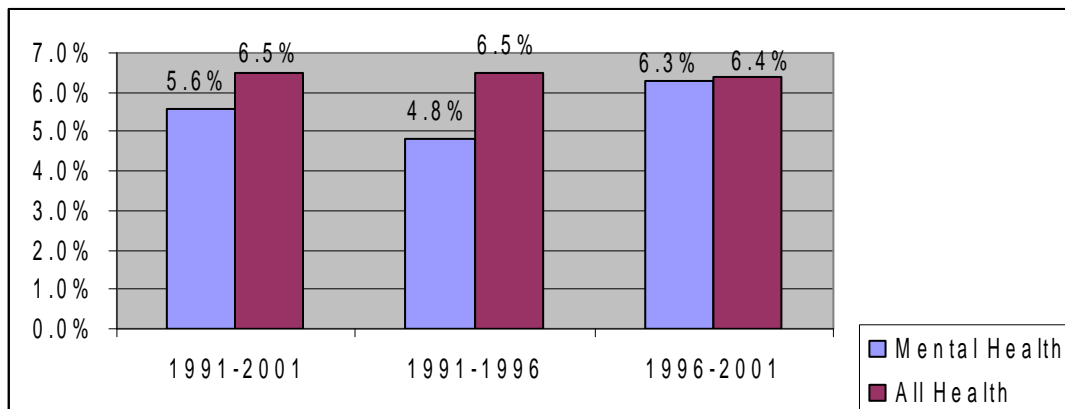
Figure 1. Growth of Mental Health and Substance Abuse Expenditures versus Total Health Expenditures, 1991-2001



Source: National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001, Chapter2, Substance Abuse and Mental Health Service Administration

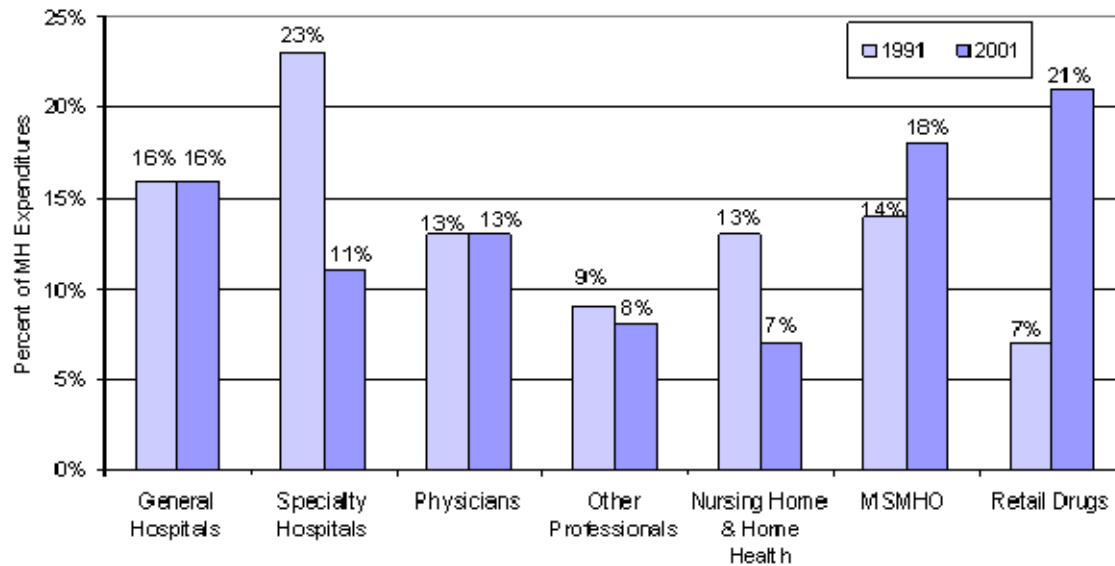
Mental Health

Figure 2. Growth of Mental Health Expenditures versus Total Health Expenditures, 1991-2001



Source: National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001, Chapter4, Substance Abuse and Mental Health Service Administration

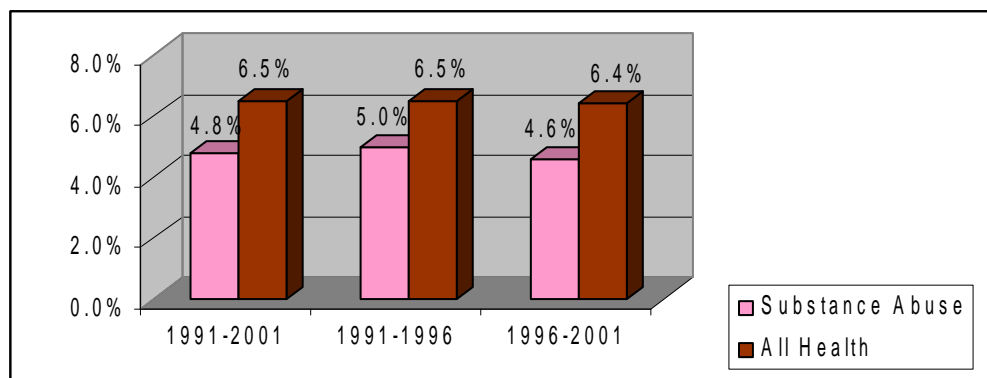
Figure 3. Mental Health Expenditures as a Percent of All Health Care Expenditures by Payer, 2001



