RECEIVED
By K Fisk at 3:39 pm, Aug 01, 2012

PETITION

Petition for Special Need Adjustment for Fixed Cardiac Catheterization Equipment

PETITIONER

Southeastern Regional Medical Center
300 West 27th Street
Lumberton, NC 28358

Reid Caldwell
Vice President, Regulatory Compliance
910.671.5860
caldwe01@srmc.org

STATEMENT OF REQUESTED ADJUSTMENT

Southeastern Regional Medical Center respectfully petitions the State Health Coordinating Council to create an adjusted need determination for one additional unit of fixed cardiac catheterization equipment in Robeson County in the *2013 State Medical Facilities Plan*.

BACKGROUND

Southeastern Regional Medical Center ("SRMC") is a 452-bed hospital in Lumberton, Robeson County. In addition to its 292 acute care beds, SRMC provides inpatient psychiatric, skilled nursing and hospice care. In 2001, the SHCC approved a petition from SRMC and Duke University Health System for an adjusted need determination for an open heart surgery program at SRMC. In May 2006, the Southeastern Heart Center opened and began providing open heart surgery, as well as interventional cardiac catheterization procedures.

The rationale for the approved petition in 2001 that led to the development of the open heart program at SRMC included the unique demographics and socioeconomic characteristics of Robeson County as well as the tendency of county residents to travel past many other providers to seek care at Duke University Hospital. SRMC'S affiliation with Duke Medicine focused not only on the implementation of an open heart program, but also an expansion of the existing cardiovascular medicine program to include twenty-four hour, seven-day-a-week on-site cardiology services and on-site coronary interventional procedures. By offering these services through a joint program with Duke, SRMC is able to provide care locally that would otherwise have caused residents to travel long distances for care. The program has been a tremendous success. Prior to 2006, an average over 50 cardiovascular patients a month were transferred from SRMC to a higher level of care. Today, the number of cardiovascular patients requiring transfer for a higher level of care is less than 2 patients per month. Offering comprehensive, high quality cardiovascular services on-site—services that meet or exceed national benchmarks high quality—has positively impacted access to, and thus utilization of,

SRMC's cardiac catheterization services. This, along with SRMC's commitment to patient safety and the demographic and socioeconomic factors in Robeson County, is driving the need for the requested adjusted need determination. Please note that while the requested adjustment would be available to any applicant in Robeson County, since only hospitals are approved for additional cardiac catheterization equipment, SRMC would be the only entity eligible to be approved in the county.

REASON FOR THE REQUESTED ADJUSTMENT

As the most recent provider in the state to initiate a new open heart surgery program, SRMC is in a unique position[1]. Some of the existing open heart providers acquired multiple cardiac catheterization labs prior to 1993, which enabled them to forego the CON and SMFP-need determination limits on additional labs established by the statutory amendments to the CON law in 1993. As a result, SRMC is currently the only open heart provider operating in North Carolina with only one cardiac catheterization lab. While it is also true that SRMC is still a relatively new and growing open heart program, and though SRMC's open heart and cardiac catheterization utilization is not as high as most other open heart programs, the need for additional cardiac catheterization equipment still exists, for the following reasons:

1. Patient Safety/Quality/Access issues
2. Value/Operational concerns
3. Demographic/Socioeconomic factors
4. Capacity constraints

Patient Safety, Quality and Access Issues

A second cardiac catheterization lab is needed to provide sufficient access for patients and to maintain patient safety and quality of care that meets or exceeds national clinical guidelines as well as the high standards established by SRMC and Duke Cardiology of Lumberton. As a result of the efforts of SRMC and Duke Cardiology, the hospital was recognized by HealthGrades as #1 for Cardiology Services and #2 for overall Cardiac Services in North Carolina in 2012. In addition, SRMC was ranked in the top 10 percent nationally for both cardiology and cardiac services in 2012. SRMC's goal is to continue its top performance in these services; however, as the only open heart provider in the state with a single catheterization lab, SRMC faces greater constraints in its ability to treat patients on a timely basis. Cardiac catheterization, particularly for patients

[1] Although Carolinas Medical Center-Pineville ("CMC-Pineville") recently began offering open heart and interventional cath services through the transfer of heart-lung bypass machines and cardiac cath equipment from its sister hospital, Carolinas Medical Center-Mercy ("CMC-Mercy"), both facilities operate under the same hospital license. Thus, the licensed entity has been providing open heart surgery services for many years. It is interesting to note that as part of its development of open heart services, CMC-Pineville was approved to relocate two cardiac catheterization labs from CMC-Mercy for a total of three labs, in order to accommodate the increased utilization expected from the relocation of the open heart program; unfortunately, SRMC does not have that option.

