UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

In the Matter of

EVANSTON NORTHWESTERN HEALTHCARE CORP.

Docket No. 9315

COMPLAINT COUNSEL'S PROPOSED FINDINGS OF FACT IN REPLY

(Public Version)

Volume IV

(CCRFF 1482-2144)

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VOLUME IV

VIII D. Changes at HPH (CCRFF 1482-2144) 845

iv. Improvements In The Care Of Heart Attack Patients At HPH Demonstrates The Improvement In HPH's QI Program Post-Merger

1482. Dr. Chassin reviewed data from the treatment of acute myocardial infarction to determine whether Evanston Hospital had a better QI program pre-Merger, whether it was successfully able to export that to HPH at the time of the Merger, and whether improvements in performance at HPH reflected those changes in a positive way. (Chassin, Tr. 5263). { } (Chassin, Tr. 5263-64; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1482:

Complaint Counsel have no specific response.

1483. Dr. Chassin looked at NRMI data for beta blockers and aspirin both pre- and post-Merger at ENH, HPH and Illinois hospitals. (Chassin, Tr. 5595-96). Dr. Chassin selected data from the State of Illinois because it was the only data available on the NRMI clinical process measures. (Chassin, Tr. 5279). This data existed because Medicare did a study of every state in the nation looking at medical records of Medicare patients to extract this very complicated clinical data set, which is comparable to the NRMI measures on process that was available for Evanston and HPH (Chassin, Tr. 5279).

Response to Finding No. 1483:

Complaint Counsel have no specific response.

1484. The strengths of the NRMI data were that this data set was continuously available to both hospitals, both hospitals subscribed to it from at least 1997 through 2003 and, thus, both hospitals submitted clinical data from the records of their patients as they were being treated on processes of care. (Chassin, Tr. 5264). In addition, the NRMI data contain four highly valid process measures of care, the validity of which was entirely consistent over the pre- and post-Merger time period. (Chassin, Tr. 5264). { } (Chassin, Tr. 5265; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1484:

Complaint Counsel do not disagree.

1485. Aspirin and beta blockers are some of the most effective medications in the treatment of heart attacks. (Chassin, Tr. 5267-68). If used within the first 24 hours of arrival and

through the hospitalization, they have an effect on immediate survival and function. (Chassin, Tr. 5268). Additionally, if these medications are continued after discharge, the effect is even greater on reducing mortality six months, a year, and two years later. (Chassin, Tr. 5268). { } (Romano, Tr. 3082, *in camera*).

Response to Finding No. 1485:

Complaint Counsel do not disagree.

1486. The administration of aspirin and beta blockers to heart attack patients are critical process measures of the effectiveness of treating heart attack patients. (Chassin, Tr. 5268). For example, aspirin or beta blockers on discharge from the hospital are measures of the long-term treatment of patients with acute myocardial infarction. (Chassin, Tr. 5270). Hospitals that have high rates of performance on such measures have better survival rates for their patients. (Chassin, Tr. 5271).

Response to Finding No. 1486:

Complaint Counsel do not disagree.

1487. One of the first critical pathways that ENH exported to HPH after the Merger was the myocardial infarction critical pathway, which emphasized improving performance on aspirin and beta blockers. (Chassin, Tr. 5266-67; RX 869; RX 1775).

Response to Finding No. 1487:

Complaint Counsel have no specific response.

1488. The NRMI data thus was an ideal way to test the relative effectiveness of Evanston Hospital's and HPH's QI programs. (Chassin, Tr. 5264).

Response to Finding No. 1488:

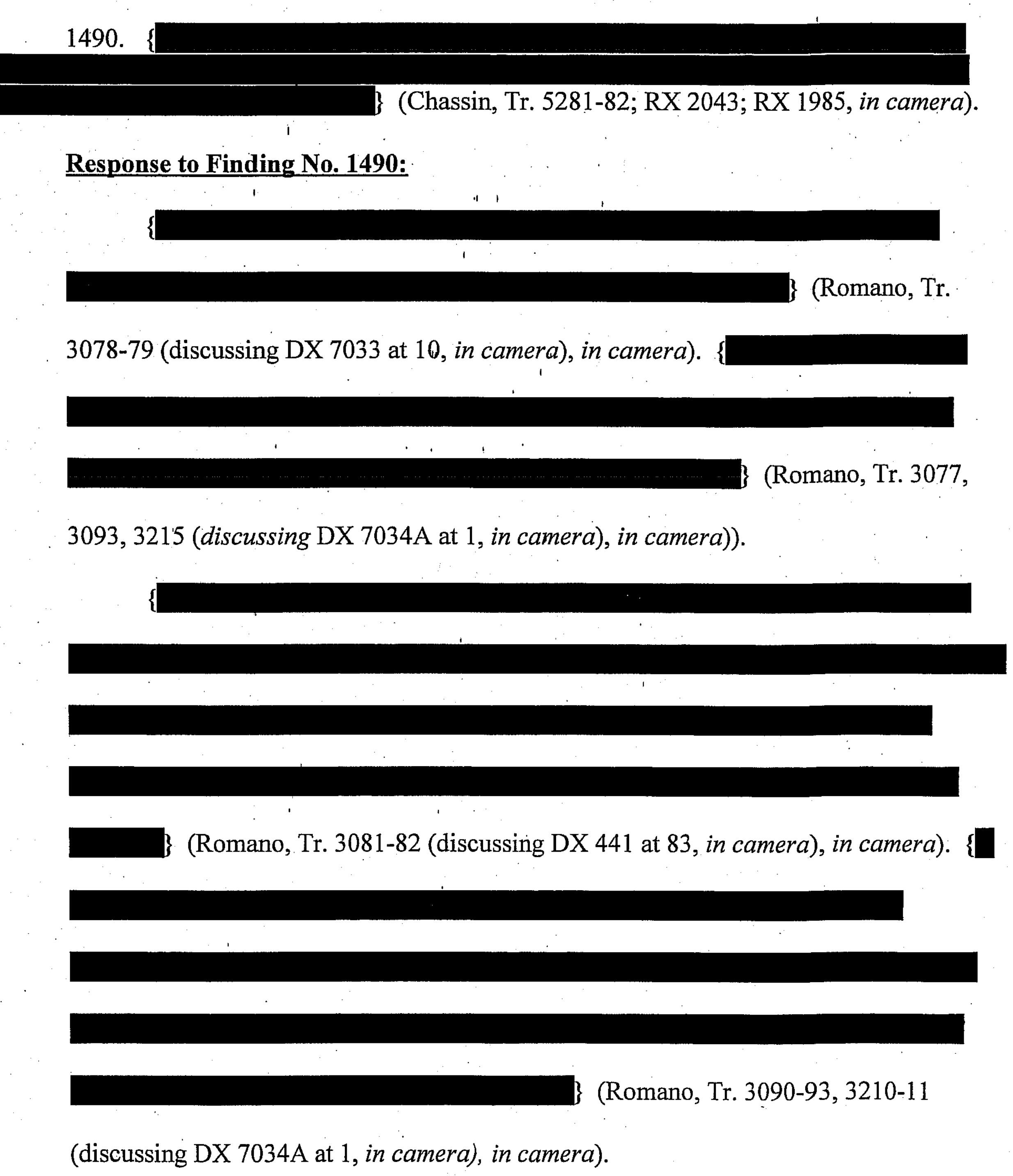
Complaint Counsel do not disagree.

(1) ENH Improved The Provision Of Aspirin To Heart Attack Patients At HPH

1489. { } (Romano, Tr. 3080, *in camera*).

Response to Finding No. 1489:

Complaint Counsel do not disagree.

1490. {} (Chassin, Tr. 5281-82; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1490:

{} (Romano, Tr. 3078-79 (discussing DX 7033 at 10, *in camera*), *in camera*). {} (Romano, Tr. 3077, 3093, 3215 (*discussing* DX 7034A at 1, *in camera*), *in camera*)).

{} (Romano, Tr. 3081-82 (discussing DX 441 at 83, *in camera*), *in camera*). {} (Romano, Tr. 3090-93, 3210-11 (discussing DX 7034A at 1, *in camera), in camera*).

1491. "Aspirin on arrival" refers to administering aspirin to patients within the first 24

hours of arrival to the hospital with a heart attack. (Chassin, Tr. 5267).

Response to Finding No. 1491:

Complaint Counsel do not disagree.

1492. { } (Chassin, Tr. 5265; RX 2043; RX 1985, *in camera*). } (Chassin, Tr. 5265; RX 2043; RX 1985; *in camera*; Romano, Tr. 3081, *in camera*).

Response to Finding No. 1492:

Respondent's finding is incomplete. { } (Romano, Tr. 3078-79 (discussing DX 7033 at 10, *in camera*), *in camera*). { } (Romano, Tr. 3077, 3093, 3215 (*discussing* DX 7034A at 1, *in camera*), *in camera*); *see* CCRFF 1490).

1493. { .} (Romano, Tr. 3081, *in camera*). { } (RX 2043; RX 1985, *in camera*).

Response to Finding No. 1493:

Respondent's finding is incomplete. { } (*See* CCRFF 1490, *in camera*).

1494. { } (Chassin, Tr. 5267; RX 2043; RX 1985, *in camera*). { } (RX 2043; RX 1985, *in camera*). { } (RX 2043; RX 1985, *in camera*).

Response to Finding No. 1494:

Respondent's finding is misleading and incomplete. Respondent's general citation to RX 1985 is contrary to the Court's April 6, 2005 Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record. Respondent has not given a specific cite to what page(s) out of an almost 650-page document Respondent is referring to. { } (*See, e.g.*, RX 1985 at ENHL 051061, 051068, 050946, 050955, 051015, 051022, 051343, 051349, *in camera*). { } (Romano, Tr. 3081-82 (discussing DX 441 at 83, *in camera*), *in camera*; *see also* CCRFF 1490).

1495. HPH's change in performance for aspirin on arrival was statistically significant at a P value less than 0.0001 level. (Chassin, Tr. 5279). This means that if the pre- and post-Merger measures of HPH's performance are equal, the chance of observing this big a difference due to chance, rather than the Merger, would be less than one in 10,000. (Chassin, Tr. 5279-80 (*discussing* DX 8079)).

Response to Finding No. 1495:

Respondent's finding is incomplete. { }

(*See* CCRFF 1490, *in camera*).

1496. { } (Chassin, Tr. 5270; RX 2043; RX 1985, *in camera*). { } (Chassin, Tr. 5282; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1496:

Respondent's finding is incomplete. { }

(*See* CCRFF 1490, *in camera*).

1497. { } (Romano, Tr. 3085, *in camera*). { } (Chassin, Tr. 5271; RX 2043; RX 1985, *in camera*). { } (Chassin, Tr. 5271; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1497:

{ } (RX 2043 at 1, *in camera*).

1498. { } (Chassin, Tr. 5282; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1498:

Respondent's finding is incomplete. {

}

(*See* CCRFF 1490, *in camera*).

(2) HPH Improved The Provision Of Beta Blockers To Heart Attack Patients After The Merger

1499. { } (Chassin, Tr. 5282-83; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1499:

Respondent's finding is incomplete. { } (Romano, Tr. 3083 (discussing DX 441 at 84, *in camera*), *in camera*).

1500. { } (Chassin, Tr. 5269; RX 2043; RX 1985, *in camera*). { } (Chassin, Tr. 5280-81; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1500:

Respondent's finding is incomplete. (*See* CCRFF 1490, 1499 ({ }), *in camera*).

1501. { } (Chassin, Tr. 5269; RX 2043; RX 1985, *in camera*). } (Chassin, Tr. 5281; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1501:

{ } (*See, e.g.*, RX 1985 at ENHL PK 051061, 051068, 050955, 051015, 051022, *in camera*).

1502. { } (Chassin, Tr. 5272; RX 2043; RX 1985, *in camera*). { } (Chassin, Tr. 5272; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1502:

Respondent's finding is incomplete. (*See* CCRFF 1490, 1499 ({ }), *in camera*). { }

1503. { } (Chassin, Tr. 5282-53; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1503:

Respondent's finding is incomplete. (*See* CCRFF 1490, 1499 ({ }), *in camera*).

1504. { }

(Chassin, Tr. 5272; RX 2043; RX 1985, *in camera*). { } (Chassin, Tr. 5272, 5282-83; RX 2043; RX 1985, *in camera*).

Response to Finding No. 1504:

Respondent's finding is incomplete. { } (*See, e.g.,* RX 1985 at ENHL PK 050948, 050956, 051016, 051023, 051062, 051069, 051343, 051350, *in camera*).

(3) The Minor Change In Performance On The NRMI Measures Are Based On An Extremely Small Sample

1505. In the year 2000 NRMI data, there was a slight dip in the performance of Evanston Hospital. Dr. Chassin attributed this dip in performance to a major revision in the NRMI data set between NRMI-III and NRMI-IV. (Chassin, Tr. 5273-74). For example, there were only 26 cases reported from Evanston Hospital in the NRMI data in year 2000 when there should have been 150 based upon the volume of heart attack cases in the years just before and after 2000. (Chassin, Tr. 5275). { } (RX 2043; RX 1985; *in camera*).

Response to Finding No. 1505:

Respondent's finding is inaccurate and misleading. (*See* CCRFF 1490, 1499 ({ }), *in camera*).

1506. Dr. Chassin found that the slight dip in NRMI data at Evanston Hospital in 2000 was not the result of any diversion of resources from Evanston to HPH around the time of the Merger. (Chassin, Tr. 5275). Further, Dr. Chassin found no evidence to support Dr. Romano's hypothesis that quality at Evanston declined because resources were purportedly diverted from Evanston Hospital to HPH. Nor did Dr. Romano cite any such evidence in support of this hypothesis. (Chassin, Tr. 5276).

Response to Finding No. 1506:

Respondent's finding is inaccurate and misleading. (*See* CCRFF 1490, 1499).

{ } (Romano, Tr. 6324-25, *in camera*).

1507. In 2001 and 2003, HPH was virtually identical to the like hospitals, meaning that under an accepted standard used to measure door-to-dilation time of 120 minutes, there were differences of only two to five minutes. These differences are not clinically significant. (Chassin, Tr. 5592-93). The 120-minute standard comes from the Joint Commission, Medicare and a variety of other organizations. (Chassin, Tr. 5593).

Response to Finding No. 1507:

Respondent's finding is incomplete. { } (Romano, Tr. 3070-72, *in camera*).

1508. Overall, assuming Dr. Romano's data are correct, HPH was within the acceptable time frames for door-to-dilation time in 2001 and 2003, and in 2002, HPH was only slightly over that based on just 16 cases. (Chassin, Tr. 5593-94). However, because the sample size for 2002 is so low – 16 total patients – it is very difficult to draw any generalized conclusions about that quality measure for that particular year. (Chassin, Tr. 5595).

Response to Finding No. 1508:

This finding is incomplete. { } (Romano, Tr. 3071-72, *in camera*). { } (Romano, Tr. 3072 (discussing DX 441 at 82, *in camera*), *in camera*).

(4) The Merger Resulted In A Dramatic

Improvement In The Care Of Heart Attack Patients At HPH

1509. { } (Chassin, Tr. 5277-78, 5281-83; RX 2043; RX 1985; *in camera*).

Response to Finding No. 1509:

This finding is incomplete. (*See* CCRFF 1490 1497, 1499, 1501, and 1504 for a complete discussion on the outcomes and processes of heart attack care at HPH and Evanston Hospital after the merger).

1510. Thus, ENH's exportation to HPH of a much more effective QI program after the Merger produced very rapid and very substantial quality improvements at HPH in highly valid process measures of care (e.g., aspirin and beta blockers). (Chassin, Tr. 5283-84).

Response to Finding No. 1510:

This finding is incomplete. (*See* CCRFF 1490 1497, 1499, 1501, and 1504 for a complete discussion on the outcomes and processes of heart attack care at HPH and Evanston Hospital after the merger).

1511. The trends in the NRMI data for HPH and Evanston Hospital with respect to administration of aspirin and beta blockers, both on admission and on discharge, are significant because they allow one to determine the effect of the Merger. (Chassin, Tr. 5273). { } (Chassin, Tr. 5273; RX 2043; RX 1985, *in camera*).

Responses to Finding No. 1511:

This finding is incomplete. (*See* CCRFF 1490 1497, 1499, 1501, and 1504 for a complete discussion on the outcomes and processes of heart attack care at HPH and Evanston Hospital after the merger).

e. ENH Corrected Serious Deficiencies In HPH's Physical Plant

i. Overview

1512. Before the Merger, HPH had significant deficiencies in its physical plant that limited HPH's capacity to render adequate care and ensure the health and safety of its patients. (Chassin, Tr. 5285-86; RX 545 at ENH JH 11578).

Response to Finding No. 1512:

This finding misstates the evidence. The deficiencies were not as significant as Respondent claims in this finding. Prior to the merger, HPH had some plant deficiencies that concerned the Department of Health and Human Services. Although merger negotiations were proceeding in earnest at this time (July 1999), HPH began correcting the deficiencies before the merger, and by the end of 1999, 114 of the 144 items flagged by the Department of Health and Human Services had been corrected (an additional 3 items were also noted for a total of 147). (RX 1379 at ENH JH 11544). The remaining items were corrected by ENH after the merger. The total cost of the repairs required by the Department of Health and Human Services totaled only $922,000. (RX 1379 at ENH JH 11545). Thus, prior to the merger, HPH addressed the issues to the satisfaction of the Department of Health and Human Services, and HPH never lost its Medicare certification at any time before the merger. (Spaeth, Tr. 2259).

The letter from the Department of Health and Human Services was tied solely to the condition of the physical plant. It had nothing to do with (1) quality of the medical staff at HPH, (2) patient outcomes at HPH, (3) quality of the medical procedures, or (4) quality of the equipment at HPH before the merger. (Hillebrand, Tr. 1775). In addition, Dr. Chassin, Respondent's expert on quality, was not aware of any instances in which

physical plant deficiencies actually led to a bad outcome in patient care at HPH before the merger. (Chassin, Tr. 5563). ENH also closed the deal to merge with HPH knowing about the deficiencies letter from the Department of Health and Human Services. (Hillebrand, Tr. 1772).

Various evidence also supports the view that the corrections were not merger specific because HPH likely would have fixed the deficiencies had the merger not occurred. Prior to the merger, HPH routinely made capital investments to upgrade and improve its facilities. (Newton, Tr. 383-84). In addition, HPH was financially strong prior to the merger. (*See, e.g.*, CCFF 303-355). Highland Park's 1999-2003 Financial Plan set forth a "long range capital budget" that included $43 million for "strategic initiatives and master plan items," including "ambulatory, assisted living and facility expansion." The plan also set aside $65 million for "[h]ospital construction, routine capital and information technology" investments, and a small amount for Lakeland Health Ventures. (Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2). The total planned investments for the time period therefore amounted to $108 million. (*See also* CCRFF 1514 in so far as this finding references alleged deficiencies of HPH facilities discovered by ENH through the due diligence process of the merger).

1513. These deficiencies, which required substantial investment to remedy, were sufficiently serious that HPH nearly lost its Medicare accreditation as a result. (RX 545 at ENH JH 11578; RX 1379 at ENH JH 11544; RX 1380 at ENH JH 11480).

Response to Finding No. 1513:

Various evidence supports the view that the deficiencies were not significant and that HPH immediately began addressing the concerns of the Department of Health and

Human Services. (*See* CCRFF 1512).

1514. Additionally, pre-Merger due diligence determined that the physical facilities at HPH needed immediate, and numerous, life safety and code compliance improvements that would require a $14-19 million investment. (RX 635 at ENH JH 4002; Neaman, Tr. 1336). These physical plant deficiencies were far more serious than those that nearly cost HPH its Medicare accreditation in that they increased the risk of adverse events at HPH (Chassin, Tr. 5285-86, 5590).

Response to Finding No. 1514:

It is not surprising that ENH's due diligence discovered some items that ENH wished to improve. Merger due diligence – which precedes a major financial transaction – is a unique event that causes institutions to look at issues they might not otherwise look at. (Chassin Tr. 5564).

Various evidence supports the view that, without the merger, these issues would have been discovered and addressed. Prior to the merger, HPH routinely made capital investments to upgrade and improve its facilities. (Newton, Tr. 383-84). In addition, HPH was financially strong prior to the merger. (*See* CCFF 303-355). Highland Park's 1999-2003 Financial Plan set forth a "long range capital budget" that included $43 million for "strategic initiatives and master plan items," including "ambulatory, assisted living and facility expansion." The plan also set aside $65 million for "[h]ospital construction, routine capital and information technology" investments, and a small amount for Lakeland Health Ventures. (Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2). The total planned investments for the time period therefore amounted to $108 million. It is therefore likely that the physical facilities would have been upgraded by HPH had the merger not occurred.

With regard to the claim in this finding that the physical facility deficiencies increased the risk of adverse events, various evidence supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516).

1515. Shortly after the Merger, ENH addressed all 144 of the life safety and code compliance issues with the HPH physical plant, as well as items that could present such problems if not addressed. (Chassin, Tr. 5287-88; RX 1379 at ENH JH 11544-45).

Response to Finding No. 1515:

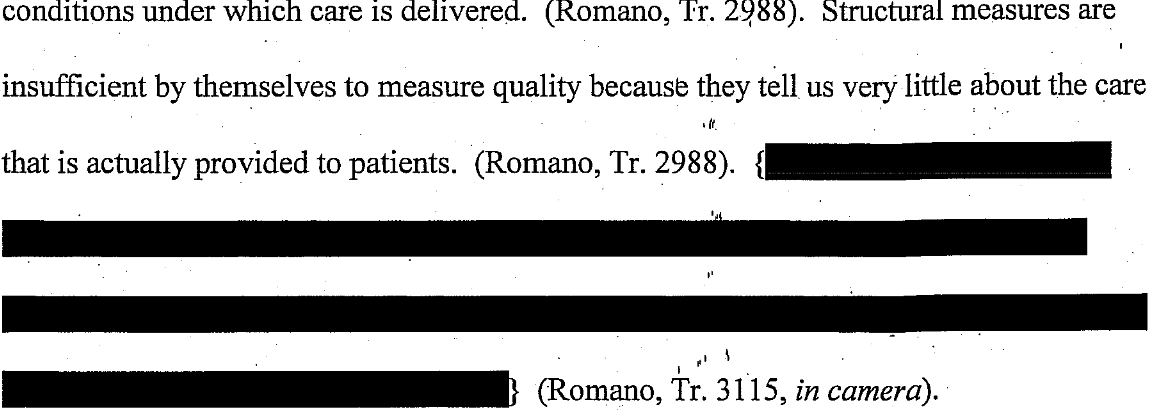
This finding misstates the evidence. During the roughly six month period between HPH's receipt of the IDPH report and the merger, even though the merger was agreed to during that period, HPH itself had addressed and corrected 114 of the 144 (not counting the 3 addition items added later) items flagged by the Department of Health and Human Services. (RX 1379 at ENH JH 11544). (*See also* CCRFF 1512).

1516. In addition to correcting the problems with HPH's physical plant, ENH also made changes to the plant that constituted improvements in quality of care. (Chassin, Tr. 5288; RX 1377 at ENH JH 11478). These improvements included building a new ambulatory care center ("ACC") that housed modern radiation equipment, a new cardiac catheterization lab to support the interventional cardiology program, renovating and expanding the ED and psychiatry units, expanding the radiology department and adding modern equipment to a variety of areas. (Chassin, Tr. 5288-89; RX 1377 at ENH JH 11478). These additions were substantial improvements to the structure of care that increased HPH's ability to deliver high quality care, thereby increasing the likelihood of desired outcomes. (Chassin, Tr. 5289).

Response to Finding No. 1516:

Various evidence supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. The changes that ENH made to the HPH plant after the merger constitute structural changes only. (Chassin, Tr. 5288-89; Romano, Tr. 2986-87). Structural measures are enabling factors that provide the

conditions under which care is delivered. (Romano, Tr. 2988). Structural measures are insufficient by themselves to measure quality because they tell us very little about the care that is actually provided to patients. (Romano, Tr. 2988). {



} (Romano, Tr. 3115, *in camera*).

Various evidence also supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). The timing of ENH's claimed physical improvements also calls into question their merger specificity. For example, planning for the ambulatory care center did not begin until December 2003, four years after the merger, and the facility did not open until more than five years after the merger, in February 2005. (O'Brien, Tr. 3498). (*See also* O'Brien, Tr. 3510 (patient room remodeling began in December 2003)).

1517. As of February 2005, ENH had completed most of the capital improvements at HPH that it started after the Merger. (Hillebrand, Tr. 1982). It is continuing to remodel HPH's radiation department and HPH's medical/surgical units, and it started construction of a new ICU. (Hillebrand, Tr. 1982). In addition to new construction of patient care areas within the hospital, ENH spent approximately $27 million in capital improvements to the HPH campus, including a new parking structure and power plant. (O'Brien, Tr. 3514-15).

Response to Finding No. 1517:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). In addition, improvements that ENH is "continuing"

to make, more than five years after the merger, cannot be attributed to the merger in light of HPH's strong pre-merger finances and the national trend of improving health care. (*See also* Romano, Tr. 3003-04 (discussing national trend)). In addition, various evidence supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516).

1518. Overall, ENH spent $120 million on capital improvements at HPH (Hillebrand, Tr. 1977; Neaman, Tr. 1250). Moreover, ENH has committed to spend an additional $45 million at HPH in the future. (Hillebrand, Tr. 1977).

Response to Finding No. 1518:

Respondent may assert that the $120 million of investment represents the procompetitive benefits of the merger. (With regard to the additional $45 million that ENH is supposedly going to spend on HPH sometime in the future, the money has not, in fact, been spent. (Hillebrand, Tr. 1977)). Moreover, too many years have passed since the merger for HPH's pre-merger strategic plans to show the amount to subtract due to what HPH would have spent on improvements in the period 2005 and onward. In other words, the $45 million figure is too uncertain to consider.) Various evidence, however, supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). Various evidence also supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). As seen in CCRFF 1514, HPH had designated $108 million for investment in facilities, construction, and equipment over a four-year period, which is substantially similar to the $120 million of investments that ENH (in self-serving testimony) claims to have made

after the merger over a period of slightly more than four years. Thus, these alleged benefits of the capital improvements are in fact not significant. Furthermore, the $120 million is a one-time expenditure, and ENH's post-merger price increases due to the merger total at least tens of millions of dollars in increased net revenue annually. (*See* CCRFF 1). Even assuming, *arguendo*, that the total capital investment in HPH somehow represents the procompetitive benefits of the merger, such benefits are still substantially outweighed by the anticompetitive impact of the merger.

ii. Before The Merger, HPH Passed The Joint Commission's Accreditation Inspections, Which Are Not A Comprehensive Assessment Of Hospital Quality, Because It Had Advance Notice Of The Inspections

1519. Joint Commission accreditation is a necessary requirement for getting Medicare payments. (Neaman, Tr. 1367; Spaeth, Tr. 2154; RX 545 at ENH JH 11578). Joint Commission accreditation is a minimum standard. (Holt-Darcy, Tr. 1421). Additionally, some MCOs have followed the government and require Joint Commission accreditation before doing business with a provider. (Neaman, Tr. 1367; Spaeth, Tr. 2154).

Response to Finding No. 1519:

Complaint Counsel have no specific response.

1520. The primary reason for the Joint Commission inspections was to ensure that hospitals were maintaining minimum standards for hospital accreditation. (Styer, Tr. 5024-25, 5030).

Response to Finding No. 1520:

Complaint Counsel have no specific response.

1521. The vast majority of hospitals in the United States receive Joint Commission accreditation. (Newton, Tr. 460-61). Further, it is common for hospitals to receive Joint Commission scores around 95. (Spaeth, Tr. 2122). For example, in April 1999, the HPH Board knew that Chicago hospitals in general received Joint Commission scores in the mid-90s. (Spaeth, Tr. 2148-49).

Response to Finding No. 1521:

This finding mischaracterizes the evidence. Mr. Spaeth testified that the JCAHO score of 96 was characterized to the HPH Board as "an exceptional outcome" even though "a lot of people" receive scores of 95. (Spaeth, Tr. 2122, 2148-49). The 96 score exceeded HPH's expectation of receiving a 90. (Spaeth, Tr. 2122, 2148-49). Dr. Chassin was aware of no data regarding the number of hospitals that receive a 95 score. (Chassin, Tr. 5625).

1522. In 1999, Joint Commission announced to hospitals in advance that it would be surveying the hospital. (Newton, Tr. 461). It was fairly easy to hire a consultant to put the paperwork together to pass inspection. (Chassin, Tr. 5588). Accordingly, HPH's pre-Merger Joint Commission scores were not necessarily a reflection of the hospital's quality. (RX 462 at ENH RS 5482).

Response to Finding No. 1522:

The cited source does not say what the last sentence of Respondent's finding claims. The cited source does not say anything about whether or not JCAHO scores reflect a hospital's quality. In addition, this finding is misleading because it implies that HPH was not a good quality hospital prior to the merger because its high JCAHO score was based upon intense preparation after learning of the date of the JCAHO survey visit. But HPH's "exceptional" JCAHO score (Spaeth, Tr. 2148-49), is consistent with extensive evidence demonstrating that HPH was a good hospital before the merger. (*See* CCFF 2295-2352). Indeed, the evidence shows that before the merger, HPH even ranked favorably when compared specifically to Evanston Hospital. For example, prior to the merger, HPH's JCAHO score of 95 exceeded Evanston's score of 94 (later upgraded to 95 in the final report) in 1999. (*See* CCFF 2301, 2303). Thus, prior to the merger

Evanston could barely match HPH in spite of the fact that it too would have known when JCAHO would conduct its survey. (Newton, Tr. 461). Finally, after the merger, HPH's JCAHO score actually declined. In 2002, HPH only received a score of 94 as part of ENH's JCAHO survey. (RX 1380 at ENH JH 11480).

1523. The Joint Commission conducted an inspection of HPH in early 1999, before the April 1999 visit by the IDPH, which was performing a look behind survey following the Joint Commission's visit. (RX 1379 at ENH JH 11544; RX 545 at ENH JH 11578).

Response to Finding No. 1523:

Complaint Counsel have no specific response.

1524. Before the Merger, HPH had advance notice of when Joint Commission would conduct a site visit. (Newton, Tr. 461). In the six weeks before Joint Commission inspections, HPH "turned itself upside down" to make sure it would meet the Joint Commission's standards. (Styer, Tr. 5030).

Response to Finding No. 1524:

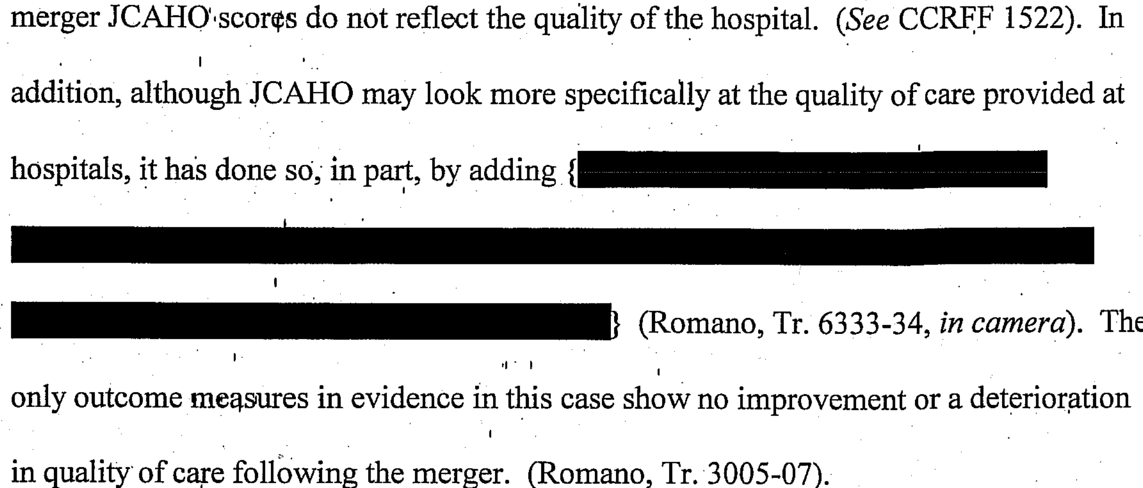
Various evidence does not support Respondent's implication that HPH's pre-merger JCAHO scores do not reflect the quality of the hospital. (*See* CCRFF 1522). In addition, Respondent provides no evidence it is not the Joint Commission's typical practice in conducting site visits to provide advance notice.

1525. Over the last three to four years, Joint Commission has dramatically changed its standards. (Spaeth, Tr. 2256-57). As of February 2005, Joint Commission looks more specifically at the quality of care provided at hospitals. (Spaeth, Tr. 2256-57). In the last two years, Joint Commission completely revised its survey and accreditation process to include unscheduled hospital visits. (Chassin, Tr. 5589; Newton, Tr. 461). At the time HPH received a score of 96 before the Merger, however, the Joint Commission was still conducting scheduled visits. (Chassin, Tr. 5589).

Response to Finding No. 1525:

Various evidence does not support Respondent's implication that HPH's pre-

merger JCAHO scores do not reflect the quality of the hospital. (*See* CCRFF 1522). In addition, although JCAHO may look more specifically at the quality of care provided at hospitals, it has done so, in part, by adding {



} (Romano, Tr. 6333-34, *in camera*). The only outcome measures in evidence in this case show no improvement or a deterioration in quality of care following the merger. (Romano, Tr. 3005-07).

iii. A 1999 IDPH Survey Uncovered Numerous Physical Plant Deficiencies At HPH That Were Not Identified By The 1999 Joint Commission Accreditation Survey

1526. In April 1999, the Illinois Department of Public Health ("IDPH"), on behalf of HCFA, conducted a "look back" survey at HPH to inspect HPH's facilities and record any deficiencies after the early 1999 Joint Commission inspection. (Hillebrand, Tr. 1773-74; Newton, Tr. 461-62; RX 528 at ENH RS 5508; RX 525). The survey team consisted of registered nurses, dieticians, sanitarians and architects who spent three days checking a variety of areas. (RX 528 at ENH RS 5508).

Response to Finding No. 1526:

Complaint Counsel have no specific response.

1527. The IDPH inspection found 144 deficiencies that were not identified during the Joint Commission inspection in early 1999. (RX 1379 at ENH JH 11544; RX 545 at ENH JH 11578).

Response to Finding No. 1527:

Various evidence supports the view that the deficiencies were not significant and that HPH immediately began addressing the concerns of the Department of Health and Human Services, even while merger negotiations were ongoing and after the merger had been agreed to. (*See* CCRFF 1512).

1528. The IDPH inspectors focused on life and fire safety deficiencies. (Hillebrand, Tr. 1774). Accordingly, the deficiencies they discovered included items such as insufficient fire resistance and lack of sprinklers. (RX 523 at ENH JH 11552-53).

Response to Finding No. 1528:

Various evidence supports the view that the deficiencies were not significant and that HPH immediately began addressing the concerns of the Department of Health and Human Services, even while merger negotiations were ongoing and after the merger had been agreed to. (*See* CCRFF 1512).

1529. The IDPH inspectors did not examine or assess the HPH medical staff, patient outcomes, the quality of the medical procedures, or the medical equipment. (Hillebrand, Tr. 1775).

