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LETTER OF TRANSMITTAL

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To:

Kelli Fisk
Administrative Assistant
Medical Facilities Planning Branch
Division of Health Service Regulation

Date: 3/4/2015 **Job Number:** 11-7007-14

Attention:

RE: Knowles, Smith and Associates Spring Petition
Policy Chan

WE ARE SENDING YOU: ☐ Shop Drawings ☐ Prints ☐ Plans ☐ Samples

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☑ Spring 2015 Petition

Copies	Date	No.	Description
1	3/4/2015		Petition and Attachments

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Remarks: Sumbitted to Kelli Fisk at the 3.4.15 SHCC Meeting

Copy To: Virginia Jones, COO

Signed: KI

Petition to the State Health Coordinating Council Regarding Methodology/ Policy Adjustment for the *2016 State Medical Facilities Plan*

March 4, 2015

Petitioner		***Contact***	
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STATEMENT OF REQUESTED ADJUSTMENT

Knowles, Smith and Associates, LLP requests the following Policy change to the *2016 State Medical Facilities Plan* (*SMFP*).

Chapter 2: Policies should be changed as follows:

- Add new **Policy OR-1**

Applications for operating rooms dedicated to pediatric dental surgery shall be exempt from the Standard Methodology for Operating Rooms in Chapter 6 provided that the operating rooms are provided in an accessible, licensed and CMS-certified ambulatory surgical facility with not more than two operating rooms ; that the applicant demonstrates that in the past year it provided dental surgery services for at least 900 Medicaid pediatric outpatient surgical cases; and that the proposed operating rooms will be located in a North Carolina county identified by the Department of Health and Human Services , Health Resources and Services Administration as having a Low Income Dental Health Professional Shortage Area score of eight or greater. Applicants proposing these operating rooms must also demonstrate:

- That they will provide at least 1,500 cases in the third year of operation, of which at least 80 percent will be Medicaid beneficiaries,
- Evidence that access to the operating rooms will be open to non-owners,
- Evidence that ambulatory surgery centers in the proposed service area cannot serve the proposed cases,
- Evidence of support from a hospital system in the service area, including evidence of an agreement with at least one hospital to provide emergency transfer support, and
- Willingness to provide the Agency with a report on outcomes by the end of the third year of operations.

In determining the need for such operating rooms, the Agency will apply a standard of 2.5 hours per case, assuming that the facility will operate eight hours per day, 52 weeks a year.

REASONS FOR THE PROPOSED CHANGES

OVERVIEW

Access to dental care, particularly pediatric dental care, is a major problem in North Carolina. In 2013, CMS reported that, of children eligible for Medicaid for 90 days, only half had seen a dentist for preventive service within a year and a quarter had received dental treatment[1]. In April 2014, the Kaiser Family Foundation summary of DHHS Health Resources and Services Administration data showed that North Carolina ranked 32nd among the United States and its territories for percent of needed dentists available[2]. (See data in Attachment A). Last year, NC was short 270 dentists and had only 43 percent of the needed supply. South Carolina, Mississippi, Kentucky and West Virginia ranked better than North Carolina in this report. Data on HRSA Dental Health Shortage Areas are in Attachment B. The PEW Charitable Trust scores states on preventive dental care initiatives. In 2010, PEW gave North Carolina a "D" rating.[3]

The result is that many North Carolina children, particularly those in low-income communities lack good dental hygiene and have multiple untreated caries in their baby teeth. They show up in emergency rooms at alarming rates, which, according to the PEW Charitable Trust, increased 16 percent between 2006 and 2009. Consequences of untreated early childhood caries still affect hundreds of thousands of children annually[4]. However, emergency departments provide only temporary relief with pain medicines and antibiotics. Treating the problem eventually involves additional costs in dental offices or in operating rooms. Dental caries are infectious. Bacteria from an untreated child can pass to other children and to adults.

Treating children with these problems requires intensive clinical, technology and anesthesia support that is not typically available in a dentist office. Cases are complex, for example, reduction of jaw fractures, root canals, and space maintainers to support the facial structure while adult teeth grow in. Most of these children are Medicaid beneficiaries. Because Medicaid does not cover anesthesia in dental offices, and because the procedures are long and require operating room level preparation and recovery support, most of these procedures occur in operating rooms under general anesthesia. In 2013, more than 90 percent of the outpatient oral surgery cases reported on License Renewal Applications occurred in hospitals, according to data in the North Carolina Health Care Facilities Database; 9.4 percent occurred in ambulatory surgical facilities. (See Attachments C and D).

[1] CMS -416 Report, FFY 2013.

[2] Kaiser Family Foundation Dental Shortage areas website http://kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/# , accessed February 24, 2015.

[3] Children's Dental Health: North Carolina, Making Coverage Matter May 2011 http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2011/05/11/childrens-dental-health-north-carolina

[4] Cassamassimo, Paul, S, et al, Beyond the Dmft, The human and economic cost of early child hood caries, JADA, Vol 140,650-657, June 2009

MEDICAID

The policy's Medicaid requirements address an access issue. Although payment is low, North Carolina Medicaid covers a professional fee for children's dental procedures. Some pediatric dentists are willing to do them. Medicaid also covers a technical fee for procedures done in hospitals and ambulatory surgery centers. North Carolina hospital licensure rules do not recognize dentists as providers who can admit independently[5]. Consequently, to meet CMS and Joint Commission requirements in hospitals[6] dentists must have a physician who meets the hospital's medical staff by-law requirements, both recertify his/her patients' histories and physicals within 24 hours prior to surgery. In an ambulatory surgery center, on the other hand, North Carolina regulations permit a dentist to admit directly and to engage an independent physician to do the required independent recertification to attest to the patients' capacity to undergo general anesthesia.

North Carolina Medicaid does not cover anesthesia cost in a physician office; it does, in a hospital or ambulatory surgery center.

ORAL SURGERY CASES

The focus on pediatric dental surgery will limit the number of facilities, yet assure growth where needed. Given the legal restrictions, few hospitals in North Carolina accommodate dental surgery. The North Carolina Healthcare Facilities Database shows only 35 percent of the 109 hospitals provided more than 50 oral surgery outpatient cases in 2013 (see Attachment C). Only 1.74 percent of operating room cases reported that year were oral surgery cases. This database does not distinguish pediatric dental cases from other oral surgical cases. The result is inconsistent reporting of cases completed in hospital procedure rooms.

Dental surgical cases are also difficult to track in the Truven database for North Carolina, because the medical codes used on billing forms are generic, for example, a complex case will be coded as" CPT 521.00, Dental Caries." This is because Hospital and Ambulatory Surgery billing forms use ICD and American Medical Association CPT or CMS HCPCS codes, rather than American Dental Association Dental codes. The latter are more detailed. Operating room case data reported on North Carolina License Renewal Application forms do not separate children from adults and lack payor class information.

[5] 10A NCAC.13B.1905(a) and 10A NCAC 13B.1902(26)

[6] *The JCAHO rule states that the "History & Physical examination must be completed by a physician (as defined in section 1861(r) of the act)". Section 1861(r) of the (U .S. Social Security Act includes Doctor of Dental Surgery and Doctor of Dental Medicine in its definition of a physician.*

SINGLE SPECIALTY PEDIATRIC AMBULATORY SURGERY CENTER

North Carolina has no dental ambulatory surgery center. Even with substantial evidence to support the quality and value associated with specialization, the state favors multi-specialty facilities in order to assure access, especially in areas with limited resources. The exceptions are the six operating rooms associated with the 2010 SMFP Single Specialty Ambulatory Surgery Demonstration Project, and grandfathered eye and women's surgical centers.

The Cumberland-Robeson area was not included in geographies that qualified for the Single Specialty Ambulatory Surgery Demonstration Project. A single specialty alternative would satisfy the need, but the option is not available. Moreover, broadly expanding a single specialty option would not target the pediatric dental surgery access problem.

Sedating children for dental surgery requires skill, precision, and specialized equipment. Children are at high risk for complications of general anesthesia. Minimizing time under general anesthesia is critical to good post-surgical outcomes. This highlights the importance of exposing a child to only one surgery that repairs all of the known problems. Stress on the family, loss of time in recovery and costs are among the many other reasons.

Any approved pediatric dental ambulatory surgery center should have enough cases for surgeons and staff to maintain and assure quality and proficiency. The recent new dental ambulatory surgery center at the University of New Mexico has two operating rooms associated with a large dental clinic. The Center for Pediatric Dentistry, a partnership of University of Washington & Seattle Children's recently redesigned its Dental Surgical Center with two operating rooms. Children's Dental Surgery Center in Santa Ana, California, the first pediatric dental surgery center in the nation to be accredited by Joint Commission, has one operating room, but supports only five pediatric dentists and serve children between 20 months and 12 years old.[7]

[7] http://www.childrensdentalsurgerycenter.com/cds-facilities.htm

SOUTHEASTERN NORTH CAROLINA ACCESS PROBLEM EXAMPLE

Data from Hospital License Renewal forms for 2014 show that in HSA V, only seven of the 17 hospitals reported outpatient oral surgery and 95 percent of the +3,600 cases occurred in three hospital systems, Cumberland, Robeson and New Hanover. (See Attachment C.)

New Hanover reports that none of its cases were pediatric. In the Cumberland / Robeson area, only two hospitals have historically offered dental surgery block time. Effective December 31, 2014, Southeastern Regional Medical Center cancelled all dental surgery block time, even at its new ambulatory surgery center. This leaves more than 500 cases a year to find a new location.

Cumberland Hospital System, which includes Cape Fear Valley Medical Center, Highsmith Rainey Hospital, and Hoke Community Medical Center, restricts dental operating room block time for pediatric dentists to the older Highsmith Rainey Long Term Acute Care Hospital. There it limits dentists to one block a week, in which dentists fill the schedule 90 percent of the time. Pediatric dentists also manage to work-in cases when other surgeon block times open up at the last minute. Cumberland Hospital System by specifically exclude pediatric dentists from the definition of "physician." In fact, the by-laws permit only an anesthesiology group to recertify patients for anesthesia. Cumberland Hospital System has only one anesthesiology group, Cumberland Anesthesia Associates (CAA). CAA bills anesthesia to Medicaid and bills the history and physical update to the dentist, $135 per case, or about five to ten percent of the total Medicaid professional reimbursement[8]. At the hospital, dentists are also at the mercy of one anesthesia group for scheduling. This combination of history and physical billing and scheduling issues does not occur in all hospitals. However, the problem of scheduling timely pediatric dental surgery does occur in other parts of the state.

Recruiting dentists to this rural area is difficult. In a three year period, our practice will hire one of fifteen interviewees. Notwithstanding the North Carolina dentist shortage, the limiting factor for dental surgery in the Cumberland / Robeson county area is not the dentists, who are willing to and do take the Medicaid cases, in both their practices and at the hospital. The limiting factor is availability of dental operating room time. In the two counties, 29 pediatric dentists performed approximately 1,700 pediatric surgeries in 2013. If access were not a problem, this group alone could treat 2,000 cases a year. The waiting time for dental operating room schedule is now three or more months. For children who have dental pain, that is an eternity.