presenting with ST-elevated myocardial infarction, or STEMI, is provided on an emergency basis to save patients' lives. When the single lab is being used for another case, either diagnostic or interventional, and a patient presents with a need for emergency intervention, the lack of a second lab can lengthen the time until that care is available. This scenario has already occurred several times. In those cases, time to intervention was delayed by as much 16 to 23 minutes, which represents as much as 25 percent of the optimal 90 minute door-to-balloon window. Each time, the cardiologist and cath team have dealt with the issue in an effective, evidence-based manner, but the potential exists for a suboptimal procedure for the patient on the table as the team completes the case expeditiously, and it clearly delays treatment of the STEMI patient. With two cath labs, such a scenario would be much less likely to occur. As the SHCC is no doubt aware, prolonged door-to-balloon or symptom-to-balloon times have been correlated with increased mortality after primary percutaneous coronary intervention (PCI)[2]. As a result, the American College of Cardiology has established as part of its "Door-to-Balloon" campaign (known as the "D2B Alliance") that patients should receive interventional treatment within fewer than 90 minutes from the time the patient arrives at the hospital. The Joint Commission has also adopted this parameter as a core quality measure. As part of this 90-minute guideline, the D2B Alliance advocates that the cath lab team be available to perform the procedure within 20 to 30 minutes of the patient's arrival at the hospital. When SRMC's only cath lab is being utilized during this crucial time, it is more challenging to meet the lifesaving guideline. Moreover, the geographic size of Robeson County—and thus longer transport time to SRMC, the only provider of interventional catheterization—makes minimizing time once the patient arrives at SRMC even more critical than in smaller geographic areas. In addition, Robeson County borders several counties that do not have interventional catheterization programs, including Columbus, Bladen, Scotland, and Hoke in North Carolina and Dillon and Marlboro in South Carolina. While SRMC is not the closest interventional provider for patients in the entirety of those counties, it is certainly the closest for many patients in those counties. Thus, to ensure patient safety, optimal quality and access to lifesaving interventional cardiac catheterization, Robeson County needs a second cardiac catheterization lab.

Value/Operational Concerns

Second, an additional cardiac catheterization lab is needed to maximize value through optimal patient throughput. With only a single lab available, it is more difficult to optimize lengths of stay for inpatients, particularly as patients waiting for a non-emergent catheterization are sometimes delayed to allow time for emergency cases. The consequence is that a non-emergent inpatient will sometimes have to wait at least one additional day, if not longer, before he or she can have the procedure performed. This lengthens patient stay and decreases patient satisfaction unnecessarily. In the wake of these capacity constraints, SRMC has begun to limit the number of outpatient catheterization patients it will allow on each day's schedule as an attempt to limit

---

[2] Stone, G. Angioplasty Strategies in ST-Segement-Elevation Myocardial Infarction. Circulation 2008. 118; 538-551

inpatient delays. However, this is not a satisfactory long-term solution for outpatients either, as they may be forced wait longer or be held in the Emergency Department pending the availability of the catheterization lab. While emergency cases will always have priority, a second lab will minimize these issues. With federal healthcare reform and reimbursement changes demanding better throughput and shorter lengths of stay, the need for a second catheterization lab to maximize value is clear.

As discussed in more detail below, Duke Cardiology of Lumberton (DCL) has established a strong reputation for excellent patient care and quality outcomes in Robeson County and, as such, has been successful in caring for patients in their home community as opposed to having them travel to remote locations for treatment. To this point in time, providing care in a solitary catheterization lab has been adequate. However, there are several issues that have now arisen that have the potential to increase risk to SRMC's patient population. Given the success of the program and the recognition SRMC and DCL have received for excellent outcomes and limited morbidity, demand has steadily increased, and the hospital certainly does not wish to see a decline in those assessments.

Demographic/Socioeconomic Factors

A third factor which demonstrates the unique circumstances in Robeson County is the demographic factors present in the county. While these issues are often overlooked in considering need for additional healthcare capacity, they drive much of the need for cardiology services in Robeson County. The following discussion highlights just a few of the unique conditions that merit special consideration of need in the county.