Response to Finding No. 1529:

Complaint Counsel agrees with this finding. (*See also* CCRFF 1512).

iv. Before The Merger, HPH Nearly Lost Its Medicare Accreditation Due To Serious Physical Plant Deficiencies That Threatened Patient Safety

1530. A hospital must be accredited to be eligible for Medicare payments. (RX 545 at ENH JH 11578). The Joint Commission accreditation survey is one way to be deemed to have meet Medicare's conditions. (RX 545 at ENH JH 11578). That survey, however, may be validated by state agencies such as the IDPH, as happened in 1999 with respect to HPH (RX 545 at ENH JH 11578).

Response to Finding No. 1530:

Various evidence supports the view that the deficiencies were not significant and that HPH immediately began addressing the concerns of the Department of Health and Human Services, even while merger negotiations were ongoing and after the merger had been agreed to. (*See* CCRFF 1512).

1531. On July 14, 1999, Peter Friend, HPH's COO, received a letter from the

Department of Health and Human Services ("HHS letter") informing HPH of numerous problems with its physical plant. (RX 545 at ENH JH 11578; Spaeth, Tr. 2257-58). The HHS letter stated that HHS had "determined that the deficiencies [at HPH] are significant and limit your hospital's capacity to render adequate care and ensure the health and safety of your patients." (RX 545 at ENH JH 11578; Chassin, Tr. 5285-86). The structural problems identified were based upon the April 1999 IDPH review. (RX 545 at ENH JH 11578).

Response to Finding No. 1531:

Various evidence supports the view that the deficiencies were not significant and that HPH immediately began addressing the concerns of the Department of Health and Human Services, even while merger negotiations were ongoing and after the merger had been agreed to. (*See* CCRFF 1512).

1532. The HHS letter threatened to pull HPH's Medicare accreditation, stating "based on the determination that your hospital does not comply with the above Condition and that significant deficiencies exist, your hospital is no longer deemed to meet the Medicare Conditions of Participation. In addition, we must terminate your Medicare agreement. The date on which your agreement terminates is July 15, 1999." (RX 545 at ENH JH 11579).

Response to Finding No. 1532:

Various evidence supports the view that the deficiencies were not significant and that HPH immediately began addressing the concerns of the Department of Health and Human Services, even while merger negotiations were ongoing and after the merger had been agreed to. (*See* CCRFF 1512).

1533. If HPH had lost its Medicare accreditation, it would have lost close to 50% of its revenue. (Spaeth, Tr. 2258).

Response to Finding No. 1533:

Various evidence supports the view that the deficiencies were not significant and that HPH immediately began addressing the concerns of the Department of Health and Human Services, even while merger negotiations were ongoing and after the merger had

been agreed to. (*See* CCRFF 1512).

1534. {[redacted]} (Spaeth, Tr. 2258-59; Newton, Tr. 464; RX 658 at ENH RS 7481, *in camera*).

Response to Finding No. 1534:

This finding misstates the evidence. In response to a question from Chief Judge McGuire, Ronald Spaeth, HPH's CEO prior to the merger, stated that HPH had indeed addressed the issues first raised by the Department of Health and Human Services to the satisfaction of the Department and that HPH never lost its Medicare certification. (Spaeth, Tr. 2259). (*See also* CCRFF 1512).

1535. ENH ultimately corrected HPH's physical plant deficiencies identified by IDPH after the Merger. (Hillebrand, Tr. 1771). Both ENH and HPH spent roughly $1 million to correct HPH's Medicare deficiencies. (Hillebrand, Tr. 1771).

Response to Finding No. 1535:

This finding misstates the evidence. During the roughly six months between the IDPH report and the merger, HPH itself had addressed and corrected 114 of the 144 (not counting the 3 additional items added later) items flagged by the Department of Health and Human Services. (RX 1379 at ENH JH 11544). (*See also* CCRFF 1512).

v. Pre-Merger Due Diligence Performed By ENH Identified Even More Serious Physical Plant Deficiencies

1536. In 1999, Hillebrand asked an architect to lead the pre-Merger due diligence review of HPH's facilities. (Hillebrand, Tr. 1906). The architect was assisted by a group of contractors, mechanical and electrical engineers, and others. (Hillebrand, Tr. 1906).

Response to Finding No. 1536:

Complaint Counsel have no specific response.

1537. The architects determined that HPH's facility problems were "high risk." (RX 635 at ENH JH 4002; Hillebrand, Tr. 1906-07). These problems included problems with the ventilation system, maintaining pressures in the isolation rooms, problems with the air handling system, maintenance of emergency power, and asbestos issues – problems that were far more serious than those identified by HHS. (Chassin, Tr. 5285-86).

Response to Finding No. 1537:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Various evidence also supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See* CCRFF 1514).

1538. The architects further noted that facilities consultants used by HPH the year before were in the process of making a number of the same recommendations "that were not disclosed to ENH until recently." (RX 635 at ENH JH 4002; Hillebrand, Tr. 1906-07).

Response to Finding No. 1538:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Various evidence also supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See* CCRFF 1514).

1539. On October 7, 1999, the architect issued a Final Due Diligence Report listing a

series of "critical facility upgrades" and the cost of those upgrades. (RX 635 at ENH JH 4012-13). "Critical facility upgrades" referred to items identified by the architects as necessary for code compliance or the reliable operation of the facility. (Chassin, Tr. 5286; RX 635 at ENH JH 4002). Items on the critical upgrade list were a direct threat to patient safety. (Chassin, Tr. 5287).

Response to Finding No. 1539:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Various evidence also supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See* CCRFF 1514).

1540. The architect estimated the cost of the critical upgrades to be $9.77 million. (Chassin, Tr. 5287; RX 635 at ENH JH 4013). The critical facility upgrades included $1.5 million for "asbestos abatement," $600,000 for "added boiler capacity," $1.8 million for "Emergency Power System Upgrades" and $1 million for "electrical issues." (RX 635 at ENH JH 4012-13).

Response to Finding No. 1540:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Various evidence also supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See* CCRFF 1514). In addition, Complaint Counsel notes that the $9.77 million figure was

well within HPH's $108 million capital budget. (Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2).

1541. The Final Due Diligence Report identified a second category of deficiencies called priority upgrades. (Chassin, Tr. 5287). Priority upgrades were items that could or would affect operations and could become code issues if they were not addressed. (Chassin, Tr. 5287). The architect estimated the cost of the priority upgrades to be $5 million. (Chassin, Tr. 5287; RX 635 at ENH JH 4016).

Response to Finding No. 1541:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Various evidence also supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See* CCRFF 1514).

1542. Before the Merger, HPH failed to encapsulate asbestos insulation around pipes and in ductwork. This resulted in the air conditioning system blowing asbestos into labor and delivery suites at the hospital. (Hillebrand, Tr. 1908).

Response to Finding No. 1542:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Various evidence also supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See*

CCRFF 1514).

1543. At the time of the Merger, HPH had only one boiler because the backup boiler had previously failed. (Hillebrand, Tr. 1908-09). Consequently, if that boiler had, HPH would have been without heat and hot water. (Hillebrand, Tr. 1908-09).

Response to Finding No. 1543:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Various evidence also supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See* CCRFF 1514).

1544. Before the Merger, HPH's facilities revealed that HPH's emergency power system was inadequate due to problems with the distribution system and the size of the generator. (Hillebrand, Tr. 1909). If forced to switch to emergency power, HPH risked losing all power. (Hillebrand, Tr. 1909).

Response to Finding No. 1544:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Various evidence also supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See* CCRFF 1514).

1545. HPH's ED also did not have an adequate supply of emergency power for the most critically ill patients, and HPH did not properly designate emergency power outlets in critical areas such as the ICU. (Hillebrand, Tr. 1909-10).

Response to Finding No. 1545:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Various evidence also supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See* CCRFF 1514).

1546. Other facility problems at HPH before the Merger included a lack of isolation rooms on the patient units, patient rooms that lacked bathrooms and cardiac monitors, showers that lacked hot water and even problems with cafeteria tray lines. (Spaeth, Tr. 2287; O'Brien, Tr. 3511).

Response to Finding No. 1546:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Various evidence also supports the view that the changes made to HPH's facilities do not necessarily constitute improvements in quality of care. (*See* CCRFF 1516). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See* CCRFF 1514).

1547. Before the Merger, HPH had inadequate parking for patients, visitors and physicians. (Hillebrand, Tr. 1978-79; O'Brien, Tr. 3513). Patients parked on community streets

instead of hospital lots. (O'Brien, Tr. 3513). Given the size of the existing lot, the only solution was to build a new parking structure. (Hillebrand, Tr. 1978-79; O'Brien, Tr. 3513-14).

Response to Finding No. 1547:

This finding is inaccurate. The testimony of Mr. Hillebrand and Ms. O'Brien, neither of whom worked at HPH prior to the merger, is contradicted by the contemporaneous assessment of ACOG. { } (RX 324 at ENH PK 029706, *in camera*). Citing Dr. Chassin, Respondent has characterized the ACOG review as a "thoroughly done, top to bottom, east to west review." (RFF 1253). Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514).

1548. HPH's facilities problems were not resolved before the Merger. (Neaman, Tr. 1259; RX 1380 at ENH JH 11480). The Final Due Diligence Report recommended that ENH "aggressively remedy critical facility needs." (RX 635 at ENH JH 4002; Neaman, Tr. 1333).

Response to Finding No. 1548:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). The pre-merger due diligence was a unique event that caused the involved parties to look closely at areas they might otherwise not have looked at. (*See* CCRFF 1514).

vi. ENH Remedied The Substantial Deficiencies To HPH's Physical Plant And Made Additional Capital Improvements That Enhanced The Quality Of Care At HPH

1549. It was important for ENH to resolve HPH's physical plant deficiencies to protect

the welfare of patients at HPH and also to protect the reputation of HPH (Neaman, Tr. 1337). ENH made significant capital improvements to the HPH campus after the Merger. (Hillebrand, Tr. 1976). These improvements were overseen by Hillebrand. (Hillebrand, Tr. 1976).

Response to Finding No. 1549:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514).

1550. After the Merger, ENH replaced the HPH patient care buildings' entire electrical distribution and ventilation systems, plumbing and waste pipes. (Hillebrand, Tr. 1982).

Response to Finding No. 1550:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514).

1551. ENH also built a completely new central plant at HPH, including a new power plant that houses utilities such as electrical generators, backup generators, boilers and air ventilation equipment. (Hillebrand, Tr. 1979; O'Brien, Tr. 3514-15; CX 6304 at 14-15 (Livingston, Dep.)).

Response to Finding No. 1551:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514).

1552. One of ENH's principles has always been to have redundant critical life safety systems. (Hillebrand, Tr. 1979-80). Accordingly, after the Merger, ENH added two boilers instead of one, put in new air handlers for the ventilation system, replaced the emergency electrical generator and added a second emergency electrical generator. (Hillebrand, Tr. 1979). Consistent with its principle of having redundant critical life safety systems, after the Merger, ENH also installed at HPH two sources of water, two sources of electricity and two sources of natural gas. (Hillebrand, Tr. 1980).

Response to Finding No. 1552:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514).

1553. In December 2003, HPH began remodeling all of its patient units. (O'Brien, Tr. 3511). Patient rooms in the first unit were gutted, and showers were installed in each room. (O'Brien, Tr. 3512; Neaman, Tr. 1351-52). Each patient room now has a cardiac monitoring unit. (O'Brien, Tr. 3512; Neaman, Tr. 1351-52). ENH also installed a central cardiac monitoring unit in the nursing station. (O'Brien, Tr. 3512; Neaman, Tr. 1351-52). The total cost of remodeling the rooms in the first unit was $5.6 million. (O'Brien, Tr. 3513).

Response to Finding No. 1553:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). In addition, no remodeling was apparently necessary to HPH's 16 "labor/delivery/recovery/post-partum (LDRP) rooms." {[redacted]

[redacted]

[redacted]

[redacted]} (RX 324 at ENH PK 029706, *in camera*).

1554. Additionally, ENH added isolation rooms to the new unit, including a positive and negative air flow room, which are used for the treatment of infectious or immunosuppressed patients. (O'Brien, Tr. 3512-13).

Response to Finding No. 1554:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514).

1555. ENH currently is in the process of remodeling patient rooms in the second unit. (O'Brien, Tr. 3513).

Response to Finding No. 1555:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). These changes are "currently in the process," five and a half years after the merger. As such, they cannot be deemed "improvements" due to the merger but are more accurately characterized as routine and ongoing capital improvements that are both consistent with the national trend and would have been carried out absent the merger.

1556. { [redacted] } (Hillebrand, Tr. 1920-21, *in camera*). ENH also remodeled the registration areas to make it more private in satisfaction of the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") regulations. (O'Brien, Tr. 3515). { [redacted] } (O'Brien, Tr. 3515; Hillebrand, Tr. 1920-21, *in camera*).

Response to Finding No. 1556:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514).

1557. Immediately after the Merger, ENH added complimentary valet parking at HPH (O'Brien, Tr. 3514). ENH also added a new four-floor garage and remodeled the remaining parking around HPH (O'Brien, Tr. 3513-14; CX 6304 at 14 (Livingston, Dep.)).

Response to Finding No. 1557:

Various evidence supports the view that the changes were not merger specific

because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). Moreover, { [redacted] } (RX 324 at ENH PK 029706, *in camera*).

(1) ENH Opened A New Open Heart Surgery Suite At HPH

1558. In April of 2000, ENH opened a new open heart surgery suite at HPH (O'Brien, Tr. 3504). Coronary artery bypass grafts ("CABG") and open heart surgery are performed in the suite. (O'Brien, Tr. 3504-05). The cost of the open heart surgery suite was $1.3 million. (O'Brien, Tr. 3505).

Response to Finding No. 1558:

Various evidence supports the view that the opening of this suite was not specific to the merger. ENH and HPH contracted to begin a joint cardiac surgery program at HPH in April 1999, before they had agreed to merge. (Rosengart, Tr. 4527-29, 4531; CX 2094).

(2) ENH Opened A New Ambulatory Care Center At HPH

1559. ENH began construction of the ACC at HPH in December 2003. (O'Brien, Tr. 3498; Hillebrand, Tr. 1981). The 67,000 square foot building has four floors. (O'Brien, Tr. 3498).

Response to Finding No. 1559:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514). In addition, Complaint Counsel reiterates that a facility for which planning began several years after the merger and which opened more

than five years after the merger cannot be deemed "merger specific" under the rigorous standards of the Merger Guidelines.

1560. Outpatients go to the ACC for diagnostic testing. (O'Brien, Tr. 3497). Four hospital services are housed in the ACC: radiation medicine, nuclear medicine, the Kellogg Cancer Care Center and the breast imaging center. (O'Brien, Tr. 3497).

Response to Finding No. 1560:

Complaint Counsel have no specific response.

1561. The ACC opened its doors in February of 2005. (O'Brien, Tr. 3498; Hillebrand, Tr. 1981). The building cost $19.5 million, and the equipment cost an additional $5.3 million. (O'Brien, Tr. 3499).

Response to Finding No. 1561:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514).

(3) ENH Purchased New Equipment For The Operating Rooms

1562. After the Merger, ENH purchased additional equipment for to the operating rooms. (O'Brien, Tr. 3505). This included equipment to enhance retina surgery, bariatric surgery, plastic surgery, neurosurgery and orthopedic surgery. (O'Brien, Tr. 3505-06). The cost of the equipment upgrades was slightly over $2 million. (O'Brien, Tr. 3506).

Response to Finding No. 1562:

Various evidence supports the view that the changes were not merger specific because HPH likely would have continued to upgrade its physical facilities in the absence of the merger. (*See* CCRFF 1514).

1563. The additional equipment helped attract physicians and cases from Evanston Hospital and Glenbrook Hospital to HPH (O'Brien, Tr. 3506).

Response to Finding No. 1563:

Complaint Counsel have no specific response.

2. ENH Made Additional Improvements To Quality Of Care And Introduced New High Quality Services

1564. After the Merger, ENH enhanced HPH's clinical services, including adding cardiac surgery, adding academic oncology through the Kellogg Cancer Center, involving academic physicians, introducing residents and interns through an academic family medicine program, doubling the staffing at the ER and introducing full-time intensivists to the ICU. (Hillebrand, Tr. 1983-84). In short, ENH honored every commitment to the community spelled out in the Letter of Intent. (Spaeth, Tr. 2274-75).

Response to Finding No. 1564:

Various evidence supports the view that the changes in clinical services were not merger specific because HPH would have made them in the absence of the merger. (*See* CCRFF 1577, 1677, 1724-25, 1867). In addition, it is inaccurate to say that the referenced services were "enhanced." { } (*See* CCRFF 1565, *in camera*). { } (*See* CCRFF 1724, *in camera*; CCFF 2140-2142, *in camera*). { } (*See* CCRFF 2146-2171, *in camera*; CCFF 2102-2103, *in camera*). {

} (*See* CCRFF 1866, *in camera*; CCFF 2144, *in camera*). The intensivist program added after the merger also did not significantly enhance physician coverage because HPH already had some physician coverage prior to the merger. (*See* CCRFF 1672). In adding intensivists, ENH merely followed a national trend; indeed, the very research it cites to support its claim that intensivists were a positive development was published after the merger. (*See* CCRFF 1677; CCFF 2394-2402).

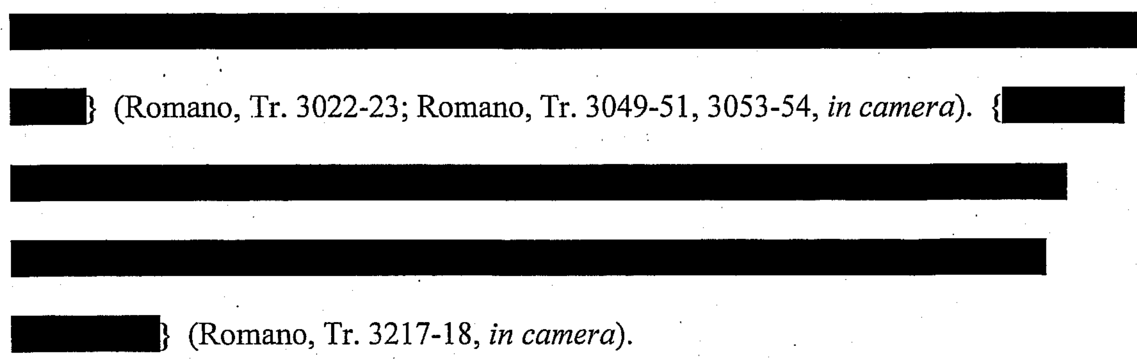
a. ENH Initiated A Cardiac Surgery Program At HPH After The Merger

i. Overview

1565. In June 2000, after the Merger, HPH became the first hospital in Lake County to perform open-heart surgery. (RX 879 at ENH GW 3252). At HPH, cardiac surgery is the most complex and highly technical care given to patients. (Chassin, Tr. 5603). The opening of the cardiac surgery program at HPH was a quality improvement in the care given to HPH patients. (Chassin, Tr. 5289).

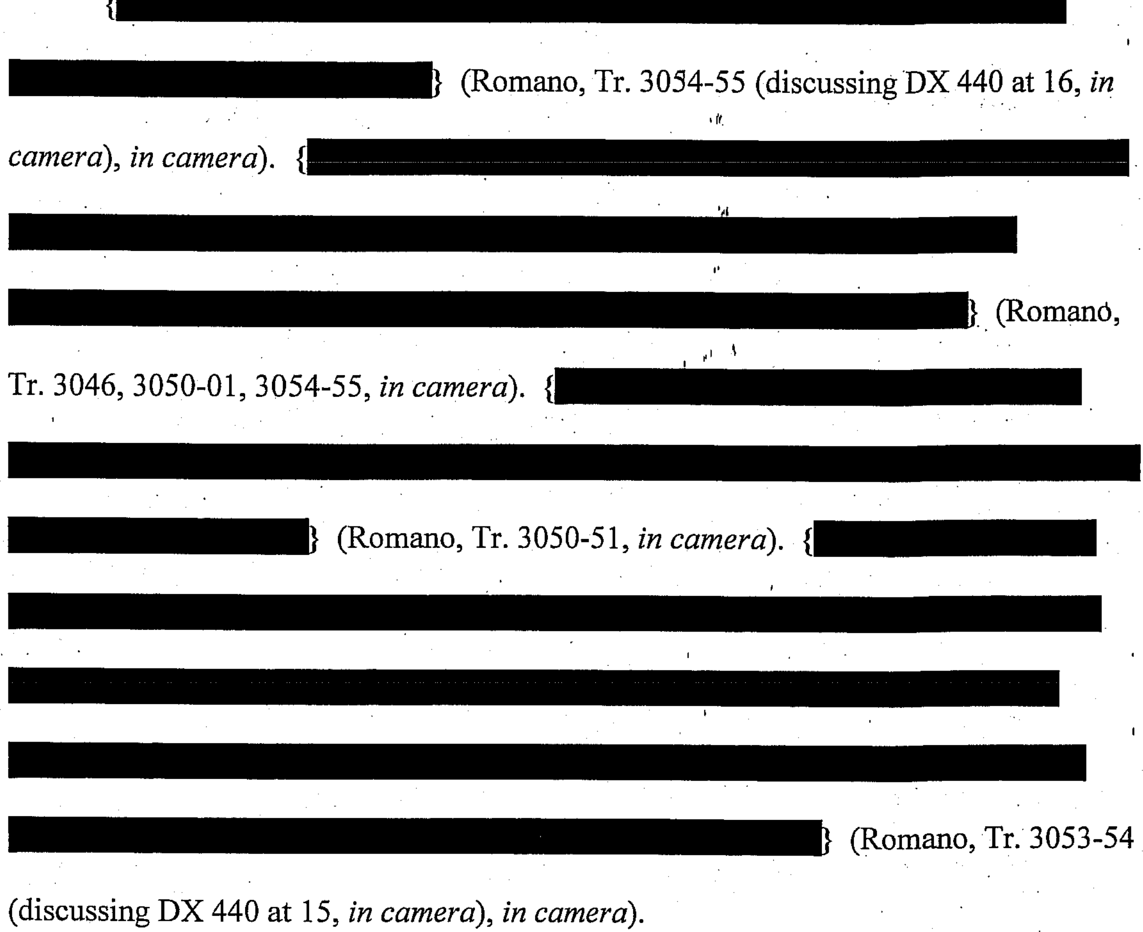
Response to Finding No. 1565:

Complaint Counsel reiterates that the issue of quality improvement is not limited to quality of care at HPH, but relates to the quality of care throughout the ENH system (where prices went up system wide). Various evidence supports the view that {



} (Romano, Tr. 3022-23; Romano, Tr. 3049-51, 3053-54, *in camera*). {

} (Romano, Tr. 3217-18, *in camera*).



{ } (Romano, Tr. 3054-55 (discussing DX 440 at 16, *in camera*), *in camera*). { } (Romano, Tr. 3046, 3050-01, 3054-55, *in camera*). { } (Romano, Tr. 3050-51, *in camera*). { } (Romano, Tr. 3053-54 (discussing DX 440 at 15, *in camera*), *in camera*).

In addition, there are many studies showing that hospitals and surgeons that do more bypass surgery have better outcomes. There is, therefore, an increasing interest in keeping surgical volumes high. (Romano, Tr. 3023). Since the merger, Highland Park Hospital has had problems generating volumes associated with optimal outcomes for the CABG program. (Romano, Tr. 3022-23). Several groups have set minimum volume standards for cardiac surgery. For example, the Leapfrog Group set a minimum standard of 450 cases per year. (Romano, Tr. 3025). Also, the American College of Cardiology ("ACC") and the American Heart Association ("AHA") set a minimum standard of 100 cases per year. (Romano, Tr. 3025-26). {

} (Romano, Tr. 3064-65, *in camera*). It should also be noted that ENH's consultant, Bain, set a target volume for cardiac surgery at Highland Park Hospital at 200 cases per year. (CX 1998 at 52).

The volume of bypass surgery performed at Highland Park Hospital in the years 2000, 2001, 2002, and 2003 was consistently and significantly below the ACC/AHA standard. (Romano, Tr. 3026 (discussing DX 7035)). {

} (Romano, Tr. 3063, *in camera*). {

} (Romano, Tr. 3064-65, *in camera*).

With regard to volumes, New York and Illinois have different approaches to cardiac surgery. New York has a model of very few centers performing very high numbers of open heart procedures. In contrast, the pattern for the State of Illinois is to have heart surgery at virtually every hospital in Chicago, so there are more cardiac surgery programs in Chicago than in the entire State of New York. Dr. Rosengart, who is in charge of ENH's Division of Cardiothoracic Surgery, agreed that the merits of the Illinois approach are debatable. (Rosengart, Tr. 4459-60). There was even concern

among Evanston Hospital cardiologists at the time of the merger that the establishment of a cardiac surgery program at Highland Park Hospital by ENH would spread resources too "thin." (CX 1998 at 21).

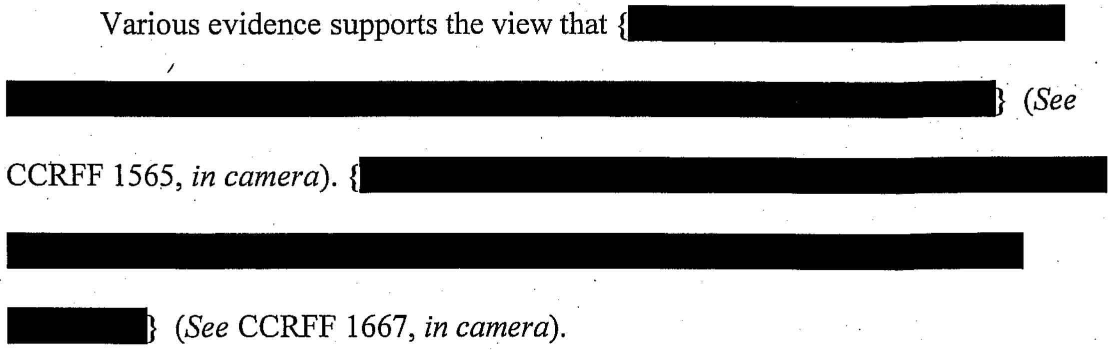
1566. Before the Merger, HPH did not have cardiac surgery or interventional cardiology, such as the capability to perform angioplasty or utilize stent technology. (Newton, Tr. 465-66; Spaeth, Tr. 2275). Dr. Romano concedes that the extension of the cardiac surgery program to HPH improved access to CABG procedures to residents of Lake County and reduced geographic disparities within the Chicago Metropolitan Statistical Area. (Romano, Tr. 3275).

Response to Finding No. 1566:

Various evidence supports the view that the changes in cardiac surgery and interventional cardiology were not merger specific because HPH would have made them in the absence of the merger. (*See* CCRFF 1577, 1649).

1567. As a general matter, cardiac surgery is an important quality enhancement for several reasons. First and foremost, cardiac surgery provides immediate life-saving treatment to patients with cardiac surgical emergencies. Cardiac surgery can also provide long-lasting benefits when patients who need cardiac surgery undergo it. (Chassin, Tr. 5290).

Response to Finding No. 1567:



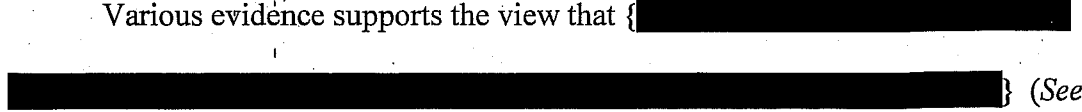
Various evidence supports the view that { } (*See* CCRFF 1565, *in camera*). { } (*See* CCRFF 1667, *in camera*).

1568. For example, if a patient presents in the HPH emergency room today with a torn aorta that closes off blood supply to the brain, that person needs immediate cardiac surgery. This has occurred recently at HPH, and the hospital was able to repair the tear in the patient's aorta and restore blood flow to the brain. Before the Merger, HPH would have had to transfer that patient by ambulance to another hospital where the patient would have to be re-evaluated and then sent to the transferee hospital's operating room for surgery. When a person has had blood

flow cut off from the brain, that person has mere minutes or, at the most, hours to receive the necessary life-saving treatment. Therefore, cardiac surgery is a very important, and often life-saving, procedure. (Rosengart, Tr. 4457-58).

Response to Finding No. 1568:

Various evidence supports the view that {

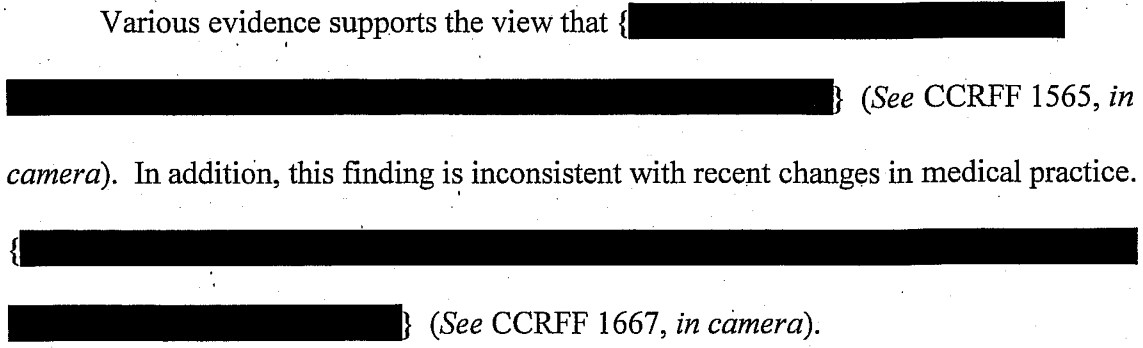


} (*See* CCRFF 1565, *in camera*). In addition, this finding cites only one specific example of a patient that actually presented with a need for emergency cardiac surgery, but does not specify whether that patient in fact required surgery in "mere minutes" or "hours." The difference is important because ENH has touted the quick driving times between the two hospitals as a reason for the alleged effectiveness of the joint cardiac surgery program. (*See* RFF 1596).

1569. Second, cardiac surgery is a necessary component of a full-service cardiology program and must be present to begin such a program at a given hospital. (Chassin, Tr. 5290).

Response to Finding No. 1569:

Various evidence supports the view that {



} (*See* CCRFF 1565, *in camera*). In addition, this finding is inconsistent with recent changes in medical practice. { } (*See* CCRFF 1667, *in camera*).

1570. Open-heart or cardiac surgery procedures include CABG (CABG technically stands for coronary artery bypass grafting), valve procedures, and surgery on the aorta. (Rosengart, Tr. 4452).

Response to Finding No. 1570:

Complaint Counsel have no specific response.

1571. The term "isolated CABG" means that only a bypass surgery was performed and no other procedure. (Rosengart, Tr. 4453). Isolated CABG surgery is performed to prevent heart attacks or myocardial infarctions and primarily to prolong life. It is also performed for patients who have symptoms of angina or chest pain, which can often be debilitating but is a life saving-operation. (Rosengart, Tr. 4454-55).

Response to Finding No. 1571:

Complaint Counsel have no specific response.

1572. Heart valve procedures are also an important part of cardiac surgery. Cardiac surgeons often repair or replace patient heart valves that no longer function properly. This operation involves surgery inside the heart, as opposed to CABG surgery where surgery is performed on the surface of the heart. Valve surgeries are performed under life-threatening circumstances. (Rosengart, Tr. 4455).

Response to Finding No. 1572:

Complaint Counsel have no specific response.

1573. Sometimes valve and CABG surgeries are performed at the same time and these surgeries would not be considered isolated CABG surgeries. (Rosengart, Tr. 4455-56).

Response to Finding No. 1573:

Complaint Counsel have no specific response.

1574. When evaluating the importance of a cardiac surgery program, one must include all of the different cardiac surgeries that are performed on patients. Isolated CABG surgeries account for only 50-70% of open heart surgery procedures performed at HPH Overall, the percent of isolated CABG surgeries is decreasing and more valve surgeries are being performed. (Rosengart, Tr. 4458).

Response to Finding No. 1574:

Complaint Counsel have no specific response.

1575. After, and as a result of, the Merger, ENH brought to HPH a "superb" cardiac surgery program and an enhanced cardiac catheterization lab. (Spaeth, Tr. 2275).

Response to Finding No. 1575:

Various evidence supports the view that {[redacted]

[redacted]} (*See* CCRFF 1565, *in camera*). Various evidence supports the view that the changes in clinical services were not merger specific because HPH would have made them in the absence of the merger. (*See* CCRFF 1577).

ii. HPH Was Not Well-Positioned To Begin A Cardiac Surgery Program

1576. {[redacted]
[redacted]} (Romano, Tr. 3059-60, *in camera*).

<u>Response to Finding No. 1576:</u>

This finding is irrelevant. The issue is not whether community hospitals have the wherewithal to implement a cardiac surgery program, but whether one could have been implemented at HPH in the absence of the merger. Various evidence supports the view that the change was not merger specific because HPH would have initiated a cardiac surgery program in the absence of the merger. (*See* CCRFF 1577).

1577. Before the Merger, HPH, as a community hospital, did not implement a cardiac surgery program. (CX 6305 at 4 (Stearns, Dep.)).

<u>Response to Finding No. 1577:</u>

Various evidence supports the view that the change is not merger specific because HPH planned to implement a cardiac surgery program without the merger and would have done so in late 1999 or early 2000, had the merger not taken place. HPH and ENH actually signed an agreement to develop a joint cardiac surgery program at Highland Park in April 1999, before they agreed to merge. (Rosengart, Tr. 4527-30, 4557; CX 2094).

The agreement to implement this program without a merger followed a planning process which had determined that the program would be feasible without a merger. (CX 92 at 12; CX 1868 at 13).

Moreover, the Certificate of Need Application for the HPH cardiac surgery program makes clear that the ENH/HPH collaboration necessary to implement the cardiac surgery program did not depend on the merger. The application represents that the program was the "culmination of a two-year cooperative planning effort" by HPH and ENH. (CX 413 at 5). It further claimed that "cardiology and cardiovascular surgery represent two clinical areas where HPH and ENH have maintained a long relationship of joint development" going back at least to 1987. (CX 413 at 5). The application was signed under oath by Mark Neaman and Ray Grady on behalf of ENH. (CX 413 at 17).

Moreover, as far back as 1997, Highland Park Hospital planned on developing a cardiovascular surgery program. (CX 1867 at 1; CX 91 at 2; CX 1869 at 4). In the late 1990s, Highland Park Hospital and ENH had considered establishing open heart surgery at Highland Park as a joint program. (Neaman, Tr. 1243; Hillebrand, Tr. 2044; Spaeth, Tr. 2117-18; CX 99 at 2). The original pre-merger discussions between Highland Park Hospital and ENH to implement an open heart surgery program at Highland Park did not concern a merger between the two hospitals. (Hillebrand, Tr. 2045).

If an open heart program with ENH was not possible, HPH was thinking about developing a relationship with Northwestern Memorial Hospital or Lutheran General Hospital involving an open heart program. (Newton, Tr. 337-38). Highland Park Hospital's proposals for a joint open heart surgery program with ENH or Northwestern

Memorial Hospital prior to the merger were viable, despite the fact that they did not involve common ownership of the hospitals. (Newton, Tr. 421-22).

