



Section Summary

The planning team conducted an analysis to determine the amount of social infrastructure required to support anticipated growth in the Fort Stewart region to 2030 based on the state Office of Planning and Budget (OPB) figures. As growth strains existing social infrastructure resources, such as schools, physicians, open space, recreation facilities, and emergency services, the communities of the region should plan for expanded services from the outset to sustain quality of life and maintain efficient and effective delivery systems.

For the purpose of this study, social infrastructure is defined as the following services and facilities:

- Education: primary, elementary, middle, and high schools;
- Child care: Pre-K programs, childcare learning centers, group day care homes, and family day care homes;
- Health care: physicians (federal and non-federal), dentists, acute care (federal and non-federal, in terms of hospital beds), and nursing homes;
- Leisure: swimming baseball fields, soccer fields, and swimming pools;
- Open space: mini-parks, neighborhood parks/playgrounds, community parks, and regional/metropolitan parks; and
- Emergency services: police stations, police officers, fire stations, and firefighters.

Descriptions for social infrastructure items are arranged topically and can be found in sections, as follows:

- Child care - Section 7, Health Care and Social Services
- Health care - Section 7, Health Care and Social Services
- Education – Section 4, Education
- Leisure - Section 3, Land Use and Open Space
- Open space - Section 3, Land Use and Open Space
- Emergency services - Section 8, Public Safety

A summary of all recommended social infrastructure provisions can be found in the Technical Appendix.

This section (Section 7) specifically addresses needs related to health care and child care. The overall health care infrastructure in the region is not adequate to provide services to a national standard for the existing population. The shortage of providers in the community creates challenges for efficient services, continuity of care, and quality care. In the absence of a stronger network of providers, population growth will widen the existing service gap. This challenge is exacerbated by Winn Army Community Hospital's (WACH) shortage and direction to send non-active duty eligible patients to the local community network for services.

Access to medical and social service providers will continue to be a challenge to the local community unless steps are taken to increase awareness and access to the providers.



Community resources outside the urban core are limited to non-existent, failing to provide ease of service to the majority of the population living in less populated areas. Recent transit services by the Coastal Regional Commission aid in addressing these needs, but more work is necessary to create a service delivery strategy that ensures convenient access to all those in need.

The child care network appears adequate to serve community needs into the future, provided that commensurate increases in providers occur with additional populations. Availability of space with existing providers, coupled with planned expansion of the installation network, provides the capacity needed into the near-term. Nearly thirty percent (30%) of the Liberty County providers support the non-traditional hours required by active duty personnel.

Growth and Assessment Analysis Findings

Growth Analysis

The planning team conducted a social infrastructure analysis using a proprietary model (Social Infrastructure model or SIF) that quantifies future needs of communities based on OPB population projection inputs combined with a comprehensive list of social infrastructure standards and targets. (See Section 2 for further detail on population projections.) The analysis performs modeling for each county in the region in five-year phases over the 20-year study period, as shown in the tables below.

Table 7.1- Population Growth - by Phase

	Phase 1	Phase 2	Phase 3	Phase 4	Total
	2010-2015	2015-2020	2020-2025	2025-2030	
Bryan	5,658	6,288	7,194	7,068	26,208
Liberty	9,997	6,803	7,708	7,373	31,881
Long	1,196	1,297	1,358	1,427	5,278
Tattnall	2,188	2,288	2,436	2,564	9,476
Region	19,039	16,676	18,696	18,432	72,843

Table 7.2- Population Growth – Cumulative

	Phase 1	Phase 2	Phase 3	Phase 4
	2010-2015	2015-2020	2020-2025	2025-2030
Bryan	5,658	11,946	19,140	26,208
Liberty	9,997	16,800	24,508	31,881
Long	1,196	2,493	3,851	5,278
Tattnall	2,188	4,476	6,912	9,476
Region	19,039	35,715	54,411	72,843

Population changes and subsequent social infrastructure requirements were also estimated for the two most populous cities in the region, Hinesville and Richmond Hill, which are also projected to experience substantial growth over the study period. These population counts are included within the respective county counts (i.e. Liberty and Bryan Counties). As State population projections are only provided on a county level, projections for the cities of Hinesville and Richmond Hill were developed by analyzing the

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population within the city limits as generated through the land use model, CommunityViz (see Section 3 for further detail).

	Phase 1	Phase 2	Phase 3	Phase 4	Total
	2010-2015	2015-2020	2020-2025	2025-2030	
Hinesville	2,307	1,514	1,827	1,751	7,399
Richmond Hill	830	1,122	1,520	1,660	5,132

	Phase 1	Phase 2	Phase 3	Phase 4
	2010-2015	2015-2020	2020-2025	2025-2030
Hinesville	2,307	3,821	5,648	7,399
Richmond Hill	830	1,952	3,472	5,132

Impacts generated solely from military growth were also modeled. US Army projections for military employment at Fort Stewart were multiplied by a factor of 1.55 to account for dependents and therefore represent total direct military-related population growth in the region. US Army projections are limited to the horizon year of 2013, as future military actions are unpredictable, making estimates for growth beyond 2013 difficult. The military projections also utilize a base year of 2007 (rather than 2010 used for regional projections) to capture the arc of the latest growth period on the installation. If a base year of 2010 was used for military projections, it would appear that military population is declining; using the base year of 2007, historic growth can be captured. Social infrastructure requirements generated from this data represent a snapshot of facility need, therefore, during a cycle of growth and give insight into the impacts of direct military growth in the near term. Impacts were modeled from 2007-2013 in two phases, based on the growth outputs below.