Heart Disease

One important demographic statistic to consider is age-adjusted death rates from heart disease. The initiation of the open heart/interventional catheterization program at SRMC has contributed to lower death rates. At the time the SHCC first granted a special need adjustment that allowed SRMC to develop its open heart program, Robeson County's age-adjusted heart disease death rate was 358.3, the state's 7th highest death rate from the disease. Based on the latest data, Robeson's death rate from heart disease has decreased significantly to 239.6, and it has dropped to being the 15th highest death rate from heart disease among North Carolina counties. Thus, improvements have been made. However, Robeson County continues to experience heart disease death rates that are significantly above those of other counties with open heart and interventional catheterization programs, as well as the North Carolina rate overall.

Not unexpectedly, most of the counties in the state where open heart surgery/interventional cardiac catheterization providers are present also have the lowest heart disease death rates. However, despite improvements since 2006, Robeson County is not among those counties. In fact, as shown in the following table, Robeson County continues to have a higher death rate from heart disease compared to the state

overall, and is the highest among counties with open heart/cardiac interventional providers.

County	Age-Adjusted Death Rate 2006-2010
Robeson	239.6
Gaston	219.9
Cumberland	212.8
Pitt	193.0
New Hanover	188.0
Craven	185.0
North Carolina	*184.9*
Cabarrus	183.8
Catawba	176.7
Buncombe	171.4
Guilford	159.5
Durham	154.2
Mecklenburg	147.4
Forsyth	144.1
Moore	142.4
Wake	142.1
Orange	141.5

Source: State Center for Health Statistics[3]; only counties with open heart and interventional catheterization providers are shown.

Statistically, Robeson County's heart disease death rate is more than 1.5 standard deviations above the North Carolina rate, and nearly three standard deviations above the lowest rate in the state (Orange County). Despite availability of open heart surgery and interventional catheterization at SRMC, as well as the hospital's ongoing efforts to improve access via heart disease screening programs, community education and outreach, and reduced time to clinic appointments, the county clearly continues to need improved access to cardiology services.

Minority Population

A significant contributing factor to the higher heart disease death rates is the high minority population, both Native and African American, residing in Robeson County. According to data from the 2010 Census, Robeson County has a much higher percentage of minority residents than the state as a whole, as shown below.

[3] http://www.schs.state.nc.us/schs/deaths/lcd/2010/heartdisease.html; page generated December 5, 2011; accessed July 9, 2012.

Race	Robeson County % of Total*	North Carolina % of Total*
White	30.7%	70.2%
Black or African American	25.4%	22.6%
American Indian and Alaska Native	40.1%	1.9%
Asian	0.9%	2.6%
Other	5.6%	5.0%

*Column may total more than 100% because individuals may report more than one race.
Source: factfinder2.census.gov; accessed July 12, 2012.

As noted in the table above, one characteristic of the service area population that is strictly unique among all North Carolina counties is the high percentage of Native Americans that reside in this area, particularly in Robeson County. This fact is significant in that, according to the American Heart Association, "Heart disease risk is also higher among Mexican Americans, American Indians, native Hawaiians and some Asian Americans. This is partly due to higher rates of obesity and diabetes[4]." According to the Indian Health Service, "At present, CHD [Coronary Heart Disease] rates in American Indians exceed rates in other US populations and may more often be fatal. Unlike other ethnic groups, American Indians appear to have an increasing incidence of CHD, likely due to the high prevalence of diabetes.[5]"

In addition to the risk of heart disease, minority group residents are more likely to die from heart disease and related conditions than the majority group residents. According to the CDC[6]:

- Heart disease is leading cause of death among American Indians and Alaska Natives.
- The heart disease death rate was 20 percent greater among American Indians and Alaska Natives (1996–1998) than among all U.S. races (1997).
- American Indians and Alaska Natives die from heart diseases at younger ages than other racial and ethnic groups in the United States. Thirty–six percent of those who die of heart disease die before age 65.

This disparity in morbidity and mortality from heart disease affects Robeson County disproportionately, as over one-third (33.9%) of the total number of American Indians in

---

4 http://www.heart.org/HEARTORG/Conditions/HeartAttack/UnderstandYourRiskofHeartAttack/Understand-Your-Risk-of-Heart-Attack_UCM_002040_Article.jsp, accessed July 12, 2012.