[8] KSA pediatric dentists try not to over-treat children, so their professional fees per case are typically low.

QUALITY MEASURES

Assurance of quality oversight is the intent of the licensure and certification components of the policy. Licensure by North Carolina DHSR and Certification by CMS will assure that the dental operating rooms operate by the same standards of quality as other operating rooms in the state. CMS accepts deemed status for operating rooms made available by the Joint Commission, Accreditation Association for Ambulatory Health Care, Inc., or URAC, and should be accepted for these facilities as well.

A mandatory eight-hour operating room schedule will enable a facility with only two operating rooms to operate with a single shift of trained operating room nurses. A longer, nine-hour schedule would require part-time staffing and could dilute staff quality and focus. As demand grows, the facility may, on its own, decide to expand hours of operation.

North Carolina does not have a model for this service, but the recently developed clinic and ambulatory surgery center at the University of New Mexico[9] demonstrates that the state is not the first to address the problem.

CLINICAL ISSUES: GENERAL ANESTHESIA FOR DENTISTRY AND CASE TIME

A pediatric dentist will use comprehensive dental rehabilitation under general anesthesia when conventional dental treatment is not an option: for example, very young with complex medical / physical / mental conditions; with a need for extensive treatment; for emergency treatment. As noted in a recent publication in *Pediatric Dentistry*:

> *The American Academy of Pediatric Dentistry (**AAPD**) endorses GA for pediatric dental patients who: are unable to cooperate; experience ineffective local anesthesia; are extremely fearful, anxious, or uncommunicative; require significant surgical procedures; can benefit from GA protecting them from psychological trauma and/or reducing medical risks; and require immediate, comprehensive oral care.[1,3] Furthermore, many medical conditions present with oral disease that must be managed in an inpatient setting, and the operating room (**OR**) is often the best place to provide such care. Pediatric dentists are trained to recognize the need for hospital-based dental treatment and to work with an anesthesia team to provide optimal care for their patients.[4] The AAPD definition of medically necessary care includes services of GA and use of surgery facilities.[5]*
>
> *Patients with an ASA classification of III or higher are usually not suitable candidates for moderate sedation and are more safely treated under GA supervised by a licensed, trained, and credentialed medical and dental team in an appropriately equipped facility.[1, 4]*

[9] https://www.healthdesign.org/clinic-design/clinic-examples/university-new-mexico-dental-clinic-and-surgery-center

> *The American Society of Anesthesiology (**ASA**) classifies patients according to their physical status as follows: (I) a normal healthy patient; (II) a patient with mild systemic disease; (III) a patient with severe systemic disease; (IV) a patient with severe systemic disease that is a constant threat to life; (V) a moribund patient who is not expected to survive without the operation; and (VI) a patient declared brain-dead whose organs are being removed for donor purposes.[6] Patients at higher medical risk during sedation are often more safely treated in the OR*[10]

In this study, the average operating time was 110 minutes, with a standard deviation of 28 minutes (1.8 to 2.3 hours).This excluded room turnover time. The American Academy of Pediatric Dentistry supports provision of general anesthesia outside the hospital in controlled circumstances.

The American Academy of Pediatric Dentistry (AAPD) endorses in-office use of deep sedation or general anesthesia administered by a trained, credentialed, and licensed pediatric dentist, dental or medical anesthesiologist, nurse anesthetist, or anesthesia assistant on select pediatric dental patients in an appropriately equipped and staffed facility.

Ninety-eight percent of pediatric dentistry programs treat patients under deep sedation / general anesthesia, with 69% of these cases occurring in an operating room environment only; 29% provide treatment under deep sedation/general anesthesia in both clinic-based and operating room settings.[11]

Three-quarters of graduating pediatric dental residents have equal or more experience with deep sedation than with minimal / moderate sedation cases. A recent study of academic pediatric dental programs reported 69 percent of their cases occurred in an operating room.[12]

AFFORDABLE CARE ACT

The Affordable Care Act permits states to include dental benefits for children in Medicaid programs and requires it in the Children's Health Insurance Program (CHIP). North Carolina Medicaid includes pediatric dental care. According to a 2009 report from the Government Accountability Office (GAO), 35 percent of children under Medicaid received dental services, up from 27 percent in the 2000 Surgeon General's Report. Most Medicaid programs experience a low rate of dentist participation. DMA statistics show that 52 percent of North Carolina Medicaid children receive at least one dental visit. CMS data report that only 24 percent receive treatment. Many participating dentists take only a few Medicaid patients. Hence, opportunities for abuse of Medicaid pediatric dental surgery are very limited.

The CHIP program faces larger challenges in low rates of dentist participation. The 2009 reauthorization of CHIP looks to improve some of the challenges historically faced to get CHIP kids dental care. Payment is lower and a third party company manages the program; participating dentists find that participation agreements are cumbersome and payments are delayed for months.

[10] Forsyth, Anna, General Anesthesia Time for Pediatric Dental Cases, Pediatr Dent 34(5)129-135, 2012
[11] American Academy of Pediatric Dentistry. Guidelines on use of anesthesia personnel in the administration of office-based deep sedation/general anesthesia to the pediatric dental patient. Reference Manual. 2009–10; 31(6):169–171.
[12] Ibid

ADVERSE EFFECTS ON PROVIDERS AND CONSUMERS OF NOT MAKING THE REQUESTED CHANGE

CONSUMERS

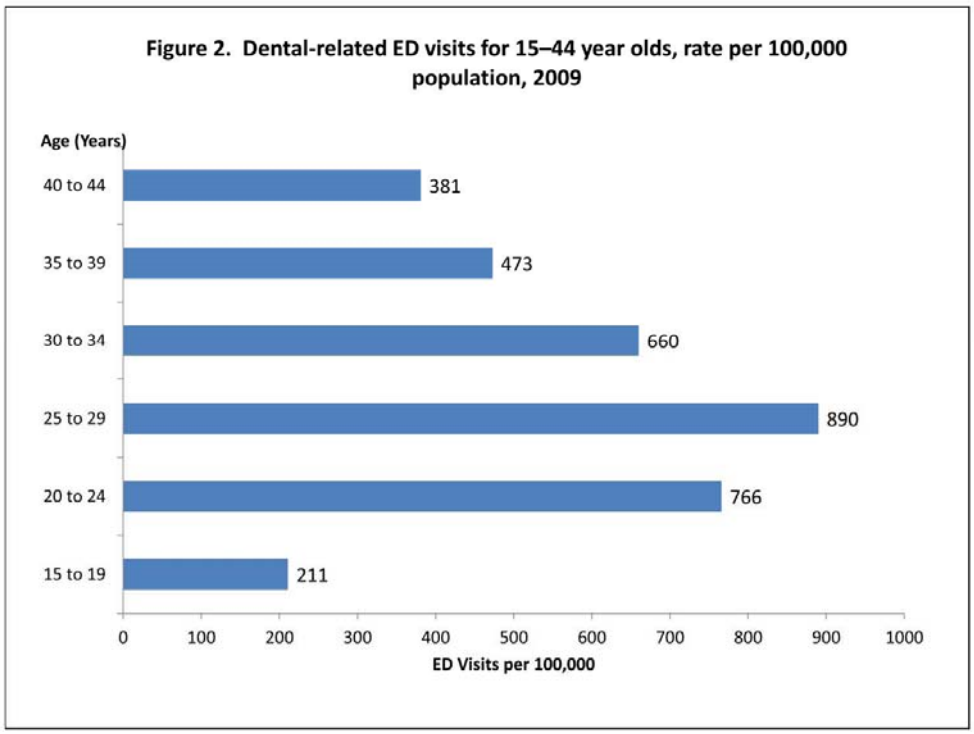
Under the current arrangement, particularly in southeastern North Carolina, pediatric patients are waiting three or more months for dental surgery. The delay is associated with available dental surgery block time. At best, these patients will become emergency room patients. Pew Charitable Trust reports a 16 percent increase in preventable dental visits to emergency rooms between 2009 and 2012.[13] Delayed early childhood dental treatment of dental caries can, at worst result in a brain abscess or sepsis.[14] Untreated early childhood caries result in poor growth, missed days of school, and poor performance in school.

Emergency care of this sort is expensive and preventable. Emergency room visits for dental pain increased from 1.0 percent of all visits to 1.06 percent between 2000 and 2010, according to a study by the American Dental Association.[15] The US Agency for Health Research and Quality reports that dental emergency visits rates are twice as high in rural and non-metropolitan areas as in large metropolitan areas with more than one million residents. The same report found that dental-related ED visit rates were four times higher among patients form the lowest income categories than from the highest income communities[16] And these ED visits do not result in treatment. They still require another visit or visits to dentists to treat the problem. These add to the cost of care. North Carolina has about 2.8 million children, of whom about 326,000 are on Medicaid.

As noted earlier, untreated dental caries will infect other people, as the affected person transfers the bacteria from his/her mouth to other people and objects. Research also shows that dental care is second only to public speaking on the fear scale. Dental fear translates to care avoidance. Getting children into a care routine removes that fear factor as they become adults. Long term, this reduces the cost of dental repair.

[13] Issue Brief, Pew Children's Dental Campaign A Costly Dental Destination, Pew Center on the States, 2012
[14] Ibid
[15] http://healthjournalism.org/blog/2014/04/lack-of-access-to-dental-care-leads-to-expensive-emergency-room-care/
[16] H-CUP Statistical Brief #143, Emergency department Visits for Dental Related Conditions, 2009 http://www.hcup-us.ahrq.gov/reports/statbriefs/sb143.pdf

Figure 2 further examines the age composition of dental-related ED visits for patients 15–44 years old. Those who were 25–29 years old had the highest rate of ED utilization for dental conditions (890 per 100,000 persons), followed by those who were 20–24 years old (766 per 100,000 persons) and 30–34 years old (660 per 100,000 persons).



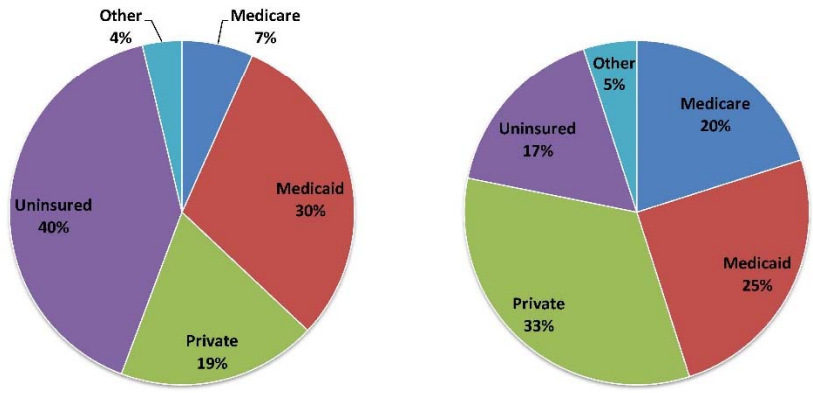
Source: AHRQ, Center for Delivery, Organization and Markets, Healthcare Cost and Utilization Project, Nationwide Emergency Department Sample, 2009

PAYERS

Medicaid, private insurance and consumer's out of pocket expenses cover dental surgery. Medicare covers it when the dental problem produces a medical emergency. With inadequate access to timely and appropriate intervention, persons for whom preventive care has failed are at risk for use of more expensive interventions. According to AHRQ, Medicaid and uninsured patients represent 70 percent of Emergency Room dental visits.