	Phase 1	Phase 2	Total
	2007-10	2010-13	
Fort Stewart	5,964	-1,186	4,479

	Phase 1	Phase 2
	2007-10	2010-13
Fort Stewart	5,964	4,779

All of the demand projections are based on the best evidence available at the time of this study. The demand predictions shown will therefore change if the underlying assumptions on population and facility standards also change. It is important that the social infrastructure recommendations set out in this document are reviewed on a regular basis as developments come forward and projections can be verified.

Issues

Health Care

EXISTING SERVICE ISSUES

The Existing Conditions report outlined current capacity and service ratios across many health care sectors in the region, including information on hospital care, doctors, dentists, and nursing homes – both for military recipients and the wider public.

Medical Services

Overall, there is a shortage in Primary Care Physicians (PCP) within the study area. As shown in Table 7.7, Liberty, Long, and Tattnall Counties are all currently in need of PCPs.

For the purpose of this analysis, FSGMP derived information on the deficit of doctors from American Medical Association (AMA) standards. For comparison's sake, the AMA's category of doctors who are in "family practice" is considered to align with doctors who are identified in this study as "primary care physicians." The figures presented below exclude both Federal providers and those residents eligible for Army care.

	Current Number of Providers	Surplus/Deficit	Source
Bryan	13	+4	FSGMP, 2010, as derived from American Medical Association standards.
Liberty	3	-9	
Long	0	-4	
Tattnall	6	-1	

NB: A positive number signifies a surplus; a negative number signifies a deficit.

Along with unmet demand, the shortage in physician supply creates ancillary issues, such as delays in the waiting area of the physicians and long lag times between requests for appointments and the actual date of scheduling.

One element of the shortage that is not clearly defined in Table 7.7 is the geographic allocation of the office locations. Providers typically locate within the densely populated area, and as is the case in Liberty County, within proximity to the hospital. As a result, communities such as Pembroke and the smaller municipalities in Liberty County support few of the providers, requiring residents of those communities to travel for basic services.

In discussions with the stakeholders, recruiting and retention for both federal and non-federal facilities continues to be a challenge in Liberty County.

Patients in the four-county region choose regional medical facilities outside of the study area either out of necessity (because the specialty is not provided) or convenience. However, the current level of PCP physicians (214, equating to 89 doctors per 1,000 population) in the Chatham County area is also slightly below the state average (1:1,000), straining the community's ability to handle the overload of patients from within the study area.

TRICARE

TRICARE is the healthcare program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses worldwide. As a major component of the Military Health System, TRICARE brings together the healthcare resources of the uniformed services and supplements them with networks of civilian healthcare professionals, institutions, pharmacies and suppliers to provide access to high quality healthcare services, while maintaining the capability to support military operations. Essentially, TRICARE is a supplementary form of insurance coverage for military personnel and their families, which allow them access to a private healthcare provider located off-base.

According to the information from the 2009 Data Command Survey, Table 7.8 shows that active duty personnel and retirees eligible for TRICARE services reside predominately in the study area (approximately 64%), as well as Chatham County. Please note that the data on family members was not clearly available and, therefore, was not included in the table.

The Partnership has noted that a small percentage of physicians practicing in the community accept TRICARE as a method of insurance coverage, limiting the options available to those without convenient access to installation medical facilities. Therefore, TRICARE acceptance is low in the local community. There is a need for additional providers that accept TRICARE as a coverage option.

	Bryan	Liberty	Long	Tattnall	Chatham	Others
TriCare Residents	2,274	13,710	832	364	7,391	2,236
Percent of all Eligible TriCare Patients Living in County	8.438%	51.143%	3.104%	1.358%	25.571%	8.386%

Source: Fort Stewart Directorate of Public Works; FSGMP, 2010

While active duty soldiers rely on the facilities available on the installation, military dependants and other eligible TRICARE members living in the community may choose, or are required to utilize, civilian medical facilities, which may be in closer proximity to their residences. The Partnership has noted that a small percentage of physicians practicing in the community accept TRICARE as a method of insurance coverage, limiting the options available to those without convenient access to installation medical facilities. Therefore, TRICARE acceptance is low in the local community. There is a need for additional providers that accept TRICARE as a coverage option.

	Bryan	Liberty	Long	Tattnall
Physicians all Specialty	71	97	3	38
Those accepting TRICARE	19	41	3	2
Percent accepting TRICARE	26.76%	42.27%	100.00%	5.26%
Primary Care Providers	27	27	3	7
PCP accepting TRICARE	9	11	3	2
Percent PCP accepting TRICARE	33.33%	40.74%	100.00%	28.57%

Source: FSGMP, 2010

Dentists

There is also a shortage of general dentistry professionals within the study area. All counties report a supply of dental care providers less than the state and national ratios. Long County lacks a single provider. Similar to the discussion related to PCP physicians, the distribution of office locations in the most populated areas creates greater demands for smaller cities and rural areas. Further research into existing capacity for dentists could help reveal trends which would ultimately impact delivery options in the future.

Nursing Homes

There are a limited number of nursing home facilities in the study area: Three (3) of the counties within the study area have only one facility, and Tattnall County has two (2) facilities. The GA Home Health Care Agency (Reidsville) and the St. Joseph's Candler Home Health Care (Hinesville) are the only agencies in the study area that offer providers for in-home care. The Partnership was not able to locate assisted living facilities (for elderly or special needs patients) within the study area. The locations of the nursing home facilities for which information was obtained are listed below.