5 http://www.ihs.gov/cio/crs/documents/Comprehensive_CVD_Screening_Information.pdf, accessed July 12, 2012.

6 http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_aian.htm, accessed July 12, 2012.

North Carolina reside in Robeson County[7] alone, and when the surrounding counties are considered, more than one-half of the state's American Indian population resides in the area. Robeson County is projected to continue being the county in the state with the highest proportion of historically "minority" groups, specifically American Indians and African Americans. The large number of both Native and African Americans living in the service area and the proclivity of these populations to cardiac problems accentuates the unique need for expanded access to heart disease-related services within this area of North Carolina.

Capacity Constraints

Finally, an additional catheterization lab is needed because of capacity constraints at SRMC. As background, it is important to compare and contrast the cardiac catheterization need methodology with those for other types of services in the SMFP. Similar to other methodologies, the cardiac catheterization need methodology considers the units of equipment needed by dividing the number of weighted procedures by some percentage of the total capacity of the equipment—in this case, 80 percent. For cardiac catheterization, the capacity is defined as 1,500 diagnostic-equivalent procedures, so 80 percent is 1,200 diagnostic-equivalent procedures. Where the methodology differs somewhat from others is the next step, Step 5, which requires the number of units of equipment needed to be rounded to the nearest whole number. In other words, the need for a second unit of cardiac catheterization equipment is not generated until a need for 1.5 units is shown. Therefore, to trigger a need determination, the existing cardiac catheterization equipment in a county must actually perform 600 procedures over the stated threshold (1,200 procedures) (e.g., a need for at least 0.5 units of equipment is required to generate a need determination for one additional unit of equipment; 0.5 x 1,200 procedures = 600 procedures). As a result of this step, providers located in counties with only one piece of cardiac catheterization equipment are forced to perform 1,800 procedures per year, or 120 percent of defined capacity, before a need is triggered for additional equipment. In areas with multiple units of existing equipment, this additional volume can be spread among those units, minimizing the impact. This burden on providers in counties with fewer units of equipment is due to the lack of a "tiering" approach for facilities/counties with less total capacity in the cardiac catheterization methodology, unlike the "tiered" approaches used in the acute care bed, operating room and MRI methodologies. As noted above, cardiac catheterization is a much different service than most of the other regulated services in the SMFP in that it is often used for emergency procedures. Most other equipment-based services, including MRI, PET, lithotripsy, gamma knife and linear accelerator treatments, are rarely, if ever used for emergency cases. Thus, with those services, when equipment reaches or exceeds capacity, patients may be inconvenienced, but rarely is emergency treatment potentially delayed as a result.

---

[7] Source: North Carolina Office of State Budget and Management population estimates by race for 2012.

As background to the growth trend in SRMC's cardiac cath volume, the Cardiology Services Department, under the guidance of Duke Cardiology of Lumberton, has developed a strong program at SRMC since 2006. Initially, a conservative approach to patient selection was utilized, and higher risk patients were referred to Duke University Hospital for their care. Progressively more difficult cases have been performed at SRMC; transfers to a higher level of care occur rarely. As the quality and reputation of the program has grown, both physicians and patients of Robeson and neighboring counties realize that they no longer need to travel to Duke University Hospital to receive the same high quality of care they expect in Durham. As patient volume has increased, Duke has increased the number of cardiologists in Robeson County. Since 2006, the number of cardiologists with the practice has grown from just two in 2006—one invasive and one interventional provided on a rotating basis—to six: one general cardiologist, one invasive cardiologist, and four interventional cardiologists. The most recent interventional cardiologist joined the practice in July 2012. Not only will this newly added interventionalist increase the capacity of Duke Cardiology of Lumberton to serve additional patients, but this physician in particular will be serving a portion of Robeson County that has historically been underserved. Because of the physicians' roots in that community, it is likely that he will garner a much more significant portion of those patients with a shared cultural heritage. Moreover, the Duke physicians have established outreach cardiology clinics with the existing cardiologists, which are also drawing patients from areas from which SRMC has not historically obtained referrals. Duke is also actively recruiting an additional cardiothoracic surgeon, which will increase open heart surgery and vascular volumes, and by extension, patients with cardiovascular disease requiring cardiac catheterizations. Given the historical trends and growth of the program in terms of both patients and physicians, it is reasonable to expect growth in utilization to continue and the need for additional cardiac catheterization equipment to persist.