ED visits and inpatient stays related to dental issues by payer
Figure 3 Illustrates the payer mix of dental-related ED visits compared to all other ED visits. Most ED visits for dental-related conditions were covered by Medicaid (30 percent) or were uninsured (40 percent).

Figure 3. Expected pay source for dental-related ED visits compared to all other ED visits, 2009



Source: AHRQ, Center for Delivery, Organization and Markets, Healthcare Cost and Utilization Project, Nationwide Emergency Department Sample, 2009

PROVIDERS

Retaining dentists is essential if North Carolina is to improve its national dental health status. Retaining dentists in rural and non-metropolitan areas is even more critical. As noted earlier, in an attractive practice located outside North Carolina's large metro areas, we successfully employ one in 15 of the qualified dentists we interview. Most states have a shortage of dentists. If dentists in North Carolina cannot practice at the top of their license, communities outside the state or certainly outside the non-metro areas will easily recruit them away. Knowles, Smith & Associates committed to building a critical mass of highly credentialed and specialized dentists who are willing to tackle the difficult problems associated with care of Medicaid and military beneficiaries. It is important to retain these skills where they are so clearly needed.

Without a Policy change, parts of the state with significant access problems for pediatric dental surgery have no options but to wait or leave. A Policy change would permit those willing to invest the time and energy to qualify to start a service when access for a significant number of residents becomes a problem.

ALTERNATIVES TO THE REQUESTED CHANGE CONSIDERED AND REJECTED

OVERVIEW

Over the past seven years, KSA tried and / or considered multiple alternatives to this proposed Policy Change in the SMFP. Each led back to the alternative proposed in this petition.

NON-SMFP ALTERNATIVES

KSA tried many different approaches to solve the pediatric access problem. In 2009, representatives approached the CON Section for an exemption to do surgery in their offices, and were informed that surgery involving Medicaid payment requires a Certificate of Need for an ambulatory surgery facility. There was then and is now no need for operating rooms in the State Medical Facilities Plan. To establish partial relief, representatives met with the Division of Medical Assistance (DMA) to request an additional billing code for the newly required H&P recertification. DMA explained that the Medicaid budget has no room for more codes. The petitioner has have met with hospital administration at both Southeastern and Cumberland County Health System, and has yet to find a solution that works within existing constraints. .

KSA dentists perform some cases at Central Carolina Hospital in Lee County. Central Carolina Hospital has capacity and accommodates the cases. It would not be a candidate for the proposed Policy. As an alternative for patient care, it is not sufficient. Though convenient for patients who live in this area, that hospital is 50 minutes from Fayetteville and 1.5 hours from Lumberton.

WAIT FOR SMFP TO SHOW NEED OR ESTABLISH A DEMONSTRATION PROJECT

It will be a long time before the SMFP shows a need for two operating rooms in Cumberland or Robeson County, and, even then, a dental surgery center would be disqualified, because it would offer surgery in only one specialty.

A demonstration project for dental surgery would provide an opportunity for the state to learn more about this service. It would limit the number of centers, but it could result in allocation of the demonstration to another part of the state and might not solve the problem in Southeastern North Carolina. A policy change, on the other hand, permits slow evolution of the program where the need is most acute.

CHANGE SMFP OPERATING ROOM METHODOLOGY

KSA looked long and hard at an additional methodology that would define in the SMFP the number and location of needed dental operating rooms. However, the state data sources proved inadequate to target the methodology to the need. We considered two methodologies that use data available to the state. However, because state data do not distinguish between pediatric and oral surgery, each allocated rooms to New Hanover County. When asked, New Hanover Regional Medical Center indicated that it does no pediatric cases in its operating rooms.

Method 1:

Chapter 6: Operating Rooms should be changed as follows:

- Add a new methodology for pediatric dental ambulatory surgery operating rooms:

In addition to the need identified by the standard methodology, apply the following Methodology for a Pediatric Dental Ambulatory Surgery Facility:

- Step 1. Delineation of Service Area(s)

Define the Pediatric Dental Service Area as the Health Systems Area. This divides the state into six areas of similar population size.

- Step 2. Calculate the number of oral surgery cases in the service area using data in license renewal applications. See Attachment D.

- Step 3. Calculate the operating room utilization by Acute Care Service Area (Table 6B, Column H divided by the product of Columns K and S) Step 4. For each HSA in which the number of outpatient oral surgery cases in step 2 exceeds 2000, add one pediatric dental operating room for each 1000 cases, not to exceed two.

HSA	Hospital OP Oral Surgery Cases 2013	Total Outpatient Oral Surgery Cases 2013	Operating Rooms Allocated
I	1990	2149	0
II	1113	1536	0
III	1783	1847	0
IV	2812	2840	2
V	3531	3633	2
VI	1858	2439	2

- Step 5. Allocate the pediatric dental operating rooms from Step 4 to Acute Care Service areas in which the operating occupancy in Step 3 exceeds 90 percent and the number of Oral Surgery Cases exceeds 900

Acute Service Area	HSA	Occupancy 2013	Oral Surgery Cases 2013	Operating Rooms Allocated
N/A	IV			0
Cumberland	V	90.8%	1130	1
New Hanover	V	94.1%	1698	1
N/A	VI			0

Supporting data are in Attachment F .This methodology appears to work but it suffers from data limitations. It provides for an even allocation of resources, to locations with evidence of high occupancy of operating rooms and a high concentration of oral surgery. However, because the data in licensure reports do not separate pediatric from adult cases, it does not target children with advanced dental disease and an unresolved problem of access to pediatric dental operating room time. Moreover, it allocates pediatric rooms to a county in which the hospital provides no pediatric dental surgery in operating rooms, New Hanover. It also produces a less efficient ambulatory surgery center, with only one operating room.

Method 2:

Chapter 6: Operating Rooms should be changed as follows:

- Add a new methodology for pediatric dental ambulatory surgery operating rooms:

In addition to the need identified by the standard methodology, apply the following Methodology for a Pediatric Dental Ambulatory Surgery Facility:

- Step 1. Delineation of Service Area(s)

Define the Pediatric Dental Service Area as the Health Systems Area. This divides the state into six areas of similar population size.

- Step 2. On a rolling basis, starting in 2016, allocate two pediatric dental operating rooms per year to one Health Systems Agency (HSA), starting with HSA V, unless the surplus of operating rooms in the HSA exceeds 35.

This allocation provides for an even allocation of resources, starting with the area with evidence of the largest need, a high concentration of children with advanced dental disease and an unresolved problem of access to pediatric dental operating room time. It is also the HSA with the lowest surplus of operating rooms according to Table 6B of the 2015 SMFP. (Attachment E)

- Step 3. In subsequent years, allocate pediatric dental operating rooms to other HSAs based on the number of pediatric dentists in the HSA that accept new Medicaid patients, if the number exceeds seven, as reported to the Division of Medical Assistance official website Dental Provider list http://www.ncdhhs.gov/dma/dental/dentalprov.htm , unless the surplus of operating rooms in the HSA exceeds 40.
- Step 4. If the surplus of operating rooms in any Acute Care Service Area in the HSA identified in Step 3 is ten or greater, allocate the operating rooms to the next HSA in Step 3

Steps 3 and 4 allocate operating rooms based on capacity provide for the need and mitigate duplication in areas with significant surplus operating room capacity.

- Add to Summary of Operating Room Inventory and Utilization the following paragraph:

'Dental surgery, particularly for pediatric Medicaid patients is problematic for hospitals. The procedures require special accommodations and equipment; new requirements for physicians other than the dental surgeon to revalidate History and Physical information prior to surgery add to costs without offsetting increases in reimbursement. Many hospitals do not offer the service. Yet, cultural dietary patterns, poor understanding of good dental hygiene, an acute shortage of dentists, especially pediatric dentists, and competition for resources contribute to a high incidence of acute dental disease in North Carolina. To make dental surgery more accessible in locations that can concentrate skills and technology, yet remain accessible to the population in need, the State Medical Facilities Plan includes a special allocation of ambulatory surgery dental operating rooms.'

Table 6E Pediatric Dental Operating Room Need Determination

Based on the Pediatric Dental Operating Room Methodology, it is determined that the Pediatric Operating Room Service Area in the table below needs additional operating rooms as specified.

Method 1

Service Area	HSA	Need Determination	CON Application* Due Date	CON Beginning Review Date
Cumberland	V	1	TBD	TBD
New Hanover	V	1	TBD	TBD

Method 2

Service Area	HSA	Need Determination	CON Application* Due Date	CON Beginning Review Date
	V	2	TBD	TBD

To assure access to these rooms by persons with the highest need, applications to provide at least 80 percent of services to pediatric Medicaid beneficiaries should take precedence over others.

Both methodologies are cumbersome, and, because adequate data are not available from Truven or from state licensure forms, it breaks down and does not focus on areas where the need is highest. Hence, this alternative was rejected.

EVIDENCE OF NON-DUPLICATION OF SERVICES

The proposed solutions focus the proposed operating rooms on populations and patients in areas with a demonstrated need. The scale of the project permits the state to increase capacity to absorb its growing population and to review progress of this approach.

EVIDENCE OF NORTH CAROLINA MEDICAL FACILITIES PLAN BASIC GOVERNING PRINCIPLES

OVERVIEW

The proposed change, either methodology or policy is consistent with Basic Governing Principles in the 2015 SMFP. The petitioner presumes these will be repeated in the *2016 SMFP*.

1. Safety and Quality

> "The appropriate measures for quality and safety should be specific to the type of facility or service regulated. Clinical outcome and safety measures should be evidence-based and objective. Patient satisfaction measures should be quantifiable. In all cases, metrics should be standardized and widely reported and preference should be given to those metrics reported on a national level."

The proposed change would put the services in a facility for which Medicaid certification automatically mandates compliance with the CMS quality star-rating system. North Carolina licensure assures that facilities approved because of this petition will provide standardized surgical metrics to the state.

2. Access

> "The SHCC assigns the highest priority to a need methodology that favors providers delivering services to a patient population representative of all payer types in need of those services in the service area. Comparisons of value and quality are most likely to be valid when services are provided to like populations. Incentives for quality and process improvement, resource maximization, and innovation are most effective when providers deliver services to a similar and representative mixture of patients.
>
> "The needs of rural and small communities that are distant from comprehensive urban medical facilities merit special consideration. In rural and small communities selective competition that disproportionately captures profitable services may threaten the viability of sole providers of comprehensive care and emergency services. For this reason methodologies that balance value, quality, and access in urban and rural areas may differ quantitatively. The SHCC planning process will promote access to an appropriate spectrum of health services at a local level, whenever feasible under prevailing quality and value standards."

The proposal provides for coverage by all payers and care for all age groups. It puts particular emphasis on persons most in need, pediatric dental patients in low-income, non-metropolitan communities. Its structure avoids placement of additional dental operating rooms in areas where hospitals are willing and able to provide the services.