- Bryan County: Bryan County Health & Rehab Center, 127 Carter Street, Richmond Hill, GA 31324
- Liberty County: Woodlands Health Care LLC, 652 North Coastal Highway, Midway, GA 31320
- Long County: Coastal Manor, 82 Industrial Park Highway 84, Ludowici, GA 31316
- Tattnall County: 1) Tattnall Healthcare Center, 142 Memorial Drive, Reidsville, GA 30453; 2) Glenvue Nursing Home, 721 North Main Street, Glennville, GA 30427

As shown in Table 7.10, Long and Tattnall Counties have a substantial existing surplus in nursing home beds, especially considering the size of the local population being served in relation to the number of nursing home beds provided.

	Current Number of Beds	Surplus/Deficit	Source
Bryan	100	+3	FSGMP, 2010.
Liberty	137	+26	
Long	108	+43	
Tattnall	252	+62	

NB: A positive number signifies a surplus; a negative number signifies a deficit.

The two most populous counties in the region (Bryan and Liberty) have experienced an increase in the elderly population cohorts over the past twenty (20) years. Table 7.11 displays the observed population data for those aged sixty-five (65) and older.

	% of Population Over 65		
	1990 Census	2000 Census	2009 Census Estimate
Bryan	7.1%	7.3%	7.4%
Liberty	3.7%	3.9%	5.9%
Long	8.5%	5.8%	8.3%
Tattnall	13.4%	11.2%	12.0%

Source: United States Census

While the elderly population is generally increasing, the need for additional nursing home beds in the future will be reduced due to an existing surplus of nursing home beds in the region. Future need is discussed more fully later in this section.

Standards of Service

To generate levels of future health care needs, existing levels of service were applied to anticipated population growth. In general, comparatively low existing standards of provision indicate an inherent need for services in a particular sector. Conversely, high standards of provision, particularly above State averages, sometimes equate to an overprovision of services.

The following tables present the standards that were used in the modeling process to generate health care need arising from population growth to 2030. In some instances, standards were derived by calculating the number of facilities (such as hospital beds) by the existing population. In other cases, State averages were used when a local standard of provision could not be calculated. Source information is provided for each standard used.

Table 7.12 - Regional Health Care Standards		
Type of Service	Standard (per 1,000 population)	Source/Notes
All Specialty Physicians		
Bryan	2.02	FSGMP, 2010 (excluding Federal doctors).
Liberty	1.28	
Long	0.19	
Tattnall	1.57	
Primary Care Physicians (PCPs)		
Bryan	0.83	FSGMP, 2010. The standard represents all non-Federal providers and population not eligible for TRICARE (i.e. military recipients have been discounted).
Liberty	0.60	
Long	0.21	
Tattnall	0.29	
Hospital Beds		
Bryan	0.52	Calculated based on FSGMP research: number of hospital beds in region divided by regional population, excluding military recipients (2009). More detailed research of service areas not only of hospitals within the study area but also in neighboring counties may alter this standard.
Liberty		
Long		
Tattnall		
Dentists		
Bryan	0.28	FSGMP, 2010. *Adequate information was not available to calculate Long County's service ratio for dentists; therefore the State average was used.
Liberty	0.22	
Long	0.50*	
Tattnall	0.13	
Nursing Home Beds		
Bryan	3.07	Calculated based on FSGMP research: number of nursing home beds in the county divided by total county population (2009).
Liberty	2.20	
Long	8.83	
Tattnall	10.29	

Table 7.13 - Fort Stewart Health Care Standards		
Type of Service	Standard (per 1,000 population)	Source/Notes
All Specialty Physicians	3.45	Calculation derived from number of Federal physicians at Winn Army Community Hospital (WACH), Tuttle, and Hawks by number of military recipients
Primary Care Physicians (PCPs)	1.36	Calculation derived from number of WACH and Hawks PCPs divided by number of military recipients
Hospital Beds	3.17	Calculation derived from number of WACH beds divided by number of military recipients
Dentists	0.50*	*No Fort Stewart-specific service ratios available or able to be calculated based on available data; GA State Averages were used (see Table 7.9).
Nursing Home Beds	4.20*	

For comparison's sake, Table 7.14 below lists Georgia state averages for standards of provision. In most instances, local standards fall well below state averages; however, military provision often surpasses state averages. Long and Tattnall Counties are different in the case of nursing home bed provision, however. Each county has an unusually large supply of nursing home beds, yielding large service ratios that go well beyond the State average. In contrast, their service standards for other care, such as specialty physicians in Long County and dentists in Tattnall County, fall substantially below the State average, as well as service standards for Bryan and Liberty Counties. Future iterations of the modeling process could generate a picture of need based on these increased standards of provision should local governments wish to improve service delivery in any sector.

Table 7.14 - Georgia State Average Health Care Standards		
Type of Service	Standard (per 1,000 population)	Source/Notes
All Specialty Physicians	2.4	Kaiser Family Foundation: statehealthfacts.org
Primary Care Physicians (PCPs)	1.0	
Hospital Beds	2.7	
Dentists	0.5	
Nursing Home Beds	4.2	

FUTURE NEED

Based solely on existing standards for health care provision and OPB population projections described above, the gross demand for health care services and facilities based on is shown below in Tables 7.15-7.19.

Delivery, however, must take into consideration net demand – accounting for surplus and deficit supplies. This analysis is presented at the end of this section in Tables 7.39-7.42.