As demonstration of the quantitative need for additional capacity at SRMC, the following table shows the growth in cardiac catheterization cases since 2006.

Year	SRMC Cath Lab Volume (diagnostic procedures)	SRMC Cath Lab Volume (interventional procedures)	SRMC Cath Lab Volume (diagnostic-equivalent procedures)
2006	652	0	652
2007	957	132	1,188
2008	830	219	1,213
2009	813	214	1,188
2010	597	186	923
2011	766	341	1,363
2012 (Annualized)*	792	425	1,541
Compound Annual Growth Rate (CAGR) for 2006 through 2011			**16%**

*Annualized based on nine months of data; through June 30, 2012, SMRC had performed 594 diagnostic and 321 interventional caths, or 1,156 diagnostic-equivalent procedures.

As shown, in 2006, the year prior to the first full year of operation of the Heart Center, SRMC performed 652 diagnostic-equivalent cardiac catheterization cases. In August 2007, primary PCI was initiated five days a week (Monday through Friday, 7:00 am to 5:30 pm) and diagnostic-equivalent cases nearly doubled. In 2008, SRMC exceeded the 80 percent threshold of 1,200 diagnostic-equivalent procedures for the first time. By 2011, after a brief period of decline following the loss and subsequent replacement of a cardiologist, that number grew to 1,363 diagnostic-equivalent cases. In February 2011, primary PCI was expanded to seven days a week, 24 hours a day, with a resulting 209 percent increase in patients receiving heart attack care locally compared to 2010. Based on the first nine months of FY 2012, SRMC is on track to perform 1,541 diagnostic-equivalent cases this year—over 100 percent of the capacity of its single catheterization lab. While the annualized data for FY 2012 have not yet been achieved or officially reported, the point is that even if this utilization is reached and SRMC exceeds 100 percent of defined capacity, no need determination will be generated because of the rounding issue described above, and the patients of Robeson County will be forced to contend with the constraints of operating above capacity. Nonetheless, SRMC is not asking the SHCC to create a need determination based on what may materialize this year; rather, SRMC believes an additional catheterization lab is warranted based on historical volumes and the other factors described above, even without considering any current volume or future growth.

Since 2006, the number of diagnostic-equivalent cases at SRMC increased at a compound annual growth rate (CAGR) of 16 percent. If 2012 data are included, the CAGR is 15 percent. In comparison, diagnostic-equivalent cases statewide *decreased* in the same time period from 128,021 to 114,904, a compound annual rate of negative two percent. Clearly, the growth of cardiac catheterization utilization in Robeson County, driven by the development of its open heart program, demonstrated excellence in service and outcomes, its distinguished population, and the efforts of the Duke providers and Southeastern Heart Center staff to enhance access and awareness by this population in need, has created a unique situation that should be addressed as such.

ADVERSE EFFECTS IF PETITION IS NOT APPROVED

The most obvious adverse effect of failure to approve the petition is the impact on patient safety and the continuing capacity constraints faced by SRMC. As volume continues to increase, the current methodology will not provide additional capacity for the foreseeable future. The ability to provide timely emergency procedures will increasingly be more challenging, and access for the underserved minority populations of Robeson County could be compromised. As the six Duke cardiologists strive to meet the needs of the population, their ability to provide invasive and interventional treatment will be limited by the capacity of the single cardiac catheterization lab. SRMC will remain the only open heart provider with only one cardiac catheterization lab and its ability to continue improving the health of area residents as a result of its program will be restricted.

ALTERNATIVES CONSIDERED

SRMC considered three primary alternatives, including maintaining the status quo, petitioning for a change in the methodology, and expanding capacity through mobile catheterization service. As described above, the status quo is already creating a situation in which maintaining a high quality of care is challenging, particularly considering the need for emergent catheterization procedures. Moreover, without a special need determination, the current methodology in the SMFP would require SRMC to operate at 120 percent of capacity for two or more years: a year at that volume to report on its licensure application, a year for that volume data to be incorporated into the planning process for the next SMFP, and at least six months, if not another year, to file the CON, have it reviewed, and, if granted, develop the additional lab. The status quo will not provide adequate access in a timely fashion, and therefore, it is not a valid consideration.