{[redacted]} (Romano, Tr. 3060, *in camera. See also* Newton, Tr. 423-24; Rosengart, Tr. 4527-28; CX 2078 (joint cardiac surgery program between Highland Park Hospital and ENH similar to other joint cardiac surgery programs not involving merger)). {[redacted]} (Romano, Tr. 3075, *in camera*). Swedish Covenant Hospital and ENH are separate hospitals. (Newton, Tr. 424). Their joint open heart surgery program did not require a merger of the hospitals, but was accomplished through a contractual arrangement. (Hillebrand, Tr. 2045-46; Rosengart, Tr. 4443, 4557; CX 2078). The original cardiac surgery affiliation agreement between ENH and Highland Park Hospital is almost identical to the agreement between ENH and Swedish Covenant. (*Compare* CX 2073 *and* CX 2094; Rosengart, Tr. 4527-28 (agreements are "relatively similar")). In addition, the CON process for Highland Park Hospital to perform cardiac surgery was essentially identical to the one for Swedish Covenant Hospital. (Rosengart, Tr. 4471-72).

In addition to doing cardiac surgery at Swedish Covenant Hospital, ENH does cardiac surgery at Weiss Hospital through an affiliation agreement. (Rosengart, Tr.

4443). Both Swedish Covenant and Weiss Hospital are essentially community hospitals. (Rosengart, Tr. 4442). Each hospital runs its own cardiac surgery program, and Dr. Rosengart, the head of ENH's Division of Cardiothoracic Surgery, makes sure there are appropriate quality assurances in place. (Rosengart, Tr. 4444). Dr. Rosengart testified that among the three hospitals, Swedish Covenant Hospital was the most ready to implement a cardiac surgery program, HPH was in an intermediate position, and Weiss hospital was in the most inferior circumstances. (Rosengart, Tr. 4490).

The mortality rates for Swedish Covenant Hospital's open heart surgery program are within acceptable limits, according to ENH. ENH is also comfortable with its results for open heart surgery at Weiss Hospital. (Rosengart, Tr. 4502-03). Both of the joint heart surgery programs get passing grades in terms of performance. (Rosengart, Tr. 4504). Mark Newton, the President of Swedish Covenant Hospital, also agrees that the arrangement between Swedish Covenant Hospital and ENH is exceeding its quality parameters. (Newton, Tr. 424).

1578. After studying the issue, pre-Merger HPH concluded that a cardiac surgery program was not an appropriate investment to make at the hospital. (CX 6305 at 4 (Stearns, Dep.)). HPH could not justify starting a cardiac surgery program as a stand-alone hospital in light of several hurdles to such a program. (CX 6305 at 9 (Stearns, Dep.)).

Response to Finding No. 1578:

The cited testimony from Mr. Stearns appears to relate to HPH beginning a cardiac surgery program on its own, a problem that was solved through the contractual agreement to start such a program with ENH, but short of a merger. Various evidence supports the view that the change was not merger specific because HPH would have

initiated a cardiac surgery program in the absence of the merger. (*See* CCRFF 1577).

1579. {[redacted]} (Rosengart, Tr. 4462; Romano, Tr. 3058-59, *in camera*). All of these individuals play an important role in the success or failure of an open heart surgery program, in fact, the weakest link in the chain of personnel really defines how successful a program can become. (Rosengart, Tr. 4462).

Response to Finding No. 1579:

This finding is irrelevant. The issue is not precisely how difficult it might be to implement a cardiac surgery program, but whether one could have been implemented at HPH in the absence of the merger. Various evidence supports the view that the change was not merger specific because HPH would have initiated a cardiac surgery program in the absence of the merger – indeed, it actually agreed to do so with ENH. (*See* CCRFF 1577).

1580. Nurses are a critical component of an open heart surgery team. ICU nurses take care of critically ill patients right after surgery. They are specially trained to run ventilators, supply multiple medications, and other tasks critical to cardiac patient care in the ICU. (Rosengart, Tr. 4463-64). Floor nurses monitor vital signs, take care of daily living activities, monitor breathing and circulation, as well as other tasks for cardiac surgery patients. (Rosengart, Tr. 4464).

Response to Finding No. 1580:

Complaint Counsel have no specific response.

1581. HPH also needed approval from the state of Illinois to offer a cardiac surgery program. (Spaeth, Tr. 2247-48).

Response to Finding No. 1581:

Complaint Counsel have no specific response.

1582. In light of these hurdles, HPH was far from prepared to begin a cardiac surgery program before the Merger. As of November 1999, there was a very rudimentary ICU. There was negligible physician supervision. There was little nursing experience in terms of open heart surgery. There was essentially no OR nursing experience for doing open heart surgery. Basically, there was a self perception throughout the hospital that "we're not ready to do open heart surgery here" and, in fact, that perception was correct. (Rosengart, Tr. 4481).

Response to Finding No. 1582:

This finding is inaccurate. In April 1999 ENH had contractually bound itself to perform cardiac surgery at the HPH that then existed. (Rosengart Tr. 4527; CX 2094 at 1). While Dr. Rosengart did not participate in the clinical assessment that preceded this agreement, he expected that one had been conducted. (Rosengart Tr. 4531). Moreover, the agreement ENH signed with HPH before the merger was nearly identical to the agreement ENH signed with Swedish Covenant, indicating that the two hospitals were roughly equally prepared to begin a cardiac surgery program. (Rosengart, Tr. 4528).

Whatever needs HPH had in the ICU and elsewhere could have been, and in fact were, addressed in a partnership short of a merger. Under the pre-merger cardiac surgery agreement between ENH and HPH, HPH committed to make payments to ENH for three years, starting at $250,000 in the first year for "replicating all protocols and practices of ENH cardiac surgery programs at HPH and training personnel." (CX 2094 at 3-4). The contract specifically contemplated "initial on-site and ongoing training at Evanston Hospital for the nursing staff in the Operating Room, the Intensive Care Unit, the surgical floor and other staff as appropriate, including anesthesia and PACU." (CX 2094 at 3-4).

1583. HPH's OR, ICU and step-down nurses had little experience or leadership capacity before the Merger. After the Merger, in contrast, nurses at HPH began a series of in-service programs at Evanston Hospital where they spent weeks or a month being trained in the Evanston Hospital ICU and OR to work with cardiac surgery patients. (Rosengart, Tr. 4482-83).

Response to Finding No. 1583:

ENH in this finding attributes to the merger training that took place in order to start a new surgery program. But in fact the parties had contractually agreed that HPH would pay for, and ENH would provide, the same training without a merger. (*See* CCRFF 1582).

1584. The entire ICU at HPH also did not have much experience or a positive track record taking care of critically ill patients. In fact, before the Merger, HPH did not have any physician leadership to help nurses take care of critically ill patients. As a result, ENH created an intensivist program after the Merger in the HPH ICU, a program that was critical in upgrading the ability of nurses to identify and treat emergent problems and heart surgery patients. *See* Section VIII.D.2.c., *supra*. The corollary of the increased abilities of ICU nurses gained from caring for critically ill heart patients is that their newly acquired training also translates to care they provide to other patients in the ICU. (Rosengart, Tr. 4483-84).

Response to Finding No. 1584:

This finding is irrelevant. The issue is not the precise extent to which HPH was prepared to implement a cardiac surgery program, but whether one could have been implemented at HPH in the absence of the merger. Various evidence supports the view that the change was not merger specific because HPH would have initiated a cardiac surgery program in the absence of the merger. (*See* CCRFF 1577). In addition, various evidence supports the view that the intensivist program could not have been a factor in developing the cardiac surgery program at HPH because the intensivist program did not even begin until a year after implementation of cardiac surgery. Cardiac surgery began at HPH in June 2000, (Rosengart, Tr. 4482; O'Brien, Tr. 3504-05), yet the intensivist program did not begin at HPH until May 2001. (O'Brien, Tr. 3529; Ankin, Tr. 5041).

1585. Moreover, the administration at HPH did not facilitate the opening of the cardiac surgery program at HPH Eventually, these administrators were removed by ENH, and ENH had

to start from the ground up to install the open heart program at HPH (Rosengart, Tr. 4484-85). There also was trepidation and an inferiority complex throughout HPH with respect to beginning the open heart program. (Rosengart, Tr. 4485-86).

Response to Finding No. 1585:

This finding is irrelevant. The issue is not the precise extent to which HPH was prepared to implement a cardiac surgery program, but whether one could have been implemented at HPH in the absence of the merger. Various evidence supports the view that the change was not merger specific because HPH would have initiated a cardiac surgery program in the absence of the merger. (*See* CCRFF 1577). In addition, Dr. Rosengart actually had more trouble with the administration at Swedish Covenant than he had with HPH (Rosengart, Tr. 4526-27). Yet, ENH operates a joint program at Swedish Covenant and the results of the program at Swedish Covenant have been within acceptable limits, according to ENH. (Rosengart, Tr. 4502).

iii. ENH Recruited A Talented Physician Leader For Cardiac Surgery Immediately After The Merger

1586. In late 1999 or early 2000, ENH expanded its cardiac surgery capabilities and added cardiac medical genetic procedures, in part, by recruiting Dr. Todd Rosengart, an experienced cardiac surgeon who testified at trial concerning how the addition of cardiac surgery at HPH after the Merger improved quality of care at that hospital and benefited its community. (Neaman, Tr. 1381; Rosengart, Tr. 4439-40).

Response to Finding No. 1586:

The cited source does not say what the last part of Respondent's finding claims. That is, the cited source does not support a finding that the addition of cardiac surgery at HPH after the merger improved quality of care at that hospital and benefitted its community. {

} (*See*

CCRFF 1565, *in camera*).

1587. Dr. Rosengart is a cardiac surgeon. (Rosengart, Tr. 4436). He was recruited to ENH as the head of the Division of Cardiothoracic Surgery. His responsibilities in this position extend to each hospital within ENH, including HPH (Rosengart, Tr. 4439-40). Dr. Rosengart is also the medical director of cardiac surgery at Weiss Hospital and Swedish Covenant Hospital in Chicago. (Rosengart Tr. 4442-43).

Response to Finding No. 1587:

Dr. Rosengart is no longer the medical director at Weiss Hospital. He delegated that responsibility to Dr. Curran. (Rosengart, Tr. 4442-43).

1588. Dr. Rosengart attended medical school at Northwestern University. (Rosengart, Tr. 4436). He completed his residency at NYU in 1989, and spent two years at the National Institute of Health. He also completed a fellowship at Cornell, New York Hospital. (Rosengart, Tr. 4436-37). Dr. Rosengart has been Board-certified in cardiac and thoracic surgery since 1990 and 1992 respectively. (Rosengart, Tr. 4437). He is licensed to practice surgery in Illinois and New York state. (Rosengart, Tr. 4437-38).

Response to Finding No. 1588:

Complaint Counsel have no specific response.

1589. Dr. Rosengart has practiced at several hospitals in New York including New York Hospital, Jamaica Hospital, and United Hospital in West Chester. (Rosengart, Tr. 4438-39).

Response to Finding No. 1589:

Complaint Counsel have no specific response.

1590. Dr. Rosengart is a member of the several academic and professional societies with respect to cardiothoracic surgery. For example, he is a member of the American College of Cardiac Surgeons, Society of Thoracic Surgery ("STS") and American Heart Association ("AHA"). In the STS, Dr. Rosengart is on the health policies committee, which develops guidelines for the practice of cardiac surgery and sets direction for it. (Rosengart, Tr. 4447-48). Dr. Rosengart also founded the Chicago Cardiothoracic Society and the 21st Century Cardiac Surgery Society. (Rosengart, Tr. 4448-49).

Response to Finding No. 1590:

Complaint Counsel have no specific response.

iv. Evanston Hospital And HPH, Since The Merger, Have An Integrated Cardiac Surgery Program That Shares An Affiliation With Other Hospitals

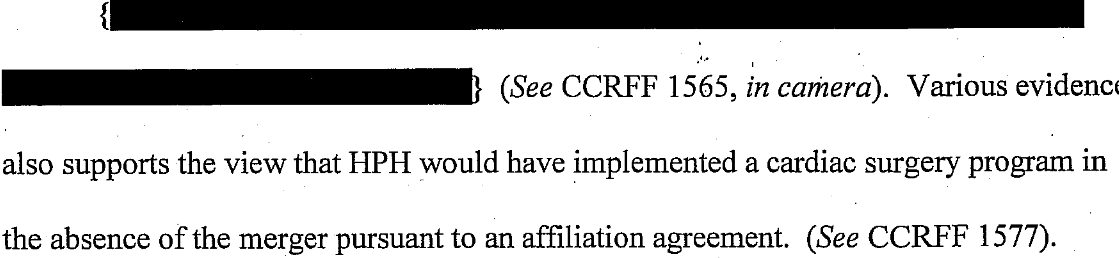
1591. The Merger provided the necessary infrastructure support to remedy the clear inability of HPH to implement a cardiac surgery program. (Rosengart, Tr. 4486-87).

Response to Finding No. 1591:

Various evidence supports the view that the change was not merger specific because HPH would have implemented a cardiac surgery program in the absence of the merger pursuant to an affiliation agreement. (*See* CCRFF 1577). Before the merger, ENH was willing to sign an agreement with HPH that provided for the same level of support in developing a cardiac surgery program as the support provided by ENH to Swedish Covenant. (Rosengart, Tr. 4527-28).

1592. Today, the practice of cardiac surgery at HPH is indistinguishable from the cardiac surgery practice at Evanston Hospital. What is being done at both campuses is state-of-the-art with respect to complexity of surgical techniques and cases, and cutting edge research. (Rosengart, Tr. 4492).

Response to Finding No. 1592:

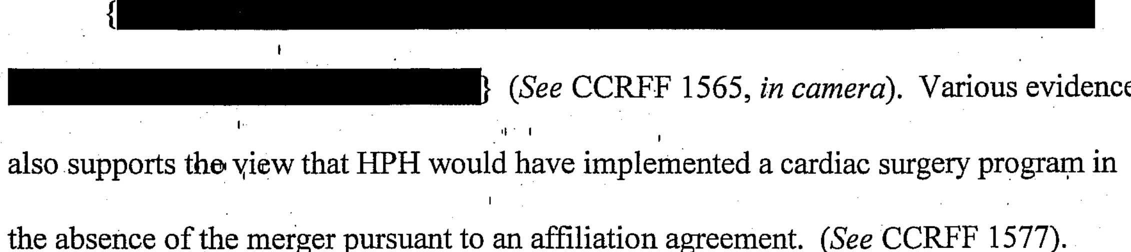


{ } (*See* CCRFF 1565, *in camera*). Various evidence also supports the view that HPH would have implemented a cardiac surgery program in the absence of the merger pursuant to an affiliation agreement. (*See* CCRFF 1577).

1593. ENH did everything that a high quality hospital would do to open a cardiac surgery program of the highest quality when it began the program at HPH (Chassin, Tr. 5291). To begin the cardiac surgery program, ENH had to acquire a Certificate of Need ("CON") from the State of Illinois. The CON is a document from the State in which the State and the hospital agree to conditions that suggest that the cardiac surgery program to be opened is of a certain

quality that it should be sanctioned by the State. The State of Illinois placed various conditions on the performance of the new cardiac surgery program at HPH during the beginning years of its operation. At the conclusion of the evaluation period, ENH received unanimous approval after the review of the CON Board for the cardiac surgery program at HPH (Rosengart, Tr. 4471-72).

Response to Finding No. 1593:



{ } (*See* CCRFF 1565, *in camera*). Various evidence also supports the view that HPH would have implemented a cardiac surgery program in the absence of the merger pursuant to an affiliation agreement. (*See* CCRFF 1577).

1594. The ENH cardiac surgeons practice at four different sites, including two non-ENH hospitals. The sites are Evanston Hospital, HPH, Swedish Covenant Hospital and Weiss Hospital. (Rosengart, Tr. 4442).

Response to Finding No. 1594:

Complaint Counsel have no specific response.

1595. Four physicians currently perform cardiac surgery at ENH and other affiliated hospitals under the direction of Dr. Rosengart. Within the ENH Medical Group, Dr. Ronald Curran and Dr. Edward Chedrawy both practice under Dr. Rosengart. Outside the Medical Group, but on staff at ENH, Dr. Michael Frank practices primarily at Evanston Hospital. (Rosengart, Tr. 4440-41).

Response to Finding No. 1595:

Complaint Counsel have no specific response.

1596. Under the protocols required by the state of Illinois for approval of the program the affiliates and HPH must be within 30 minutes travel time for physicians. The close location of these affiliated programs allows ENH physicians to meet that requirement. (Rosengart, Tr. 4475).

Response to Finding No. 1596:

The physical distance is of course the same with and without the merger. ENH physicians would have been equally close to HPH had the April 1999 cardiac surgery

agreement gone into place without the merger. Moreover, the cited source does not say what the last sentence of Respondent's finding claims.

1597. It is important for physicians to be in close proximity to the hospital where they perform cardiac surgery because patients suffering from acute heart attacks or emergency cardiac situations need attention quickly or may die. In fact, the State of Illinois required that at least one HPH cardiothoracic surgeon should reside within 30 minutes travel time from HPH (Rosengart, Tr. 4545; RX 901 at ENH JH 11513).

Response to Finding No. 1597:

The physical distance is of course the same with and without the merger. ENH physicians would have been equally close to HPH had the April 1999 cardiac surgery agreement gone into place without the merger.

1598. The ENH open heart surgery program is an adult cardiac surgery program with a volume between 500 and 600 open heart procedures per year.

Response to Finding No. 1598:

While this figure may be an accurate count of the total heart surgeries at Evanston Hospital and HPH, that does not mean it is appropriate to lump them all together for purposes of determining whether the volume is acceptable. As noted by ENH, the State of Illinois required a separate certificate of need for the HPH program. (RFF 1593). The state appears to have looked at HPH volume separately from Evanston hospital. (*See* RX 901 (amendment to certificate of need lowering volume requirements for certain procedures done at HPH)). Before the merger, ENH's consultant, Bain, set a target volume of 200 cases per year at HPH (CX 1998 at 52). And Complaint Counsel's expert, Dr. Romano found it appropriate to consider HPH's volume against the threshold volumes set by various organizations. (Romano, Tr. 3025-26). When HPH's volumes are

broken out separately, the volume of bypass surgery performed at Highland Park Hospital in the years 2000, 2001, 2002, and 2003 was consistently and significantly below the ACC/AHA standard. (Romano, Tr. 3026 (discussing DX 7035))

1599. The cardiac surgery that takes place at Evanston Hospital and HPH is part of a single program, the ENH cardiac surgery program, and both locations involve very intensive reporting and monitoring. (Rosengart, Tr. 4452-53). In other words, the program at HPH is not a stand-alone cardiac surgery program. It functions as one program with Evanston Hospital. Specifically, Dr. Rosengart sees the ENH program as having two operating rooms that are several miles away instead of 50 feet apart. (Rosengart, Tr. 4498).

Response to Finding No. 1599:

The Certificate of Need application filed with the State of Illinois took a quite different position from that asserted by Dr. Rosengart at trial. In RFF 1599-1601, relying on Dr. Rosengart's testimony, Respondent distinguishes between the program at HPH (the merged entity) and that at Swedish Covenant (through affiliation agreement). But the Certificate of Need application stated that ENH would "simultaneously initiate joint programs with both Highland Park Hospital and Swedish Covenant Hospital" and that, at both institutions, ENH would adopt a "single program multi-site approach." (CX 413 at 7). With regard to distance, the cited source states that the two operating rooms are located 5 miles apart, not "several" miles. (Rosengart, Tr. 4498). In its Certificate of Need application, HPH and ENH stated that the distance was 11 miles. (CX 413 at 27).

1600. Neither Weiss Hospital nor Swedish Covenant Hospital are hospitals owned or operated by ENH. Accordingly, ENH cardiac surgeons practice at these two sites only via an affiliation agreement. (Rosengart, Tr. 4443).

Response to Finding No. 1600:

ENH represented to the state of Illinois that it could operate a "single program

multi site approach" at both HPH and Swedish Covenant without distinguishing between a program run at a merged entity and one run through affiliation agreement. (*See* CCRFF 1599).

1601. The affiliation agreements in place ensure that Weiss Hospital and Swedish Covenant Hospital are independent from ENH; those hospitals basically run their own programs. (Rosengart, Tr. 4444). The Weiss Hospital and Swedish Covenant Hospital affiliation agreements are modeled very closely after each other. (Rosengart, Tr. 4489). Essentially, these agreements allow the ENH team of surgeons to practice cardiac surgery at the affiliated hospitals. (Rosengart, Tr. 4443-44).

Response to Finding No. 1601:

ENH represented to the state of Illinois that it could operate a "single program multi-site approach" at both HPH and Swedish Covenant without distinguishing between a program run at a merged entity and one run through affiliation agreement. (*See* CCRFF 1599). In addition, the affiliation agreement between ENH and Swedish Covenant Hospital is modeled on the agreement that ENH signed with HPH prior to the merger. (*Compare* CX 2073 *and* CX 2094; Rosengart, Tr. 4527-28).

1602. The only other individuals covered under the affiliation agreements are the ENH perfusionists, or the people who run the heart/lung machine during surgery. A heart/lung machine takes over the function of the heart beating and the lungs working for a patient undergoing cardiac surgery. The perfusionist runs the machine and is literally in complete control of the patient's vital heart and lung function. (Rosengart, Tr. 4464-65). ENH provides the perfusionists for the open heart programs at these hospitals. (Rosengart, Tr. 4500-01, 4461-62).

Response to Finding No. 1602:

Complaint Counsel have no specific response.

v. HPH Had Equal Or Lesser Ability To Accept A New Cardiac Surgery Program Than The ENH-Affiliated Hospitals

1603. Swedish Covenant Hospital was much better prepared than HPH to accept a new cardiac surgery program before the beginning of the HPH open heart program. (Rosengart, Tr. 4487-88). Specifically, Swedish Covenant Hospital had its own nurses in place. Swedish Covenant Hospital already had advanced practice nurses with significant cardiac surgery experience, the hospital already had intensive care unit physician coverage, and the hospital already had an administration that understood what it would take to run a cardiac surgery program. (Rosengart, Tr. 4487-88).

Response to Finding No. 1603:

This finding is irrelevant. The issue is not the precise extent to which HPH was prepared to implement a cardiac surgery program, but whether a program could have been implemented at HPH in the absence of the merger. Various evidence supports the view that the change was not merger specific because HPH would have initiated a cardiac surgery program in the absence of the merger. (*See* CCRFF 1577).

In addition, various evidence supports the view that HPH did not have a lesser ability to accept a new cardiac surgery program than Weiss Hospital. Dr. Rosengart clearly testified that among the three hospitals (HPH, Weiss, and Swedish Covenant) where ENH opened a program, Swedish Covenant was the most ready to implement cardiac surgery , HPH was in an intermediate position, and Weiss hospital was in the most inferior circumstances. (Rosengart, Tr. 4490). Thus, HPH was better prepared than Weiss Hospital.

Also, part of this finding is contradicted by other testimony of Dr. Rosengart. Although Dr. Rosengart states that Swedish Covenant had an administration that understood what it would take to run a cardiac surgery program, he testified elsewhere that he had some trouble with the administration at Swedish Covenant (more trouble than he had with HPH). (Rosengart, Tr. 4526-27). Such trouble questions the testimony that

any management difficulties at HPH would have precluded implementation of a program at least as successful as the program at Swedish Covenant.

1604. Weiss Hospital was more like HPH than Swedish Covenant Hospital in its ability to accept a cardiac surgery program. Weiss Hospital had (and still has) depleted infrastructure and capital resources. There were deficiencies in teaching, administration and nursing. (Rosengart, Tr. 4469, 4490).

Response to Finding No. 1604:

This finding is irrelevant. The issue is not the precise extent to which HPH was prepared to implement a cardiac surgery program, but whether a program could have been implemented at HPH in the absence of the merger. Various evidence supports the view that the change was not merger specific because HPH would have initiated a cardiac surgery program in the absence of the merger. (*See* CCRFF 1577). In addition, various evidence supports the view that HPH did not have a lesser ability to accept a new cardiac surgery program than Weiss Hospital. (*See* CCRFF 1603). Finally, ENH is comfortable with its results for open heart surgery at Weiss Hospital. (Rosengart, Tr. 4502-03). Thus, there is every reason to expect that a similar or better program could have been implemented at HPH if HPH and ENH had gone ahead with their plans to implement such a program short of a merger.

1605. Having a strong hospital administration is critical to the operation of an open heart surgery program. There are constant needs and demands placed on a program of this type and, as a result, many things about the program have to be continually modified and upgraded by the hospital administration for the program to function well over time. (Rosengart, Tr. 4466-67). For example, the operating room lights at Weiss Hospital are substandard and the Weiss administration has been slow to respond to fix them. (Rosengart, Tr. 4469).

Response to Finding No. 1605:

Complaint Counsel have no specific response.

vi. The Post-Merger, Integrated ENH/HPH Cardiac Surgery Program Provides Excellent Care To Patients

1606. Evanston Hospital clearly recognized the complexities of the challenges it was undertaking with respect to implementing cardiac surgery at HPH The roll-out plan for HPH called for careful initial patient selection. In the first six to nine months the cases selected to be done at HPH were not high risk. As systems were perfected and the surgeons became more comfortable with the skill level of the cardiac surgery teams, the acuity of cases were increased. (Rosengart, Tr. 4491).

Response to Finding No. 1606:

Complaint Counsel does not dispute that ENH took several steps that were appropriate for an effective roll out of the cardiac surgery program. { } (*See* CCRFF 1565, *in camera*). Moreover, there is no reason these steps could not have been taken if the parties had gone ahead with their plan to start the program without the merger.

1607. In-depth analyses of HPH's cardiac surgery program, described in more detail below, indicate that the program has been implemented successfully and is run through very high quality structures and processes. In addition, the conclusion that the structures and processes dedicated to cardiac surgery at HPH are of the highest quality is supported by the fact that the mortality and major complication rates at HPH for cardiac surgery have been better than or equal to national benchmarks for an extended period of time. (Chassin, Tr. 5299-300).

Response to Finding No. 1607:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. { } (*See* CCRFF 1565, *in camera*).

(1) The Mortality Rate For Cardiac Surgery At HPH Compares Favorably To The Best Surgery Centers In The Country

1608. The most overwhelming outcome measure when evaluating the performance of a cardiac surgery program is mortality. (Rosengart, Tr. 4521-22). It is the "gold standard" of outcome measures used to measure the quality of open heart surgery programs. (Rosengart, Tr. 4522-23).

Response to Finding No. 1608:

Complaint Counsel have no specific response.

1609. The mortality rate at HPH compares favorably to the best cardiac surgery centers in the country. (Rosengart, Tr. 4522-24).

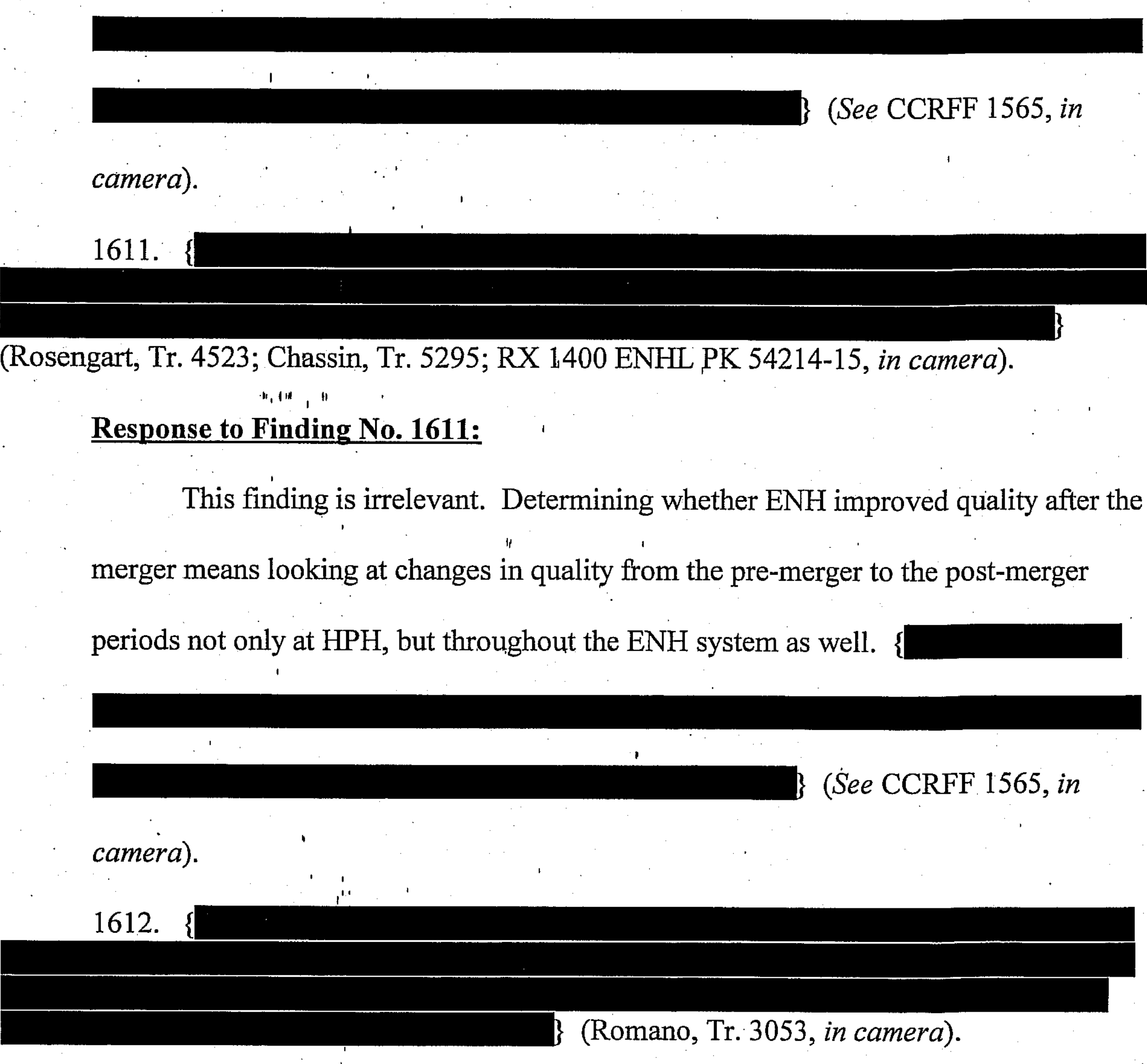
Response to Finding No. 1609:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. { } (*See* CCRFF 1565, *in camera*).

1610. { } (Chassin, Tr. 5294; RX 1400 at ENHL PK 54798-806, *in camera*).

Response to Finding No. 1610:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. {



} (*See* CCRFF 1565, *in camera*).

1611. {

} (Rosengart, Tr. 4523; Chassin, Tr. 5295; RX 1400 ENHL PK 54214-15, *in camera*).

Response to Finding No. 1611:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. {

} (*See* CCRFF 1565, *in camera*).

1612. {

} (Romano, Tr. 3053, *in camera*).

Response to Finding No. 1612:

Complaint Counsel have no specific response.

1613. ENH is very diligent in the way it reports all data to STS. STS is a voluntary registry that enables health care providers to compare the results of cardiac surgery at different institutions across the country. (Rosengart, Tr. 4511-12). {

} (RX 1411 at ENHL PK 51119, *in camera*; Romano, Tr. 3046, *in camera*).

Response to Finding No. 1613:

Complaint Counsel have no specific response.

1614. { } (RX 1411 at ENHL PK 51180, *in camera*). Moreover, HPH is lower than the benchmark for cardiac surgery programs in New York State, which is also 2.3%. (Chassin, Tr. 5294).

Response to Finding No. 1614:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. { } (*See* CCRFF 1565, *in camera*).

1615. { } (Romano, Tr. 3059, *in camera*). Further, the State of Illinois during the CON process stipulated that the HPH cardiac surgery program must have an annual a mortality rate of no more than 5%. (Rosengart, Tr. 4477-78).

Response to Finding No. 1615:

Complaint Counsel have no specific response.

1616. The mortality rate for each cardiothoracic surgeon performing isolated bypass or CABG surgery at HPH in the initial year of the program at or below 3%. Dr. Votapka's mortality rate was .6%, Dr. Rosengart's mortality rate was 1.4%, and Dr. Frank's mortality rate was 3.1%. (Rosengart, Tr. 4477-78; RX 1371 at ENH JH 11538).

Response to Finding No. 1616:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. {

} (*See* CCRFF 1565, *in camera*).

(2) HPH Complication Rates For Cardiac Surgery Are Below National Benchmarks

1617. Complications can be grouped into at least two categories, major and minor. Major complications are life threatening. They include stroke, sternal wound infection, renal failure, or significant bleeding. (Rosengart, Tr. 4510). Minor complications are not life threatening and include things like leg wound infections. (Rosengart, Tr. 4510).

Response to Finding No. 1617:

Complaint Counsel have no specific response.

1618. Major Complication rates are important measurements in the quality of a cardiac surgery program. This is true because cardiac surgery must be performed with very low complication rates if it is to provide long-term benefits of prolonged life, improved functioning and reduced pain. (Chassin, Tr. 5293).

Response to Finding No. 1618:

Complaint Counsel have no specific response.

1619. The commonly accepted major complications of cardiac surgery include re-operations, permanent stroke that causes cerebral damage, damage to the brain, kidney failure and deep sternal wound infections. (Chassin, Tr. 5298).

Response to Finding No. 1619:

Complaint Counsel have no specific response.

1620. In general, patient outcomes measured when evaluating the performance of a cardiac surgery program include major complications, minor complications, length of stay and mortality. (Rosengart, Tr. 4508-09, 4521-22). Complications are an adverse event that may or may not be influenced by a practice pattern. (Rosengart, Tr. 4509).

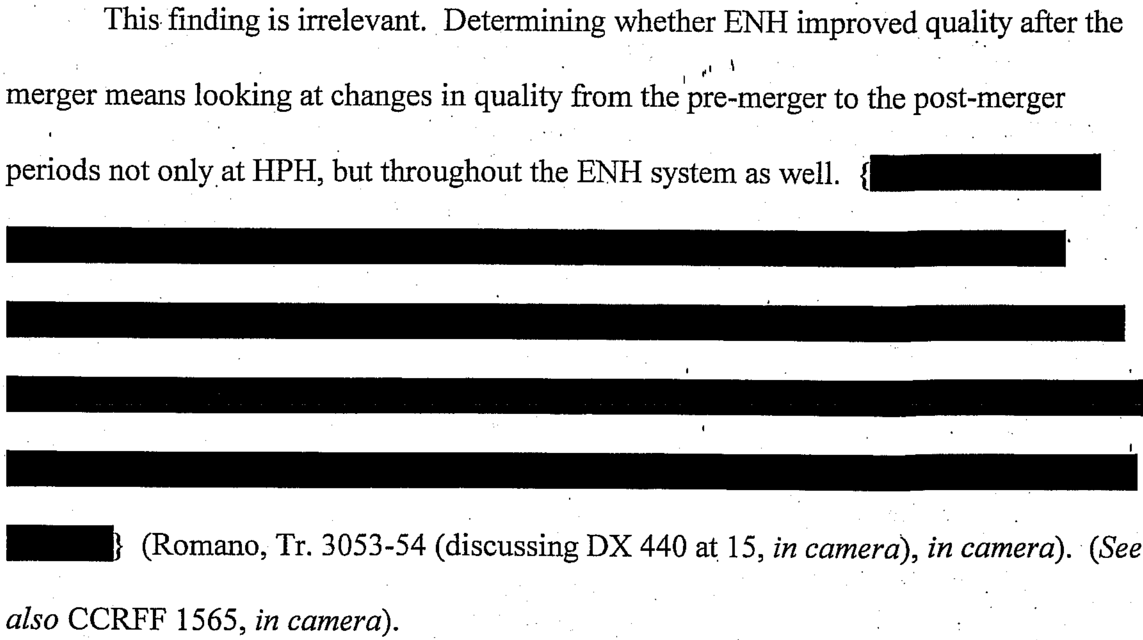
Response to Finding No. 1620:

Complaint Counsel have no specific response.