3. Value

> "The SHCC encourages the development of value-driven health care by promoting collaborative efforts to create common resources such as shared health databases, purchasing cooperatives, and shared information management, and by promoting coordinated services that reduce duplicative and conflicting care."

By requiring facilities approved under the proposed change to maintain transfer agreements with at least one hospital, the petition meets this principle. The alternative, not having capacity for pediatric dental surgery, produces multiple unnecessary and costly emergency room visits that do not treat the problem.

CONCLUSION

A policy change to accommodate licensed and certified dental operating rooms in areas that have significant concentrations of unmet need would provide for orderly growth, prevent unnecessary duplication, would help retain dentists in underserved areas, and would add value to the state's health care delivery system.

Of the 2.8 million children in the state, 326,000 are eligible for Medicaid in a given month. There are 157 pediatric dentists, of whom DMA reports 127 accept Medicaid and 111 are accepting new patients. Clearly, the need is greater than the supply of dentists. Many hospitals cannot accommodate the care demands. Encouraging systematic growth of quality pediatric dental care would prevent unnecessary and expensive emergency room visits, support military and low income families and help retain and increase the number of highly qualified providers in shortage areas in the state.

ABOUT THE PETITIONER

Knowles, Smith &Associates , LLP (KSA) is the largest, multi-specialty dental practice in the Fayetteville region; it has nine board certified specialists, two dentists that are on faculty at UNC-CH, and ECU Dental schools, respectively. One provider is an MD/Oral Surgeon specializing in facial aesthetics and facial reconstruction. The practice employs six CRNAs, who work in the offices daily to assure safe sedation procedures. Among its dentists, two are IV sedation certified general dentists, and KSA managing partner, Anuj James, DDS, serves on the Board for the American Academy of Group Dental Practices. Faith McGibbon, DDS, is a senior partner with KSA, and a pediatric dentist responsible for the pediatric dental team. KSA dentists maintain credentials to practice at Cumberland Health System hospitals, Cape Fear Valley Medical Center and Highsmith Rainey Hospital, at Central Carolina Hospital, and at Southeastern Regional Medical Center. Practice staff includes 27 licensed Dental Hygienists. The practice collectively serve 30 percent military or retired military and 35 to 40 percent Medicaid beneficiaries.

KSA dba Village Family Dental has twenty four general dentists, nine specialists including prosthodontics, periodontics, endodontics and oral surgery, and eight pediatric dentists who rotate through the 11 offices in the Cumberland County area. Pediatric specialists see 15-20 children daily in each location, approximately *100 children per day.* The majority of these children are in low wealth, minority families and struggle with access to care issues. KSA is one of the few practices in the area that accepts NC Medicaid/HealthChoice, particularly for children under age 8. KSA takes pride in providing the same quality of care for all of our patients, regardless of their ability to pay or payment method.

KSA was founded in 1985 on the principle that every patient is treated the same regardless of socioeconomic class or payer method. In addition, we have spent the last thirty years focusing on prevention. Each year we visit every primary school in our three counties and do a presentation about prevention to children pre-k thru 5th grade. Each child is given a dental kit including toothbrush, toothpaste, floss and a training guide. We run a bi-weekly cartoon and activity in the Cumberland County schools children's magazine that teaches children how to take care of their teeth. Our hygienists use the CAMBRA assessment program, which gives each patient a risk assessment based on their current status, medical condition, and previous dental history. With the assessment, the patient is given educational material on how to prevent further dental related issues- brush and floss daily, nutrition, etc.

ATTACHMENTS

Attachment A

Dental Health Professional Shortages by State, 2014

Dental Health Professional Shortages by State 2014

Location	Total Dental Care HPSA Designations	Percent of Need Met	Practitioners Needed to Remove HPSA Designation	Rank % need met
United States	**4,878**	**40.8%**	**7,208**	
Federated States of Micronesia	6	0.0%	27	1
Republic of Palau	2	0.0%	5	2
American Samoa	2	8.4%	13	3
U.S. Virgin Islands	5	8.6%	26	4
Connecticut	37	10.7%	86	5
Northern Mariana Islands	2	15.6%	15	6
District of Columbia	10	17.2%	17	7
Florida	220	17.3%	860	8
Missouri	160	24.5%	286	9
Tennessee	140	25.8%	353	10
South Dakota	56	26.1%	24	11
Alabama	62	27.0%	304	12
Georgia	148	27.1%	280	13
Washington	107	28.2%	177	14
New Jersey	35	30.6%	18	15
Illinois	161	30.8%	401	16
Arizona	170	31.7%	431	17
Rhode Island	14	33.1%	33	18
New Mexico	78	33.4%	139	19
Montana	75	34.6%	28	20
Maine	76	38.1%	46	21
Ohio	126	39.0%	244	22
Oregon	91	39.1%	160	23
Pennsylvania	160	40.3%	302	24
Kansas	134	40.3%	89	25
Hawaii	19	40.7%	6	26
California	341	41.3%	193	27
Colorado	82	41.7%	82	28
Michigan	212	41.8%	128	29
Nevada	48	42.7%	69	30
Wisconsin	95	43.3%	123	31
North Carolina	129	43.8%	270	32

Location	Total Dental Care HPSA Designations	Percent of Need Met	Practitioners Needed to Remove HPSA Designation	Rank % need met
United States	**4,878**	**40.8%**	**7,208**	
Virginia	83	46.8%	123	33
Delaware	6	47.1%	31	34
Arkansas	82	47.5%	90	35
Minnesota	124	47.8%	94	36
New York	129	50.8%	241	37
Indiana	47	51.7%	65	38
Idaho	70	52.3%	55	39
North Dakota	35	52.8%	7	40
Iowa	117	53.2%	59	41
Utah	48	53.4%	68	42
Maryland	39	54.9%	49	43
Massachusetts	64	55.0%	72	44
Mississippi	108	55.9%	206	45
South Carolina	79	57.8%	162	46
Wyoming	22	61.6%	7	47
New Hampshire	22	62.0%	4	48
Louisiana	102	62.0%	194	49
Texas	240	63.7%	349	50
West Virginia	94	64.0%	39	51
Kentucky	87	64.9%	32	52
Oklahoma	96	66.1%	15	53
Puerto Rico	22	66.7%	1	54
Alaska	57	68.8%	9	55
Vermont	26	84.1%	1	56
Nebraska	74	84.2%	0	57
Guam	1	NSD	NSD	
Marshall Islands	1	NSD	NSD	

Source: http://kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/

Attachment B

HRSA Dental Health Shortage Areas

Find Shortage Areas: HPSA by State & County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA Eligible for the Medicare Physician Bonus Payment
MUA/P by State & County

Criteria:

State: North Carolina
County: All Counties
ID: All
Date of Last Update: All Dates
HPSA Score (lower limit): 0
Discipline: Dental
Metro: All
Status: Designated
Type: All

Results: 240 records found.
(Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee. They are not listed separately.)

HPSA Name	ID	Type	FTE *	Score
001 - Alamance County				
Low Income - Alamance County	6379993799	HPSA Population	7	9
Alamance		Single County		
003 - Alexander County	No HPSAs in this county.			
005 - Alleghany County				
Low Income - Alleghany County	6379993746	HPSA Population	0	15
Alleghany		Single County		
007 - Anson County				
Brown Creek Correctional Institution	63799937B7	Correctional Facility	0	12
Lanesboro Correctional Institution	63799937A9	Correctional Facility	1	3
Anson Regional	6379993785	Comprehensive Health Center		16
Low Income - Anson County	63799937A4	HPSA Population	1	16
Anson		Single County		
009 - Ashe County				
Low Income - Ashe County	63799937B8	HPSA Population	1	17
Ashe		Single County		
011 - Avery County				
Mountain View Correctional Institution	6379993707	Correctional Facility	1	3
Low Income - Avery County	6379993740	HPSA Population	0	18
Avery		Single County		
013 - Beaufort County				
Metropolitan Community Health	63799937A7	Comprehensive Health Center		10
Low Income - Beaufort County	6379993765	HPSA Population	1	19
Beaufort		Single County		
015 - Bertie County				
Bertie County Rural Health Association	63799937B3	Comprehensive Health Center		0
Low Income - Bertie County	6379993737	HPSA Population	0	15
Bertie		Single County		
017 - Bladen County				
Low Income - Bladen County	6379993723	HPSA Population	3	15
Bladen		Single County		
019 - Brunswick County				
Low Income - Brunswick County	6379993758	HPSA Population	2	17
Brunswick		Single County		
021 - Buncombe County				
Western North Carolina Community Health	6379993776	Comprehensive Health Center		11
023 - Burke County				
Low Income - Burke County	6379993744	HPSA Population	4	10
Burke		Single County		
025 - Cabarrus County				
Cabarrus Health Alliance Dental Clinic	63799937G6	Other Facility	3	7
Cabarrus Community Health Center	63799937A3	Comprehensive Health Center		8
Low Income - North Central Cabarrus	6379993756	HPSA Population	3	10
407.01		Census Tract		
407.02		Census Tract		
407.03		Census Tract		
408		Census Tract		
409		Census Tract		
410		Census Tract		
411		Census Tract		
419.01		Census Tract		
419.02		Census Tract		
420		Census Tract		
421.01		Census Tract		
421.02		Census Tract		
423		Census Tract		
424.01		Census Tract		
424.02		Census Tract		
027 - Caldwell County				
Collettsville Medical Center	63799937GC	Rural Health Clinic	0	0
West Caldwell Health Council, Inc.	63799937G4	Comprehensive Health Center	0	16
029 - Camden County	No HPSAs in this county.			
031 - Carteret County	No HPSAs in this county.			
033 - Caswell County				
Caswell Family Medical Center	6379993778	Comprehensive Health Center		17
Low Income - Caswell County	6379993733	HPSA Population	1	14
Caswell		Single County		
035 - Catawba County	No HPSAs in this county.			