Table 7.15 - Bryan County Health Care Demand (Gross) Arising from New Population - Cumulative

	By Phase 1	By Phase 2	By Phase 3	By Phase 4
	2010-2015	2015-2020	2020-2025	2025-2030
All Specialty Physicians	11.4	24.1	38.7	52.9
Primary Care Physicians (PCPs)	4.7	9.9	15.9	21.8
Hospital Beds	2.9	6.2	10.0	13.6
Dentists	1.6	3.3	5.4	7.3
Nursing Home Beds	17.4	36.7	58.8	80.5

Table 7.16 - Liberty County Health Care Demand (Gross) Arising from New Population - Cumulative

	By Phase 1	By Phase 2	By Phase 3	By Phase 4
	2010-2015	2015-2020	2020-2025	2025-2030
All Specialty Physicians	12.8	21.5	31.4	40.8
Primary Care Physicians (PCPs)	6.0	10.1	14.7	19.1
Hospital Beds	5.2	8.7	12.7	16.6
Dentists	2.2	3.7	5.4	7.0
Nursing Home Beds	22.0	37.0	53.9	70.1



Table 7.17 - Long County Health Care Demand (Gross) Arising from New Population - Cumulative				
	By Phase 1	By Phase 2	By Phase 3	By Phase 4
	2010-2015	2015-2020	2020-2025	2025-2030
All Specialty Physicians	0.2	0.5	0.7	1.0
Primary Care Physicians (PCPs)	0.3	0.5	0.8	1.1
Hospital Beds	0.6	1.3	2.0	2.7
Dentists	0.6	1.2	1.9	2.6
Nursing Home Beds	10.6	22.0	34.0	46.6

Table 7.18 - Tattnall County Health Care Demand (Gross) Arising from New Population - Cumulative				
	By Phase 1	By Phase 2	By Phase 3	By Phase 4
	2010-2015	2015-2020	2020-2025	2025-2030
All Specialty Physicians	3.4	7.0	10.9	14.9
Primary Care Physicians (PCPs)	0.6	1.3	2.0	2.7
Hospital Beds	1.1	2.3	3.6	4.9
Dentists	0.3	0.6	0.9	1.2
Nursing Home Beds	22.5	46.1	71.1	97.5

Table 7.19 - Fort Stewart Health Care Demand (Gross) Arising from New Population - Cumulative		
	By Phase 1	By Phase 2
	2007-2010	2010-2013
All Specialty Physicians	20.6	16.5
Primary Care Physicians (PCPs)	8.1	6.5
Hospital Beds	18.9	15.1
Dentists	3.0	2.4
Nursing Home Beds	25.1	20.1

Social Service Providers

Greater awareness and access to available human service providers is needed

There is a need to raise awareness of available human service providers and to ensure that those in need of the services can access the providers. During the course of the analysis, staff had challenges in making contact and coordinating with numerous agencies that provide services to needed populations. Patrons with fewer resources likely face a greater challenge in accessing those agencies that provide necessary services.

Concurrent with the challenges associated with coordinating with the agencies, a stronger means of physical access is necessary to ensure that clients can obtain needed services. The majority of the service providers are located within the urban core of the communities, such as Hinesville, Pembroke-Richmond Hill, Glennville, and Reidsville. However, the populations they serve are distributed throughout the counties, creating transportation issues with getting to service providers.

Child Care and Early Education

Head Start Programs are in High Demand

The Georgia Head Start Association, Inc. (GHSA) is a statewide non-profit organization whose mission is to enhance the capability of local Head Start programs to deliver quality comprehensive services to children and their families. GHSA represents the 30 Head Start and Early Head Start agencies in the State of Georgia that provide these services to over 24,000 low-income preschool children from birth through five-years-old and their families. Despite a drop in the demand for child care services associated with the current deployment cycle, the “Head Start” programs are functioning at full capacity with a waiting list in all four counties, suggesting a greater demand for the program.

Child Care Demands Will Continue to Rise

Overall, the region has an adequate number of child care facility providers to meet current demands, but will require commensurate growth in the industry to support growing populations. However, existing spare capacity should be absorbed before new facilities are provided. Providers in Long County are most strained and may require additional providers before the other communities.

A variety of child care options is currently available in the region, catering to different age groups in different settings. The Georgia Department of Early Care and Learning (DECAL) administers the Georgia Pre-K Program, licenses child care centers, home-based child care, and several other programs targeted to maintain the welfare of children. The programs administered by DECAL fall into one of the following four categories, as listed in Table 7.20. Fort Stewart also offers child care options on post, which sometimes vary slightly from the typical child care options in the rest of the region. These special cases are recognized in the table below.

	Ages Served	Definition
Pre-K Programs	3-4 years	Offered at local public schools or through child care learning centers. Usually operate on the regular school system calendar for the length of a typical school day.
Child Care Learning Centers	0-17 years	Operated by a person, corporation, or institution. Licensed for 19 or more children.
Group Day Care Homes	0-17 years	Operated by a person, corporation, or institution. Licensed for 7-18 children.
Family Day Care Homes	0-17 years	Operated in a private residential home. For 3-6 children.
Fort Stewart Child Care Development Centers	0-5 years	
Fort Stewart School-aged Program	6-12 years	Operates for full days during school holidays and vacations. Provides recreational and educational activities before and after school.
Fort Stewart Youth and Teen Center	13-18 years	

A variety of child care options is currently available in the region, catering to different age groups in different settings. The Georgia Department of Early Care and Learning (DECAL) administers the Georgia Pre-K Program, licenses child care centers, home-based child care, and several other programs targeted to maintain the welfare of children.

As discussed in the section on child care in the Existing Conditions report, child care is well-utilized in most of the study area, with most facilities reporting capacity at around 78% (although Tattnall County’s enrollments were considerably lower). The Existing Conditions report details licensed capacity for child care facilities in each county. However, for the purpose of this analysis, existing spare capacity is most

critical to understand how and when new demand for child care might be absorbed in the future. Table 7.21 presents existing capacity for these child care facilities. For Fort Stewart, expansion to existing facilities is planned to occur in 2010. This additional capacity is listed in Table 7.22.