1621. The data regarding measurement of major complication rates associated with HPH's cardiac surgery program amplify the conclusion drawn from the low mortality rate in patients who undergo isolated CABG at HPH Both of these seminal indicators show that the roll-out of the cardiac surgery program at HPH by ENH was done in an extremely high-quality way with outcomes that were equal to or better than national standards. (Chassin, Tr. 5299).

Response to Finding No. 1621:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. {

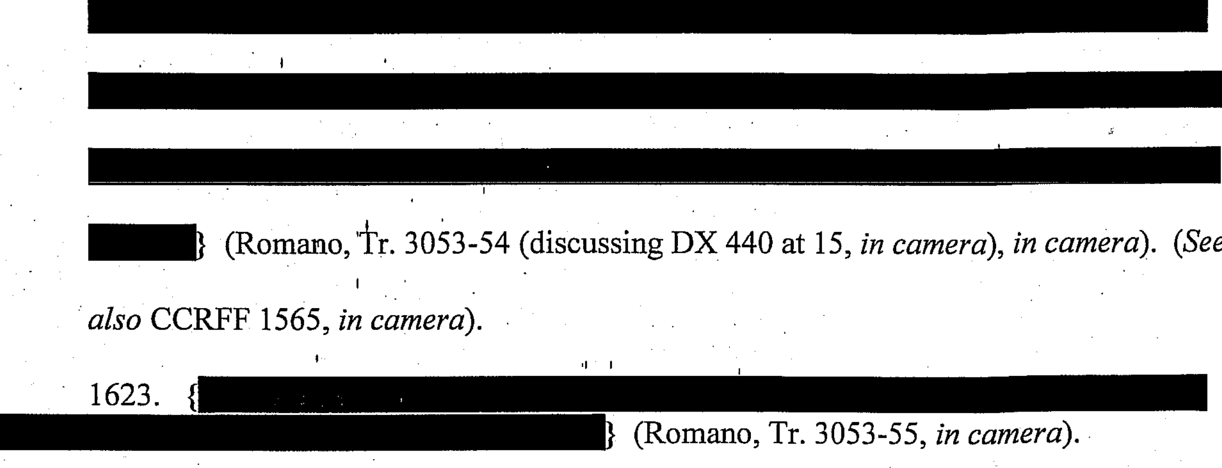


} (Romano, Tr. 3053-54 (discussing DX 440 at 15, *in camera*), *in camera*). (*See also* CCRFF 1565, *in camera*).

1622. Overall, the rate of major complications accepted as measures of quality for cardiac surgery were lower at HPH than national benchmarks established by STS. HPH's rate of re-operation was about 1.8%, while the accepted national benchmark published by STS is much higher, approximately 5.3%. The rate of permanent stroke at HPH was equal to the STS national benchmark at 1.54%. The rate of kidney failure at HPH was much lower at 1.16%, as compared to 3.48% nationally. Finally, the rate of deep sternal wound infection was about equal at less than 1% to national benchmarks. (Chassin, Tr. 5299; RX 1571 at ENHL PK 52193).

Response to Finding No. 1622:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. {



} (Romano, Tr. 3053-54 (discussing DX 440 at 15, *in camera*), *in camera*). (*See also* CCRFF 1565, *in camera*).

1623. { } (Romano, Tr. 3053-55, *in camera*).

Response to Finding No. 1623:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. {

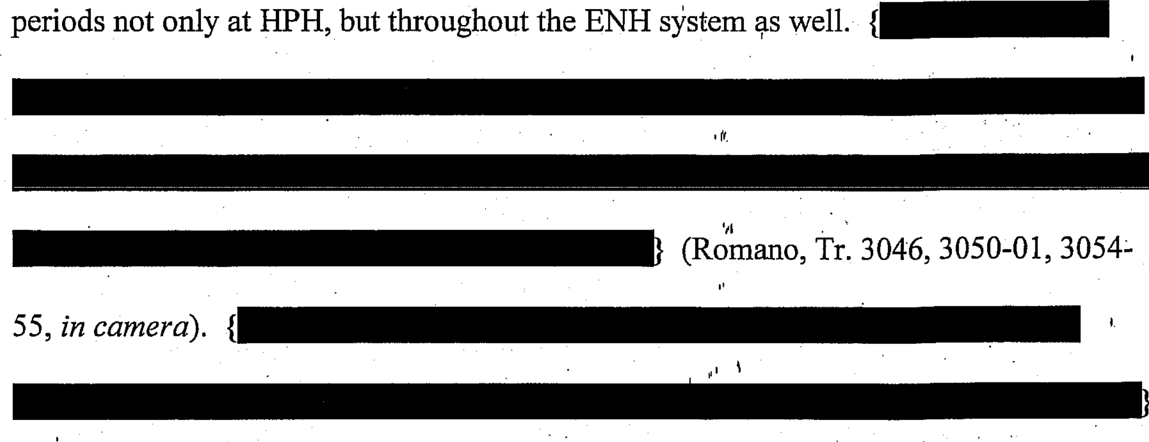
} (Romano, Tr. 3053-54 (discussing DX 440 at 15, *in camera*), *in camera*). (*See also* CCRFF 1565, *in camera*).

1624. The more minor a complication is, the less accurate its reporting in the STS database. (Rosengart, Tr. 4513-14). However, the rates of minor complications at ENH have been very good and are evidence of good performance. (Rosengart, Tr. 4515).

Response to Finding No. 1624:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger

periods not only at HPH, but throughout the ENH system as well. {



} (Romano, Tr. 3046, 3050-01, 3054-55, *in camera*). { } (Romano, Tr. 3050-51, *in camera*). (*See also* CCRFF 1565, *in camera*).

1625. Certain complications, such as atrial fibrillation, which is an abnormal heart beat, are not useful in evaluating the performance of a cardiac surgery program. Atrial fibrillation is also an outcome. Outcomes like atrial fibrillation are not useful to measure performance because their occurrence is not influenced by whether any aspect of care is changed. In other words, it is not a benchmark for bad performance because no change in care is known to prevent it. (Rosengart, Tr. 4508-09).

Response to Finding No. 1625:

Complaint Counsel have no specific response.

1626. Leg wound infections are a minor complication of cardiac surgery. Overall, the leg wound infection rate is low at ENH. Literature and medical research in cardiac surgery show leg wound infection rates within 30 days of surgery to be occur within 10-20% of patients nationally. (Rosengart, Tr. 4514-16).

Response to Finding No. 1626:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. { } (Romano, Tr. 3046, 3050-01, 3054-

55, *in camera*). {[redacted]}

(Romano, Tr. 3050-51, *in camera*). (*See also* CCRFF 1565, *in camera*).

1627. The leg wound infection rate at ENH when compared to STS national benchmarks may have increased due to a difference in practice patterns. For example, at ENH the way referral patterns are set up, all of the patients essentially come back to ENH with any complication they may have. In comparison, a New York City hospital may get referrals from 20 or 30 miles away and frequently will see patients of surgery and not see them for any follow-up. So if a leg wound infection occurred within the 30 day window measured by STS it would not be voluntarily reported at the city hospital and the city hospital's performance would look better than a hospital like ENH that sees the same patients over and over again. (Rosengart, Tr. 4512, 4514-15).

Response to Finding No. 1627:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods not only at HPH, but throughout the ENH system as well. {[redacted]} (Romano, Tr. 3046, 3050-01, 3054-55, *in camera*). {[redacted]}

(Romano, Tr. 3050-51, *in camera*). (*See also* CCRFF 1565, *in camera*).

vii. The Merger Was Essential To The Success Of HPH's Cardiac Surgery Program

1628. The Merger was necessary to produce the extremely high quality cardiac surgery program at HPH today. This is true because cardiac surgery is a highly complex and team-dependant service. In fact, cardiac surgery is probably the most complex and team-dependant service that exists at HPH post-Merger. The close collaboration of all team

members, from the perfusionist to the surgeon to the physician's assistant to the ICU or OR nurses is absolutely necessary to the performance of high quality cardiac surgery. This collaborative culture did not exist at HPH before the Merger. (Chassin, Tr. 5392).

Response to Finding No. 1628:

Various evidence supports the view that HPH had planned to implement a cardiac surgery program and would have implemented such a program in the absence of the merger. Hence the merger was not necessary and the change was not merger specific. (*See* CCRFF 1577).

1629. If the cardiac surgery program at HPH had been launched without the Merger, the program would have been of significantly lesser quality. It is likely that the level of cardiac surgery would be similar to that practiced at Weiss Hospital or Swedish Covenant Hospital. (Chassin, Tr. 5392-93).

Response to Finding No. 1629:

This finding is inaccurate and inconsistent with statements made to the State of Illinois in the HPH/ENH Certificate of Need Application. There, HPH represented that there would be a "single program multi site approach" at both HPH and Swedish Covenant. (CX 413 at 7). In addition, any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant or Weiss would have been acceptable to ENH. According to Dr. Rosengart, the mortality rates for Swedish Covenant Hospital's open heart surgery program are within acceptable limits. ENH is also comfortable with its results for open heart surgery at Weiss Hospital. (Rosengart, Tr. 4502-03). Both the Swedish and the Weiss joint heart surgery programs get passing grades in terms of performance. (Rosengart, Tr. 4504). Mark Newton, the President of Swedish Covenant Hospital, also agrees that the arrangement between

Swedish Covenant Hospital and ENH is exceeding its quality parameters. (Newton, Tr. 424).

(1) As A Result Of The Merger, HPH Is An Integrated Part Of The ENH Cardiac Surgery Program

1630. As discussed above, neither Weiss Hospital nor Swedish Covenant Hospital are hospitals owned or operated by ENH. ENH cardiac surgeons practice at these two sites only via an affiliation agreement. (Rosengart, Tr. 4443). Swedish Covenant Hospital functions as a stand-alone cardiac surgery program. No overlap extends between the programs other than the fact that ENH surgeons and perfusionists work there at Swedish Covenant Hospital under the affiliation agreement. (Rosengart, Tr. 4500-01).

Response to Finding No. 1630:

Dr. Rosengart's statements at trial are inconsistent with the claim in the Certificate of Need application which represents that the "single program multi site approach" would be implemented at both HPH and Swedish Covenant. (CX 413 at 7).

1631. Weiss Hospital's cardiac program similarly functions independently from ENH. (Rosengart, Tr. 4444, 4489).

Response to Finding No. 1631:

Complaint Counsel have no specific response.

1632. At HPH and Evanston Hospital, the same team of OR nurses rotates between the two sites. In contrast, Swedish Covenant Hospital and Weiss Hospital have their own OR nurses, nurse practitioners, and physicians' assistants. (Rosengart, Tr. 4465-66).

Response to Finding No. 1632:

Complaint Counsel have no specific response.

1633. ICU and Floor nurses utilized in the cardiac surgery program are specific to each site. The nurses at Evanston Hospital/HPH, however, are under the same umbrella of nursing leadership and are free to train throughout the system. (Rosengart, Tr. 4466).

Response to Finding No. 1633:

Complaint Counsel have no specific response.

1634. The quality assurance program in place at Evanston Hospital with respect to cardiac surgery extends to HPH, but not to the affiliated hospitals. (Rosengart Tr. 4467-68; 4550).

Response to Finding No. 1634:

This finding is inaccurate. Various evidence supports the view that although each affiliated hospital runs its own cardiac surgery program, Dr. Rosengart makes sure there are appropriate quality assurances in place. (Rosengart, Tr. 4444, 4550).

1635. Aside from the surgeons, the only individuals covered under the affiliation agreements with Weiss Hospital and Swedish Covenant Hospital are the ENH perfusionists, or the people who run the heart/lung machine during surgery. (Rosengart, Tr. 4444, 4489, 4500-01, 4461-62).

Response to Finding No. 1635:

Complaint Counsel have no specific response.

(2) Due To The Level Of Integration Engendered By The Merger, HPH Performs Higher Quality Cardiac Surgery Than Affiliated Hospitals

1636. Overall, the quality of cardiac surgery performed at ENH (Evanston Hospital and HPH) is higher than the quality of cardiac surgery performed at the affiliated sites, Swedish Covenant Hospital and Weiss Hospital. (Rosengart, Tr. 4504).

Response to Finding No. 1636:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. {

} (*See* CCRFF 1565, *in camera*). In addition, any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant or Weiss would have been acceptable to ENH. (*See* CCRFF 1629).

1637. First, as a result of the integrated relationship between Evanston Hospital and HPH, and the more attenuated affiliation between ENH and Weiss Hospital and Swedish Covenant Hospital, there are a number of cardiac surgery procedures only done at HPH and Evanston Hospital that are not performed at Weiss Hospital or Swedish Covenant Hospital. These cutting-edge procedures are being done at few other places in Chicago, Illinois, or even nationally. (Rosengart, Tr. 4492-93).

Response to Finding No. 1637:

Mr. Neaman's sworn statement in the Certificate of Need application draws no such distinction between the "integrated affiliation" between ENH and HPH and the "more attenuated affiliation" between ENH and Swedish Covenant. Mr. Neaman stated that there would be a "single program multi site approach" at both. (CX 413 at 7). Moreover, determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. (*See* CCRFF 1636). ENH has offered no reason why there is any need to perform these "cutting edge" procedures at HPH. The two hospitals are located quite close together geographically, so that patients could easily drive to Evanston hospital, just as the doctors routinely drive between the two hospitals. (*See, e.g.,* Rosengart, Tr. 4545 (noting ample time available to one of the patients on whom such a "cutting edge" procedure was performed)).

1638. As Dr. Rosengart put it: "We are not doing [advanced surgical techniques] at either Swedish or Weiss. I wouldn't feel comfortable. It really involves a lot of integration of anesthesia, nursing, equipment, resources and things like that, and by virtue of not having that sort of commonality of the team, probably would not – certainly no in – not in the near future do it at either of those sites." (Rosengart, Tr. 4493).

Response to Finding No. 1638:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. { [redacted] } (*See* CCRFF 1565, *in camera*). In addition, any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant or Weiss would have been acceptable to ENH. (*See* CCRFF 1629).

1639. Operating Weiss Hospital's cardiac program via affiliation does not afford complete control of the cardiac surgery program there by ENH. (Rosengart, Tr. 4444). While Dr. Rosengart ensures that the surgical team under his control provides the requisite high-quality care, Swedish Covenant and Weiss Hospitals, as affiliate programs, have a great deal of independence and, thus, ENH does not control all aspects of care that potentially affect patient outcomes. (Rosengart, Tr. 4444). As a result, the performance of cardiac surgery at Weiss Hospital is not satisfactory. Issues with administration, resources, and the ability to upgrade have not been able to be dealt with within the affiliation relationship between ENH and Weiss Hospital. Surgeries performed at Weiss Hospital are kept more basic and patients with complex cases are transferred to Evanston Hospital due to the level of comfort ENH surgeons have with the infrastructure in place at Weiss Hospital. (Rosengart, Tr. 4503-04).

Response to Finding No. 1639:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger

periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. (*See* CCRFF 1636). Respondent cites pages 4503-04 of Dr. Rosengart's testimony for the proposition that "the performance of cardiac surgery at Weiss hospital is not satisfactory." In fact, Dr. Rosengart testified that "we're comfortable with our results, but we're not satisfied with our results. . . ." (Rosengart, Tr. 4503). Dr. Rosengart later testified that Weiss and Swedish Covenant "get passing grades." (Rosengart, Tr. 4542).

1640. For example, vein harvesting techniques using periscopes through a one inch incision are done at Evanston Hospital and HPH and not at Swedish Covenant Hospital or Weiss Hospital. Moreover, bloodless surgery, which is cardiac surgery performed without blood transfusions, is performed at HPH and Evanston Hospital, but not at Swedish Covenant Hospital or Weiss Hospital. Only a handful of hospitals in the country are doing bloodless surgery. (Rosengart, Tr. 4494-96).

Response to Finding No. 1640:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. { } (*See* CCRFF 1565, *in camera*). In addition, any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant or Weiss would have been acceptable to ENH. (*See* CCRFF 1629).

1641. Second, private and government funded research take place at Evanston Hospital and HPH, but not at Swedish Covenant Hospital or Weiss Hospital. Research is not performed at

Swedish Covenant Hospital or Weiss Hospital because under the affiliation agreement they maintain separate infrastructure, separate Institutional Review Boards, and separate contracting practices. (Rosengart, Tr. 4496-97).

Response to Finding No. 1641:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. { } (*See* CCRFF 1565, *in camera*). In addition, any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant or Weiss would have been acceptable to ENH. (*See* CCRFF 1629).

1642. Another specific example of the benefit of the integration achieved through the Merger involves the use of new stenting technology. Two years ago, a new kind of stent came out that cardiologists use. That was something that Evanston Hospital and HPH were able to adopt simultaneously and far ahead of other cardiac programs in Chicago. This took place because of the common structure between HPH and Evanston Hospital, and the adoption of the new stent technology is a benefit to patients. (Rosengart, Tr. 4496-97).

Response to Finding No. 1642:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. {

} (*See* CCRFF 1565, *in camera*). In addition, any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant or Weiss would have been acceptable to ENH. (*See* CCRFF 1629).

1643. Third, outcome data confirms that the quality of cardiac surgery performed at HPH since the Merger is of a higher quality than that done by hospitals with cardiac surgery programs opened through affiliation with ENH. Specifically, although the mortality rates at Swedish Covenant Hospital are within acceptable limits, HPH has had much better outcomes with 0 mortality for CABG patients in the last two and a half years. (Rosengart, Tr. 4502-05).

Response to Finding No. 1643:

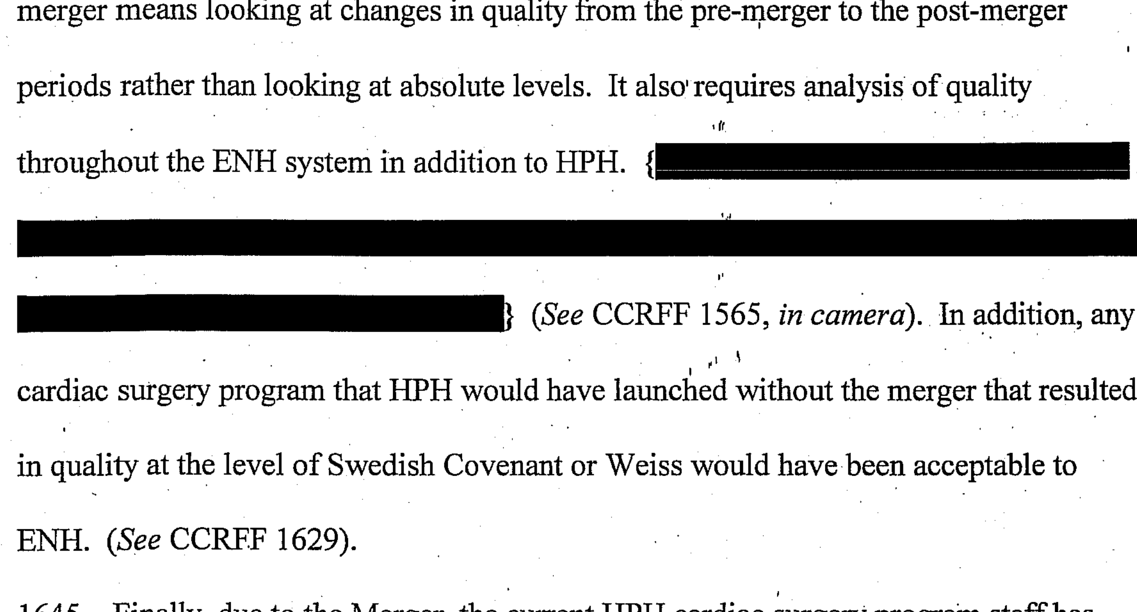
This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels., It also requires analysis of quality throughout the ENH system in addition to HPH. {

} (*See* CCRFF 1565, *in camera*). In addition, any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant or Weiss would have been acceptable to ENH. (*See* CCRFF 1629).

1644. Moreover, the length of stay for cardiac surgery patients is longer at Swedish Covenant Hospital than at HPH. As a result, patients who receive cardiac surgery at Swedish Covenant Hospital stay in the hospital longer for recovery and the costs incurred by the hospitals to perform cardiac surgery are also higher at Swedish Covenant Hospital than at HPH. (Rosengart, Tr. 4501-02).

Response to Finding No. 1644:

This finding is irrelevant. Determining whether ENH improved quality after the



merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. { } (*See* CCRFF 1565, *in camera*). In addition, any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant or Weiss would have been acceptable to ENH. (*See* CCRFF 1629).

1645. Finally, due to the Merger, the current HPH cardiac surgery program staff has access to ENH's state-of-the-art medical technology. (Rosengart, Tr. 4566).

Response to Finding No. 1645:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. { } (*See* CCRFF 1565, *in camera*). In addition, any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant or Weiss would have been acceptable to ENH. (*See* CCRFF 1629).

1646. At the end of the day, it is likely that if cardiac surgery at HPH had been installed via affiliation absent the Merger, such affiliation would have resulted in a program no better than that at Swedish Covenant Hospital or Weiss Hospital. (Chassin, Tr. 5392-93).

Response to Finding No. 1646:

This finding is irrelevant. Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. { } (*See* CCRFF 1565, *in camera*). In addition, any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant or Weiss would have been acceptable to ENH. (*See* CCRFF 1629).

b. ENH Successfully Established An Interventional Cardiology Program At HPH

i. Overview

1647. { } (Chassin, Tr. 5303; Romano, Tr. 3067, *in camera*). HPH did not have an interventional cardiology program before the Merger. (Chassin, Tr. 5303).

Response to Finding No. 1647:

{ }

(Romano, Tr. 3069, *in camera*). Thus, some form of treatment was available to HPH patients pre-merger.

1648. An interventional cardiology program benefits patient care in several ways: (1) patients with acute myocardial infarctions (heart attacks) can be effectively treated by applying interventional procedures to open up their blocked coronary arteries immediately within a few hours of their arrival; (2) patients already admitted to the hospital who have heart attacks requiring emergency treatment can be treated at the same hospital rather than having to be transferred to another hospital; and (3) patients with chronic heart disease may be treated closer to their homes, which is more convenient for the patient. (Chassin, Tr. 5303-04).

Response to Finding No. 1648:

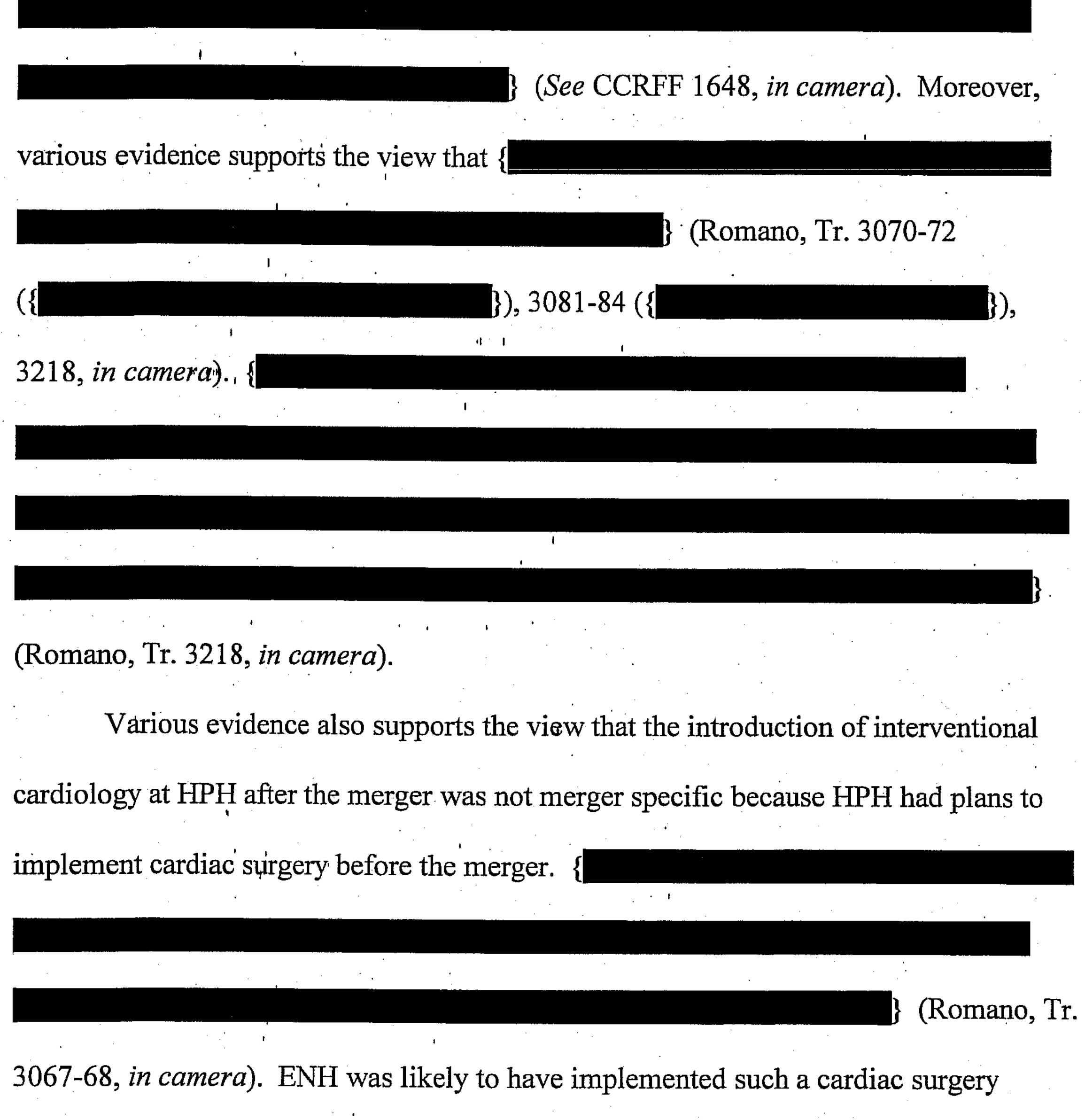
{ [redacted] } (Romano, Tr. 3070, *in camera*).

{ [redacted] } (Romano, Tr. 6303-04 (discussing DX 440 at 28, *in camera*), *in camera*, 3083-84 (discussing DX 441 at 85, *in camera*), *in camera*, 3071-72, *in camera*). (*See also* CCFF 2074, *in camera*). The benefit of treating chronically ill patients at HPH is minimal at best; as Dr. Rosengart testified, it is easy for doctors to drive between the two hospitals. (Rosengart, Tr. 4498-99). It would be no harder for patients not needing emergency care.

1649. After the Merger, ENH established an interventional cardiology at HPH that improved the quality of care available to patients. (Chassin, Tr. 5304-05).

Response to Finding No. 1649:

Complaint Counsel reiterates that the issue of quality improvement is not limited to quality of care at HPH, but relates to the quality of care throughout the ENH system (where prices went up system wide). { [redacted]



} (*See* CCRFF 1648, *in camera*). Moreover, various evidence supports the view that { } (Romano, Tr. 3070-72 ({ }), 3081-84 ({ }), 3218, *in camera*). { }

(Romano, Tr. 3218, *in camera*).

Various evidence also supports the view that the introduction of interventional cardiology at HPH after the merger was not merger specific because HPH had plans to implement cardiac surgery before the merger. { } (Romano, Tr. 3067-68, *in camera*). ENH was likely to have implemented such a cardiac surgery program had the merger not occurred – indeed it had already contracted to do so. (*See* CCRFF 1577). That would have removed the only then existing barrier to creating an interventional cardiology program. Physician skill was certainly not a barrier; HPH already had several cardiologists on staff who knew how to do interventional cardiology and were in fact privileged to do so at other hospitals. (Romano, Tr. 3067).

ii. Before The Merger, HPH Could Not Treat Heart

Attack Patients With Interventional Cardiology Procedures

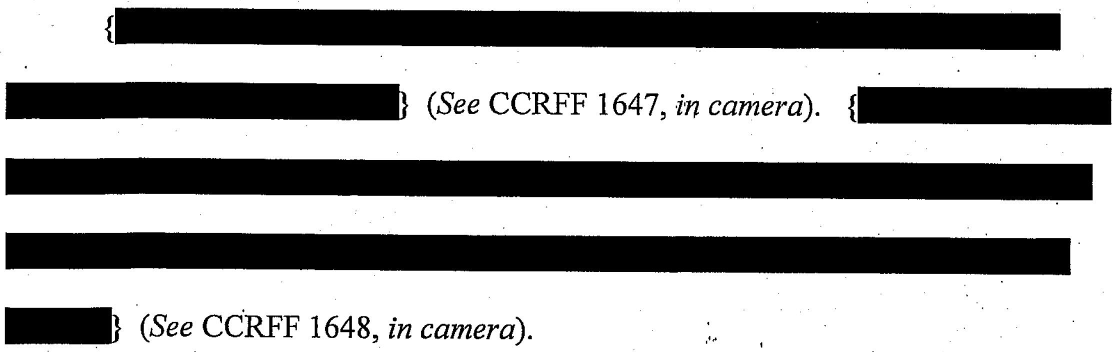
1650. Before the Merger, HPH had a diagnostic catheterization laboratory that performed only diagnostic catheterizations. (Chassin, Tr. 5304; O'Brien, Tr. 3489; Hillebrand, Tr. 1980). Diagnostic catheterizations allow a physician to determine the degree of blockage in a vessel, but do not cure that problem or treat it. (Chassin, Tr. 5304; O'Brien, Tr. 3489).

Response to Finding No. 1650:

{ } (*See* CCRFF 1647, *in camera*).

1651. Interventional cardiology, on the other hand, treats or cures blockage in vessels. (Chassin, Tr. 5304; O'Brien, Tr. 3489). Before the Merger, HPH did not have an interventional cardiology laboratory. (Chassin, Tr. 5304). Accordingly, emergent (emergency) or other procedures to cure coronary blockages could not be performed at HPH. (Chassin, Tr. 5304). Thus, before the Merger, many patients with acute myocardial infarction (heart attack) were transferred out of HPH. (Chassin, Tr. 5316; RX 2042).

Response to Finding No. 1651:



{ } (*See* CCRFF 1647, *in camera*). { } (*See* CCRFF 1648, *in camera*).

1652. Additionally, HPH's pre-Merger cardiac catheterization lab was a converted x-ray room, and the equipment in the lab was purchased in 1988. (Hillebrand, Tr. 1980; O'Brien, Tr. 3488). At the time of the Merger, HPH was having difficulty with its cardiac catheterization lab. (Spaeth, Tr. 2290).

Response to Finding No. 1652:

The last sentence of this finding is ambiguous because the cited source does not explain or even describe the difficulty. Various evidence supports the view that upgrades

to the cardiac catheterization lab at HPH after the merger were not merger specific because HPH likely would have continued to upgrade its physical facilities had the merger not occurred. Prior to the merger, HPH routinely made capital investments to upgrade and improve its facilities. (Newton, Tr. 383-84). HPH was financially strong prior to the merger. (*See* CCFF 303-355). Highland Park's 1999-2003 Financial Plan set forth a "long range capital budget" that included $43 million for "strategic initiatives and master plan items," including "ambulatory, assisted living and facility expansion." The plan also set aside $65 million for "[h]ospital construction, routine capital and information technology" investments, and a small amount for Lakeland Health Ventures. (Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2). The total planned investments for the time period therefore amounted to $108 million.

iii. After The Merger, ENH Established A Successful Interventional Cardiology Program At HPH

1653. After the Merger, and in conjunction with the introduction of cardiac surgery at HPH, ENH built a new cardiac catheterization lab at HPH that performed both diagnostic and interventional procedures such as angioplasties. (Hillebrand, Tr. 1980). The new cardiac catheterization lab was completed in March of 2002 at a cost of over $2.5 million. (O'Brien, Tr. 3490).

Response to Finding No. 1653:

Various evidence supports the view that upgrades to the cardiac catheterization lab at HPH after the merger were not merger specific because HPH likely would have upgraded its physical facilities had the merger not occurred. (*See* CCRFF 1652).

1654. The new cardiac catheterization lab has three suites and affords enhanced training for HPH's cardiologists. (Hillebrand, Tr. 1980; Spaeth, Tr. 2275). The lab equipment is brand new, and it is capable of enhancing images from the older piece of equipment. (O'Brien, Tr. 3490). It also has broadcasting capabilities, which gives physicians at other campuses the ability

to view a case taking place at HPH or vice versa. (O'Brien, Tr. 3490).

Response to Finding No. 1654:

Various evidence supports the view that upgrades to the cardiac catheterization lab at HPH after the merger were not merger specific because HPH likely would have upgraded its physical facilities had the merger not occurred. (*See* CCRFF 1652).

(1) HPH's Interventional Cardiology Program Has Obviated The Need To Transfer Acute Heart Attack Patients To Other Hospitals

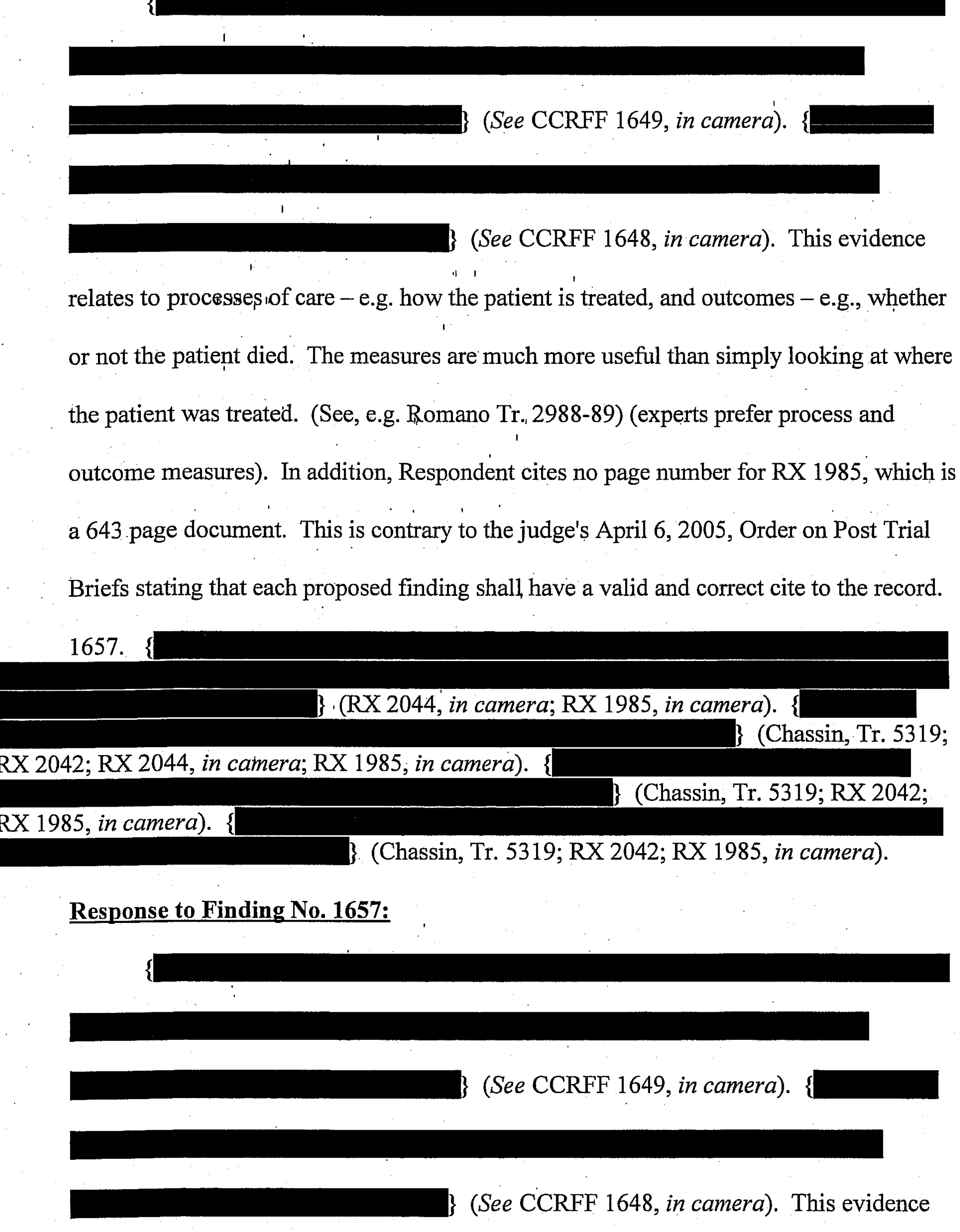
1655. The enhanced cardiac services at HPH are a "fabulous" upgrade for the Highland Park community because they allow a patient to move from the HPH ED to the catheterization lab for a stent, all without having to leave the HPH campus. (Spaeth, Tr. 2275). Indeed, after the Merger, HPH ceased transferring patients with acute heart attacks outside of HPH. (Chassin, Tr. 5316; RX 2042).