037 - Chatham County				
Low Income - Chatham County	6379993751	HPSA Population	3	9
Chatham		Single County		
039 - Cherokee County				
Low Income - Cherokee County	6379993731	HPSA Population	0	20
Cherokee		Single County		
041 - Chowan County				
Medically Indigent - Chowan County	6379993708	HPSA Population	0	14
Chowan		Single County		
043 - Clay County				
Low Income - Clay County	6379993726	HPSA Population	0	13
Clay		Single County		
045 - Cleveland County				
Low Income - Cleveland County	6379993734	HPSA Population	5	9
Cleveland		Single County		
047 - Columbus County				
Chadbourn Family Practice Center	63799937GA	Rural Health Clinic	0	11
Columbus County Community Health Center	63799937G5	Rural Health Clinic	0	10
Low Income - Columbus County	6379993739	HPSA Population	2	20
Columbus		Single County		
049 - Craven County				
Low Income - Craven County	6379993722	HPSA Population	3	12
Craven		Single County		
051 - Cumberland County				
Low Income - Cumberland County	6379993715	HPSA Population	17	9
Cumberland		Single County		
053 - Currituck County	No HPSAs in this county.			
055 - Dare County	No HPSAs in this county.			
057 - Davidson County	No HPSAs in this county.			
059 - Davie County	No HPSAs in this county.			
061 - Duplin County				
Low Income - Duplin County	6379993730	HPSA Population	3	16
Duplin		Single County		
063 - Durham County				
Lincoln Community Health Center	6379993782	Comprehensive Health Center		16
Low Income - Durham County	6379993752	HPSA Population	13	8
Durham		Single County		
065 - Edgecombe County				
Opportunities Industrialization Center Inc.	63799937GH	Comprehensive Health Center	0	20
Rocky Mount OIC Family Medical Center	63799937C2	Federally Qualified Health Center Look A Like		0
Low Income - Edgecombe County	6379993717	HPSA Population	3	19
Edgecombe		Single County		
067 - Forsyth County				
Southside United Health Center	63799937GI	Comprehensive Health Center	0	22
069 - Franklin County				
Low Income - Franklin County	6379993738	HPSA Population	2	14
Franklin		Single County		
071 - Gaston County				
Gaston Family Health Services, Inc.	6379993788	Comprehensive Health Center		18
073 - Gates County				
Low Income - Gates County	6379993704	HPSA Population	0	16
Gates		Single County		
075 - Graham County				
Low Income - Graham County	63799937B6	HPSA Population	1	12
Graham		Single County		
077 - Granville County				
Granville Internal Medical and Geriatrics	63799937B1	Rural Health Clinic		2
Federal Correctional Complex - Butner	6379993712	Correctional Facility	0	12
079 - Greene County				
Greene County Health Care, Inc.	6379993777	Comprehensive Health Center		14
Eastern Correctional Institution (Eci) Maury	6379993762	Correctional Facility	0	6
Low Income - Greene County	6379993769	HPSA Population	2	12
Greene		Single County		
081 - Guilford County				
Triad Adult and Pediatric Medicine	63799937GB	Comprehensive Health Center	0	19
Low Income - Guilford County	63799937G8	HPSA Population	21	6
Guilford		Single County		
083 - Halifax County				
Low Income - Halifax County	6379993796	HPSA Population	3	16
Halifax		Single County		
085 - Harnett County				
First Choice Community Health Centers	6379993786	Comprehensive Health Center		18
Low Income - Harnett County	6379993714	HPSA Population	3	15
Harnett		Single County		
087 - Haywood County				
Low Income - Haywood County	6379993741	HPSA Population	3	10
Haywood		Single County		
089 - Henderson County				
Blue Ridge Community Health Services, Inc.	6379993797	Comprehensive Health Center		6
Low Income/Migrant Farmworker - Henderson County	6379993710	HPSA Population	4	7
Henderson		Single County		
091 - Hertford County				
Roanoke-Chowan Community Health Center	63799937A6	Comprehensive Health Center		0
Low Income - Hertford County	6379993761	HPSA Population	0	17
Hertford		Single County		
093 - Hoke County				
Low Income - Hoke County	6379993750	HPSA Population	1	13
Hoke		Single County		
095 - Hyde County				
Ocracoke Health Center	637999370A	Comprehensive Health Center	0	9
097 - Iredell County				

Harmony Medical Care PA	63799937B2	Rural Health Clinic		0
099 - Jackson County				
Low Income - Jackson County	63799937A8	HPSA Population	1	18
Jackson		Single County		
101 - Johnston County				
Benson Area Medical Center	63799937GD	Rural Health Clinic	0	9
103 - Jones County				
Low Income - Jones County	6379993721	HPSA Population	0	16
Jones		Single County		
105 - Lee County				
Low Income - Lee County	6379993745	HPSA Population	3	12
Lee		Single County		
107 - Lenoir County				
Kinston Community Health Center	6379993798	Comprehensive Health Center		18
Low Income - Lenoir County	6379993727	HPSA Population	5	12
Lenoir		Single County		
109 - Lincoln County No HPSAs in this county.				
113 - Macon County				
Low Income - Macon County	6379993720	HPSA Population	2	16
Macon		Single County		
115 - Madison County				
Hot Springs Health Program	63799937A1	Federally Qualified Health Center Look A Like		18
Low Income - Madison County	6379993743	HPSA Population	1	14
Madison		Single County		
117 - Martin County				
Low Income - Martin County	6379993766	HPSA Population	0	18
Martin		Single County		
111 - McDowell County No HPSAs in this county.				
119 - Mecklenburg County				
C.W. Williams Community Health Center	6379993792	Comprehensive Health Center		10
Low Income - Central Charlotte	6379993772	HPSA Population	5	10
1		Census Tract		
13		Census Tract		
14		Census Tract		
26		Census Tract		
3		Census Tract		
36		Census Tract		
37		Census Tract		
4		Census Tract		
41		Census Tract		
42		Census Tract		
45		Census Tract		
46		Census Tract		
47		Census Tract		
48		Census Tract		
49		Census Tract		
5		Census Tract		
50		Census Tract		
51		Census Tract		
52		Census Tract		
53.01		Census Tract		
6		Census Tract		
7		Census Tract		
8		Census Tract		
9		Census Tract		
9803		Census Tract		
121 - Mitchell County				
Bakersville Community Medical Clinic	63799937GG	Comprehensive Health Center	0	20
Low Income - Mitchell County	6379993729	HPSA Population	0	16
Mitchell		Single County		
123 - Montgomery County				
Low Income - Montgomery County	6379993749	HPSA Population	1	14
Montgomery		Single County		
125 - Moore County No HPSAs in this county.				
127 - Nash County				
Low Income - Nash County	6379993759	HPSA Population	4	13
Nash		Single County		
129 - New Hanover County				
New Hanover	6379993787	Comprehensive Health Center		15
Low Income - New Hanover County	6379993728	HPSA Population	8	11
New Hanover		Single County		
131 - Northampton County				
Rural Health Group, Inc.	63799937A2	Comprehensive Health Center		22
Low Income - Northampton County	6379993795	HPSA Population	1	19
Northampton		Single County		
133 - Onslow County				
Low Income - Onslow County	6379993773	HPSA Population	3	13
Onslow		Single County		
135 - Orange County				
Piedmont Health Services	6379993779	Comprehensive Health Center		19
137 - Pamlico County				
Low Income - Pamlico County	6379993724	HPSA Population	0	13
Pamlico		Single County		
139 - Pasquotank County				
Low Income - Pasquotank County	6379993793	HPSA Population	1	14
Pasquotank		Single County		
141 - Pender County				
Black River Family Practice-Burgaw	63799937C4	Rural Health Clinic		2
Maple Hill Medical Center	63799937C3	Rural Health Clinic		1
Black River Health Center-Atkinson	63799937B9	Rural Health Clinic		2
Low Income - Pender County	6379993763	HPSA Population	3	12
Pender		Single County		
143 - Perquimans County No HPSAs in this county.				
145 - Person County				

Stedman-Wade Health Services	6379993771	Comprehensive Health Center		0
Person Family Medical Center	6379993770	Comprehensive Health Center		13
147 - Pitt County				
Low Income - Pitt County	6379993747	HPSA Population	7	17
Pitt		Single County		
149 - Polk County				
Collins Dental Center	63799937G3	Other Facility	1	17
151 - Randolph County				
Medical Resource Center for Randolph County, Inc.	63799937B4	Comprehensive Health Center		20
Low Income - Randolph County	6379993768	HPSA Population	5	15
Randolph		Single County		
153 - Richmond County				
Low Income - Richmond County	6379993753	HPSA Population	1	15
Richmond		Single County		
155 - Robeson County				
Dr. Arthur Jr. Robinson Medical Clinic	63799937G1	Rural Health Clinic		16
Fairmont Medical Clinic	63799937D1	Rural Health Clinic		0
Maxton Family Practice Center	63799937C9	Rural Health Clinic		16
Riverquest Medical Care	63799937C8	Rural Health Clinic		16
Rowland Medical Clinic	63799937C7	Rural Health Clinic		14
Johnson Medical Clinic	63799937C6	Rural Health Clinic		16
Robeson Healthcare Corporation	6379993775	Comprehensive Health Center		18
Low Income - Robeson County	6379993732	HPSA Population	8	12
Robeson		Single County		
157 - Rockingham County				
RMSA Health Center, Inc.	63799937C1	Federally Qualified Health Center Look A Like		0
159 - Rowan County				
Low Income - Rowan County	6379993748	HPSA Population	5	8
Rowan		Single County		
161 - Rutherford County				
Community Clinic of Rutherford County	63799937GE	Federally Qualified Health Center Look A Like	0	18
Low Income - Rutherford County	63799937G7	HPSA Population	1	17
Rutherford		Single County		
163 - Sampson County				
Goshen Medical Center	6379993789	Comprehensive Health Center		10
Tri-County Community	6379993781	Comprehensive Health Center		15
Low Income - Sampson County	6379993719	HPSA Population	6	7
Sampson		Single County		
165 - Scotland County				
Laurel Hill Medical Clinic	63799937GF	Rural Health Clinic	0	6
167 - Stanly County				
Low Income - Stanly County	63799937G2	HPSA Population	3	8
Stanly		Single County		
169 - Stokes County No HPSAs in this county.				
171 - Surry County				
Low Income - Surry County	6379993735	HPSA Population	3	13
Surry		Single County		
173 - Swain County				
PHS Indian Hospital-Cherokee	63799937GK	Indian Health Service Facility	0	20
Analenisigi Center	63799937G9	Native American Tribal Population	0	7
Low Income - Swain County	6379993757	HPSA Population	0	19
Swain		Single County		
175 - Transylvania County No HPSAs in this county.				
177 - Tyrrell County				
Low Income - Tyrrell County	6379993764	HPSA Population	0	11
Tyrrell		Single County		
179 - Union County No HPSAs in this county.				
181 - Vance County No HPSAs in this county.				
183 - Wake County				
North Carolina Department of Health and Human Services	6379993784	Comprehensive Health Center		12
Wake Health Services, Inc.	6379993780	Comprehensive Health Center		3
185 - Warren County				
Warren County	637185	HPSA Geographic	3	12
Warren		Single County		
187 - Washington County				
Low Income - Washington County	6379993767	HPSA Population	0	17
Washington		Single County		
189 - Watauga County				
High Country Community Health	63799937GJ	Comprehensive Health Center	0	4
Low Income - Watauga County	63799937B5	HPSA Population	1	17
Watauga		Single County		
191 - Wayne County				
Low Income - Wayne County	6379993754	HPSA Population	5	11
Wayne		Single County		
193 - Wilkes County				
Low Income - Wilkes County	6379993794	HPSA Population	6	9
Wilkes		Single County		
195 - Wilson County				
Carolina Family Health Center	6379993790	Comprehensive Health Center		10
Low Income - Wilson County	6379993760	HPSA Population	4	12
Wilson		Single County		
197 - Yadkin County				
Low Income - Yadkin County	6379993755	HPSA Population	2	13
Yadkin		Single County		
199 - Yancey County				
Low Income - Yancey County	6379993736	HPSA Population	0	17
Yancey		Single County		

Data as of: 1/1/2015

* This attribute represents the number of non-federal practitioners providing ambulatory patient care in the Health Professional Shortage Area (HPSA) expressed as full-time equivalents.