Source: National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001, Chapter 4, Substance Abuse and Mental Health Service Administration

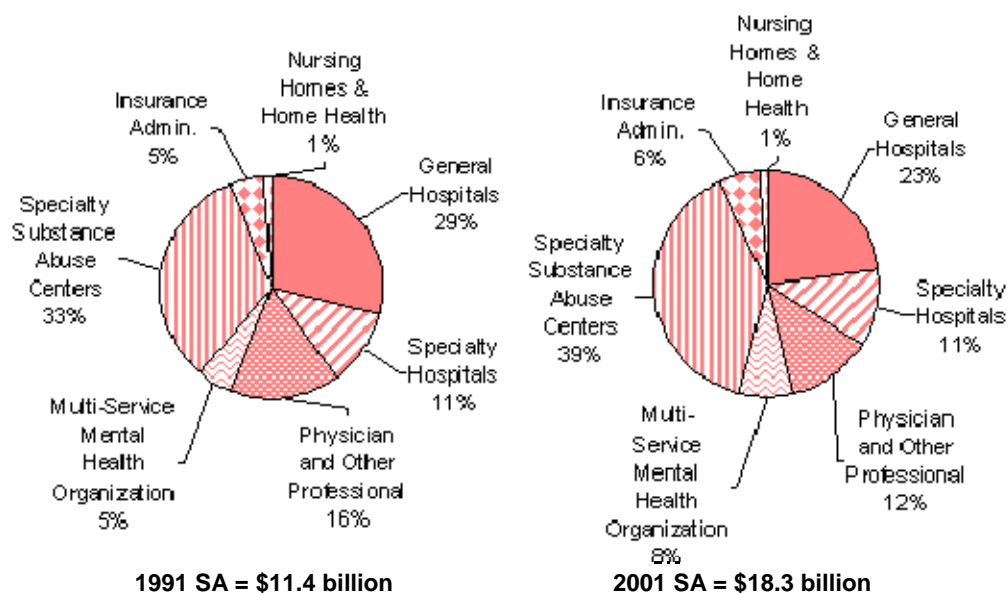
Substance Abuse

Figure 4. Growth of Substance Abuse Expenditures Compared to All Health, 1991 - 2001 and Five-Year Increments



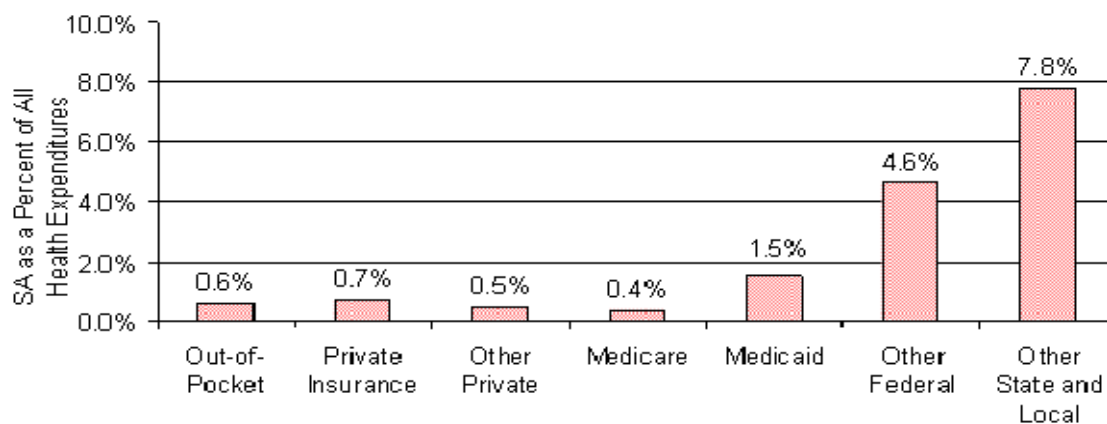
Source: National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001, Chapter 6, Substance Abuse and Mental Health Service Administration

Figure 5. Distribution of Substance Abuse Expenditures by Provider, 1991 and 2001



Source: National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001, Chapter 6, Substance Abuse and Mental Health Service Administration

Figure 6: Substance Abuse Expenditures as a Percent of All Health Care Expenditures by Payer, 2001



Source: National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001, Chapter 5, Substance Abuse and Mental Health Service Administration

Miscellaneous Data

Figure 7. MENTAL HEALTH SERVICE UTILIZATION, 2004