Response to Finding No. 1655:

{ } (*See* CCRFF 1649, *in camera*). { } (*See* CCRFF 1648, *in camera*).

1656. { } (Chassin, Tr. 5317-18; RX 2042; RX 2044, *in camera*; RX 1985, *in camera*). { } (Chassin, Tr. 5318-19; RX 2042; RX 1985, *in camera*). { } (Chassin, Tr. 5319; RX 2042; RX 2044, *in camera*; RX 1985, *in camera*).

Response to Finding No. 1656:



{ } (*See* CCRFF 1649, *in camera*). { } (*See* CCRFF 1648, *in camera*). This evidence relates to processes of care – e.g. how the patient is treated, and outcomes – e.g., whether or not the patient died. The measures are much more useful than simply looking at where the patient was treated. (See, e.g. Romano Tr. 2988-89) (experts prefer process and outcome measures). In addition, Respondent cites no page number for RX 1985, which is a 643 page document. This is contrary to the judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record.

1657. { } (RX 2044, *in camera*; RX 1985, *in camera*). { } (Chassin, Tr. 5319; RX 2042; RX 2044, *in camera*; RX 1985, *in camera*). { } (Chassin, Tr. 5319; RX 2042; RX 1985, *in camera*). { } (Chassin, Tr. 5319; RX 2042; RX 1985, *in camera*).

Response to Finding No. 1657:

{ } (*See* CCRFF 1649, *in camera*). { } (*See* CCRFF 1648, *in camera*). This evidence

relates to processes of care (*i.e.*, how the patient was treated), and outcomes (*i.e.*, whether or not the patient died). These measures are much more useful than simply looking at where the patient was treated. (*See, e.g.*, Romano Tr. 2988-89 (experts prefer to rely on process and outcome measures)). In addition, Respondent cites no page number for RX 1985, which is a 643 page document. This is contrary to the judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record.

1658. This reduction in heart attack patients being transferred from HPH is a substantial quality improvement because there is a medical risk when transferring a patient in the middle of an acute heart attack. (Chassin, Tr. 5319-20).

Response to Finding No. 1658:

{ } (*See* CCRFF 1649, *in camera*). { } (*See* CCRFF 1648, *in camera*). T This evidence relates to processes of care (*i.e.*, how the patient was treated), and outcomes (*i.e.*, whether or not the patient died). These measures are much more useful than simply looking at where the patient was treated or whether some theoretical risk was eliminated. (*See, e.g.*, Romano Tr. 2988-89 (experts prefer to rely on process and outcome measures)).

1659. { } (Romano, Tr. 3069-70, *in camera*).

Response to Finding No. 1659:

This is a highly selective citation to Dr. Romano's testimony, since on balance his view was that heart attack care, the improvement of which is a major aspect of the claimed interventional cardiology improvement {[redacted] } (Romano, Tr. 3007). In addition, {[redacted] } (*See* CCRFF 1649, *in camera*).

1660. The quality of HPH's interventional cardiology program has been recognized by other physicians and hospitals in the region. (Chassin, Tr. 5320). {[redacted] } (Chassin, Tr. 5319-20; RX 2042; RX 2044, *in camera*; RX 1985, *in camera*).

Response to Finding No. 1660:

{[redacted] } (*See* CCRFF 1649, *in camera*). {[redacted] } (*See* CCRFF 1648, *in camera*). Respondent also failed to cite a number for RX 1985, which is a 643 page document. This is contrary to the judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record.

(2) The Interventional Cardiology Program At HPH Has Achieved High Quality Outcomes

1661. ENH conceived, launched and implemented the interventional cardiology program at HPH in a very high quality way. (Chassin, Tr. 5307). As a result, the interventional cardiology program represents a major quality improvement for HPH. (Chassin, Tr. 5307).

Response to Finding No. 1661:

{ [redacted] } (*See* CCRFF 1649, *in camera*).

{ [redacted] } (*See* CCRFF 1648, *in camera*).

1662. This conclusion is based on the very low mortality rate from elective percutaneous coronary interventions ("PCIs"), the acceptable mortality rate for emergent PCIs, the achievement of reasonable volumes, the implementation of the ability to treat acute heart attack patients on site emergently with PCI and the effect of the entire program on treatment patterns for patients with acute heart attacks. (Chassin, Tr. 5308).

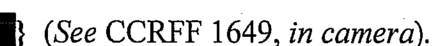
Response to Finding No. 1662:

Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. { [redacted] } (*See* CCRFF 1649, *in camera*). { [redacted] } (*See* CCRFF 1648, *in camera*).

1663. Elective PCIs are procedures that can be scheduled in advance for patients who are not critically ill, who have chronic disease and who do not need the procedure within minutes or hours. (Chassin, Tr. 5306).

Response to Finding No. 1663:

{[redacted]

[redacted]}  (*See* CCRFF 1649, *in camera*).

1664. HPH has performed about 350 PCI cases per year every since the first full year of the program's operation in 2001. (Chassin, Tr. 5308). The mortality rate for the elective PCI program is 0.6%, which is very comparable to national benchmarks. (Chassin, Tr. 5308).

Response to Finding No. 1664:

Determining whether ENH improved quality after the merger means looking at changes in quality from the pre-merger to the post-merger periods rather than looking at absolute levels. It also requires analysis of quality throughout the ENH system in addition to HPH. {[redacted]

[redacted]} (*See* CCRFF 1649, *in camera*).

(3) On-Site Cardiac Surgery At HPH Is Needed To Continue The Interventional Cardiology Program

1665. ENH took several steps to implement the interventional cardiology program at HPH, including: (1) establishing a cardiac surgery program; (2) identifying experienced interventional cardiologists that were part of the cardiology group at HPH but performing interventions elsewhere and bringing them onto the HPH staff as interventionalists; (3) training the nursing staff and technicians, and (4) installing quality assurance/quality improvement programs that would be overseen by the chief of cardiology at ENH. (Chassin, Tr. 5305-06).

Response to Finding No. 1665:

Respondent concedes that there were "experienced cardiologists that were part of the cardiology group at HPH [and] performing interventions elsewhere." Again, all that was required to implement the interventional cardiology program was a cardiac surgery program, which would have happened without the merger anyway. (*See* CCRFF 1577).

(*See also* CCRFF 1667).

1666. Shortly after the Merger, ENH also implemented a number of educational initiatives to prepare HPH physicians to perform elective PTCA (angioplasty)/stent procedures. (RX 984 at ENHL PK 51618-19).

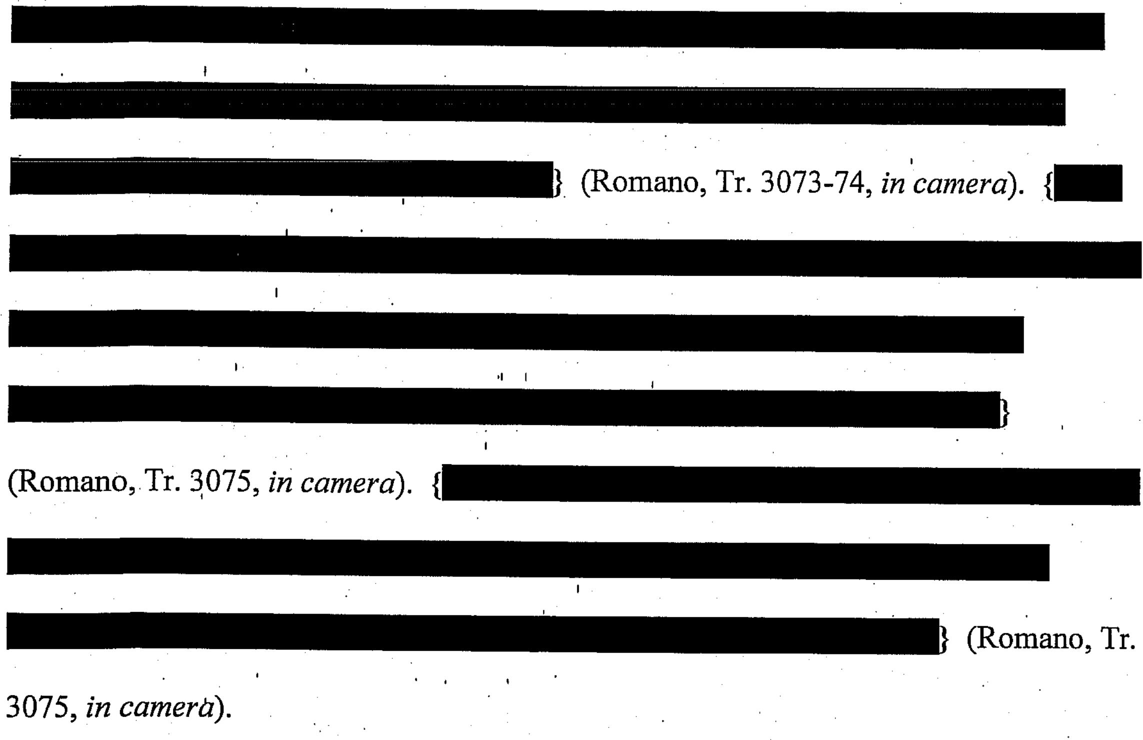
Response to Finding No. 1666:

See CCRFF 1665,1667.

1667. { } (Chassin, Tr. 5306-07; Romano, Tr. 3068, *in camera*).

Response to Finding No. 1667:

Various evidence supports the view that it is likely that HPH would continue its cardiac surgery program after a divestiture (*see* CCRFF 2490). Even if, *arguendo*, HPH did not continue its cardiac surgery program after divestiture, { } (Romano, Tr. 3194, *in camera*). { } (Romano, Tr. 3073, *in camera*). { } (Romano, Tr. 3073-74, *in camera*). {



} (Romano, Tr. 3073-74, *in camera*). {

}

(Romano, Tr. 3075, *in camera*). {

} (Romano, Tr. 3075, *in camera*).

1668. The American College of Cardiology ("ACC") and the American Heart Association ("AHA") strongly recommend that elective PCI programs always be backed up by cardiac surgery. (Chassin, Tr. 5307). Further, the state of Illinois and the ACC/AHA guidelines require that an elective interventional cardiology program must have cardiac surgery backup within the hospital. (Rosengart, Tr. 4506-07).

Response to Finding No. 1668:

Various evidence supports the view that it is likely that HPH would continue its cardiac surgery program after a divestiture (*see* CCRFF 2490). {

} (*See* CCRFF 1667, *in camera*).

1669. Cardiac surgical backup is also desirable in emergent PCI procedures. (Chassin, Tr. 5323).

Response to Finding No. 1669:

Various evidence supports the view that it is likely that HPH would continue its cardiac surgery program after a divestiture (*see* CCRFF 2490). {[redacted]} (*See* CCRFF 1667, *in camera*).

1670. Moreover, HPH, which performs only 50 or 60 emergent PCI cases annually, does not have a high enough volume to support a stand-alone emergent PCI program (without cardiac surgery). (Chassin, Tr. 5323, 5325). A hospital cannot employ a full-time physician based on upon 50 or 60 cases a year and, therefore, without cardiac surgery, HPH would have to contract with an interventional cardiologist based at another hospital. (Chassin, Tr. 5324-25).

Response to Finding No. 1670:

Various evidence supports the view that it is likely that HPH would continue its cardiac surgery program after a divestiture (*see* CCRFF 2490). {[redacted]} (*See* CCRFF 1667, *in camera*).

1671. {[redacted]} (Romano, Tr. 3067-68, *in camera*).

Response to Finding No. 1671:

This is a misleading citation to Dr. Romano's testimony. {[redacted]} (*See* CCRFF 1667, *in camera*). {[redacted]

} (*See* CCRFF 2490).

c. The Merger Substantially Improved HPH's Intensive Care Services

i. Overview

1672. ENH added an intensivist program to HPH after the Merger, an improvement that enhanced quality of care in HPH's ICU. (Ankin, Tr. 5041; RX 1099 at ENHE F35 340; O'Brien, Tr. 3528-29; Chassin, Tr. 5328).

<u>Response to Finding No. 1672:</u>

Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. For example, prior to the merger there was a physician present at HPH during nighttime and weekend hours who would evaluate patients in the ICU and talk to the attending physician. (Ankin, Tr. 5058). In addition, there was also physician coverage at HPH before the merger in the emergency room which at times would include more than one physician. (Harris, Tr. 4277). Although these pre-merger physicians who provided coverage at HPH may not have been classified as "intensivists," Dr. Ankin himself (one of HPH's current "intensivists") is not board certified as an intensivist. (Ankin, Tr. 5038).

In addition, there is no evidence that the intensivist program has actually improved patient outcomes at HPH. Dr. Ankin did not try to determine how much, if at all, mortality rates have improved for Highland Park Hospital since the intensivist program was implemented in 2001. (Ankin, Tr. 5091). In addition, Peggy King, a Senior Vice President at ENH and quality coordinator, did not approach Dr. Ankin about

ascertaining how outcomes at Highland Park Hospital changed since the merger. (Ankin, Tr. 5091-92). Dr. Ankin also believed that his routine for treating critically ill patients at HPH did not affect his patients. (Ankin, Tr. 5047).

1673. An intensivist program is a program that tasks the intensivists with supervising all clinical activity in the care of critically ill patients in the ICU and being available upon request to assist primary care physicians in the care of their patients. (Ankin, Tr. 5039). Most of the patients in the ICU are critically ill, injured or unstable patients with cardiac failure or respiratory failure. (Ankin, Tr. 5035).

Response to Finding No. 1673:

Complaint Counsel have no specific response.

1674. An intensivist is a physician who specializes in the care of intensive care patients and, as a result, has more experience dealing with the complications of those critically ill people and is less prone to make mistakes. (Ankin, Tr. 5035-36; O'Brien, Tr. 3529). Intensivists also have an administrative role in overseeing and coordinating the medical and nursing staff that provide care to critically ill patients in the ICU. (Ankin, Tr. 5036). An intensivist is empowered by the hospital's administration to make judgments about when patients should be transferred out of the ICU. (Ankin, Tr. 5036-37).

Response to Finding No. 1674:

Complaint Counsel have no specific response.

1675. Physicians have acted as intensivists for a long time, although it is relatively new as an established field in medicine. (Ankin, Tr. 5038).

Response to Finding No. 1675:

The finding is incomplete. Various evidence supports the view that, because of the evolving consensus regarding the benefits of intensivists, much of which developed post-merger, the intensivist program at HPH was not merger specific. (*See* CCRFF 1677).

1676. Dr. Ankin, who is a board-certified physician in internal and pulmonary medicine, testified about HPH's post-Merger intensivist program at trial. (Ankin, Tr. 5033). Dr. Ankin is

President of a private practice organization called Pulmonary Physicians of the North Shore ("PPONS"). (Ankin, Tr. 5033). He has been practicing as a pulmonologist in the Chicago North Shore for over 25 years, and he has been admitting patients to HPH during this entire period. (Ankin, Tr. 5033). Dr. Ankin is an independent practitioner with admitting privileges at several hospitals – including HPH, Lake Forest, Rush North Shore and Condell. (Ankin, Tr. 5034).

Response to Finding No. 1676:

Complaint Counsel have no specific response.

ii. HPH's ICU Had Gaps In Patient Care Before The Merger

1677. HPH did not have an intensivist program before the Merger. (Ankin, Tr. 5045; Spaeth, Tr. 2278; Newton, Tr. 470-71).

Response to Finding No. 1677:

The finding is incomplete. Various evidence also support the view that implementation of the intensivist program at HPH was not merger specific because HPH could have started a program on its own in the absence of the merger.

{ }

(Romano, Tr. 3113-14, *in camera*). { } (Romano, Tr. 3113-14, *in camera*). Thus, there has been increasing pressure from employers and purchasers for hospitals to provide intensivist coverage, and many hospitals have established such coverage. (Romano, Tr. 3003).

{

} (Ankin, Tr. 5103-04; CX 2176, *in camera*). {

} (Ankin, Tr. 5063; CX 2176, *in camera*). PPONS would be free to enter into a contract with a new owner of Highland Park Hospital. (Ankin, Tr. 5104). If there was a new owner of HPH and it agreed to a contract similar to the current contract, PPONS would entertain servicing the intensivist contract for the new owner. (Ankin, Tr. 5105).

Various evidence support the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

1678. {

} (Ankin, Tr. 5046; RX 989 at ENHL MO 7123, *in camera*).

Response to Finding No. 1678:

The finding is misleading. {

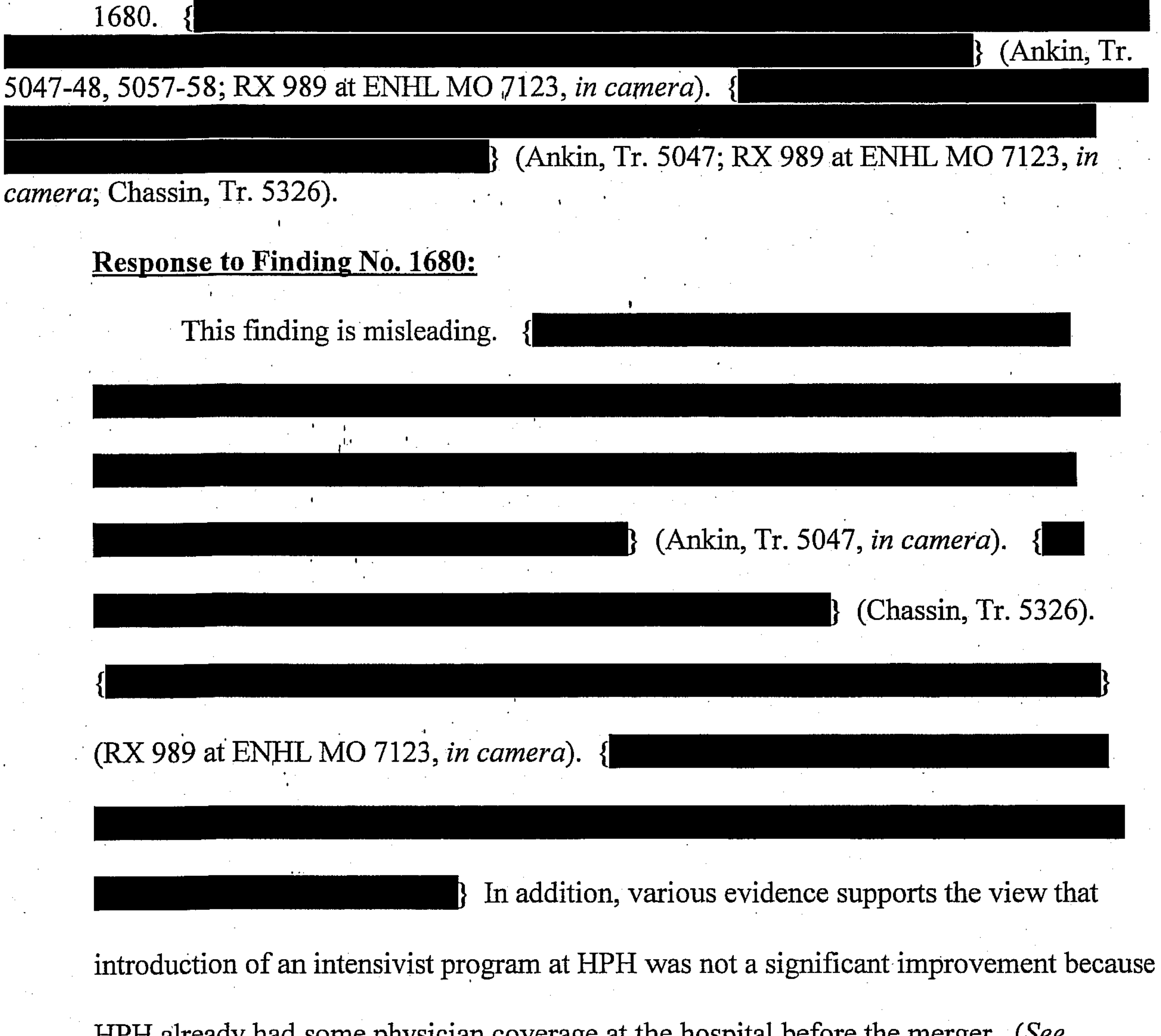
} Moreover, various evidence support the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

1679. Before the Merger, HPH provided physician coverage of its ICU in the manner similar to most other community hospitals – meaning that the attending physician would come to the ICU, see his or her patient, finish rounds and return to his or her office. (Ankin, Tr. 5046). {

} (Ankin, Tr. 5046; RX 989 at ENHL MO 7123, *in camera*).

Response to Finding No. 1679:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

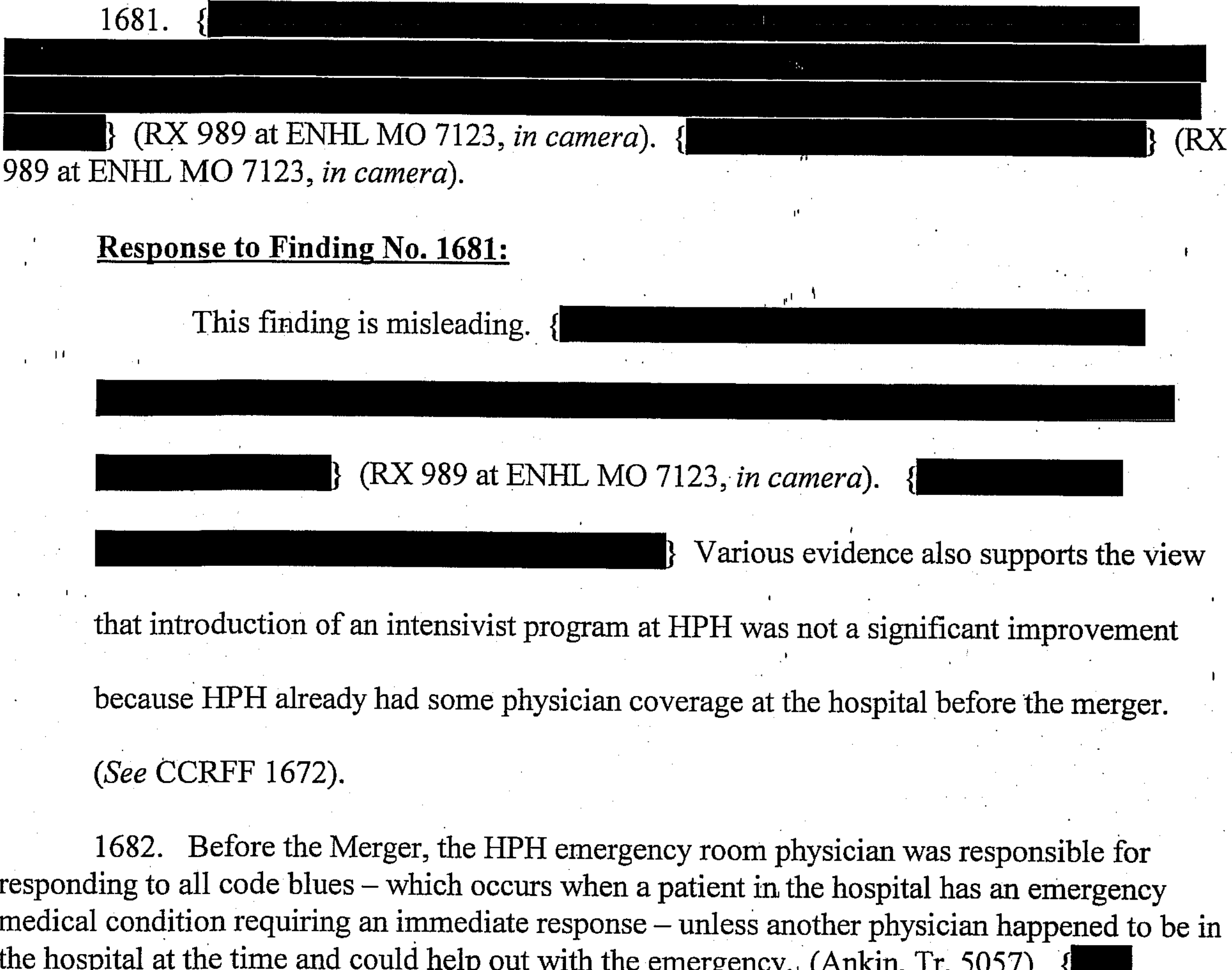


1680. { } (Ankin, Tr. 5047-48, 5057-58; RX 989 at ENHL MO 7123, *in camera*). { } (Ankin, Tr. 5047; RX 989 at ENHL MO 7123, *in camera*; Chassin, Tr. 5326).

Response to Finding No. 1680:

This finding is misleading. { } (Ankin, Tr. 5047, *in camera*). { } (Chassin, Tr. 5326). { } (RX 989 at ENHL MO 7123, *in camera*). { } In addition, various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See*

CCRFF 1672).



1681. { } (RX 989 at ENHL MO 7123, *in camera*). { } (RX 989 at ENHL MO 7123, *in camera*).

Response to Finding No. 1681:

This finding is misleading. { } (RX 989 at ENHL MO 7123, *in camera*). { } Various evidence also supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

1682. Before the Merger, the HPH emergency room physician was responsible for responding to all code blues – which occurs when a patient in the hospital has an emergency medical condition requiring an immediate response – unless another physician happened to be in the hospital at the time and could help out with the emergency. (Ankin, Tr. 5057). { } (Ankin, Tr. 5057; O'Brien, Tr. 3530; RX 989 at ENHL MO 7123, *in camera*).

Response to Finding No. 1682:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

1683. Moreover, before the Merger, if a patient on a general medical floor at HPH required intensive care services in a short time-frame, hospital personnel generally would have to contact the attending physician at home or the office. (Ankin, Tr. 5060-61). The attending physician would then make arrangements to come to the hospital to see that patient whose condition had worsened. (Ankin, Tr. 5061). Not having an intensivist available during the day to respond to such urgent requests for consultations led to delays in caring for a critically ill patient. (Ankin, Tr. 5061-62).

Response to Finding No. 1683:

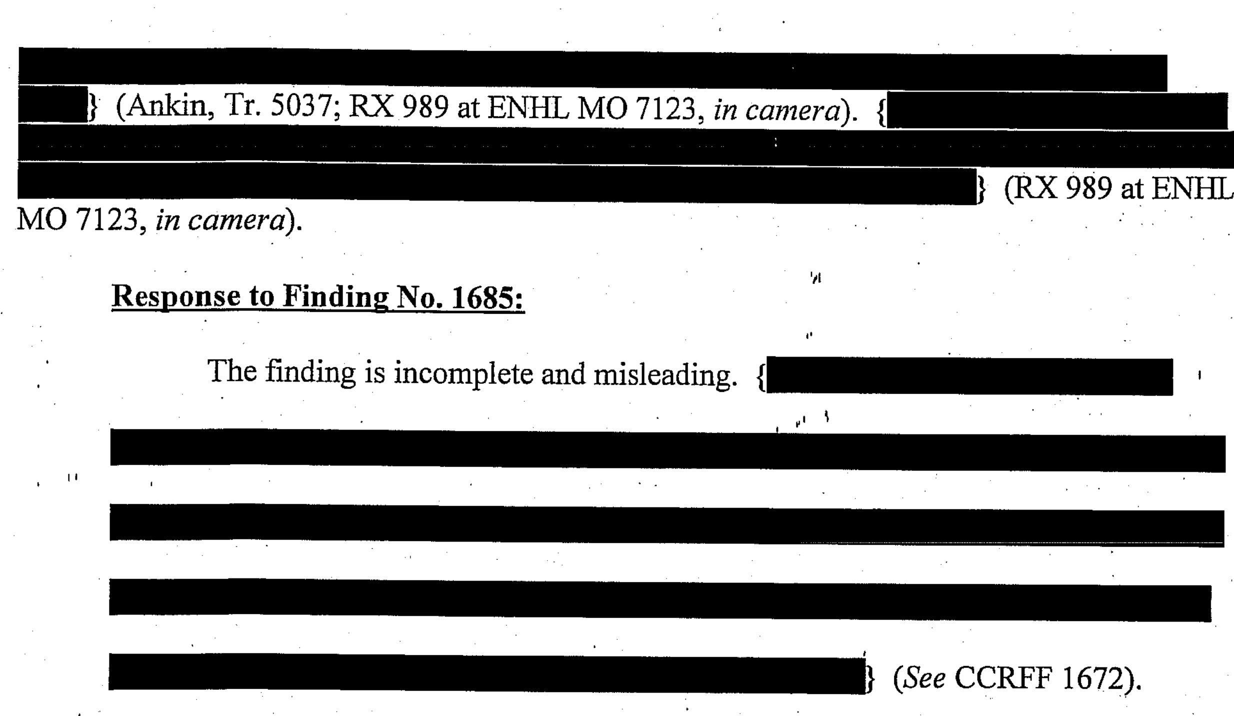
The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

1684. The faster a critically ill patient receives an intervention, the more likely it is that patient will recover. (Ankin, Tr. 5061). Being able to respond to critically ill patients within five minutes is much preferable to assessing that patient within thirty minutes. (Ankin, Tr. 5061-62). A delay of 25 minutes without therapy and a medical intervention may be fatal to many patients. (Ankin, Tr. 5060-62). Accordingly, the ICU arrangement at HPH before the Merger – where there was no staff physician in charge of taking care of critically ill and unstable patients –put critically ill patients at risk. (Chassin, Tr. 5326).

Response to Finding No. 1684:

As discussed above, ENH concedes that this state of affairs was similar to most community hospitals. (RFF 1679). ENH does not point to any specific patient either put "at risk" or actually harmed, and the consensus in favor of hiring intensivists was evolving. Moreover, various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

1685. {



} (Ankin, Tr. 5037; RX 989 at ENHL MO 7123, *in camera*). { } (RX 989 at ENHL MO 7123, *in camera*).

Response to Finding No. 1685:

The finding is incomplete and misleading. { } (*See* CCRFF 1672).

iii. The Addition Of Intensivist Coverage After The Merger Eliminated The Gaps In ICU Patient Care At HPH

1686. { } (Ankin, Tr. 5050-51; O'Brien, Tr. 3530; RX 989 at ENHL MO 7123, *in camera*).

Response to Finding No. 1686:

The finding is misleading. Various evidence supports the view that the intensivist program implemented at HPH after the merger was not merger specific. (*See* CCRFF 1677).

1687. A number of studies have been published showing that having intensivists improves outcomes in ICUs. (Romano, Tr. 3003). Having patients in ICUs managed by physicians who specialize in such care leads to better outcomes for patients. (Romano, Tr. 3003).

Response to Finding No. 1687:

This finding is incomplete. It leaves out the date of the referenced studies, which

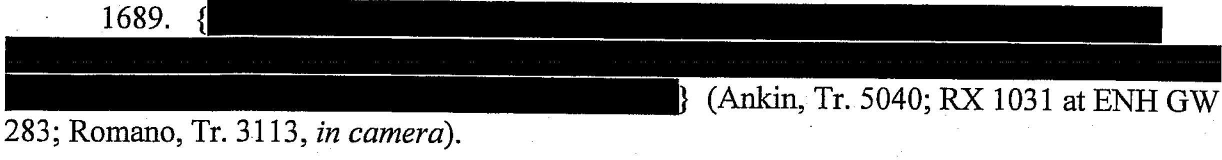
Dr. Romano stated were "from 1999 to 2004." (Romano, Tr. 3003). Respondent's use of studies performed principally after the merger to bolster its claim that intensivists are an improvement makes even clearer that any improvement was not merger specific. It was only after the merger that a consensus in favor of the use of intensivists emerged, and as a result, HPH and "many hospitals have established such contracts." (Romano, Tr. 3003). (*See also* CCRFF 1677). In addition, various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

1688. In particular, studies done by a variety of different institutions have shown that intensivist programs reduce mortality by 10-15%. (Ankin, Tr. 5039). Intensivist programs also decrease the length of a patient's stay in the ICU, decrease infection rates as well as increase nurse satisfaction and nurse retention. (Ankin, Tr. 5039; RX 1111 at ENH GW 276).

Response to Finding No. 1688:

This finding is incomplete. The studies to which Dr. Ankin referred were "in 2000" and "a year prior" to that. (Ankin, Tr. 5040). In addition, various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

1689. {



} (Ankin, Tr. 5040; RX 1031 at ENH GW 283; Romano, Tr. 3113, *in camera*).

Response to Finding No. 1689:

This finding is incomplete. {

} (Romano, Tr. 3113-14, *in camera*. *See also* CCRFF 1677). In addition, various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

1690. ENH implemented the intensivist program at HPH in 2001 by contracting with PPONS. (Ankin, Tr. 5041; RX 1099 at ENHE F35 340; O'Brien, Tr. 3528-29). { } (Ankin, Tr. 5063; RX 1084 at ENHL MA, *in camera*; O'Brien, Tr. 3530-31).

Response to Finding No. 1690:

The finding is misleading. Various evidence supports the view that the intensivist program implemented at HPH after the merger was not merger specific. (*See* CCRFF 1677).

(1) Intensivists Have Broad ICU Responsibilities At HPH

1691. The intensivist program at HPH, headed by Dr. Ankin, is an effective collaboration with the private medical staff at HPH. (RX 1111 at ENH GW 277; RX 1099 at ENHE F35 340). The intensivists from PPONS are responsible for directing the care of patients in HPH's ICU to improve patient care and patient safety. (Ankin, Tr. 5042-43; RX 1084 at ENHL MA 4-5).

Response to Finding No. 1691:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger.

(*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1692. Dr. Ankin and six physicians from PPONS are responsible for being physically present at HPH, primarily in the ICU, and providing intensivist services on a 12-hour-a-day basis for five days a week. (Ankin, Tr. 5041; 5048; RX 1084 at ENHL MA 5; Spaeth, Tr. 2278; O'Brien, Tr. 3528-29; RX 1099 at ENHE F35 340; Chassin, Tr. 5326).