NEW SEARCH | MODIFY SEARCH CRITERIA

June 25, 2014 Federal Register Notice

NOTE: Below are lists of designated HPSAs that reflect the publication of the Federal Register notice on June 25, 2014. This Federal Register notice reflects the status of HPSAs as of May 23, 2014. The main impact of this Federal Register publication will be to officially withdraw those HPSAs that have been in "proposed for withdrawal" status since the last Federal Register notice was published on June 27, 2013. HPSAs that have been placed in “proposed for withdrawal” status since May 23, 2014 will remain in that status until the publication of the next Federal Register notice. If there are any questions about the status of a particular HPSA or area, we recommend that you contact the state primary care office in your state; a listing can be obtained at http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffices.html.

- County and County Equivalent Listing – Primary Care (approx. 359 KB)
- County and County Equivalent Listing – Dental Care (approx. 297 KB)
- County and County Equivalent Listing – Mental Care (approx. 355 KB)

Online Processing of Shortage Designation Applications Suspended

Daily updates of Health Professional Shortage Area (HPSA) data have been suspended and are scheduled to resume on March 21, 2015. State Primary Care Office and/or the appropriate Shortage Designation Project Officer.

Attachment C

Oral Surgery Procedures by Hospital by Health Service Area, 2013

Oral Surgery Procedures by Hospital by Health Service Area, 2013

HSA	Location	Primary Name	Inpatient Oral Cases	Outpatient Oral Cases	Total Oral Cases
I	Haywood	MedWest Haywood	667	58	725
I	Henderson	Margaret R. Pardee Memorial Hospital	0	376	376
I	Jackson	MedWest Harris	2	350	352
I	Catawba	Frye Regional Medical Center	0	328	328
I	Buncombe	Mission Hospital	16	297	313
I	Catawba	Catawba Valley Medical Center	22	198	220
I	Cleveland	Cleveland Regional Medical Center	0	98	98
I	Watauga	Watauga Medical Center	1	80	81
I	Burke	CMC - Blue Ridge	8	63	71
I	Henderson	Park Ridge Health	1	41	42
I	Macon	Angel Medical Center	0	35	35
I	Cherokee	Murphy Medical Center	0	27	27
I	Cleveland	Kings Mountain Hospital	0	25	25
I	Wilkes	Wilkes Regional Medical Center	0	7	7
I	Alleghany	Alleghany Memorial Hospital	0	4	4
I	Ashe	Ashe Memorial Hospital	0	3	3
I	Avery	Charles A. Cannon, Jr. Memorial Hospital	0	0	0
I	Caldwell	Caldwell Memorial Hospital	0	0	0
I	Macon	Highlands-Cashiers Hospital	0	0	0
I	McDowell	The McDowell Hospital	0	0	0
I	Mitchell	Blue Ridge Regional Hospital	0	0	0
I	Polk	St. Luke's Hospital	0	0	0
I	Rutherford	Rutherford Regional Medical Center	0	0	0
I	Transylvania	Transylvania Regional Hospital	0	0	0
II	Forsyth	Novant Health Forsyth Medical Center	14	517	531
II	Guilford	Cone Health	40	265	305

HSA	Location	Primary Name	Inpatient Oral Cases	Outpatient Oral Cases	Total Oral Cases
II	Forsyth	North Carolina Baptist Hospital	29	241	270
II	Forsyth	Novant Health Medical Park Hospital	0	33	33
II	Randolph	Randolph Hospital	0	28	28
II	Davidson	Lexington Medical Center	1	22	23
II	Rockingham	Morehead Memorial Hospital	0	4	4
II	Surry	Northern Hospital of Surry County	0	3	3
II	Alamance	Alamance Regional Medical Center	0	0	0
II	Davidson	Novant Health Thomasville Medical Center	0	0	0
II	Davie	Davie County Hospital	0	0	0
II	Guilford	High Point Regional Health System	0	0	0
II	Guilford	Kindred Hospital - Greensboro	0	0	0
II	Rockingham	Annie Penn Hospital	0	0	0
II	Stokes	Pioneer Community Hospital of Stokes	0	0	0
II	Surry	Hugh Chatham Memorial Hospital	0	0	0
II	Yadkin	Yadkin Valley Community Hospital	0	0	0
III	Mecklenburg	Novant Health Presbyterian Medical Center	17	422	439
III	Lincoln	Carolinas Medical Center-Lincoln	0	347	347
III	Gaston	CaroMont Regional Medical Center	10	298	308
III	Mecklenburg	Carolinas Medical Center-University	44	184	228
III	Iredell	Iredell Memorial Hospital	0	200	200
III	Stanly	Stanly Regional Medical Center	0	101	101
III	Mecklenburg	Carolinas Medical Center Mercy-Pineville	35	62	97
III	Iredell	Lake Norman Regional Medical Center	11	67	78
III	Mecklenburg	Novant Health Huntersville Medical Center	17	51	68
III	Rowan	Novant Health Rowan Medical Center	2	30	32
III	Mecklenburg	Carolinas Medical Center	1	13	14
III	Union	Carolinas Medical Center-Union	0	6	6

HSA	Location	Primary Name	Inpatient Oral Cases	Outpatient Oral Cases	Total Oral Cases
III	Mecklenburg	Novant Health Matthews Medical Center	0	2	2
III	Cabarrus	Carolinas Medical Center-NorthEast	0	0	0
III	Iredell	Davis Regional Medical Center	0	0	0
III	Mecklenburg	Novant Health Charlotte Orthopedic Hospital	0	0	0
IV	Orange	University of North Carolina Hospitals	238	1111	1349
IV	Lee	Central Carolina Hospital	0	564	564
IV	Durham	Duke University Hospital	8	258	266
IV	Wake	Duke Raleigh Hospital	0	237	237
IV	Wake	WakeMed	57	139	196
IV	Chatham	Chatham Hospital	0	182	182
IV	Franklin	Novant Health Franklin Medical Center	0	162	162
IV	Durham	Duke Regional Hospital	22	94	116
IV	Wake	Rex Hospital	1	48	49
IV	Wake	WakeMed Cary Hospital	5	10	15
IV	Durham	North Carolina Specialty Hospital	0	7	7
IV	Granville	Granville Health System	0	0	0
IV	Johnston	Johnston Memorial Hospital	0	0	0
IV	Person	Person Memorial Hospital	0	0	0
IV	Vance	Maria Parham Medical Center	0	0	0
V	New Hanover	New Hanover Regional Medical Center	10	1688	1698
V	Cumberland	Highsmith-Rainey Specialty Hospital	1	1093	1094
V	Robeson	Southeastern Regional Medical Center	0	653	653
V	Harnett	Betsy Johnson Hospital	0	36	36
V	Cumberland	Cape Fear Valley Medical Center	9	26	35
V	Moore	FirstHealth Moore Regional Hospital	0	31	31
V	Scotland	Scotland Memorial Hospital	0	4	4
V	Anson	Anson Community Hospital	0	0	0

HSA	Location	Primary Name	Inpatient Oral Cases	Outpatient Oral Cases	Total Oral Cases
V	Bladen	Cape Fear Valley-Bladen County Hospital	0	0	0
V	Brunswick	J. Arthur Dosher Memorial Hospital	0	0	0
V	Brunswick	Novant Health Brunswick Medical Center	0	0	0
V	Columbus	Columbus Regional Healthcare System	0	0	0
V	Montgomery	FirstHealth Montgomery Memorial Hospital	0	0	0
V	Pender	Pender Memorial Hospital	0	0	0
V	Richmond	FirstHealth Richmond Memorial Hospital	0	0	0
V	Richmond	Sandhills Regional Medical Center	0	0	0
V	Sampson	Sampson Regional Medical Center	0	0	0
VI	Wayne	Wayne Memorial Hospital	30	597	627
VI	Craven	CarolinaEast Medical Center	38	518	556
VI	Wilson	Wilson Medical Center	0	364	364
VI	Nash	Nash General Hospital	3	168	171
VI	Onslow	Onslow Memorial Hospital	2	98	100
VI	Lenoir	Lenoir Memorial Hospital	8	51	59
VI	Pasquotank	Albemarle Health: A Vidant Partner in Health	1	29	30
VI	Carteret	Carteret General Hospital	1	28	29
VI	Dare	The Outer Banks Hospital	0	5	5
VI	Beaufort	Vidant Beaufort Hospital	0	0	0
VI	Bertie	Vidant Bertie Hospital	0	0	0
VI	Chowan	Vidant Chowan Hospital	0	0	0
VI	Duplin	Vidant Duplin Hospital	0	0	0
VI	Edgecombe	Vidant Edgecombe Hospital	0	0	0
VI	Halifax	Halifax Regional Medical Center	0	0	0
VI	Hertford	Vidant Roanoke-Chowan Hospital	0	0	0
VI	Martin	Martin General Hospital	0	0	0

HSA	Location	Primary Name	Inpatient Oral Cases	Outpatient Oral Cases	Total Oral Cases
VI	Pitt	Vidant Medical Center	0	0	0
VI	Washington	Washington County Hospital	0	0	0
		Total for all Hospitals	***1,372***	***13,087***	***14,459***

Source: North Carolina Healthcare Facilities Database, 2013

Attachment D

Oral Surgery Procedures by Ambulatory Surgery Center by Health Service Area, 2013

Oral Surgery Procedures by Ambulatory Surgery Center by Health Service Area, 2013

HSA	Location	Primary Name	Oral Cases
I	Wilkes	Wilkes Regional Medical Center ASC	147
I	Catawba	Viewmont Surgery Center	12
I	Buncombe	Asheville Eye Surgery Center	0
I	Buncombe	FEMCARE	0
I	Buncombe	Orthopaedic Surgery Center of Asheville	0
I	Buncombe	The Endoscopy Center	0
I	Burke	Surgery Center of Morganton Eye Physicians	0
I	Catawba	Graystone Eye Surgery Center	0
I	Cleveland	Cleveland Ambulatory Services	0
I	Cleveland	Eye Surgery Center of Shelby	0
I	Henderson	Carolina Mountain Gastroenterology Endoscopy Center	0
I	Macon	Western Carolina Endoscopy Center	0
II	Guilford	High Point Surgery Center	244
II	Guilford	Surgical Center of Greensboro	164
II	Guilford	Greensboro Specialty Surgical Center	15
II	Forsyth	Piedmont Outpatient Surgery Center, LLC	0
II	Forsyth	Plastic Surgery Center of North Carolina	0
II	Guilford	Carolina Birth Center	0
II	Guilford	Piedmont Surgical Center	0
II	Guilford	Surgical Eye Center	0
II	Randolph	Central Piedmont Surgery Center	0
III	Cabarrus	Gateway Surgery Center	64
III	Cabarrus	Eye Surgery Center and Laser Clinic	0
III	Gaston	CaroMont Specialty Surgery	0
III	Iredell	Iredell Head Neck and Ear Ambulatory Surgery Center Inc	0
III	Iredell	Iredell Surgical Center	0
III	Mecklenburg	Carolina Center for Specialty Surgery	0
III	Mecklenburg	Carolinas Gastroenterology Center-Medical Center Plaza	0
III	Mecklenburg	Charlotte Surgery Center	0
III	Mecklenburg	Matthews Surgery Center	0
III	Mecklenburg	Novant Health Ballantyne Outpatient Surgery	0
III	Mecklenburg	Novant Health Huntersville Outpatient Surgery	0
III	Mecklenburg	SouthPark Surgery Center	0
III	Union	Presbyterian SameDay Surgery Center-Monroe	0
III	Union	Union West Surgery Center	0
IV	Durham	James E. Davis Ambulatory Surgical Center	28
IV	Wake	Blue Ridge Surgery Center	0
IV	Wake	Capital City Surgery Center	0
IV	Wake	Raleigh Orthopaedic Surgery Center	0