	Child Care Learning Centers	Group Day Care Homes	Family Day Care Homes	Source
Bryan County	291	7	6	FSGMP, 2009
Liberty County	514	7	69	
Long County	10	0	9	
Tattnall County	109	11	17	

NB: Information was unavailable for Pre-K facilities

	Pre-K Facilities	Facilities for School-aged Children	Source
Fort Stewart	288	144	FSGMP, 2009

NB: Information was unavailable for Youth and Teen facilities

The tables below illustrate child care demand arising from population increases in the number of children in the region. Demand is based on a set of service ratios developed from the current number of facilities and enrollment. A more detailed explanation of methodology, including service standards, will be included in a Technical Appendix. The first table shows future demand for Pre-K programs for each county. Because baseline information was made available to allow a calculation, Fort Stewart's Pre-K needs are described in terms of capacity and facility needs (rather than simply the number of programs required). The subsequent tables show gross demand for child care slots (i.e. raw numbers generated from the model) and net demand, taking into consideration existing spare capacity at facilities, as illustrated in Tables 7.21 and 7.22 above. Net demand is then converted into the number of facilities which will be required, based on the average facility capacities shown above.

	By Phase 1	By Phase 2	By Phase 3	By Phase 4
	2010-2015	2015-2020	2020-2025	2025-2030
Bryan County	1.1	1.4	1.9	2.5
Liberty County	4.0	4.6	5.4	6.8
Long County	0.3	0.3	0.4	0.5
Tattnall County	0.5	0.6	0.7	0.9



Table 7.24 - Bryan County Child Care Demand Arising from New Population - Slots

		By Phase 1	By Phase 2	By Phase 3	By Phase 4
		2010-2015	2015-2020	2020-2025	2025-2030
Child Care Learning Centers	<i>Gross</i>	258	533	819	981
	<i>Net</i>	0	500	819	981
Group Day Care Homes	<i>Gross</i>	8	16	24	29
	<i>Net</i>	1	16	24	29
Family Day Care Homes	<i>Gross</i>	7	15	23	28
	<i>Net</i>	1	15	23	28

Table 7.25 - Bryan County Child Care Demand Arising from New Population - Facilities

	By Phase 1	By Phase 2	By Phase 3	By Phase 4
	2010-2015	2015-2020	2020-2025	2025-2030
Child Care Learning Centers	0	4.3	7.1	8.5
Group Day Care Homes	0.1	1.0	1.5	1.8
Family Day Care Homes	0.2	2.5	3.8	4.7

Table 7.26 - Liberty County Child Care Demand Arising from New Population - Slots					
		By Phase 1	By Phase 2	By Phase 3	By Phase 4
		2010-2015	2015-2020	2020-2025	2025-2030
Child Care Learning Centers	Gross	339	612	872	977
	Net	0	437	872	977
Group Day Care Homes	Gross	8	15	21	24
	Net	1	15	21	24
Family Day Care Homes	Gross	69	124	177	198
	Net	0	124	177	198

Table 7.27 - Liberty County Child Care Demand Arising from New Population - Facilities					
		By Phase 1	By Phase 2	By Phase 3	By Phase 4
		2010-2015	2015-2020	2020-2025	2025-2030
Child Care Learning Centers		0	3.5	7.0	7.9
Group Day Care Homes		0.1	0.8	1.2	1.3
Family Day Care Homes		0	20.7	29.5	33.0

Table 7.28 - Long County Child Care Demand Arising from New Population - Slots					
		By Phase 1	By Phase 2	By Phase 3	By Phase 4
		2010-2015	2015-2020	2020-2025	2025-2030
Child Care Learning Centers	Gross	15	31	46	52
	Net	5	31	46	52
Group Day Care Homes	Gross	6	12	18	20
	Net	6	12	18	20
Family Day Care Homes	Gross	7	15	21	24
	Net	0	13	21	24

Table 7.29 - Long County Child Care Demand Arising from New Population - Facilities					
		By Phase 1	By Phase 2	By Phase 3	By Phase 4
		2010-2015	2015-2020	2020-2025	2025-2030
Child Care Learning Centers		0.1	0.7	1.0	1.2
Group Day Care Homes		0.3	0.7	1.0	1.1
Family Day Care Homes		0	2.2	3.5	4.0

Table 7.30 - Tattnall County Child Care Demand Arising from New Population - Slots					
		By Phase 1	By Phase 2	By Phase 3	By Phase 4
		2010-2015	2015-2020	2020-2025	2025-2030
Child Care Learning Centers	<i>Gross</i>	39	79	115	130
	<i>Net</i>	0	9	115	130
Group Day Care Homes	<i>Gross</i>	11	23	33	37
	<i>Net</i>	0	23	33	37
Family Day Care Homes	<i>Gross</i>	17	33	48	54
	<i>Net</i>	0	33	48	54

Table 7.31 - Tattnall County Child Care Demand Arising from New Population - Facilities					
		By Phase 1	By Phase 2	By Phase 3	By Phase 4
		2010-2015	2015-2020	2020-2025	2025-2030
Child Care Learning Centers		0	0.1	1.8	2.0
Group Day Care Homes		0	1.3	1.8	2.1
Family Day Care Homes		0	5.5	8.0	9.0

Table 7.32 - Fort Stewart Child Care Demand Arising from New Population - Slots			
		By Phase 1	By Phase 2
		2007-2010	2010-2013
Pre-K	<i>Gross</i>	15	31
	<i>Net</i>	5	31
Facilities for School-aged Children	<i>Gross</i>	6	12
	<i>Net</i>	6	12

* Facilities for school-aged children are being constructed with future capacity of 144 slots; no growth indicated, however, for this phase

Recommendations

Introduction

There is an existing need to supplement the local communities' medical infrastructure with additional physicians, dentists, and primary care providers and increase the percentage of physicians accepting TRICARE. Increased awareness of social service programs and transportation to those programs are also necessary to improve access, particularly for residents in outlying parts of the study area.