Response to Finding No. 1692:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1693. In general, intensivists at HPH are involved in several activities, including: multidisciplinary ICU teaching, critical care evaluation, utilization of ICU beds, critical care pathway establishment, emergency-code response hospital-wide, urgent evaluations and monitoring clinical care of patients in the step-down unit (a unit providing a lesser intensity of care than the ICU). (RX 1111 at ENH GW 277; RX 1084 at ENHL MA 5; Ankin, Tr. 5041-43).

Response to Finding No. 1693:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1694. In particular, there are daily patient rounds in the ICU at HPH starting at 9:00 a.m., with a group of individuals involved in the patient's care, including the intensivist, nurses, a dietician, a physical therapist, a social worker, a chaplain and a discharge planner – all of whom meet to discuss the needs of each patient in the ICU. (Ankin, Tr. 5054; RX 1099 at ENHE F35

340; Chassin, Tr. 5327). The purpose of these multidisciplinary rounds is to improve patient care by anticipating patient needs ahead of time so that there are no gaps in care. (Ankin, Tr. 5054; Chassin, Tr. 5327, 5331). HPH did not have multidisciplinary rounds before the Merger. (Ankin, Tr. 5054; Chassin, Tr. 5331).

Response to Finding No. 1694:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1695. { } (Ankin, Tr. 5037; RX 989 at ENHL MO 7123, *in camera*; RX 1084 at ENHL MA 5; Ankin, Tr. 5043-44).

Response to Finding No. 1695:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1696. The intensivists at HPH are also responsible for responding to patient emergencies in other areas of the hospital, in addition to the ICU. (Ankin, Tr. 5056; RX 1099 at ENHE F35 340; O'Brien, Tr. 3530). { } (RX 989 at ENHL MO 7124, *in camera*; RX 1084 ENHL MA 5). More importantly, the intensivists are available to see patients anywhere in the hospital who are rapidly deteriorating and who require intensive care services within a short period of time. (Ankin, Tr. 5056-57; Chassin, Tr. 5329). This additional physician coverage was a quality of care improvement. (Chassin, Tr. 5328).

Response to Finding No. 1696:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672).

1697. Dr. Ankin's practice also has monthly meetings with the Evanston and Glenbrook intensivists to coordinate care in the ICUs of all three ENH hospitals, discuss process and performance improvement and to discuss research projects and care paths. (Ankin, Tr. 5051). The meetings are an occasion to discuss research projects that are carried out at the ENH hospitals. (Ankin, Tr. 5052).

Response to Finding No. 1697:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1698. In addition, Dr. Ankin's group has coordinated with the intensivists at both Glenbrook and Evanston Hospitals to develop a variety of new critical pathways, including ventilator management and diabetic sugar control. (Ankin, Tr. 5052).

Response to Finding No. 1698:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1699. Dr. Ankin's group has worked on research projects with intensivists at Evanston

and Glenbrook Hospitals involving medications for sepsis and medications to reduce the need for blood transfusions. (Ankin, Tr. 5052).

Response to Finding No. 1699:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1700. The HPH intensivists, who are responsible for all of the patients in the ICU, have the opportunity to consult with the primary care physicians for each of those patients. (Ankin, Tr. 5043). Further, intensivists at HPH have the ability to discuss a patient's care with family members and help coordinate patient care for ICU patients through all of the physicians and specialists. (Ankin, Tr. 5043).

Response to Finding No. 1700:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1701. After the Merger, ENH also added a physician in training as a fellow to the intensivist team to supplement intensivist coverage. (Ankin, Tr. 5058). Currently, the fellow – or house physician – arrives each night at 6:00 p.m., consults with the attending intensivist about particular patients in the ICU and is responsible for evaluating and caring for ICU patients until the intensivist returns in the morning. (Ankin, Tr. 5058-59).

Response to Finding No. 1701:

The finding is incomplete and misleading. Various evidence supports the view

that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1702. The intensivists at HPH are on call during evening hours and on weekends to respond to patient emergencies in the ICU, if necessary, come to the hospital during the evening hours to respond to a patient who was unstable. (Ankin, Tr. 5058-60). In addition, the intensivists at HPH respond to consultation requests by a physician or nurse for patients whose condition is rapidly deteriorating. (Ankin, Tr. 5060; RX 1084 at ENHL MA 5; RX 1099 at ENHE F35 340).

Response to Finding No. 1702:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

1703. Dr. Ankin has, over the past four years, frequently received such consultation requests for deteriorating patients, usually for patients admitted to a general medical floor outside the ICU. (Ankin, Tr. 5060).

Response to Finding No. 1703:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). To the extent it was an improvement, it merely reflected the emerging national consensus and was not merger specific. (*See* CCRFF 1677).

(2) The Intensivist Program Complemented The Introduction Of Cardiac Surgery At HPH

1704. The addition of cardiac surgery at HPH after the Merger changed the ICU by requiring that ICU personnel learn to care for cardiac surgery patients after their surgery. (Ankin, Tr. 5063-64). Cardiac surgery patients are often sick and unstable patients and go directly from the operating room to the ICU, and their post-operative care requires sophisticated machinery, medications and medical care. (Ankin, Tr. 5064). Caring for cardiac surgery patients in the ICU requires a high degree of intelligence and focus. (Ankin, Tr. 5064).

Response to Finding No. 1704:

The finding is incomplete and misleading. Complaint Counsel reiterates that the introduction of cardiac surgery was not merger specific. (*See* CCRFF 1577). Various evidence supports the view that the intensivist program also was not merger specific. (*See* CCRFF 1677). Thus, the claimed benefit from the combination of the two would have taken place with or without the merger.

1705. There are situations in which a patient in the ICU is so sick and unstable that he or she cannot be safely transferred to another hospital by ambulance. (Ankin, Tr. 5066). One of the problems for a community hospital that does not have a cardiac surgery program is that patients who come to the hospital with a heart attack may be too unstable to transfer to a hospital with cardiac surgery capabilities. (Ankin, Tr. 5066).

Response to Finding No. 1705:

The finding is incomplete and misleading. Complaint Counsel reiterates that the introduction of cardiac surgery was not merger specific. (*See* CCRFF 1577). Various evidence supports the view that the intensivist program also was not merger specific. (*See* CCRFF 1677). Thus, the claimed benefit from the combination of the two would have taken place with or without the merger.

1706. Dr. Ankin had a patient in the HPH ICU a few months ago who had a heart attack and was too unstable to transfer. But because of HPH's cardiac surgery program instituted after the Merger, this patient was evaluated by the cardiac surgeons, operated on and discharged in

better condition from HPH. (Ankin, Tr. 5066). This patient could not have had her cardiac surgery procedure at HPH before the Merger. (Ankin, Tr. 5066). In contrast, before the Merger, HPH patients who needed to be transferred but were too unstable to transfer died. (Ankin, Tr. 5068).

Response to Finding No. 1706:

The finding is incomplete and misleading. Complaint Counsel reiterates that the introduction of cardiac surgery was not merger specific. (*See* CCRFF 1577). Various evidence supports the view that the intensivist program also was not merger specific. (*See* CCRFF 1677). Thus, the claimed benefit from the combination of the two would have taken place with or without the merger.

1707. Finally, there is a relationship between the quality of ICU services at a hospital and the maintenance of a cardiac surgery program. (Chassin, Tr. 5604). At HPH, the ICU serves as the joint cardiac surgery and other critical care areas for the hospital. (Chassin, Tr. 5604). Once the nurses are trained to handle the complicated cardiac surgery cases, those skills spill over into their ability to care for other critically ill patients in the ICU for other medical reasons. (Chassin, Tr. 5604).

Response to Finding No. 1707:

The finding is incomplete and misleading. Complaint Counsel reiterates that the introduction of cardiac surgery was not merger specific. (*See* CCRFF 1577). Various evidence supports the view that the intensivist program also was not merger specific. (*See* CCRFF 1677). Thus, the claimed benefit from the combination of the two would have taken place with or without the merger.

(3) The Intensivist Program Improved Nursing Care In The HPH ICU

1708. The intensivists have an active role in educating the nursing staff at HPH, both during patient rounds and during the intensivist's 12-hour shift. (Ankin, Tr. 5068; RX 1084 at ENHL MA 5).

Response to Finding No. 1708:

Complaint Counsel have no specific response.

1709. As part of the roll-out of the cardiac surgical program, ENH brought the HPH ICU nurses to Evanston Hospital for intensive training. (Chassin, Tr. 5330). Those nurses returned to HPH and both cardiac and ICU patients benefited from improved care. (Chassin, Tr. 5330). The improved nurse staffing in the HPH ICU enhanced the ability of the intensivists to care for patients in the ICU. (Ankin, Tr. 5069-70).

Response to Finding No. 1709:

The finding is misleading. ENH cannot attribute this benefit to the merger because it contracted to do exactly the same thing without the merger. (CX 2094 at 3-4).

1710. Moreover, a nurse practitioner was added to the ICU staff at HPH after the Merger, and this addition increased the capacity of the ICU to provide excellent care. (Chassin, Tr. 5328; RX 1445 ENHL PK 51621).

Response to Finding No. 1710:

Complaint Counsel have no specific response.

iv. The Intensivist Program Improved The Overall Quality Of Care For HPH's Critically Ill Patients

1711. ENH improved the quality of care in HPH's ICU by adding an intensivist program, by instituting a program to train ICU nurses to handle more complicated patients and by bringing a more sophisticated style of care to ICU patients. (Chassin, Tr. 5326-27).

Response to Finding No. 1711:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). Various evidence supports the view that the intensivist program also was not merger specific. (*See* CCRFF 1677).

1712. The intensivist program at HPH was an improvement in quality of care because full-time intensivists improve mortality and reduce complications. (Chassin, Tr. 5328.) The changes ENH made to the HPH ICU, including providing full-time intensivist coverage and adding pharmacists to the multi-disciplinary rounds in the ICU, are improvements in the quality of ICU care. (Chassin, Tr. 5328).

Response to Finding No. 1712:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). Various evidence supports the view that the intensivist program also was not merger specific. (*See* CCRFF 1677).

1713. Dr. Romano concedes that the implementation of the intensivist program at HPH was likely to improve patient outcomes, reduce mortality in the ICU and lead to improvements in quality of care. (Romano, Tr. 3318).

Response to Finding No. 1713:

The finding is incomplete and misleading. Various evidence supports the view that introduction of an intensivist program at HPH was not a significant improvement because HPH already had some physician coverage at the hospital before the merger. (*See* CCRFF 1672). The studies on which Dr. Romano's conclusion was based were published from 1999-2004. (Romano, Tr. 3003). In addition, other evidence supports the view that the intensivist program was not merger specific. (*See* CCRFF 1677).

v. **HPH Had No Plans To Adopt An Intensivist Program Before The Merger**

1714. There is no record evidence that HPH had any plan to adopt an intensivist program before the Merger. (Ankin, Tr. 5045).

Response to Finding No. 1714:

Respondent's finding is incomplete. Various evidence supports the view that the intensivist program implemented at HPH after the merger was not merger specific. (*See* CCRFF 1677).

1715. Before the Merger, neither Dr. Ankin nor his private practice, PPONS, had any contractual relationship with HPH to direct the critical care of patients in the ICU. (Ankin, Tr. 5045).

Response to Finding No. 1715:

Respondent's finding is incomplete. Various evidence supports the view that the intensivist program implemented at HPH after the merger was not merger specific. (*See* CCRFF 1677).

1716. Before the Merger, nobody from HPH ever approached Dr. Ankin to request that he initiate an intensivist program. (Ankin, Tr. 5045).

Response to Finding No. 1716:

Respondent's finding is incomplete. Various evidence supports the view that the intensivist program implemented at HPH after the merger was not merger specific. (*See* CCRFF 1677).

1717. One year after the HPH intensivist program started, and due to the success of that program, Dr. Ankin, in his capacity as a Board member of Lake Forest Hospital, suggested to that hospital's Board and its administration that the hospital begin an intensivist program. (Ankin, Tr. 5072-73). The Lake Forest Board of Directors initiated an intensivist program because it saw the advantages to patient care and patient safety of having such a program. (Ankin, Tr. 5073).

Response to Finding No. 1717:

Respondent's finding is irrelevant. This case is about Evanston's merger with Highland Park in 2000, not Lake Forest Hospital. (*See* CCRFF 1677).

1718. Lake Forest had no intent to adopt an intensivist program before Dr. Ankin made

this suggestion based on his positive experiences with HPH's post-Merger intensivist program. (Ankin, Tr. 5073-74).

Response to Finding No. 1718:

Respondent's finding is irrelevant. This case is about Evanston's merger with Highland Park in 2000, not Lake Forest Hospital. Respondent's finding is also incomplete. Various evidence supports the view that the intensivist program implemented at HPH after the merger was not merger specific. (*See* CCRFF 1677).

1719. The intensivist program at Lake Forest is only eight hours each day, rather than 12 hours at HPH. (Ankin, Tr. 5074). Lake Forest Hospital has only eight hours of intensivist coverage because it could not afford a 12-hour per day program. (Ankin, Tr. 5074).

Response to Finding No. 1719:

Respondent's finding is irrelevant. This case is about Evanston's merger with Highland Park in 2000, not Lake Forest Hospital. Respondent's finding is also incomplete. Various evidence supports the view that the intensivist program implemented at HPH after the merger was not merger specific. (*See* CCRFF 1677).

1720. Dr. Ankin also recommended to Rush North Shore that it begin an intensivist program. Nevertheless, that hospital did not institute such a program because it could not afford it. (Ankin, Tr. 5074).

Response to Finding No. 1720:

Respondent's finding is irrelevant. This case is about Evanston's merger with Highland Park in 2000. It is not about whether Rush North Shore has an intensivist program or not. Respondent's finding is also incomplete. (*See also* CCRFF 1677).

1721. Intensivist programs, such as the one instituted at HPH after the Merger, are not common in community hospitals (such as HPH before the Merger). (Chassin, Tr. 5329). The Leapfrog Group conducted a survey that tallied the number of hospitals reporting intensivist programs. (Chassin, Tr. 5329-30). Only six out of 37 hospitals reporting to LeapFrog in Illinois

had intensivist programs, and three of those six hospitals were the ENH hospitals. (Chassin, Tr. 5330; Romano, Tr. 3324). The Leapfrog Group survey ranked the ENH hospitals as the top hospital system in the State of Illinois in 2005. (Neaman, Tr. 1291).

Response to Finding No. 1721:

Respondent's finding is incomplete. Various evidence supports the view that the intensivist program implemented at HPH after the merger was not merger specific. (*See* CCRFF 1677). In addition, the Leapfrog Group survey that tallied the number of hospitals reporting intensivist programs is not credible. The majority of the hospitals in the state of Illinois did not even respond to the survey. (Romano, Tr. 3324). One hospital, Lake Forest, is not on the list although Lake Forest does have an intensivist program. (Romano, Tr. 3425; Ankin, Tr. 5073).

d. The Merger Substantially Improved Oncology Services At ENH

i. Overview

1722. Before the Merger, HPH's oncology program was designated by the American College of Surgeons, a national organization charged with certifying cancer programs at community and academic hospitals and academic institutions, as a community oncology program. (Dragon, Tr. 4320-21). The level of care provided for oncology patients was very typical of an average community hospital. (Dragon, Tr. 4309).

Response to Finding No. 1722:

The finding is misleading. Nothing in the cited testimony indicates that there is anything deficient about a community oncology program, and indeed, Dr. Dragon led the "community" program at HPH both before the merger and for almost three years after the merger, until becoming director of the Kellogg Cancer Center at HPH in December 2002. (Dragon, Tr. 4304, 4306, 4309, 4320-21). Moreover, the pre-merger HPH provided

services that had an "academic component": HPH had a "clinical trials program" and Dr. Dragon held an "academic appointment at Northwestern." (Dragon, Tr. 4321-22).

1723. For example, as was typical in community hospitals, necessary support services such as pharmacy services, psychology, and nutritionists were not coordinated in a central location, thus requiring sick patients to travel to multiple locations to receive these important services. (Dragon, Tr. 4318-19; Chassin, Tr. 5369). Also, as was typical in community hospitals, HPH did not have any specialty oncologists before the Merger. (Dragon, Tr. 4315-17).

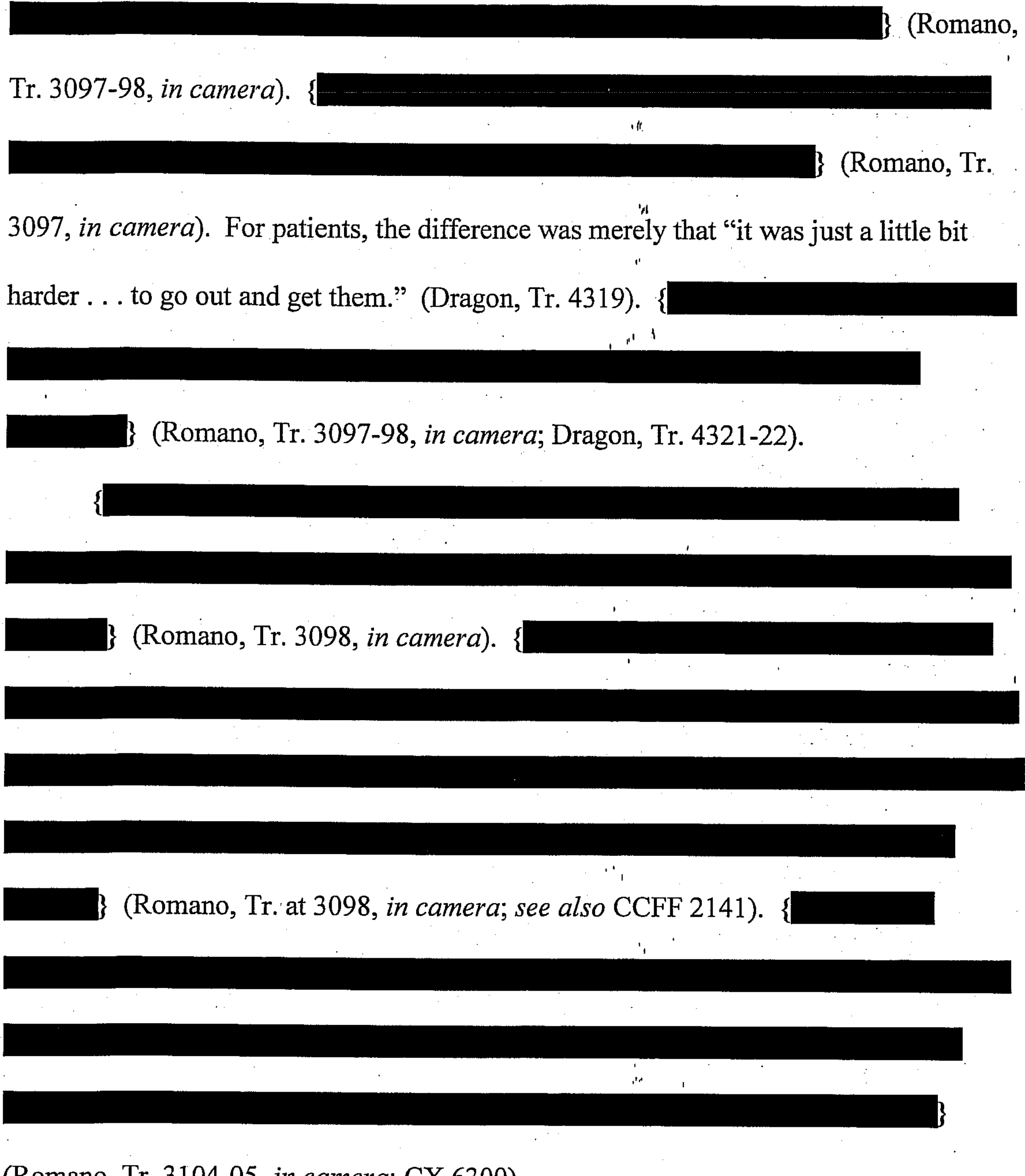
Response to Finding No. 1723:

The finding is incomplete and misleading. The cited testimony indicates that the referenced services were in fact provided to HPH patients, as was typical of community hospitals. (Dragon, Tr. 4318-19). The only difference was "it was just a little bit harder . . . to go out and get them." (Dragon, Tr. 4319).

1724. ENH made two major improvements to oncology services at ENH after the Merger: (1) it brought a multidisciplinary approach to cancer care through the extension of the Kellogg Cancer Center to HPH, and (2) it introduced subspecialty oncologists to HPH. (Chassin, Tr. 5369, 5371).

Response to Finding No. 1724:

The finding is incomplete and misleading. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. { } (Romano, Tr. 3097-98, *in camera*). { } (Romano, Tr. 3097, *in camera*; Dragon, Tr. 4390-91). {



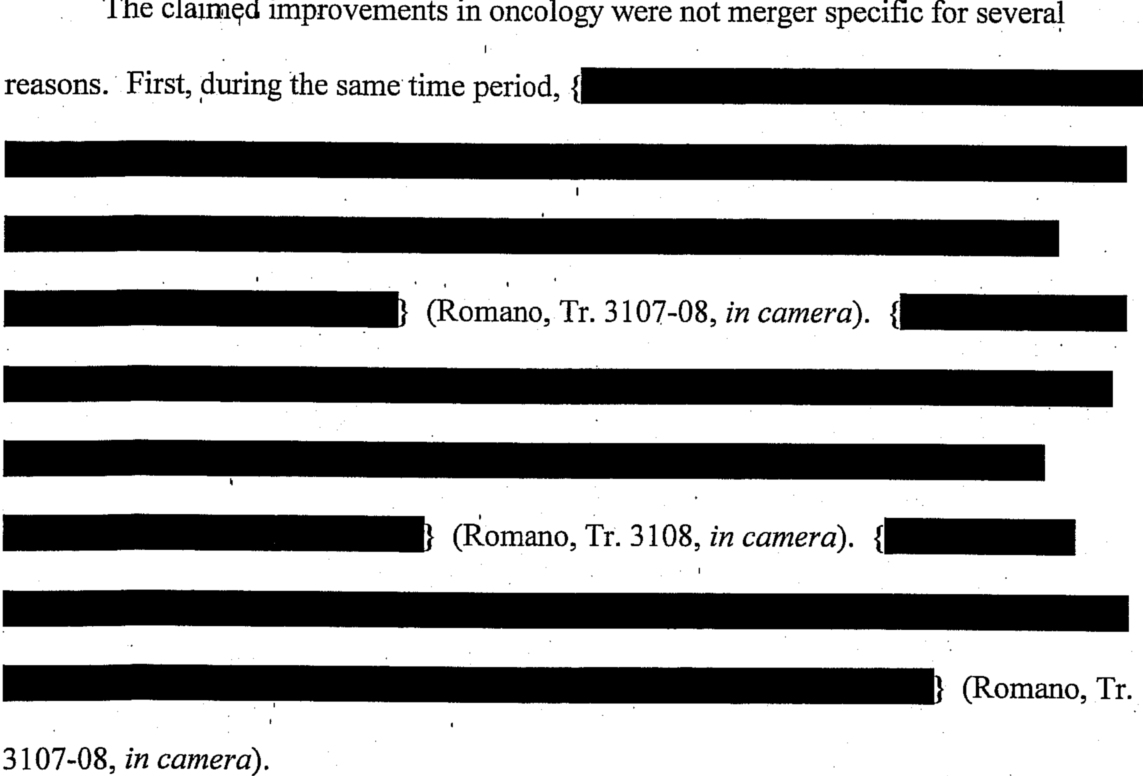
} (Romano, Tr. 3097-98, *in camera*). { } (Romano, Tr. 3097, *in camera*). For patients, the difference was merely that "it was just a little bit harder . . . to go out and get them." (Dragon, Tr. 4319). { } (Romano, Tr. 3097-98, *in camera*; Dragon, Tr. 4321-22).

{ } (Romano, Tr. 3098, *in camera*). { } (Romano, Tr. at 3098, *in camera*; *see also* CCFF 2141). { } (Romano, Tr. 3104-05, *in camera*; CX 6300).

Patient outcome measures for oncology include survival rates, symptom management, and quality of life. ENH as an institution does not look at these measures on a regular basis. (Dragon, Tr. 4397-98). Dr. Dragon had no measurements beyond his own personal observations to compare quality of life before 2002 with quality of life after

2002. (Dragon, Tr. 4406). Furthermore, Mary O'Brien, President of Highland Park Hospital, did not know how bringing the Kellogg Cancer Care Center to Highland Park Hospital impacted patient outcomes for cancer care. (O'Brien, Tr. 3565). She was also unaware of what the patient outcomes for cancer care were at Highland Park Hospital before the merger. (O'Brien, Tr. 3568).

The claimed improvements in oncology were not merger specific for several reasons. First, during the same time period, {



} (Romano, Tr. 3107-08, *in camera*). {

} (Romano, Tr. 3108, *in camera*). {

} (Romano, Tr. 3107-08, *in camera*).

Second, the timing of ENH's implementation of its multidisciplinary approach suggest that it was in fact part of this trend, rather than a change specifically attributable to the merger. It was not until three years after the merger, in December 2002, that Dr. Dragon was appointed to head the Kellogg Cancer Center at HPH and bring its services to that facility. (Dragon, Tr. 4306-07). While ENH says the Kellogg Cancer Center was set up as a temporary facility before December 2002, ENH cites to no credible evidence of its

activities before Dr. Dragon took over the program. (*See* CCRFF 1755)). At that time Dr. Dragon had been in private practice and had been credentialed to practice at Highland Park Hospital in 1999. (Dragon, Tr. 4304). After Dr. Dragon became director of the Kellogg Cancer Care Center in December 2002, the Center moved into the same office space that Dr. Dragon had been using for his private practice, which was located in the medical office building across the street from Highland Park Hospital. (Dragon, Tr. 4389). It was not until February 2005 that the Kellogg Cancer Care Center moved to its present location. (Dragon, Tr. 4390).

Third, before the merger, Highland Park Hospital was pursuing joint programs in oncology with other hospitals, such as ENH and Northwestern Memorial Hospital, that did not involve a merger. (Neaman, Tr. 1243; Hillebrand, Tr. 2044; Newton, Tr. 420; CX 1867 at 1-3; Spaeth, Tr. 2223-28; CX 1866 at 1, 5. *See also* CX 1862; CX 99 at 2). As far back as 1998, Highland Park Hospital wanted to develop a "center of excellence" for cancer care services. (CX 91 at 2; CX 1869 at 4). Moreover, in the late 1990s, Highland Park Hospital and ENH had considered implementing a cancer care program at Highland Park as a joint program. (Neaman, Tr. 1243; Hillebrand, Tr. 2044; Spaeth, Tr. 2223-28). As a matter of fact, Highland Park was considering implementing a joint comprehensive oncology program with its local physicians, particularly a local medical group practice, Physician Reliance Network. (CX 1868 at 13; CX 99 at 2). Highland Park Hospital had also considered an oncology program with Northwestern Memorial Hospital prior to the merger. (Newton, Tr. 420; CX 1866 at 1, 5). There is every reason to believe that, without the merger, HPH would have implemented a program many other hospitals were

then implementing, that HPH had been planning before the merger, at least by the time that ENH got around to doing so, in December 2002, three years after the merger.

1725. ENH also built an entirely new facility for oncology services at HPH, purchased new and additional equipment that typically would not be found in a community hospital and improved access to research trials. (Dragon, Tr. 4370-71; Chassin 5371).

Response to Finding No. 1725:

The cited source does not say what Respondent's finding claims about adding new equipment to HPH that would not be found in a community hospital. In addition, various evidence supports the view that upgrades to cancer care facilities at HPH after the merger – the most significant of which, the new facility, took ENH five years – were not merger specific. (CCRFF 1724). During those five years, HPH likely would have upgraded its physical facilities had the merger not occurred. (CCRFF 1724).

Prior to the merger, HPH routinely made capital investments to upgrade and improve its facilities. (Newton, Tr. 383-84). HPH was financially strong prior to the merger. (*See* CCFF 303-355). Highland Park's 1999-2003 Financial Plan set forth a "long range capital budget" that included $43 million for "strategic initiatives and master plan items," including "ambulatory, assisted living and facility expansion." The plan also set aside $65 million for "[h]ospital construction, routine capital and information technology" investments, and a small amount for Lakeland Health Ventures. (Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2). The total planned investments for the time period therefore amounted to $108 million.

The facility and equipment changes made in connection with cancer care at HPH after the merger are structural changes. (Romano, Tr. 2986-87). Structural measures are

enabling factors that provide the conditions under which care is delivered. (Romano, Tr. 2988). Structural measures are insufficient by themselves to measure quality because they tell us very little about the care that is actually provided to patients. (Romano, Tr. 2988).

1726. As a result of these post-Merger improvements, the American College of Surgeons changed its designation of HPH's oncology program from a community oncology program to an academic hospital cancer center. (Dragon, Tr. 4360). These post-Merger improvements represent substantial quality improvements for cancer patients at HPH. (Chassin, Tr. 5369).

Response to Finding No. 1726:

The finding is incomplete and misleading. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). Various evidence also supports the view that the pre-merger HPH oncology services had some academic aspects. (*See* CCRFF 1722).

1727. Dr. Leon Dragon, a practicing physician, medical oncologist, and medical director of the Kellogg Cancer Center at HPH since 2002, testified at trial about HPH's oncology services pre- and post-Merger. (Dragon, Tr. 4300, 4306). Dr. Dragon has practiced medicine for 27 years and is familiar with the different oncology practices in the Chicago area. (Dragon, Tr. 4303). He first began practicing medicine at HPH in 1999 and spent about half of his time at HPH by the time of the Merger or earlier. (Dragon, Tr. 4309-10).

Response to Finding No. 1727:

Complaint Counsel have no specific response.

1728. As the medical director of the Kellogg Cancer Center at HPH, Dr. Dragon was charged with developing the cancer program at HPH and integrating it with the services then organized and available at Evanston and Glenbrook Hospitals to create a freestanding facility at HPH that would offer both the clinical services and clinical research services available at the other two sites. (Dragon, Tr. 4306-07).

Response to Finding No. 1728:

The finding is incomplete and misleading. Dr. Dragon was given this task in December 2002, three years after the merger, { [redacted] } (Dragon, Tr. 4306-07; Romano, Tr. 3107-08, *in camera*).

ii. Pre-Merger Cancer Services At HPH Were Typical Of A Community Hospital

(1) Pre-Merger Cancer Services At HPH Lacked Full Time Employed Oncologists

1729. Before the Merger, all of the oncologists practicing at HPH were private practitioners. (Dragon, Tr. 4310). HPH employed two full-time equivalent oncologists, but 90% of the care rendered by those physicians and their group was office-based. (Dragon, Tr. 4310). Two other oncologists who were based at Lake Forest Hospital had privileges at HPH, but they primarily saw outpatient referrals for physicians on staff at HPH in their office at Lake Forest Hospital. (Dragon, Tr. 4309-10).

Response to Finding No. 1729:

Complaint Counsel have no specific response.

1730. The services generally provided by private practice oncologists are based on their ability to generate revenue. (Dragon, Tr. 4311-12).

Response to Finding No. 1730:

Complaint Counsel have no specific response.

(2) Pre-Merger Cancer Support And Ancillary Services At HPH Were Limited

1731. Oncology support or ancillary services for cancer patients generally include psycho-social counseling, specialized pharmacy, blood transfusions, and dietary services. (Dragon, Tr. 4312-13, 4317). Oncology patients utilize these services to address important health issues attendant to cancer care. (Dragon, Tr. 4317). For example, cancer patients require dietary services because such patients have problems with gastrointestinal function, appetite, and weight loss. (Dragon, Tr. 4317). Additionally, specialized pharmacy services are needed to deal with chemotherapy drugs, the adjustment of pain medication, narcotics, and anti-nausea medication or anti-emetics. (Dragon, Tr. 4317).

Response to Finding No. 1731:

The cited source does not say what Respondent's finding claims regarding the purpose and need of ancillary services.

1732. Typically, private practice oncologists do not provide ancillary or support services for oncology patients because they generally lose money proving such services. (Dragon, Tr. 4312-13).

Response to Finding No. 1732:

Respondent's finding is irrelevant and misleading. Respondent does not claim that this finding has anything to do with HPH. In any event, Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1733. Before the Merger, cancer patients at HPH were referred to social workers or psychiatrists outside of the oncology physicians' practices and outside HPH. (Dragon, Tr. 4318). Many of the support services were not covered by health insurance, so patients had to pay for them out of pocket. (Dragon, Tr. 4318). Even if their insurance carrier covered the costs, however, the cancer patients still had to get the services on their own elsewhere in the community. (Dragon, Tr. 4318). This uncoordinated approach made it more difficult for chronically-ill patients who were undergoing cancer treatments to get needed services on their own. (Dragon, Tr. 4318-19).

Response to Finding No. 1733:

The finding is misleading. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). Regarding the difficulty of obtaining the services, Dr. Dragon's testimony was that "it was just a little bit harder for chronically ill patients undergoing treatment to go out and get them on their own somewhere else, but they were available." (Dragon, Tr. 4319).

(3) Pre-Merger Cancer Patients At HPH Lacked Access To Specialists

1734. All of the medical oncologists caring for patients at HPH before the Merger were generalists. (Dragon, Tr. 4315).

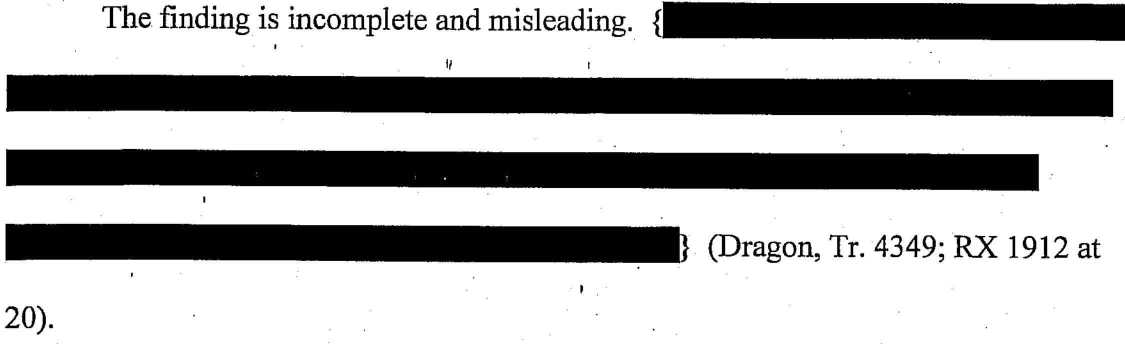
Response to Finding No. 1734:

Complaint Counsel have no specific response.

1735. Many HPH oncology patients who needed to see a specialist before the Merger went to either the University of Chicago or Northwestern Memorial, both of which are located 25 to 35 miles south of HPH. (Dragon, Tr. 4349).