HSA	Location	Primary Name	Oral Cases
IV	Wake	Raleigh Plastic Surgery Center	0
IV	Wake	Rex Surgery Center of Cary, LLC	0
IV	Wake	Southern Eye Associates Ophthalmic Surgery Center	0
IV	Wake	Triangle Orthopaedic Surgery Center	0
IV	Wake	W. F. Endoscopy Center, LLC	0
V	Moore	Surgery Center of Pinehurst	102
V	Cumberland	Fayetteville Ambulatory Surgery Center	0
V	Moore	The Eye Surgery Center of the Carolinas	0
V	New Hanover	Wilmington SurgCare	0
VI	Pitt	Vidant SurgiCenter	581
VI	Carteret	The Surgical Center of Morehead City	0
VI	Dare	RMS Surgery Center	0
VI	Lenoir	Park Endoscopy Center	0
VI	Nash	Boice-Willis Clinic Endoscopy Center	0
VI	Wayne	Goldsboro Endoscopy Center	0
VI	Wilson	Eastern Regional Surgical Center	0
VI	Wilson	Wilson OB-GYN	0
		Total for all Ambulatory Surgery Centers	***1,357***
		Percent of all oral surgery procedures performed in ASC versus Hospital	***9.4%***

Source: North Carolina Healthcare Facilities Database, 2013

Attachment E

SMFP Table 6B: Projected Operating Room Need for 2017, Expanded and Sorted by HSA

SMFP Table 6B: Projected Operating Room Need for 2017; Expanded and Sorted by HSA

HSA	A	B	C	E	T	U	V	W
	Operating Room Service Areas (Single-county service areas are in bold. Counties in multicounty service areas are in italics with a shaded "total" row below.)	2013 Inpatient Cases (without exclusions)	Inpatient Case Time Standard (3 hours)	2013 Ambulatory Cases	Projected Operating Room Deficit or Surplus (Surplus shows as a "-")	Projected Need for New Operating Rooms	Cumulative need in Health Service Area	Rank order
I	Alexander	0	3.0	0	-2.00	0		
I	Alleghany	37	3.0	277	-1.72	0		
I	Ashe	183	3.0	506	-1.30	0		
I	Avery	145	3.0	331	-1.50	0		
I	*Buncombe*	12,100	3.0	28,743	-3.49	0		
I	*Madison*	0	3.0	0	0.00	0		
I	*Yancey*	0	3.0	0	0.00	0		
I	Burke	1,188	3.0	5,809	-4.53	0		
I	Caldwell	1,332	3.0	3,046	-2.45	0		
I	Catawba	5,756	3.0	18,408	-13.97	0		
I	*Cherokee*	469	3.0	2,065	-1.60	0		
I	*Clay*	0	3.0	0	0.00	0		
I	Cleveland	1,935	3.0	7,766	-0.74	0		
I	Haywood	1,187	3.0	3,693	-2.05	0		
I	Henderson	2,590	3.0	9,384	-3.94	0		
I	*Graham*	0	3.0	0	0.00	0		
I	*Jackson*	632	3.0	3,677	-1.99	0		
I	*Swain*	0	3.0	0	-1.00	0		
I	Macon	236	3.0	1,813	-4.17	0		
I	McDowell	236	3.0	882	-1.91	0		

HSA	A	B	C	E	T	U	V	W
	Operating Room Service Areas (Single-county service areas are in bold. Counties in multicounty service areas are in italics with a shaded "total" row below.)	**2013 Inpatient Cases (without exclusions)**	**Inpatient Case Time Standard (3 hours)**	**2013 Ambulatory Cases**	**Projected Operating Room Deficit or Surplus (Surplus shows as a "-")**	**Projected Need for New Operating Rooms**	**Cumulative need in Health Service Area**	**Rank order**
I	Mitchell	274	3.0	637	-2.06	0		
I	Polk	373	3.0	617	-1.89	0		
I	Rutherford	1,462	3.0	1,660	-1.37	0		
I	Transylvania	413	3.0	1,834	-1.83	0		
I	Watauga	809	3.0	3,476	-1.84	0		
I	Wilkes	619	3.0	3,002	-1.59	0		
	Buncombe Madison Yancey	12,100	3.0	28,743	-3.72	0		
	Cherokee Clay	469	3.0	2,065	-1.60	0		
	Jackson Graham Swain	632	3.0	3,677	-2.95	0		
	HSA I subtotal				**-67.21**		**-67.21**	**6**
II	*Alamance*	1,942	3.0	7,165	-3.01	0		
II	*Caswell*	0	3.0	0	0.00	0		
II	Davidson	1,293	3.0	5,595	-2.39	0		
II	Davie	0	3.0	408	-1.67	0		
II	Forsyth	26,403	3.0	45,495	-2.07	0		
II	Guilford	17,548	3.0	42,629	-28.01	0		
II	Randolph	1,090	3.0	2,979	-2.86	0		
II	Rockingham	1,352	3.0	3,455	-4.15	0		
II	Stokes	0	3.0	530	-3.59	0		
II	Surry	1,793	3.0	5,150	-2.00	0		
II	Yadkin	1	3.0	312	-1.75	0		

HSA	A	B	C	E	T	U	V	W
	Operating Room Service Areas (Single-county service areas are in bold. Counties in multicounty service areas are in italics with a shaded "total" row below.)	**2013 Inpatient Cases (without exclusions)**	**Inpatient Case Time Standard (3 hours)**	**2013 Ambulatory Cases**	**Projected Operating Room Deficit or Surplus (Surplus shows as a "-")**	**Projected Need for New Operating Rooms**	**Cumulative need in Health Service Area**	**Rank order**
	Alamance Caswell	1,942	3.0	7,165	-3.02	0		
	HSA II subtotal				**-54.52**		**-54.52**	**4**
III	Cabarrus	4,880	3.0	14,850	-4.00	0		
III	Gaston	4,044	3.0	12,364	-7.17	0		
III	Iredell	3,261	3.0	13,023	-3.56	0		
III	Lincoln	653	3.0	2,054	-1.23	0		
III	Mecklenburg	34,040	3.0	85,700	-15.36	0		
III	Rowan	3,005	3.0	7,337	-0.17	0		
III	Stanly	595	3.0	2,253	-2.21	0		
III	Union	1,453	3.0	6,458	-0.93	0		
	HSA III subtotal				**-34.63**		**-34.63**	**3**
IV	Chatham	15	3.0	411	-1.62	0		
IV	Durham	21,236	3.0	34,350	-6.91	0		
IV	Franklin	109	3.0	816	-3.13	0		
IV	Granville	649	3.0	2,471	0.04	0		
IV	Johnston	1,457	3.0	5,198	-1.11	0		
IV	Lee	810	3.0	3,403	-1.74	0		
IV	Orange	12,460	3.0	16,896	-5.88	0		
IV	Person	301	3.0	797	-2.87	0		
IV	*Vance*	941	3.0	2,231	-1.73	0		
IV	*Warren*	0	3.0	0	0.00	0		
IV	Wake	20,057	3.0	60,307	-9.80	0		

HSA	A	B	C	E	T	U	V	W
	Operating Room Service Areas (Single-county service areas are in bold. Counties in multicounty service areas are in italics with a shaded "total" row below.)	**2013 Inpatient Cases (without exclusions)**	**Inpatient Case Time Standard (3 hours)**	**2013 Ambulatory Cases**	**Projected Operating Room Deficit or Surplus (Surplus shows as a "-")**	**Projected Need for New Operating Rooms**	**Cumulative need in Health Service Area**	**Rank order**
IV	Vance Warren	941	3.0	2,231	-1.74	0		
	HSA IV subtotal				**-36.49**		**-36.49**	**2**
V	Anson	19	3.0	86	-0.90	0		
V	Bladen	273	3.0	469	-1.18	0		
V	Brunswick	1,280	3.0	4,234	0.02	0		
V	Columbus	1,120	3.0	2,985	-0.82	0		
V	Cumberland	6,539	3.0	19,773	-2.08	0		
V	Harnett	834	3.0	2,411	-6.49	0		
V	Hoke	0	3.0	0	-3.00	0		
V	Montgomery	0	3.0	139	-1.89	0		
V	Moore	5,669	3.0	16,905	-2.24	0		
V	New Hanover	9,506	3.0	29,139	0.45	0		
V	Pender	18	3.0	273	-1.73	0		
V	Richmond	705	3.0	1,825	-3.41	0		
V	Robeson	1,613	3.0	3,703	-4.51	0		
V	Sampson	623	3.0	1,576	-5.71	0		
V	Scotland	1,170	3.0	3,451	-0.43	0		
	HSA V subtotal				**-33.92**		**-33.92**	**1**
VI	*Beaufort*	531	3.0	2,855	-2.01	0		
VI	*Hyde*	0	3.0	0	0.00	0		
VI	Bertie	3	3.0	695	-1.44	0		
VI	Carteret	1,569	3.0	3,654	-1.29	0		

HSA	A	B	C	E	T	U	V	W
	Operating Room Service Areas (Single-county service areas are in bold. Counties in multicounty service areas are in italics with a shaded "total" row below.)	2013 Inpatient Cases (without exclusions)	Inpatient Case Time Standard (3 hours)	2013 Ambulatory Cases	Projected Operating Room Deficit or Surplus (Surplus shows as a "-")	Projected Need for New Operating Rooms	Cumulative need in Health Service Area	Rank order
VI	*Chowan*	388	3.0	1,152	-1.44	0		
VI	*Tyrrell*	0	3.0	0	0.00	0		
VI	*Craven*	3,008	3.0	9,375	-4.36	0		
VI	*Jones*	0	3.0	0	0.00	0		
VI	*Pamlico*	0	3.0	0	0.00	0		
VI	Dare	287	3.0	1,904	-0.96	0		
VI	Duplin	450	3.0	1,333	-1.17	0		
VI	Edgecombe	716	3.0	1,651	-2.55	0		
VI	*Halifax*	1,236	3.0	2,588	-2.04	0		
VI	*Northampton*	0	3.0	0	0.00	0		
VI	Hertford	599	3.0	1,710	-2.69	0		
VI	Lenoir	972	3.0	2,696	-5.29	0		
VI	Martin	253	3.0	506	-1.21	0		
VI	Nash	1,714	3.0	6,522	-5.13	0		
VI	Onslow	1,465	3.0	3,984	-3.07	0		
VI	*Camden*	0	3.0	0	0.00	0		
VI	*Currituck*	0	3.0	0	0.00	0		
VI	*Gates*	0	3.0	0	0.00	0		
VI	*Pasquotank*	774	3.0	4,072	-3.60	0		
VI	*Perquimans*	0	3.0	0	0.00	0		
VI	*Greene*	0	3.0	0	0.00	0		
VI	*Hyde*	0	3.0	0	0.00	0		