Short-Term

Immediate action needs to be devoted to addressing the service deficit of providers in the short-term and to retain providers that do locate to the area.

The Liberty County Health Department has coordinated a local planning group comprised of community leaders that acts as an informal county-wide coordinating entity. The group can serve as a model for other counties to emulate and once in place, create a larger-regional entity that can address needs throughout the study area.

The local and federal medical providers need to create a regional strategy for recruiting physicians to the area that might include cooperation with larger provider networks in Chatham County for those specialties that cannot be supported by local needs alone.

There may be an opportunity for the Liberty Regional Medical Center to collaborate with or consolidate under the larger networks associated with the Savannah medical facilities. Local officials and the hospital authority should review this potential strategy as a means to increase the presence and access to primary care physician and other physician needs.

There are opportunities available under several federal provisions through the National Defense Authorization Act for FY 2010 (P.L. 111-84) that allow joint military and non-military medical providers to collaborate and provide services. LRMC and The Doctor's Hospital of Tattnall County should coordinate with WACH to determine if this type of arrangement can be implemented locally. There are specific examples of this successful coordination at Fort Drum, New York; Yuma Proving Grounds, Arizona, and on a provider-specific basis at Fort Stewart/Fraser Center.

Seek a TRICARE waiver to increase reimbursements

The level of reimbursement is often a disincentive for providers to participate. However, TRICARE will permit waivers that increase reimbursement rates through either a "network" basis (if availability of an adequate number and mix of qualified health care providers in a network in a specific locality is not found) or "locality" basis (if access to specific health care services is severely impaired). The local authorities or entities (such as those proposed above) can submit requests for waivers

There is a need to increase awareness of the service providers located in the study area

Access to service providers requires knowledge of the provider. The study area should coordinate an effort with local governments, service providers and Fort Stewart staff to assemble a single document that introduces the service amenities and local providers as a tool for newly assigned Fort Stewart troops/staff. The document would also be available for local realtors or other private entities that interact with new residents of the community.

There is a continued demand for Head Start programs in all Counties

Local officials and service providers should coordinate with the State Program Managers at Georgia Head Start Association to explore the expansion of local facilities to meet demands.

The local and federal medical providers need to create a regional strategy for recruiting physicians to the area that might include cooperation with larger provider networks in Chatham County for those specialties that cannot be supported by local needs alone.

Long-Term

Define and implement service delivery strategies for increasing access from rural areas

The medical and social service providers in the area are located in the predominately urban areas of the county, creating both a distribution shortage and access challenge for those patrons located outside of the urban core. The communities need to concurrently look towards solutions that bring providers to the rural area, rural patrons to the urban location of the providers and combinations of both. Cooperative efforts with school districts, an agency that serves nearly all school-aged children in the communities may help to address these needs.

Increase after school/summer programs

Common to multiple elements, there is need for an increased presence in after-school and youth activities. Activities need not be recreationally oriented, but could also focus on educational and social issues addressing teenage concerns.

An aging population will need additional resources

While it is accurate to note that the general population cohorts define a young community, the historical trend is that those populations over age sixty-five (65) have increased in recent years and can be expected to continue increasing in future years. The community currently has limited resources to allow for aging in place or full life cycle care. The limits on aging in place and care opportunities create a displacement of those seniors that require convalescent or nursing care as a component of daily life.

Add child care facilities with future growth

The series of tables below shows the demand for child care in the Fort Stewart region based on the above analysis. Recommendations on the provision of facilities is based on the net number of children requiring care and the average size of facilities in terms of capacity, as presented in Tables 7.21-32 above. More detailed discussions with service providers should take place to formulate delivery option strategies to help successfully satisfy child care demand.

	Recommended Provision	Comments
Bryan	<ul style="list-style-type: none"> 1 Pre-K program 	Demand for Child Care Learning Centers is absorbed by existing capacity, requiring no new facilities. Spare capacity in existing facilities satisfies minimal demand for Group and Family Day Care Home slots. An appropriate location for the Pre-K program should be identified.
Liberty	<ul style="list-style-type: none"> 4 Pre-K programs 	Demand for Child Care Learning Centers is absorbed by existing capacity, requiring no new facilities. Spare capacity in existing facilities satisfies demand for Group and Family Day Care Home slots. An appropriate location for the Pre-K program should be identified. Appropriate locations for the Pre-K programs should be identified.
Long	<ul style="list-style-type: none"> No new child care provision 	Minimal demand for Child Care Learning Centers is absorbed by existing facilities. Demand not adequate for new Pre-K programs or Group / Family Day Care Homes.

Table 7.33 - Child Care Delivery Recommendation, 2010-2015		
	Recommended Provision	Comments
Tattnall	<ul style="list-style-type: none"> No new child care provision 	All demand for child care is absorbed by existing facilities. Demand not adequate for new Pre-K programs.
Fort Stewart	<ul style="list-style-type: none"> No new child care provision 	As explained above, Fort Stewart's growth was calculated in phases different from the counties so that the spike in growth on base occurring from 2007 -2013 could be captured. Phase 1 (2007-2010) growth, therefore, can be seen as historic need, whereas Phase 2 (2010-2013) represents future need. Projecting forward, extra capacity will be needed for 38 Pre-K children in existing facilities, though the bulk of demand is absorbed by the planned construction of another Pre-K facility. No new facilities/ capacity is required for school-aged children. In fact, no significant growth is anticipated in the relevant age groups.