Response to Finding No. 1735:

The finding is incomplete and misleading. {



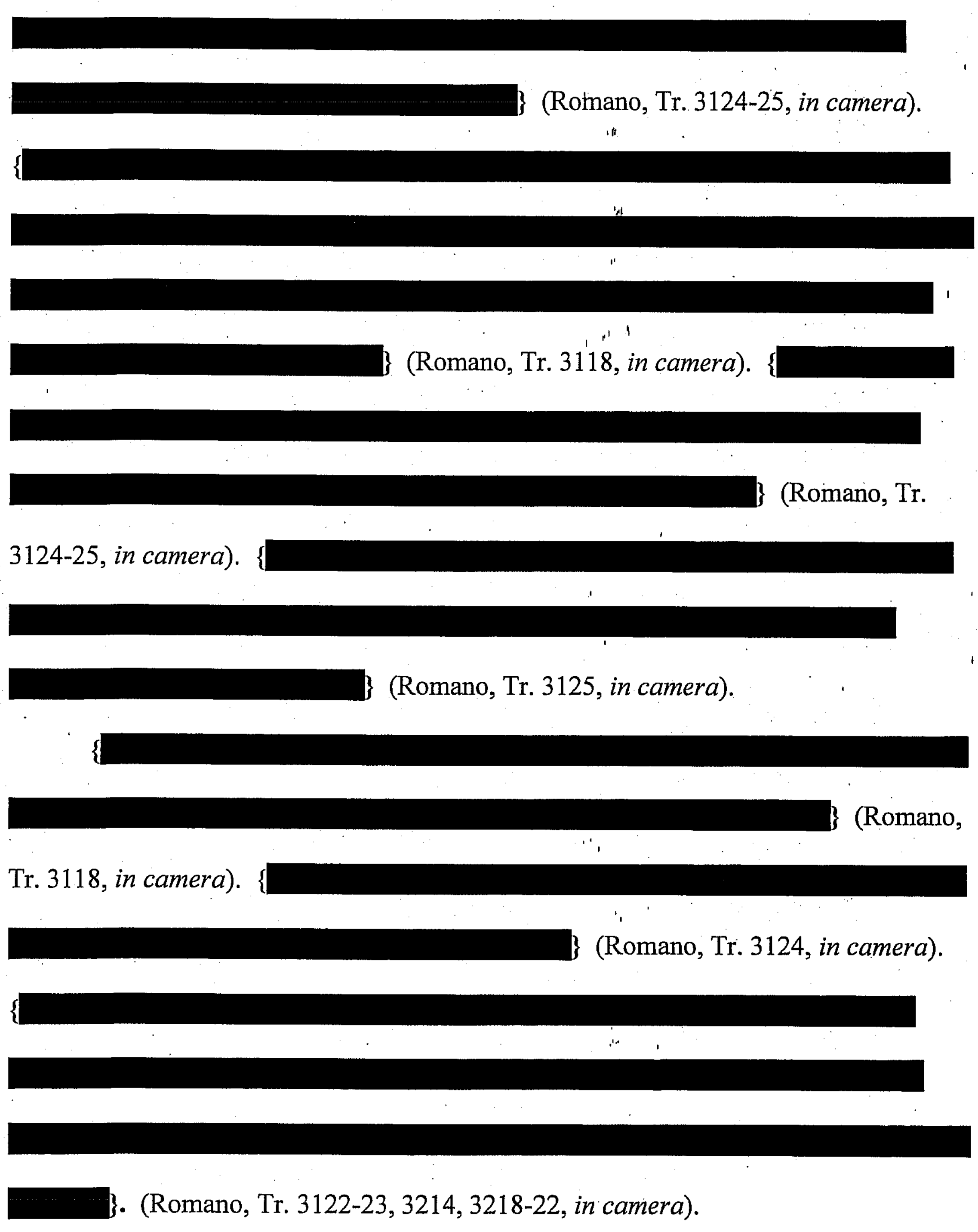
} (Dragon, Tr. 4349; RX 1912 at 20).

(4) **Pre-Merger Cancer Services At HPH Lacked Academic Research And Clinical Trials**

1736. Before the Merger, the HPH oncology program did not have an academic orientation. (Dragon, Tr. 4322). Few physicians had academic appointments to any teaching or research institutions, and aside from putting the occasional patient put on clinical trials, no teaching was done. (Dragon, Tr. 4322; Spaeth, Tr. 2294).

Response to Finding No. 1736:

The finding is incomplete and misleading. Dr. Dragon himself did have an academic appointment. (Dragon, Tr. 4322). Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). In addition, various evidence supports the view that academic affiliation does not improve the quality of care. Expert testimony established that {



} (Romano, Tr. 3124-25, *in camera*). {

} (Romano, Tr. 3118, *in camera*). {

} (Romano, Tr. 3124-25, *in camera*). {

} (Romano, Tr. 3125, *in camera*).

{

} (Romano, Tr. 3118, *in camera*). {

} (Romano, Tr. 3124, *in camera*).

{

}. (Romano, Tr. 3122-23, 3214, 3218-22, *in camera*).

1737. HPH had a small clinical trial program before the merger. (Dragon, Tr. 4322). Immediately before the Merger, HPH was engaged in only one clinical trial – a national study looking at breast cancer prevention run through HPH. (Dragon, Tr. 4322, 4331-32).

Response to Finding No. 1737:

The finding is misleading. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1738. Academic research in oncology is usually performed via clinical trials. (Dragon, Tr. 4325). There are three different types of clinical trials: (1) cooperative group trials; (2) industry-based trials; and (3) institutional-based or Phase II trials. (Dragon, Tr. 4325-26).

Response to Finding No. 1738:

The finding is incomplete and misleading. Various evidence supports the view that academic affiliation does not improve quality of care. (*See* CCRFF 1736).

1739. Cooperative group trials are National Cancer Institute sponsored trials that cooperatively tie together a number of groups nationally and hundreds of institutions to research the effectiveness of cancer treatments. (Dragon, Tr. 4327). Initially, there were a relatively small number of cooperative group trials at HPH. (Dragon, Tr. 4328). Before the Merger, however, these trials were taken away from HPH. (Dragon, Tr. 4328-30).

Response to Finding No. 1739:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1740. Before the Merger, HPH had an Institutional Review Board ("IRB") in place to review potential clinical trials or studies involving human subjects or materials. (Dragon, Tr. 4331). IRBs ensure that the utilization of human subjects or materials in a hospital is reviewed at the community or institutional level for appropriateness and ethical standards. (Dragon, Tr. 4331-32).

Response to Finding No. 1740:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1741. Once the cooperative group trials were taken out of HPH, all review of studies in which HPH patients were participating was done by a freestanding IRB that was not part of the hospital. (Dragon, Tr. 4332). As a result, the community and HPH had no ability to weigh in on the ethical or organizational elements of those studies. (Dragon, Tr. 4332-33).

Response to Finding No. 1741:

The finding is incomplete and misleading. Various evidence supports the view that Dr. Dragon himself did not have any concern that the review of studies in which HPH patients were participating was done by a freestanding IRB that was not part of the hospital. (Dragon, Tr. 4332). In addition, various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

(5) Pre-Merger Cancer Services At HPH Had Inadequate Facilities And Equipment

1742. Before the Merger, the only site at HPH offering organized chemotherapy services was Dr. Dragon's office. (Dragon, Tr. 4333). His office contained a communal or open room with nine treatment chairs with some curtains. (Dragon, Tr. 4333).

Response to Finding No. 1742:

The finding is incomplete and misleading. ENH itself deemed Dr. Dragon's office to be an acceptable location for several years following the merger, from 2002 until February 2005. (Dragon, Tr. 4390-91). Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger was not merger specific because HPH likely would have upgraded its physical facilities had the merger not occurred. (*See* CCRFF 1725). Various evidence also shows that the manner in which HPH provided cancer care after the merger did not significantly change for many years. Dr. Dragon is the medical director of the Kellogg Cancer Care Center at Highland Park

Hospital, a position he has held since December 2002. (Dragon, Tr. 4306). Prior to this, Dr. Dragon was in private practice when he first became credentialed to practice at Highland Park Hospital in 1999. (Dragon, Tr. 4304). After Dr. Dragon became director of the Kellogg Cancer Care Center in December 2002, the Center moved into the same office space that Dr. Dragon had been using for his private practice, which was located in the medical office building across the street from Highland Park Hospital. (Dragon, Tr. 4389). It was not until February 2005 that the Kellogg Cancer Care Center moved to its present location. (Dragon, Tr. 4390).

1743. Additionally, HPH did not own any equipment or facilities dedicated to treating oncology patients. (Dragon, Tr. 4333-34). For instance, the linear accelerator at HPH was not owned by HPH, but by an independent practice. (Newton, Tr. 469). A linear accelerator is a piece of equipment used to provide radiation therapy. (Dragon, Tr. 4334). Specifically, a linear accelerator generates electrons at a high level of intensity to treat a localized part of a patient's body. (Dragon, Tr. 4334-35).

Response to Finding No. 1743:

The finding is incomplete and misleading. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because HPH likely would have upgraded its physical facilities had the merger not occurred. (*See* CCRFF 1725). With regard to the linear accelerator, HPH did not purchase a new one until the opening of the Ambulatory Care Center five years after the merger. (Dragon, Tr. 4367-69, 4390).

1744. Moreover, the linear accelerator at HPH pre-Merger was very antiquated and outdated. (Dragon, Tr. 4334). It was two generations beyond what would be considered modern at the time, and below what typical community hospitals in Chicago would have had at that time. (Dragon, Tr. 4336-37). Specifically, the linear accelerator was incapable of giving modern radiation therapy voltage, was incapable of giving intensity-modulated radiotherapy, and the energy was lower than was needed to give effective treatment for specific curative therapies.

(Dragon, Tr. 4338-39).

Response to Finding No. 1744:

The finding is irrelevant. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because HPH likely would have upgraded its physical facilities had the merger not occurred. (*See* CCRFF 1725).

1745. Additionally, the linear accelerator was housed in a shielded vault in the basement of the professional office building at HPH, a place constructed for that particular linear accelerator and too small for a new one. (Dragon, Tr. 4336-37; Newton, Tr. 469).

Response to Finding No. 1745:

The finding is irrelevant. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because HPH likely would have upgraded its physical facilities had the merger not occurred. (*See* CCRFF 1725).

1746. Because HPH did not own the linear accelerator (it was owned by a private practice) or have space for a new one, HPH could not upgrade the linear accelerator. (Dragon, Tr. 4336-37; Newton, Tr. 469).

Response to Finding No. 1746:

The cited source does not say what Respondent's finding claims. After the merger, HPH could have built new facilities to house a new linear accelerator. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because HPH likely would have upgraded its physical facilities had the merger not occurred. (*See* CCRFF 1725). In addition, the new linear accelerator was just made available with the opening of the ambulatory care center in February 2005.

(Dragon, Tr. 4368-69, 4390).

1747. Before the Merger, the radiation equipment used to treat cancer patients also was antiquated and not owned by the HPH, but by private practice physicians. (Dragon, Tr. 4334). Radiation equipment is used to treat local sites of tumors. (Dragon, Tr. 4335). The equipment can be used for curative purposes or to palliate symptoms, like pain. (Dragon, Tr. 4335). Radiation oncology and radiation therapy are an integral part of the modern day management of cancer. (Dragon, Tr. 4335-36).

Response to Finding No. 1747:

The finding is incomplete and misleading. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because HPH likely would have upgraded its physical facilities had the merger not occurred. (*See* CCRFF 1725).

1748. Some physicians used every opportunity to refer patients to other radiation therapy facilities. (Dragon, Tr. 4340).

Response to Finding No. 1748:

Complaint Counsel have no specific response.

(6) Pre-Merger Cancer Services At HPH Lacked Quality Assurance

1749. Before the Merger, there were no quality assurance programs in place with respect to oncology at HPH. (Dragon, Tr. 4341).

Response to Finding No. 1749:

The finding is incomplete. Dr. Dragon also testified that he is not familiar directly with quality assurance tools. (Dragon, Tr. 4340-41). This indicates that even after the merger, Dr. Dragon and ENH have no quality assurance programs in place with respect to oncology at HPH. In addition, various other evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See*

CCRFF 1724).

iii. ENH Made Major Improvements To The HPH Oncology Program That Significantly Expanded HPH's Cancer Services And Improved The Quality Of Cancer Care At HPH

1750. After the Merger, ENH made major improvements to the oncology program at HPH by exporting its multidisciplinary approach to HPH and introducing subspecialty oncologists to HPH. (Chassin, Tr. 5369-70).

Response to Finding No. 1750:

The finding is incorrect. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

(1) The Kellogg Cancer Center Brought A Multidisciplinary Approach To HPH

1751. The Kellogg Cancer Care Center is a Center of Excellence. (Spaeth, Tr. 2237-38). A Center of Excellence is a clinical program that seeks to care for the patient's specific disease through the support of various clinical, research and social services all targeted toward that specific disease. (Spaeth, Tr. 2237-38).

Response to Finding No. 1751:

The finding is incomplete and misleading. HPH considered making cancer care a Center of Excellence itself without the merger. (CX 91 at 2; CX 1869 at 4). In addition, various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1752. The Kellogg Cancer Center was started at Evanston Hospital more than 20 years ago. (Dragon, Tr. 4342).

Response to Finding No. 1752:

The finding is incomplete and misleading. Despite this history, the center was not

brought to HPH in any meaningful way for three years following the merger. (*See* CCRFF 1724, 1755).

1753. Today the Kellogg Cancer Center consists of three ambulatory or outpatient cancer centers: one at Evanston Hospital, one at Glenbrook Hospital, and one at HPH. (Dragon, Tr. 4342; Neaman, Tr. 1352).

Response to Finding No. 1753:

The finding is incomplete. Respondent fails to mention that the outpatient center was not brought to HPH until three years after the merger. (*See* CCRFF 1724).

1754. The Kellogg Cancer Center outpatient center at HPH is managed by physician leaders at HPH, but the management and administration of the HPH unit reports to a central management at Evanston Hospital. (Dragon, Tr. 4343).

Response to Finding No. 1754:

The finding is incomplete. Respondent fails to mention that the leader at HPH, of course, is Dr. Dragon, the same person who led oncology at HPH before the merger, and for three years after the merger under the same pre-merger model. (*See* CCRFF 1724, 1755).

1755. The Kellogg Cancer Center was first opened at HPH as a temporary facility in the Summer of 2000. (Dragon, Tr. 4342; (CX 6304 at 14 (Livingston, Dep.)). Between its opening in June 2000 and September 2002, the HPH branch of the Kellogg Cancer Center recorded more than 1,500 patient visits. (RX 1341 at ENHE TH 975).

Response to Finding No. 1755:

Respondent has put in no credible evidence regarding the activities of the Kellogg Cancer Center at HPH between its installation as a "temporary" facility in the Summer of 2000 and Dr. Dragon's appointment to head the program in December 2002. Dr. Dragon testified only that "I believe a functioning facility as a temporary unit was placed in the

hospital in the summer of 2000." (Dragon, Tr. 4342). Dr. Dragon went on to testify as to his experience as Director of that facility, which began in December 2002. (Dragon, Tr. 4306, 4343). Thus, the only testimony was Dr. Dragon's "belief" about activities in which he was not involved.

The source for the proposition that the Center saw 1,500 patients from June 2000 to September 2000 is not a business document but instead an "FTC Backgrounder" advocacy piece. The document appears to be intended to convince the reader that the merger was beneficial notwithstanding the FTC investigation. (RX 1341).

Dr. Dragon testified that when he took over in December 2002, "the charge was to develop the cancer program at Highland Park, integrate it with the services then organized and available at Evanston and Glenbrook to create another freestanding facility at Highland Park. . . ." (Dragon, Tr. 4306). It appears that little had been done at the "temporary" facility before his tenure.

1756. By extending the Kellogg Cancer Center to HPH after the Merger, HPH became a multidisciplinary academic oncology center that combines both medical oncology, radiation therapy and breast cancer centers. (Dragon, Tr. 4343-44; Neaman, Tr. 1352; Spaeth, Tr. 2276). Patients are cared for by a team consisting of the physician oncologist, nurse, pharmacist, psychologist, social worker, and nutritionist. (Chassin, Tr. 5369).

Response to Finding No. 1756:

The finding is misleading. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1757. Moreover, after HPH's oncology program was merged with ENH, all of the oncology patients at HPH were included in weekly multidisciplinary site-specific care conferences. (Dragon, Tr. 4322). These conferences include discussions about cases involving

breast cancer, thoracic cancers, hematologic malignancies, gynecological cancers, sarcomas and melanomas, and gastrointestinal cancer. (Dragon, Tr. 4322-23).

Response to Finding No. 1757:

The finding is misleading. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1758. During these conferences a number of physicians from different disciplines, including medical oncologists, surgeons, radiation oncologists, diagnostic radiologists, and pathologists discuss the treatment of each patient. (Dragon, Tr. 4324-25). This interaction is critical because it assures the most up-to-date and modern thoughts and treatment are applied to each case presented at the conference. (Dragon, Tr. 4323-25).

Response to Finding No. 1758:

The finding is misleading. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1759. Multidisciplinary site-specific oncology conferences are generally performed by academic hospitals. (Dragon, Tr. 4325). Community hospitals in the Chicago area do not have conferences like these to discuss their patients. (Dragon, Tr. 4325). Typically, a community hospital like HPH would only have a weekly tumor board, which is a general conference at which two or three patients might be presented from the whole institution. (Dragon, Tr. 4363).

Response to Finding No. 1759:

The finding is misleading. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). In addition, various evidence supports the view that the alleged academic affiliation brought to HPH has not improved quality of care. (*See* CCRFF 1736).

1760. ENH recently opened a brand new Ambulatory Care Center ("ACC") at HPH that houses Medical Oncology, the Cardiac Stress Center, the new Breast Imaging Center, and the

departments of Nuclear Medicine, Rehabilitation Medicine, and Radiation Therapy. (Dragon, Tr. 4367). The Kellogg Cancer Center occupies an entire floor of the ACC and is outfitted with private treatment rooms for patients who receive chemotherapy. (Hillebrand, Tr. 1981; O'Brien, Tr. 3503).

Response to Finding No. 1760:

The finding is incomplete and misleading. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because, during the five years it took ENH to build the ACC, HPH likely would have upgraded its physical facilities had the merger not occurred. (*See* CCRFF 1725).

1761. With the construction of a new ACC at HPH, HPH now has a comprehensive community-based ambulatory facility to provide multidisciplinary cancer care – including medical oncology, radiation oncology and ancillary services – under one roof. (Dragon, Tr. 4346).

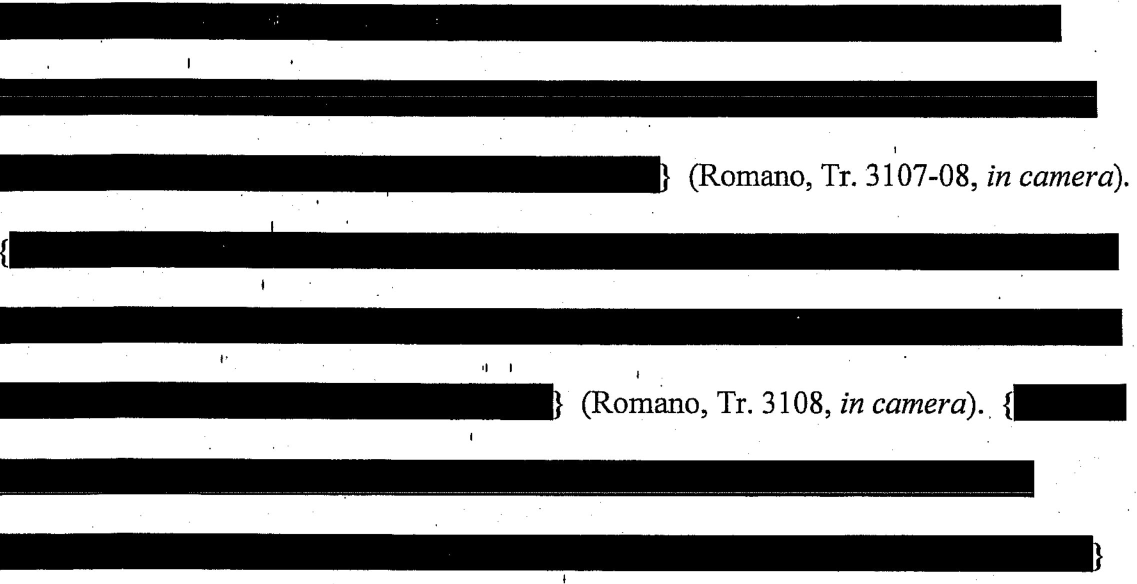
Response to Finding No. 1761:

The finding is incomplete and misleading. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because, during the five years it took ENH to build the ACC, HPH likely would have upgraded its physical facilities had the merger not occurred. (*See* CCRFF 1725).

1762. Community hospitals typically do not have centers similar to the Kellogg Cancer Center. (Neaman, Tr. 1352). In fact, no service similar to the Kellogg Cancer Center was available at HPH before the Merger. (Spaeth, Tr. 2276).

Response to Finding No. 1762:

The finding is incomplete and misleading. The situation that existed in 2000 has changed drastically during the three years (until December 2002) it took ENH to bring multidisciplinary cancer care to HPH and the five years (until February 2005) it took ENH to build the Ambulatory Care Center. {


} (Romano, Tr. 3107-08, *in camera*).
{
} (Romano, Tr. 3108, *in camera*). {
}

(Romano, Tr. 3107-08, *in camera*). Moreover, various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

(2) ENH Improved Ancillary And Support Services For Cancer Patients After The Merger

1763. Ancillary services for cancer patients are not merely changes for the sake of convenience. (Dragon, Tr. 4356). These services are very important to the day-to-day quality of life of cancer patients. (Dragon, Tr. 4356).

<u>Response to Finding No. 1763:</u>

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1764. Today, HPH offers a host of ancillary and support services to cancer patients directly on-site – including social services, psycho-social support, oncology pharmacy services and dietary services. (Dragon, Tr. 4352). These services are all provided by trained professionals who are members of the staff at the Kellogg Cancer Center. (Dragon, Tr. 4352).

<u>Response to Finding No. 1764:</u>

The finding is incomplete and misleading. These services were available pre-merger, just "it was just a little bit harder" to get them. (Dragon, Tr. 4319). {[REDACTED]}. (*See* CCRFF 1724).

1765. For example, licensed clinical social workers are available to cancer patients at HPH. (Dragon, Tr. 4354). They not only counsel patients and families, but also help with placement issues, arrange for home care and organize many of the complicated issues related to the management of chronic care illness at home. (Dragon, Tr. 4354).

Response to Finding No. 1765:

The finding is incomplete and misleading. Similar support services for oncology patients were available pre-merger, just "it was just a little bit harder" to get them. (Dragon, Tr. 4317-19). {[REDACTED]}. (*See* CCRFF 1724).

1766. Trained and licensed psychologists are also available on-site to cancer patients at HPH. (Dragon, Tr. 4354). The psychologists who care for patients at HPH and the Kellogg Cancer Center specialize in oncology-related psychology issues. (Dragon, Tr. 4354). Psychological care is very important to establish good quality of life for oncology patients. (Dragon, Tr. 4354-55).

Response to Finding No. 1766:

The finding is incomplete and misleading. Similar support services for oncology patients were available pre-merger, just "it was just a little bit harder" to get them. (Dragon, Tr. 4317-19). {[REDACTED]

}. (*See* CCRFF 1724).

1767. The Kellogg Cancer Center at HPH has registered pharmacists who are specifically trained in oncology pharmacy services. (Dragon, Tr. 4355). One or two pharmacists and often a technician are available at any time to help prepare medications. (Dragon, Tr. 4355). The specialized oncology pharmacists are able to help coordinate the management of pain medication and anti-nausea medication for cancer patients. (Dragon, Tr. 4355). Before the Merger, nurses mixed the drugs. (Dragon, Tr. 4355).

Response to Finding No. 1767:

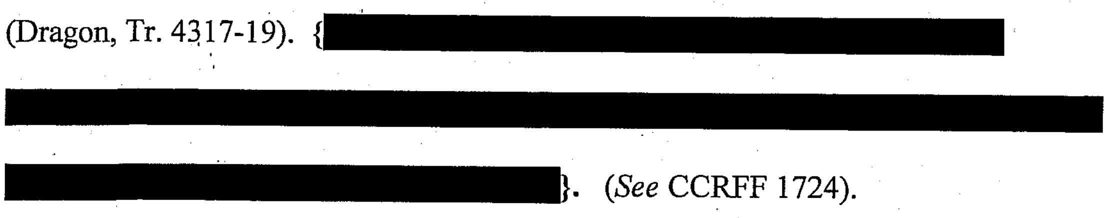
The finding is incomplete and misleading. Similar support services for oncology patients were available pre-merger, just "it was just a little bit harder" to get them. (Dragon, Tr. 4317-19). {

}. (*See* CCRFF 1724).

1768. Trained and licensed nutritionists and dieticians are also available to cancer patients at HPH directly through the Kellogg Cancer Center. (Dragon, Tr. 4353). Cancer patients suffer from changes in appetite, weight loss and bowel function and often require fairly complicated changes in dietary support to keep from losing weight. (Dragon, Tr. 4353). These services are important for the physical well-being of patients. (Dragon, Tr. 4353-54).

Response to Finding No. 1768:

The finding is incomplete and misleading. Similar support services for oncology patients were available pre-merger, just "it was just a little bit harder" to get them. (Dragon, Tr. 4317-19). {



}. (*See* CCRFF 1724).

1769. Finally, there is a collaborative nurse system at the Kellogg Cancer Center where all clinicians have a nurse that works with that physician's group of patients and is available to those patients for counseling, discussion of test scheduling and clinical problems. (Dragon, Tr. 4359-60).

Response to Finding No. 1769:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1770. These support services at HPH are part of the ongoing cancer management at HPH. (Dragon, Tr. 4353). Patients are often able to receive ancillary services at HPH while they are undergoing their chemotherapy treatments. (Dragon, Tr. 4353). Moreover, the providers of support services at HPH seamlessly share patient records with the oncologists providing patient care. (Dragon, Tr. 4358).

Response to Finding No. 1770:

The finding is incomplete and misleading. These ancillary services were available pre-merger, just "it was just a little bit harder" to get them. (Dragon, Tr. 4319).

{[REDACTED]}. (*See* CCRFF 1724).

1771. The coordinated provision of support services at HPH today is typically only seen in academic hospitals. (Dragon, Tr. 4359).

Response to Finding No. 1771:

The finding is misleading. {[REDACTED]} (Romano, Tr. 3107-08, *in camera*). {[REDACTED]

} (Romano, Tr. 3108, *in camera*).

(3) ENH Provided More Qualified Staff And An Academic Affiliation To HPH's Cancer Program After The Merger

1772. The Kellogg Cancer Center at HPH has 10 practicing oncologists, none of whom is a private practitioner. (Dragon, Tr. 4347). Every physician at the Kellogg Cancer Center at HPH is an employed member of the Division of Hematology/Oncology of ENH. (Dragon, Tr. 4347).

Response to Finding No. 1772:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1773. Additionally, all oncologists at HPH and the Kellogg Cancer Center are Board-certified and on the faculty of Northwestern University Medical School, and nurses and pharmacists also maintain oncology certification. (RX 1341 at ENHE TH 975; Dragon, Tr. 4361).

Response to Finding No. 1773:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). In addition, various evidence supports the view that academic affiliation does not improve quality of care. (*See* CCRFF 1736).

(4) ENH Improved Patient Access To Specialists At HPH After The Merger

1774. After the Merger, subspecialty oncologists were available to HPH patients. (Chassin, Tr. 5370). The Kellogg Cancer Center at HPH has a broad range of sub-specialist oncologists – including sub-specialists in breast oncology, thoracic oncology, hematologic malignancies, melanoma, head and neck cancer, and sarcoma. (Dragon, Tr. 4347-48).

Response to Finding No. 1774:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1775. The level of expertise by specialized practitioners who are focused in one academic area far exceeds the expertise general oncologists could expect to attain. (Dragon, Tr. 4350).

Response to Finding No. 1775:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). In addition, various evidence supports the view that academic affiliation does not improve quality of care. (*See* CCRFF 1736).

1776. Before the Merger, none of the physicians on staff at HPH had sub-specialties. (Dragon, Tr. 4348). Accordingly, patients had to leave the community to get access to the oncology specialists who are at HPH today, often traveling long distances for such consultations. (Dragon, Tr. 4350-51; Chassin, Tr. 5370). When a patient is dealing with a chronic debilitating illness, it is far superior from a quality of life standpoint to get health care treatment near home. (Dragon, Tr. 4350-51).

Response to Finding No. 1776:

The finding is incomplete and misleading. Before the merger, many HPH oncology patients who needed a specialist went to Evanston Hospital. (Dragon, Tr. 4348-49). In addition, various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

{[redacted]

[redacted]} (*See* CCRFF 1724).

1777. The availability of the sub-specialists provides HPH physicians with learning opportunities in the form of consultations and conferences. (Chassin, Tr. 5370).

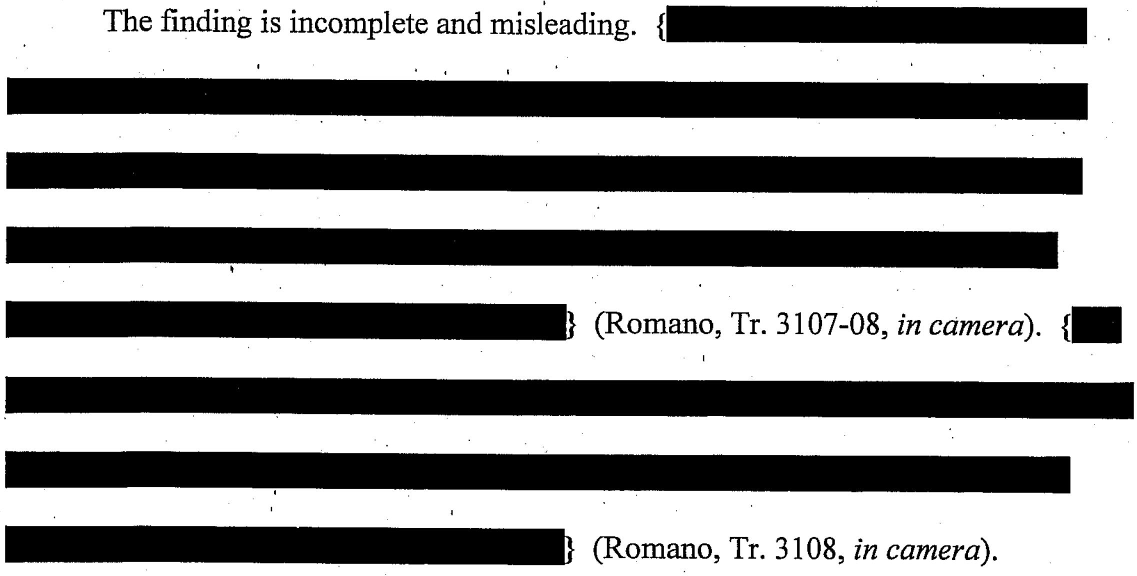
Response to Finding No. 1777:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724).

1778. The kind of sub-specialty care ENH brought to HPH after the Merger is typical of the care provided at academic medical centers. (Chassin, Tr. 5371).

Response to Finding No. 1778:

The finding is incomplete and misleading. {



} (Romano, Tr. 3107-08, *in camera*). {

} (Romano, Tr. 3108, *in camera*).

(5) ENH Provided Increased Academic Research And Clinical Trials To HPH's Cancer Program After The Merger

1779. Another improvement ENH brought to HPH that improved the quality of care in oncology at HPH was increased access to research trials. (Chassin, Tr. 5371). Research trials are important to patients and physicians because they give physicians the opportunity to be involved in new treatments and to keep abreast of new developments. (Chassin, Tr. 5371).

Response to Finding No. 1779:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). In any event, the same benefit could have been brought to HPH without a merger, just as was done at several other community hospitals during the same time period, and as HPH had already considered doing prior the merger. (*See* CCRFF 1724).

1780. After the Merger, cancer patients at the HPH branch of the Kellogg Cancer Center had access to at least 78 clinical trials administered directly through the Kellogg Cancer Center. (RX 1723).

Response to Finding No. 1780:

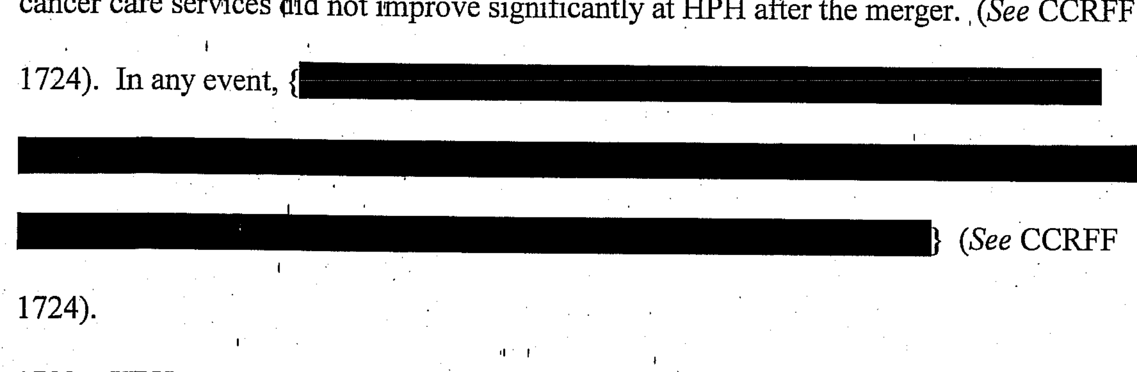
The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). In any event, {[redacted]} (*See* CCRFF 1724).

1781. Moreover, the National Cancer Institute has recognized the Kellogg Cancer Center, and HPH as a unit of the Kellogg Cancer Center, as a Community Clinical Oncology Program ("CCOP"). (Dragon, Tr. 4344). The National Cancer Institute is a federally funded research organization based in Bethesda, Maryland that is responsible for research funded at institutions nationally. (Dragon, Tr. 4344). The Kellogg Cancer Center is one of 50 Community Clinical Oncology Programs that are funded nationally by the National Cancer Institute. (Dragon, Tr. 4344). The designation of HPH as a CCOP means that the Kellogg Cancer Center is funded to be active in areas of clinical research and prevention of cancer. (Dragon, Tr. 4345). The level of research that is required to have funding for this program is extraordinary for a community hospital, and it gives patients at HPH access to a broad range of treatment and prevention trials. (Dragon, Tr. 4344-45; RX 1341 at ENE TH 975).

Response to Finding No. 1781:

The finding is irrelevant. Various evidence supports the view that the quality of

cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). In any event, {



} (*See* CCRFF 1724).

1782. HPH was not a CCOP before the Merger. (Dragon, Tr. 4345). Generally, community hospitals would not be designated CCOPs because the resources needed to obtain the funding and the breadth of care are beyond the scope of a relatively small community hospital. (Dragon, Tr. 4345-46).

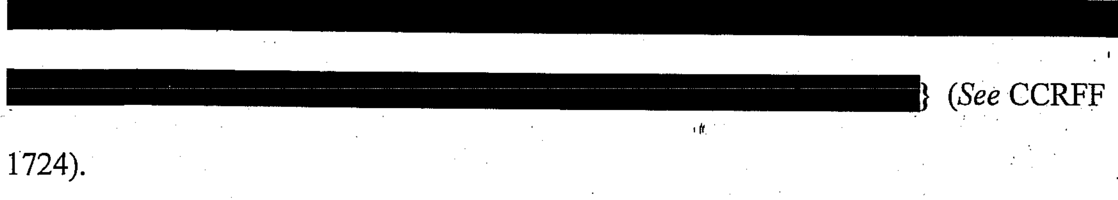
Response to Finding No. 1782:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). In any event, { } (*See* CCRFF 1724).

1783. HPH and ENH now have a single IRB, which is composed of a diverse group of people – including physicians, attorneys, and community representatives. (Dragon, Tr. 4364). Clinical trials at HPH, Evanston Hospital, or Glenbrook Hospital must be presented and formally sanctioned by the IRB. (Dragon, Tr. 4364). The IRB makes decisions on clinical trials based on what the Board feels to be ethically and scientifically acceptable. (Dragon, Tr. 4364-65).