HSA	A	B	C	E	T	U	V	W
	Operating Room Service Areas (Single-county service areas are in bold. Counties in multicounty service areas are in italics with a shaded "total" row below.)	**2013 Inpatient Cases (without exclusions)**	**Inpatient Case Time Standard (3 hours)**	**2013 Ambulatory Cases**	**Projected Operating Room Deficit or Surplus (Surplus shows as a "-")**	**Projected Need for New Operating Rooms**	**Cumulative need in Health Service Area**	**Rank order**
VI	*Pitt*	12,152	3.0	20,143	-1.19	0		
VI	Washington	0	3.0	197	-1.85	0		
VI	Wayne	2,588	3.0	7,184	-2.97	0		
VI	Wilson	871	3.0	4,751	-3.51	0		
VI	Beaufort Hyde	531	3.0	2,855	-1.86	0		
VI	Chowan Tyrrell	388	3.0	1,152	-1.45	0		
VI	Craven Jones Pamlico	3,008	3.0	9,375	-4.40	0		
VI	Halifax Northampton	1,236	3.0	2,588	-2.07	0		
VI	Pasq-Cam-Cur-Gat-Perq	774	3.0	4,072	-3.54	0		
VI	Pitt Greene Hyde	12,152	3.0	20,143	-1.33	0		
	HSA VI subtotal				**-62.42**		**-62.42**	**5**
	State Total	**252,309**		**646,204**	**-262**	**0**		

Source: 2015 SMFP highlighted cells are surpluses greater than 5. Columns from Table 6B with V and W added.

Attachment F

SMFP Table 6B: Operating Room Occupancy by HSA, 2013

Table 6B:Operating Room Occupancy by H S A 2013

	A	H	K	S	X	Y
HSA	**Operating Room Service Areas (Single-county service areas are in bold. Counties in multicounty service areas are in italics with a shaded "total" row below.)**	**2013 Total Estimated Hours (D+G)**	**Standard Hours per OR per Year (9 hours x 260 days x .8)**	**Adjusted Planning Inventory**	**Utilization (H / S * K)**	**Outpatient Surgical Cases**
I	**Alexander**	0	1,872	2	0.00%	
I	**Alleghany**	526	1,872	2	14.05%	
I	**Ashe**	1,308	1,872	2	34.94%	
I	**Avery**	932	1,872	2	24.89%	
I	*Buncombe*	79,414	1,872	48	88.38%	
I	*Madison*	0	1,872	0	#DIV/0!	
I	*Yancey*	0	1,872	0	#DIV/0!	
I	**Burke**	12,278	1,872	11	59.63%	
I	**Caldwell**	8,565	1,872	7	65.36%	
I	**Catawba**	44,880	1,872	38	63.09%	
I	*Cherokee*	4,504	1,872	4	60.15%	
I	*Clay*	0	1,872	0	#DIV/0!	
I	**Cleveland**	17,454	1,872	10	93.24%	98
I	**Haywood**	9,100	1,872	7	69.44%	
I	**Henderson**	21,846	1,872	16	72.94%	
I	*Graham*	0	1,872	0	#DIV/0!	
I	*Jackson*	7,412	1,872	6	65.99%	
I	*Swain*	0	1,872	1	0.00%	
I	**Macon**	3,428	1,872	6	30.52%	
I	**McDowell**	2,031	1,872	3	36.16%	
I	**Mitchell**	1,778	1,872	3	31.66%	
I	**Polk**	2,044	1,872	3	36.40%	
I	**Rutherford**	6,876	1,872	5	73.46%	
I	**Transylvania**	3,990	1,872	4	53.29%	
I	**Watauga**	7,641	1,872	6	68.03%	
I	**Wilkes**	6,360	1,872	5	67.95%	
I	**Buncombe Madison Yancey**	79,414	1,872	48	88.38%	
I	**Cherokee Clay**	4,504	1,872	4	60.15%	
I	**Jackson Graham Swain**	7,412	1,872	7	56.56%	
	subtotal					
II	*Alamance*	16,574	1,872	12	73.78%	
II	*Caswell*	0	1,872	0	#DIV/0!	
II	**Davidson**	12,272	1,872	9	72.84%	
II	**Davie**	612	1,872	2	16.35%	
II	**Forsyth**	147,452	1,872	83	94.90%	274
II	**Guilford**	116,588	1,872	93	66.97%	
II	**Randolph**	7,738	1,872	7	59.05%	

Table 6B:Operating Room Occupancy by H S A 2013

	A	H	K	S	X	Y
HSA	**Operating Room Service Areas (Single-county service areas are in bold. Counties in multicounty service areas are in italics with a shaded "total" row below.)**	**2013 Total Estimated Hours (D+G)**	**Standard Hours per OR per Year (9 hours x 260 days x .8)**	**Adjusted Planning Inventory**	**Utilization (H / S * K)**	**Outpatient Surgical Cases**
II	**Rockingham**	9,238	1,872	9	54.83%	
II	**Stokes**	795	1,872	4	10.62%	
II	**Surry**	13,104	1,872	9	77.78%	
II	**Yadkin**	471	1,872	2	12.58%	
II	**Alamance Caswell**	16,574	1,872	12	73.78%	
	subtotal					
III	**Cabarrus**	36,915	1,872	25	78.88%	
III	**Gaston**	30,678	1,872	24	68.28%	
III	**Iredell**	29,318	1,872	20	78.31%	
III	**Lincoln**	5,040	1,872	4	67.31%	
III	**Mecklenburg**	230,670	1,872	149	82.70%	
III	**Rowan**	20,020	1,872	11	97.22%	30
III	**Stanly**	5,164	1,872	5	55.17%	
III	**Union**	14,046	1,872	9	83.37%	
	subtotal				#DIV/0!	
IV	**Chatham**	662	1,872	2	17.68%	
IV	**Durham**	115,233	1,872	73	84.32%	
IV	**Franklin**	1,551	1,872	4	20.71%	
IV	**Granville**	5,654	1,872	3	100.68%	0
IV	**Johnston**	12,168	1,872	8	81.25%	
IV	**Lee**	7,534	1,872	6	67.08%	
IV	**Orange**	62,724	1,872	41	81.72%	
IV	**Person**	2,098	1,872	4	28.02%	
IV	*Vance*	6,170	1,872	5	65.92%	
IV	*Warren*	0	1,872	0	#DIV/0!	
IV	**Wake**	150,632	1,872	97	82.95%	
	Vance Warren	6,170	1,872	5	65.92%	
	subtotal					
V	**Anson**	186	1,872	1	9.94%	
V	**Bladen**	1,522	1,872	2	40.65%	
V	**Brunswick**	10,191	1,872	6	90.73%	0
V	**Columbus**	7,838	1,872	5	83.74%	
V	**Cumberland**	49,276	1,872	29	90.77%	1119
V	**Harnett**	6,118	1,872	10	32.68%	
V	**Hoke**	0	1,872	3	0.00%	
V	**Montgomery**	208	1,872	2	5.56%	
V	**Moore**	42,364	1,872	26	87.04%	

Table 6B:Operating Room Occupancy by H S A 2013

	A	H	K	S	X	Y
HSA	**Operating Room Service Areas (Single-county service areas are in bold. Counties in multicounty service areas are in italics with a shaded "total" row below.)**	**2013 Total Estimated Hours (D+G)**	**Standard Hours per OR per Year (9 hours x 260 days x .8)**	**Adjusted Planning Inventory**	**Utilization (H / S * K)**	**Outpatient Surgical Cases**
V	**New Hanover**	72,226	1,872	41	94.10%	1688
V	**Pender**	464	1,872	2	12.39%	
V	**Richmond**	4,852	1,872	6	43.20%	
V	**Robeson**	10,394	1,872	10	55.52%	
V	**Sampson**	4,233	1,872	8	28.27%	
V	**Scotland**	8,686	1,872	5	92.80%	4
	subtotal					
VI	*Beaufort*	5,876	1,872	5	62.78%	
VI	*Hyde*	0	1,872	0	#DIV/0!	
VI	**Bertie**	1,052	1,872	2	28.10%	
VI	**Carteret**	10,188	1,872	7	77.75%	
VI	*Chowan*	2,892	1,872	3	51.50%	
VI	*Tyrrell*	0	1,872	0	#DIV/0!	
VI	*Craven*	23,086	1,872	17	72.54%	
VI	*Jones*	0	1,872	0	#DIV/0!	
VI	*Pamlico*	0	1,872	0	#DIV/0!	
VI	**Dare**	3,717	1,872	3	66.19%	
VI	**Duplin**	3,350	1,872	3	59.65%	
VI	**Edgecombe**	4,624	1,872	5	49.40%	
VI	*Halifax*	7,590	1,872	6	67.57%	
VI	*Northampton*	0	1,872	0	#DIV/0!	
VI	**Hertford**	4,362	1,872	5	46.60%	
VI	**Lenoir**	6,960	1,872	9	41.31%	
VI	**Martin**	1,518	1,872	2	40.54%	
VI	**Nash**	14,925	1,872	13	61.33%	
VI	**Onslow**	10,371	1,872	9	61.56%	
VI	*Camden*	0	1,872	0	#DIV/0!	
VI	*Currituck*	0	1,872	0	#DIV/0!	
VI	*Gates*	0	1,872	0	#DIV/0!	
VI	*Pasquotank*	8,430	1,872	8	56.29%	
VI	*Perquimans*	0	1,872	0	#DIV/0!	
VI	*Greene*	0	1,872	0	#DIV/0!	
VI	*Hyde*	0	1,872	0	#DIV/0!	
VI	*Pitt*	66,670	1,872	38	93.72%	0
VI	**Washington**	296	1,872	2	7.91%	
VI	**Wayne**	18,540	1,872	13	76.18%	
VI	**Wilson**	9,740	1,872	9	57.81%	

Table 6B:Operating Room Occupancy by H S A 2013

	A	H	K	S	X	Y
HSA	**Operating Room Service Areas (Single-county service areas are in bold. Counties in multicounty service areas are in italics with a shaded "total" row below.)**	**2013 Total Estimated Hours (D+G)**	**Standard Hours per OR per Year (9 hours x 260 days x .8)**	**Adjusted Planning Inventory**	**Utilization (H / S * K)**	**Outpatient Surgical Cases**
VI	**Beaufort Hyde**	5,876	1,872	5	62.78%	
VI	**Chowan Tyrrell**	2,892	1,872	3	51.50%	
VI	**Craven Jones Pamlico**	23,086	1,872	17	72.54%	
VI	**Halifax Northampton**	7,590	1,872	6	67.57%	
VI	**Pasq-Cam-Cur-Gat-Perq**	8,430	1,872	8	56.29%	
VI	**Pitt Greene Hyde**	66,670	1,872	38	93.72%	0
	subtotal					
	State Total			**1,226**		