Table 7.34 - Child Care Delivery Recommendation, 2015-2020		
	Recommended Provision	Comments
Bryan	<ul style="list-style-type: none"> 4 Child Care Learning Centers 1 Group Day Care Home 2 Family Day Care Homes 	Remaining capacity at existing Child Care Learning Centers will be filled, yet further demand calls for 4 new Child Care Learning Centers. Demand not adequate for additional Pre-K program.
Liberty	<ul style="list-style-type: none"> 3 Child Care Learning Centers 20 Family Day Care Homes 	Due to a high proportion usage of Child Care Learning Centers and Family Day Care Homes and increasing population, many new facilities will be required during this phase. No new Group Day Care Homes required. Added pressure will be placed on existing Pre-K programs; extra capacity should be sought at existing facilities.
Long	<ul style="list-style-type: none"> 2 Family Day Care Homes 	Additional demand will be placed on existing Child Care Learning Centers and Group Day Care Homes, but no new facilities are warranted. Demand not adequate for additional Pre-K program.
Tattnall	<ul style="list-style-type: none"> 1 Group Day Care Home 5 Family Day Care Homes 	Minimal demand for a Child Care Learning Center. Demand not adequate for additional Pre-K program, though extra capacity should be sought at existing facilities.

(Long County) Demand is not strong enough to warrant new doctors, hospital beds, or dentists. Although population is increasing, the current rates of provision are low for Long County, yielding demand which may not accurately reflect true need.

Table 7.35 - Child Care Delivery Recommendation, 2020-2025		
	Recommended Provision	Comments
Bryan	<ul style="list-style-type: none"> • 3 Child Care Learning Centers (7 total) • 1 Family Day Care Home (3 total) 	Extra demand from previous phase plus additional growth warrants the need for 3 new Child Care Centers. Added pressure will be placed on existing Pre-K programs; extra capacity should be sought at existing facilities.
Liberty	<ul style="list-style-type: none"> • 1 Pre-K program (5 total) • 4 Child Care Learning Centers (7 total) • 1 Group Day Care Home • 9 Family Day Care Homes (29 total) 	Demand from previous phase plus increased growth warrants the development of 4 new Child Care Learning Centers.
Long	<ul style="list-style-type: none"> • 1 Child Care Learning Center • 1 Group Day Care Home • 1 Family Day Care Center (3 total) 	Adequate demand is realized for a new Child Care Learning Center and a new Group Day Care Home. Demand not adequate for additional Pre-K program.
Tattnall	<ul style="list-style-type: none"> • 1 Child Care Learning Center • 3 Family Day Care Homes (8 total) 	One new Child Care Learning Center will be required, plus additional demand will need to be absorbed in existing facilities. Demand only slightly increases for Pre-K programs and Group Day Care Homes, still placing pressure on existing facilities.

Table 7.36 - Child Care Delivery Recommendation, 2025-2030		
	Recommended Provision	Comments
Bryan	<ul style="list-style-type: none"> • 1 Pre-K program (2 total) • 1 Child Care Center (8 total) • 1 Family Day Care Home (4 total) 	One additional Child Care Center is warranted, and additional pressure will be placed on existing facilities as well. Pressure is added to existing Group and Family Day Care Home facilities, yet no new facility is warranted. Demand is sufficient for a new Pre-K program, plus the need to seek additional capacity at existing programs.
Liberty	<ul style="list-style-type: none"> • 1 Pre-K program (6 total) • 4 Family Day Care Homes (33 total) 	Additional capacity will be needed in existing Child Care Learning Centers, though no new additional facility is warranted. No additional Group Day Care Homes required. Demand is sufficient for a new Pre-K program, plus the need to seek additional capacity at existing programs.
Long	<ul style="list-style-type: none"> • 1 Family Day Care Home (4 total) 	Demand not adequate for additional Pre-K program nor additional Child Care Learning Centers or Group Day Care Homes. One additional Family Day Care Home will be needed.

Table 7.36 - Child Care Delivery Recommendation, 2025-2030		
	Recommended Provision	Comments
Tattnall	<ul style="list-style-type: none"> • 1 Child Care Learning Center (2 total) • 1 Group Day Care Home (2 total) • 1 Family Day Care Home (9 total) 	Demand increases to warrant the addition of new facilities. Growth is nearly adequate for a new Pre-K program yet still falls short; additional capacity needs to continue to be sought at existing facilities.

Add health care professionals and facilities with future growth

The following tables describe a phased approach to delivering health care to accommodate population growth, taking into consideration the surplus/deficit of PCPs and nursing home beds which currently exists in the area. The recommendations therefore represent net demand for health care services and facilities.

Table 7.37 - Health Care Delivery Recommendation, 2010-2015		
	Recommended Provision	Comments
Bryan	<ul style="list-style-type: none"> • 11 specialty physicians • 2 hospital beds • 1 dentist • 14 nursing home beds 	Currently Bryan County has a surplus of 4 PCPs; this surplus should be able to absorb new growth in the first phase. A current surplus of 3 nursing home beds is absorbed by new growth, yet demand will still require 14 additional nursing home beds.
Liberty	<ul style="list-style-type: none"> • 12 specialty physicians • 15 PCPs • 5 hospital beds • 2 dentists 	A significant number of PCPs is needed to accommodate new growth and an existing deficit. An existing surplus of 26 nursing home beds absorbs the demand for 17 beds arising from growth, so no new provision is recommended.
Long	<ul style="list-style-type: none"> • 4 PCPs 	Demand is not strong enough to warrant new doctors, hospital beds, or dentists. Although population is increasing, the current rates of provision are low for Long County, yielding demand which may not accurately reflect true need. However, 4 PCPs are recommended to make up for a current deficit. An existing surplus of 43 nursing home beds absorbs the demand for 10 beds arising from growth, so no new provision is recommended. Sensitivity testing using other standards of provision nearer State averages might help approximate real requirements to satisfy demand.