SRMC also considered expanding its capacity through the use of a mobile catheterization service. While this service may be helpful to rural providers, as the SHCC is aware, it is not an optimal long-term solution for a provider with sufficient volume to sustain an additional fixed catheterization lab and a robust cardiac program. Within the past couple years, the SHCC approved the development of shared fixed catheterization labs in Scotland and Lee counties to replace mobile service, in part due to the issues surrounding the use of mobile catheterization at higher volume sites. Moreover, the number of available mobile catheterization labs in the state is limited and subject to contracts with providers; thus, the availability of a mobile catheterization lab for long-term use at SRMC is inadequate.

SRMC also contemplated petitioning for a methodology change that would address the capacity and rounding issues discussed above for single-catheterization providers. However, such a petition would need to be filed in the spring in order to be considered. Given the robust discussion of cardiac catheterization following a petition filed last summer, SRMC was hopeful that a methodology change would be discussed in the spring of 2012, either through a petition or by the Technology and Equipment Committee. Since no change was discussed or made, any change to the methodology that might alleviate the capacity issues at SRMC would not be made until 2014 at the earliest; therefore, SRMC believes a special need adjustment for Robeson County is warranted.

EVIDENCE THAT THE PROPOSED CHANGE WOULD NOT RESULT IN UNNECESSARY DUPLICATION

SRMC does not believe the allocation of a second cardiac catheterization lab in Robeson County would result in unnecessary duplication, for several reasons. First, SRMC is the only provider of interventional cardiac catheterization in Robeson County; therefore, it is the only facility that can provide access to this lifesaving service in the county, and it would not be duplicating any other facilities that can provide timely access to the service. Next, SRMC is already exceeding the utilization threshold of 80 percent, or 1,200 procedures, at which the need for another lab is generated. The historical trend of growth in utilization indicates that another lab can reasonably be developed and be

effectively utilized without concern that it would compromise the utilization of any existing equipment. Finally, even considering providers in other counties, the three closest providers of interventional cardiac catheterization services have maintained adequate utilization of their existing equipment, notwithstanding the development of SRMC's service. Specifically, based on the data in Table 9W in the *Proposed 2013 State Medical Facilities Plan*, FirstHealth Moore Regional Hospital, Cape Fear Valley Medical Center and New Hanover Regional Medical Center are at 78 percent, 84 percent and 88 percent of capacity—all at or near the 80 percent threshold to generate the need for an additional lab in their counties. Thus, the development of an additional cardiac catheterization lab in Robeson County will not be unnecessarily duplicative of existing health services.

EVIDENCE OF CONSISTENCY WITH THE THREE BASIC PRINCIPLES

SRMC believes the petition is consistent with the three basic principles: quality and safety, access and value. First, quality and safety are clearly enhanced through the development of additional cardiac catheterization capacity, as described above. Without sufficient capacity, particularly for a service often provided on an emergent basis, like interventional cardiac catheterization, quality can suffer and patient care may not be optimal.

Access is also promoted through the allocation of a second catheterization lab. As discussed above, Robeson County is a large geographic area surrounded by several counties without access to interventional catheterization in their county. Having an additional catheterization lab in the county will provide geographic access to a region beyond Robeson. Moreover, given the need for emergent, life-saving catheterization procedures particularly in the case of patients presenting with STEMI, a second catheterization lab expands temporal access to these patients. Robeson County is also unique in its demography; the large percentage of minorities, who are also often medically underserved, will benefit from the expanded catheterization capacity in the county.

The petition also promotes value. A second catheterization lab will ensure that patients—both inpatients and outpatients—receive care in a timely manner, enabling patients to be discharged within an appropriate timeframe, which will prevent unnecessary expenditures by the patients and payors.

CONCLUSION

SRMC believes that unique circumstances in Robeson County warrant a second unit of cardiac catheterization equipment. Specifically:

- SRMC is the only North Carolina open heart surgery provider with only one cardiac catheterization lab—no backup for emergency cases and operational difficulties providing 24/7 coverage with only one lab;

- Robeson County continues to have one of the highest heart disease rates in the state, but improvements since the development of its open heart/interventional catheterization program indicate that these services are responsible for an improving trend;
- Robeson County is demographically unique in the state, and the high proportion of American Indian and African Americans, which have higher incidence of heart disease, create a need for greater access to related services, including cardiac catheterization; and,
- SRMC has already achieved the 80 percent utilization threshold at which a second catheterization lab is needed; based on historical growth trends, an additional unit of equipment will be well-utilized.

These factors contribute to unique circumstances in Robeson County that require a special need adjustment for additional cardiac catheterization equipment.

Thank you for your consideration.