Table 7.37 - Health Care Delivery Recommendation, 2010-2015		
	Recommended Provision	Comments
Tattnall	<ul style="list-style-type: none"> • 3 specialty physicians • 1 PCP • 1 hospital bed 	As with Long County, Tattnall County's current provision rates are low in certain sectors, namely for PCPs and dentists. Because of these low rates of provision, adequate demand does not exist for new PCPs or dentists. An existing surplus of 62 nursing home beds absorbs the demand for 12 beds arising from growth, so no new provision is recommended. However 1 PCP is recommended to make up for a current deficit.
Fort Stewart	<ul style="list-style-type: none"> • 16 specialty physicians • 6 PCPs • 15 hospital beds • 2 dentists • 20 nursing home beds 	The demand for doctors and hospital beds is for those located in Federal facilities. Dentist and nursing home bed need will need to be supplied in the community.

Table 7.38 - Health Care Delivery Recommendation, 2015-2020		
	Recommended Provision	Comments
Bryan	<ul style="list-style-type: none"> • 13 specialty physicians (24 total) • 5 PCPs • 4 hospital beds (6 total) • 2 dentists (3 total) • 19 nursing home beds (33 total) 	With surplus PCP capacity absorbed in the first phase of growth, new demand generates the need for 5 additional PCPs.
Liberty	<ul style="list-style-type: none"> • 9 specialty physicians (21 total) • 4 PCPs (19 total) • 3 hospital beds (8 total) • 1 dentist (3 total) • 11 nursing home beds 	Demand for 15 nursing home beds is partially absorbed in surplus capacity so that only 11 nursing home beds are required.
Long	<ul style="list-style-type: none"> • 1 hospital bed • 1 dentist 	Current standards of provision indicate that no specialty physicians or PCPs are needed at this time. Demand for 11 nursing home beds is absorbed in surplus capacity so that no new provision is required.
Tattnall	<ul style="list-style-type: none"> • 4 specialty physicians (7 total) • 1 PCP • 1 hospital bed (2 total) 	No dentists are required under current standards of provision. Demand for 23 nursing home beds is absorbed in surplus capacity so that no new provision is required.

Table 7.39 - Health Care Delivery Recommendation, 2020-2025		
	Recommended Provision	Comments
Bryan	<ul style="list-style-type: none"> • 14 specialty physicians (38 total) • 6 PCPs (11 total) • 4 hospital beds (10 total) • 2 dentists (5 total) • 22 nursing home beds (55 total) 	With surplus PCP capacity absorbed in the first phase of growth, new demand generates the need for 5 additional PCPs.
Liberty	<ul style="list-style-type: none"> • 10 specialty physicians • 4 PCPs (23 total) • 4 hospital beds (12 total) • 2 dentists (5 total) • 16 nursing home beds (27 total) 	Demand for 15 nursing home beds is partially absorbed in surplus capacity so that only 11 nursing home beds are required.
Long	<ul style="list-style-type: none"> • 1 hospital bed (2 total) 	Current standards of provision indicate that no specialty physicians or PCPs are needed at this time. Demand for 11 nursing home beds is absorbed in surplus capacity so that no new provision is required.
Tattnall	<ul style="list-style-type: none"> • 3 specialty physicians (10 total) • 1 PCP (3 total) • 1 hospital bed (3 total) • 9 nursing home beds 	No dentists are required under current standards of provision. Demand for 23 nursing home beds is absorbed in surplus capacity so that no new provision is required.

Table 7.40 - Health Care Delivery Recommendation, 2025-2030		
	Recommended Provision	Comments
Bryan	<ul style="list-style-type: none"> • 14 specialty physicians (52 total) • 6 PCPs (17 total) • 3 hospital bed (13 total) • 2 dentists (7 total) • 22 nursing home beds (77 total) 	-
Liberty	<ul style="list-style-type: none"> • 9 specialty physicians (40 total) • 5 PCPs (28 total) • 4 hospital beds (12 total) • 2 dentists (7 total) • 17 nursing home beds (44 total) 	-

Table 7.40 - Health Care Delivery Recommendation, 2025-2030		
	Recommended Provision	Comments
Long	<ul style="list-style-type: none"> • 1 specialty physician • 1 PCP (5 total) • 1 dentist (2 total) • 3 nursing home beds 	Only 1 specialty physician is required over the entire study period. Current standards of provision alone would have yielded the need for only 1 PCP over the 20-year study time period. However, due to an existing noted shortage, the total number of PCPs required increased to 5. Demand for hospital beds is not adequate to warrant any additional provision. Demand for 12 nursing home beds is partially absorbed in surplus capacity so that only 3 nursing home beds are required by the end of the study period.
Tattnell	<ul style="list-style-type: none"> • 4 specialty physicians (14 total) • 1 hospital bed (4 total) • 1 dentist • 26 nursing home beds (35 total) 	No further PCP provision is generated based on current standards, yielding the total need for only 3 PCPs over the study period. Only 1 dentist total is required by 2030.