Response to Finding No. 1783:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). In any event, {

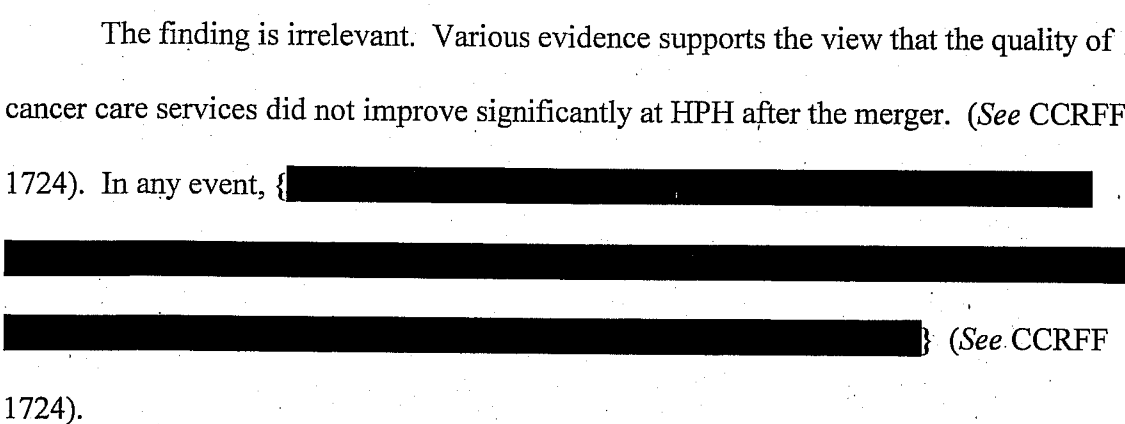


} (*See* CCRFF 1724).

1784. Moreover, academic institutions typically do not allow patients to be on clinical trials outside the purview of its IRB because patient interests require that the hospital be involved in assessing the ethical and scientific bases for research on patients under the hospital's care. (Dragon, Tr. 4365-66).

Response to Finding No. 1784:

The finding is irrelevant. Various evidence supports the view that the quality of cancer care services did not improve significantly at HPH after the merger. (*See* CCRFF 1724). In any event, {



} (*See* CCRFF 1724).

(6) ENH Provided State-Of-The-Art Equipment And Advanced Services To HPH's Cancer Program After The Merger

1785. Diagnostic equipment is very important in the treatment of cancer patients. (Dragon, Tr. 4367). Diagnostic equipment is used to assess the activity of disease and a patient's response to treatment. (Dragon, Tr. 4367). It is essential to correctly diagnose a patient's cancer in order to treat it. (Dragon, Tr. 4366-67).

Response to Finding No. 1785:

The finding is irrelevant. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because HPH likely would have upgraded its diagnostic facilities had the merger not occurred. (*See* CCRFF 1724, 1725).

1786. The ACC at HPH houses a new linear accelerator. (Dragon, Tr. 4369). The linear accelerator gives state-of-the-art treatment, including intensity modulated radiotherapy, which is a type of localizing therapy to treat smaller areas of disease without injuring healthy tissue around them. (Dragon, Tr. 4369-70).

Response to Finding No. 1786:

The finding is misleading. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because HPH, during the five years it took ENH to place the new linear accelerator in the Ambulatory Care Center, likely would have upgraded its cancer treatment equipment had the merger not occurred. (*See* CCRFF 1724, 1725).

1787. After the Merger, ENH purchased a CT/PET scan for HPH that is used to treat oncology patients. (Dragon, Tr. 4370). A CT/PET scan is the latest generation of positive emission tomography scanning device. (Dragon, Tr. 4370-71). Before the Merger, HPH and Evanston Hospital did not have a CT/PET scan machine. (Dragon, Tr. 4371). CT/PET scan machines are rarely found in community hospitals. (Dragon, Tr. 4372).

Response to Finding No. 1787:

The finding is incomplete and misleading. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because HPH likely would have upgraded its equipment had the merger not occurred. (*See* CCRFF 1724, 1725). In addition, HPH did not have a CT/PET machine before the merger because such a combined machine did not exist before the merger. (Newton, Tr. 469-70).

1788. Today, complex procedures and treatments, such as interventional radiology, thermal ablation and endoscopic ultrasound, are available to cancer patients at HPH. (Dragon, Tr. 4377). Services such as these would not be available in a typical community hospital and would almost always be done in an academic hospital. (Dragon, Tr. 4376-78).

Response to Finding No. 1788:

The finding is irrelevant and misleading. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because HPH likely would have upgraded its program had the merger not occurred. (*See* CCRFF 1724, 1725). In addition, various evidence supports the view that academic affiliation does not improve quality of care. (*See* CCRFF 1736).

1789. The changes in radiology and the new equipment purchased by ENH for HPH constitute improvements in quality of care. (Chassin, Tr. 5372).

Response to Finding No. 1789:

The finding is incorrect. Various evidence supports the view that upgrades to cancer care facilities at HPH after the merger were not merger specific because HPH likely would have upgraded its program had the merger not occurred. (*See* CCRFF 1724, 1725).

e. The Merger Substantially Expanded And Improved Laboratory Services At HPH

i. Overview

1790. It is estimated that 70% of medical decisions are based on the results that come from the laboratory. (Victor, Tr. 3636). Pathology is the study and diagnosis of disease using clinical laboratory techniques. (Victor, Tr. 3583).

Response to Finding No. 1790:

Complaint Counsel have no specific response.

1791. Laboratory services at HPH before the Merger and after the Merger until June 1, 2001, were provided by two laboratories: (1) an immediate response or "stat" laboratory within HPH ("HPH Lab"); and (2) Consolidated Medical Labs ("CML"), which provided comprehensive laboratory services, located ten miles away. (O'Brien, Tr. 3507-08).

Response to Finding No. 1791:

Complaint Counsel do not disagree.

1792. An immediate response laboratory provides urgent results. (Victor, Tr. 3598). The tests performed in an immediate response laboratory are generally far less complex than the tests performed in a full service laboratory. (Victor, Tr. 3598).

Response to Finding No. 1792:

This finding is incomplete. For situations that are not urgent, a lab specimen can safely be sent off-site for testing. (Victor, Tr. 3640). Only 21% of the lab specimens taken at ENH are done immediately at the request of a physician. (CX 1561). Thus, physicians need immediate results for only a small fraction of lab tests.

1793. CML was a joint venture between Lake Forest Hospital and HPH. (Victor, Tr. 3599; O'Brien, Tr. 3507). Before the Merger, HPH outsourced laboratory testing to CML. (Victor, Tr. 3599).

Response to Finding No. 1793:

Respondent's finding is incomplete. After the merger, HPH still sends over 15% of its lab work off-site for testing. (RX 888 at ENHE TV 1262; CX 1561).

1794. ENH took over the HPH Lab on June 1, 2000. (Victor, Tr. 3600). It did not take over the HPH Lab immediately after the Merger because the joint venture between Lake Forest Hospital and HPH had to be unraveled first. (Victor, Tr. 3600).

Response to Finding No. 1794:

Complaint Counsel have no specific response.

1795. When ENH took over the HPH Lab on June 1, 2000, there were numerous problems at the HPH Lab. (Victor, Tr. 3602). ENH fixed these problems and converted the HPH Lab from an immediate response laboratory to a full service laboratory. (Victor, Tr. 3600-01, 3615-20). Additionally, ENH brought all of the microbiology, immunologic, and molecular diagnostic testing to Evanston Hospital, where there are specialists in each field, and brought specialist oversight and an academic focus to the HPH Lab. (Victor, Tr. 3621-26, 3628-29, 3634-35).

Response to Finding No. 1795:

Respondent's finding is irrelevant. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1796. The changes made by ENH post-Merger improved quality in the HPH Lab. (Chassin, Tr. 5349). The costs of these quality improvements exceeded a $1,000,000. (Victor, Tr. 3617).

Response to Finding No. 1796:

Respondent's finding is incorrect. ENH has presented no hard evidence that the changes made by ENH to the HPH lab after the merger affected the key outcome measures of turnaround times and mislabeled specimens. The changes were rather structural changes that reflect a different operating philosophy between two hospital organizations.

Although asserting that turnaround times have improved after the merger, Respondent presented no evidence showing to what extent this might have impacted patient care. For example, Dr. Victor, who is the Chairman of ENH's Department of Pathology, had no statistics to back up any claim that turnaround time at the lab at Highland Park Hospital was longer before June 1, 2000, than it was after that date. (Victor, Tr. 3643). He also had no statistics to show to what extent there were mislabeled specimens at the Highland Park Hospital lab prior to June 1, 2000. (Victor, Tr. 3643-44). In fact, Dr. Victor's overall view of quality improvement at Highland Park Hospital's lab after June 1, 2000, was not based upon any statistics or studies at all. (Victor, Tr. 3644).

Prior to the time that ENH took over the management of the lab at Highland Park Hospital, Dr. Victor had not even been to Highland Park Hospital's lab to assess its quality. (Victor, Tr. 3642).

In addition, the changes that ENH made to the HPH lab after the merger are of a type that constitute structural changes. (Chassin, Tr. 5288-89, Romano, Tr. 2986-87). Structural measures are enabling factors that provide the conditions under which care is delivered. (Romano, Tr. 2988). Structural measures are insufficient by themselves to measure quality because they tell us very little about the care that is actually provided to patients. (Romano, Tr. 2988).

The facts surrounding the changes at the HPH lab after the merger mostly reflect a difference in operating philosophy between two hospital organizations. For example, prior to the merger, HPH and Lake Forest Hospital operated Consolidated Medical Labs ("CML") as a joint venture that consisted of a main lab with two satellite labs, one at HPH and one at Lake Forest. (Victor, Tr. 3640). The satellite labs at HPH and Lake Forest were immediate response labs doing only "stat" testing, which is testing that must be performed immediately. (Victor, Tr. 3639-40). Thus, before the merger there were actually two separate and independent hospitals, HPH and Lake Forest, each of which had an interest in the performance of CML. (Victor, Tr. 3640). That CML was important to two hospitals indicates that the quality of CML work not only would have been strictly monitored, but would have been maintained at a high level.

After the merger, ENH preferred to expand and operate the lab at HPH as more of a full service lab with greater testing responsibilities at that particular location. (Victor,

Tr. 3640-41). Because a lab specimen can safely be sent off-site for testing in the 79% of situations that are not urgent (Victor, Tr. 3640), it was not necessary that the lab at HPH be expanded. (CX 1561 at 1). The post-merger lab at HPH today simply serves a different role than it did prior to the merger. (Victor, Tr. 3641). It would also not be unusual that such an expansion would involve capital spending and training of personnel.

Finally, various evidence also supports the view that changes in the lab at HPH were not merger specific because HPH was fully capable of investing $1,000,000 in its laboratory without the merger. (*See* CCRFF 1811).

1797. Dr. Thomas A. Victor, the Chairman of the Department of Pathology at ENH since 1995 and a board certified pathologist, testified about the quality issues he observed when ENH took over the HPH Lab on June 1, 2000, the steps ENH took to remedy the problems, and other changes made by ENH to expand and improve laboratory services at ENH. (Victor, Tr. 3582-83, 3587). Dr. Victor was in charge of converting the HPH Lab to a full service laboratory. (Victor, Tr. at 3600-01).

Response to Finding No. 1797:

Respondent's finding is irrelevant. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Although in charge of converting the HPH Lab to a full-service laboratory, Dr. Victor had not been to Highland Park Hospital's lab prior to the time that ENH took over management of the lab to assess its quality. (Victor, Tr. 3642).

ii. ENH Decided To Close CML Because It Was Inefficient

1798. At the time of the Merger, under the direction of Dr. Victor and the pathologists, ENH had a team of 20 people review the services provided at the HPH Lab. (O'Brien, Tr. 3507). The review team also took into account the views of physicians who utilized the laboratories. (O'Brien, Tr. 3507-09).

Response to Finding No. 1798:

Complaint Counsel have no specific response.

1799. The assessment concluded that the equipment in the stat laboratory was old, that the operating costs of CML were much higher than the operating costs of the laboratory unit at Evanston and Glenbrook Hospitals and that turnaround times were cause for concern. (O'Brien, Tr. 3508).

Response to Finding No. 1799:

Respondent's finding is misleading and irrelevant. Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1800. As a result of the assessment, ENH dissolved the CML arrangement before June 1, 2001. (O'Brien, Tr. 3509). The laboratory services CML previously provided were divided between Evanston Hospital and HPH. (O'Brien, Tr. 3509; RX 888 at ENHE TV 1262).

Response to Finding No. 1800:

Complaint Counsel have no specific response.

iii. ENH Found Several Quality Issues When It Took Over The HPH Lab On June 1, 2000

1801. When ENH took over the HPH Lab on June 1, 2000, there were problems with the equipment, the personnel, the environmental controls, and the water, as well as with the policies and procedures at the HPH Lab. (Victor, Tr. 3602; Chassin, Tr. 5350).

Response to Finding No. 1801:

Respondent's finding is misleading and irrelevant. Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(1) ENH Found That The HPH Lab Had Equipment Issues

1802. There were five problems areas with respect to the automated instrumentation at the HPH Lab when ENH took over on June 1, 2000: (1) Hitachi analyzer, (2) Cell Dyne

hematology analyzer, (3) blood gas machines, (4) coag machine, and (5) cardiac markers. (Victor, Tr. 3602-03).

Response to Finding No. 1802:

Respondent's finding is misleading and irrelevant. Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1803. In general, automated instruments are preferred to manual testing because automated instruments provide a more rapid turnaround time and use established and standardized methodologies. (Victor, Tr. 3593).

Response to Finding No. 1803:

Complaint Counsel have no specific response.

1804. The Hitachi analyzer, used to perform chemistry tests in the HPH Lab, was not consistent in its performance. (Victor, Tr. 3603). It is important to have a properly functioning Hitachi analyzer because many of the tests required by the clinical staff to manage their patients are chemistry tests, many of which are also stat tests. (Victor, Tr. 3603). Nevertheless, the HPH Lab's Hitachi analyzer broke down frequently and had problems with certain test results, including potassium and billirubin. (Victor, Tr. 3603).

Response to Finding No. 1804:

Respondent's finding is misleading and irrelevant. Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1805. HPH Lab personnel were not capable of fixing the problems with the Hitachi analyzer. (Victor, Tr. 3604). Accordingly, if the Hitachi analyzer in the HPH Lab broke down, the HPH Lab personnel would have to wait until somebody came from CML to repair the instrument. (Victor, Tr. 3604). If the delay in repairing the instrument were long enough, the HPH Lab would have to send the tests to CML to be performed. (Victor, Tr. 3604).

Response to Finding No. 1805:

Respondent's finding is irrelevant. Various evidence also supports the view that

the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1806. The HPH Lab had only one good hematology analyzer that was not capable of performing a five-part differential, a test used to look at the different percentage of cells and the types of cells that are circulating in the blood. (Victor, Tr. 3605). Additionally, the HPH Lab did not have a backup hematology analyzer. (Victor, Tr. 3605).

Response to Finding No. 1806:

Respondent's finding is irrelevant. Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1807. The HPH Lab's blood gas machines could not be properly calibrated, were not functioning properly and were not giving proper results. (Victor, Tr. 3606-07).

Response to Finding No. 1807:

Respondent's finding is irrelevant. Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1808. The HPH Lab had only one coag analyzer, which is used to measure the clotting capability of an individual's blood. (Victor, Tr. 3607). The coag analyzer was incapable of doing multiple specimens at the same time, thus causing problems with respect to turnaround time of the needed results. (Victor, Tr. 3607).

Response to Finding No. 1808:

Respondent's finding is irrelevant. Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1809. The HPH Lab used an Axsym device for cardiac markers that required a lot of time for preparation of the sample. (Victor, Tr. 3608). This was problematic because the

pathology laboratories at ENH are often asked to perform tests for cardiac markers by the emergency department, and it is very important to get the result back as quickly as possible. (Victor, Tr. 3608).

Response to Finding No. 1809:

Respondent's finding is irrelevant. Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1810. Nor did the HPH Lab have the full panel of cardiac markers they should have had. (Victor, Tr. 3608).

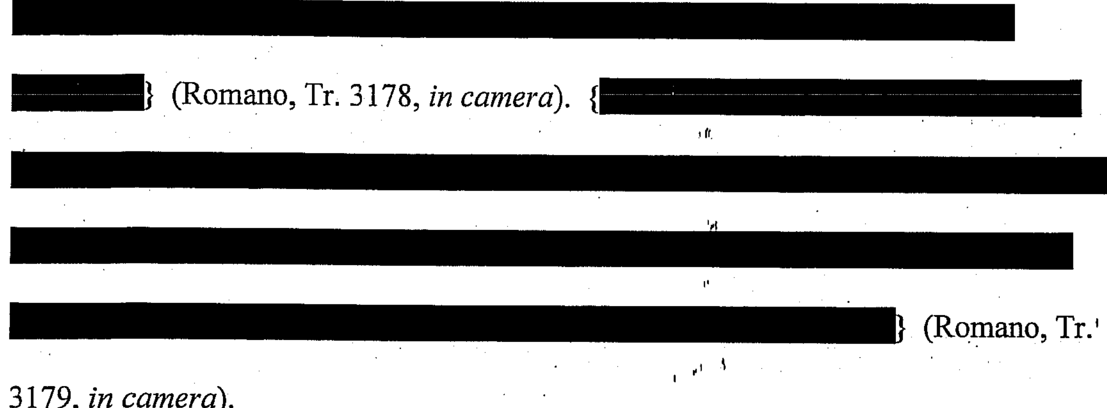
Response to Finding No. 1810:

Respondent's finding is irrelevant. Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1811. Finally, the equipment in the HPH Lab was not state-of-the-art. (Victor, Tr. 3614). To the contrary, the equipment in the HPH stat laboratory was purchased, on average, five to ten years earlier than the equipment in the laboratories of Evanston and Glenbrook Hospitals. (O'Brien, Tr. 3508).

Response to Finding No. 1811:

Various evidence supports the view that any necessary updates in the lab equipment at HPH were not merger specific because HPH likely would have made them in the absence of the merger. Specifically, HPH's 1999-2003 Financial Plan called for spending $1.55 million on CML central lab equipment. (CX 545 at 19). The changes made by ENH, which HPH was financially capable of making on its own, were consistent with the ordinary practices of all hospital laboratories, which HPH would have been expected to follow. {



} (Romano, Tr. 3178, *in camera*). {

} (Romano, Tr. 3179, *in camera*).

In addition to investments specifically budgeted for laboratory equipment, HPH routinely made capital investments to upgrade and improve its facilities prior to the merger. (Newton, Tr. 383-84). In addition, HPH was financially strong prior to the merger. (*See* CCFF 303-355). Highland Park's 1999-2003 Financial Plan set forth a "long range capital budget" that included $43 million for "strategic initiatives and master plan items," including "ambulatory, assisted living and facility expansion." The plan also set aside a separate $65 million for "[h]ospital construction, routine capital and information technology" investments, and a small amount for Lakeland Health Ventures. (Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2). The total planned investments for the time period therefore amounted to at least $108 million.

(2) ENH Found That The HPH Lab Had Personnel Issues

1812. The HPH Lab had few certified medical technologists. (Victor, Tr. 3608).

<u>Response to Finding No. 1812:</u>

Respondent's finding is misleading. The lab at HPH before the merger could not be expected to have had many certified medical technologists because it only was a stat

lab at that time. (*See* CCRFF 1796).

1813. Additionally, the HPH Lab used several personnel who were part-time, many of whom had only just been trained on the job, and many of whom had fewer than three or four months of training. (Victor, Tr. 3608).

Response to Finding No. 1813:

Respondent's finding is irrelevant. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1814. Part-time staff are a problem because there is no continuity with regard to their performing tests in the laboratory, and they usually are not well-trained and cannot handle problems as they arise while performing tests. (Victor, Tr. 3609). Moreover, some of the individuals in the HPH Lab had criminal records. (Victor, Tr. 3609).

Response to Finding No. 1814:

The sole source for this finding is Dr. Victor. Respondent fails to provide any evidence to support this finding's claims. In any event, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1815. In addition, pathologists at the HPH Lab were generalists. (Chassin, Tr. 5352). Nor did CML have specialists in each different field of pathology overseeing the testing that was performed there. (Victor, Tr. 3628-29). Rather, CML had eight pathologists whose major function was anatomic pathology – diagnosing surgical specimens – that also covered clinical pathology. (Victor, Tr. 3629).

Response to Finding No. 1815:

Respondent's finding is irrelevant. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(3) ENH Found That The HPH Lab Had Environmental Controls Issues

1816. The temperature in a laboratory must be kept at a constant level for the machines in the laboratory to function properly. (Victor, Tr. 3609).

Response to Finding No. 1816:

Complaint Counsel have no specific response.

1817. Before the Merger, it was not possible to control the temperature in the laboratory so that it could remain at a constant value. (Victor, Tr. 3609).

Response to Finding No. 1817:

The finding is unclear as to where it was not possible to control the temperature in the laboratory. In any event, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(4) ENH Found That The HPH Lab Had Water Issues

1818. The water in the HPH Lab was contaminated and had material floating in it. (Victor, Tr. 3609).

Response to Finding No. 1818:

Respondent's sole support for this finding is Dr. Victor. Respondent provides no evidence to support the finding's claim. The finding also fails to provide a time period, whether it was before or after the merger. If this claim applies to after the merger, Respondent's witness then testified against any quality improvements to HPH by ENH. In any event, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(5) ENH Found That The HPH Lab Did Not Have A Histology Laboratory

1819. A histology laboratory is a laboratory in which tissues are received and prepared for microscopic study. (Victor, Tr. 3610; O'Brien, Tr. 3507).

Response to Finding No. 1819:

Complaint Counsel have no specific response.

1820. It is important to have a histology laboratory on site because: (1) it allows the pathologist to work back and forth with the technician to make sure that he or she gets an optimal section to make a diagnosis; (2) the histologist can more conveniently change the way he or she is producing a section when necessary; and (3) staining quality can be controlled. (Victor, Tr. 3610-11).

Response to Finding No. 1820:

Respondent's finding is irrelevant and misleading. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the

merger. (*See* CCRFF 1811).

1821. The HPH Lab did not have a histology laboratory on site before the Merger. (RX 850).

Response to Finding No. 1821:

Respondent's finding is irrelevant and misleading. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(6) ENH Found That The HPH Lab Did Not Have A Cytology Laboratory

1822. A cytology laboratory is a laboratory in which cell specimens are prepared, usually from fluids and sometimes from needle aspirates, to be read by the pathologist to make a diagnosis. (Victor, Tr. 3611).

Response to Finding No. 1822:

Complaint Counsel have no specific response.

1823. It is important to have a cytology laboratory on site because it is important for the pathologist and cytologist to be present together at the same time so that the pathologist can look at the cytology specimen and evaluate the quality of the preparation. (Victor, Tr. 3611).

Response to Finding No. 1823:

Respondent's finding is irrelevant and misleading. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1824. The HPH Lab did not have a cytology laboratory on site. (RX 850).

Response to Finding No. 1824:

Respondent's finding is irrelevant and misleading. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(7) ENH Found That The HPH Lab Did Not Have Adequate Laboratory Manuals

1825. The HPH Lab did not have laboratory manuals for all of the tests it was running. (Victor, Tr. 3611-12). It is important to have laboratory manuals: (1) because they are required for approval by regulatory agencies; and (2) in the event a technologist needs to look at the way a procedure has to be done. (Victor, Tr. 3612).

Response to Finding No. 1825:

The sole support for this finding is Dr. Victor. Respondent provides no evidence to support the claims made in this finding. In any event, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1826. The HPH Lab did not have safety manuals or quality control manuals. (Victor, Tr. 3612). The lack of quality control manuals was an issue because, without them, it is not possible for the technician to ensure that the instrumentation is functioning properly. (Victor, Tr. 3613).

Response to Finding No. 1826:

The sole support for this finding is Dr. Victor. Respondent provides no evidence to support the claims made in this finding. In any event, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

iv. ENH Made Numerous Quality Improvements To The HPH Lab

1827. Following the Merger, ENH made improvements in the laboratory at HPH, including expanding and upgrading the defective equipment, hiring and training qualified personnel, building a new histology and cytology laboratory at HPH, and changing procedures with respect to proficiency and quality testing in machinery. (Chassin, Tr. 5350-51). These improvements all improved the quality of care rendered at HPH. (Chassin, Tr. 5351).

Response to Finding No. 1827:

The cited source does not say what the last sentence of Respondent's finding claims. The cited testimony refers to changes made in the HPH lab after the merger, but the testimony does not say that the changes improved the quality of care rendered at HPH. In addition, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(1) ENH Improved The HPH Lab's Equipment

1828. Over the course of the Summer of 2000, ENH replaced the outdated equipment in the HPH Lab with new equipment that was state of the art. (Victor, Tr. 3616-17).

Response to Finding No. 1828:

Respondent's finding is incomplete and misleading. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1829. Specifically, ENH: (1) replaced the existing blood gas machines with state-of-the-art blood gas machines (Radiometers); (2) replaced the Hitachi analyzer with a Beckmann LX 20, which is a state-of-the-art chemical analyzer; (3) purchased a Beckmann CX-9 as a backup analyzer; (4) replaced the coagulation machines with two machines that could do more than one test at a time and handle emergencies; (5) replaced the Axsym cardiac marker equipment with a Stratus, which did comprehensive cardiac markers; and (6) upgraded the hematology instrumentation so that it would be able to do a full automated differential and added a backup for the hematology analyzer. (Victor, Tr. 3615-16).

Response to Finding No. 1829:

Respondent's finding is irrelevant, incomplete and misleading. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1830. The new laboratory equipment installed by ENH at the HPH Lab in the Summer of 2000 cost over $1 million. (Victor, Tr. 3717).

Response to Finding No. 1830:

Respondent's finding is irrelevant and misleading. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the

merger. (*See* CCRFF 1811).

(2) ENH Improved The HPH Lab's Personnel

1831. ENH brought the laboratory manager from Glenbrook Hospital to HPH. (Victor, Tr. 3617). It also replaced all of the personnel who were not registered medical technologists with registered medical technologists. (Victor, Tr. 3617-18). All of the personnel currently in the HPH Lab are registered medical technologists. (Victor, Tr. 3617-18).

Response to Finding No. 1831:

Respondent's finding is incomplete and misleading. After the merger, ENH selected Dr. Barbara Golden, *who previously worked as a pathologist at CML* (the principal laboratory used by HPH before the merger), as vice chair of ENH's Department of Pathology and as the medical director of the laboratory at HPH. (RX 850). In addition, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796).

1832. To provide appropriate coverage of clinical pathology at the HPH Lab, Dr. Robert Rosecrans, a clinical laboratory scientist who specializes in clinical chemistry, was placed full time at the HPH Lab in the Fall of 2000. (Victor, Tr. 3618; RX 943)

Response to Finding No. 1832:

Complaint Counsel have no specific response.

(3) ENH Improved The HPH Lab's Environmental Systems

1833. ENH modified the temperature control in the HPH Lab so that it would achieve the appropriate temperatures for the instrumentation. (Victor, Tr. 3618-19).

Response to Finding No. 1833:

Respondent's finding is irrelevant. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various

evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(4) ENH Improved The HPH Lab's Water System

1834. ENH changed the HPH Lab water system by putting in new piping and a new filtration system. (Victor, Tr. 3619).

Response to Finding No. 1834:

Respondent's finding is irrelevant. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(5) ENH Constructed A Histology Laboratory At The HPH Lab

1835. ENH built a new histology laboratory at HPH over the Summer, Fall and Winter of 2000. (Victor, Tr. 3619). The cost of the new histology laboratory was about $600,000. (O'Brien, Tr. 3510).

Response to Finding No. 1835:

Respondent's finding is irrelevant. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(6) ENH Constructed A Cytology Laboratory At

The HPH Lab

1836. ENH built a new cytology laboratory at HPH over the Summer, Fall and Winter of 2000. (Victor, Tr. 3619).

Response to Finding No. 1836:

Respondent's finding is irrelevant. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(7) ENH Improved The HPH Lab's Laboratory Manuals

1837. ENH immediately created procedure manuals for the tests performed in the HPH Lab. (Victor, Tr. 3619-20). ENH also developed quality control and safety manuals. (Victor, Tr. 3619-20).

Response to Finding No. 1837:

Respondent's finding is irrelevant. Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(8) ENH Improved The HPH Lab's Quality Control

1838. ENH monitored quality control data on every HPH Lab shift and over periods of time to make sure that the tests were yielding accurate results. (Victor, Tr. 3620).ENH also implemented proficiency testing at the HPH Lab. (Victor, Tr. 3620).

Response to Finding No. 1838:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1839. ENH obtains samples from and gives its test results on those samples to the College of American Pathologists to ensure that ENH benchmarks with every other laboratory in the country that participates in that College of American Pathologists' program. (Victor, Tr. 3620). ENH participates in this survey program so that every two years the Pathology Department at HPH is reviewed to make sure that it is meeting all of the laboratory standards. (Victor, Tr. 3621).

Response to Finding No. 1839:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1840. ENH implemented competency training at the HPH Lab, periodically testing the technologists to make sure that they are competent and know how to perform the testing for which they are responsible. (Victor, Tr. 3620).

Response to Finding No. 1840:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1841. ENH measured turnaround times at the HPH Lab to make sure it was meeting standards. (Victor, Tr. 3620-21).

Response to Finding No. 1841:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(9) ENH Improved Microbiology Testing

1842. Microbiology tests are used to identify organisms causing an infection. (Victor, Tr. 3622).

Response to Finding No. 1842:

Complaint Counsel have no specific response.

1843. ENH transferred all of the microbiology testing at HPH to Evanston Hospital. (Victor, Tr. 3621).

Response to Finding No. 1843:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1844. Evanston Hospital has three specialists in microbiology. (Victor, Tr. 3622). Before the Merger, CML did not have any specialists in microbiology. (Victor, Tr. 3622).

Response to Finding No. 1844:

The cited source does not say what the last sentence of Respondent's finding claims. The source indicates that Dr. Victor did not know whether CML had any specialists in microbiology. In addition, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various

evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1845. Additionally, ENH has instituted at least two programs at HPH to control nosocomial infections – *i.e.*, infections that are acquired in the hospital. (Victor, Tr. 3623).

Response to Finding No. 1845:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(10) ENH Improved Immunology Testing

1846. ENH brought all of the immunology testing at the HPH Lab to Evanston Hospital. (Victor, Tr. 3624). Evanston Hospital has a nationally recognized specialist in immunology. (Victor, Tr. 3625).

Response to Finding No. 1846:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(11) ENH Improved Molecular Diagnostic Testing

1847. Molecular diagnostic testing is used to identify genetic diseases or proclivity to diseases that are caused by specific gene expressions. (Victor, Tr. 3625-26).

Response to Finding No. 1847:

Complaint Counsel have no specific response.

1848. ENH brought all of the molecular diagnostic testing at the HPH Lab to Evanston Hospital. (Victor, Tr. 3625).

Response to Finding No. 1848:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1849. Evanston Hospital has specialists in molecular diagnostics. (Victor, Tr. 3626). Before the Merger, CML was not able to perform molecular diagnostic testing. (Victor, Tr. 3626).

Response to Finding No. 1849:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(12) ENH Improved The HPH Lab's Computer System

1850. On June 1, 2000, ENH installed a new computer system at the HPH Lab. (Victor, Tr. 3627-28; RX 850; RX 888 at ENHE TV 1262). As a result of the Merger, and the integration of HPH's site into ENH's multi-site laboratory system, it was necessary to install a new laboratory information system that was capable of handling a multi-site laboratory. (RX 888 at ENHE TV 1262). The implementation was accomplished in a mere two and a half months, something which ordinarily would have required between nine and twelve months to complete. (RX 888 at ENHE TV 1262).

Response to Finding No. 1850:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the

view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1851. The new system dramatically improved results reporting and laboratory information availability and was further improved by the later addition of and integration with Epic. (Chassin, Tr. 5352; Victor, Tr. 3627; RX 888 at ENHE TV 1262). This new laboratory information system improved the quality of care at HPH. (Chassin, Tr. 5352).

Response to Finding No. 1851:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(13) ENH Established Oversight Of The HPH Lab By ENH Specialists

1852. After ENH took over the HPH Lab on June 1, 2000, the clinical laboratory directors at ENH immediately became responsible for the laboratory at HPH. (Victor, Tr. 3628). The clinical laboratory directors at ENH are all specialists in one subspecialty of clinical pathology and are each board certified in their respective specialties. (Victor, Tr. 3628).

Response to Finding No. 1852:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1853. Access to subspecialty pathologists improved the quality of care at HPH. (Chassin, Tr. 5352). Specialists are up to date on all of the technology and thinking that involves their area of specialization and are better equipped to choose the appropriate testing systems for their specialties. Further, specialists are well equipped to offer consultation to any of the clinical staff who need to understand the results they are producing in the laboratory and to obtain consultative information with regard to the care of their patients. (Victor, Tr. 3629).

Response to Finding No. 1853:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(14) ENH Established The Rotation Of Pathologists Among The ENH Hospitals

1854. The ENH Pathology Department has 19 faculty members. (Victor, Tr. 3588.) These 19 faculty members rotate though the laboratories at Glenbrook Hospital, Evanston Hospital and HPH. (Victor, Tr. 3588-89).

Response to Finding No. 1854:

Complaint Counsel have no specific response.

1855. Additionally, immediately after ENH took over the HPH Lab, pathologists from HPH began rotating to Evanston Hospital, and pathologists from Evanston Hospital began rotating to the HPH Lab. (Victor, Tr. 3629-30). This was done because the pathologists at Evanston Hospital see more complex specimens, and it allowed pathologists to stay abreast of all of the modern thinking and modern technologies relating to the practice of pathology. (Victor, Tr. 3589).

Response to Finding No. 1855:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

v. ENH's Improvements To The HPH Lab Have Improved Quality And/Or Resulted In Efficiencies

(1) ENH's Improvements To The HPH Lab Dramatically Improved The Turnaround Time

For Tests Performed In The HPH Lab

1856. Turnaround time is the time it takes to do a test. (Victor, Tr. 3643). Turnaround times at the HPH Lab decreased dramatically after ENH took over the HPH Lab, as a result of the improvements ENH made to the HPH Lab. (Victor, Tr. 3632-34; Chassin, Tr. 5353).

Response to Finding No. 1856:

Although Respondent asserts that turnaround time decreased after the merger, there is no evidence showing to what extent that change has an impact on patient care at HPH. In addition, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1857. For example, in 2000-2001, the turnaround time for a basic metabolic pathway testing system decreased from 40 minutes to 30 minutes. (Victor, Tr. 3633). Also, in 2000-2001, the turnaround time for a CBC coming into the laboratory decreased from 80 minutes to 20 minutes. (Victor, Tr. 3633). The decreased turnaround times resulted in improved quality of care. (Chassin, Tr. 5353).

Response to Finding No. 1857:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1858. Additionally, ENH has improved the manner in which specimens at HPH are transported to the laboratory at HPH. (Victor, Tr. 3634). ENH has implemented a pneumatic tube system which allows specimens to be transported from the Kellogg Cancer Center directly to the hospital laboratory, and this system allows for a much faster turnaround time. (Victor, Tr. 3634).

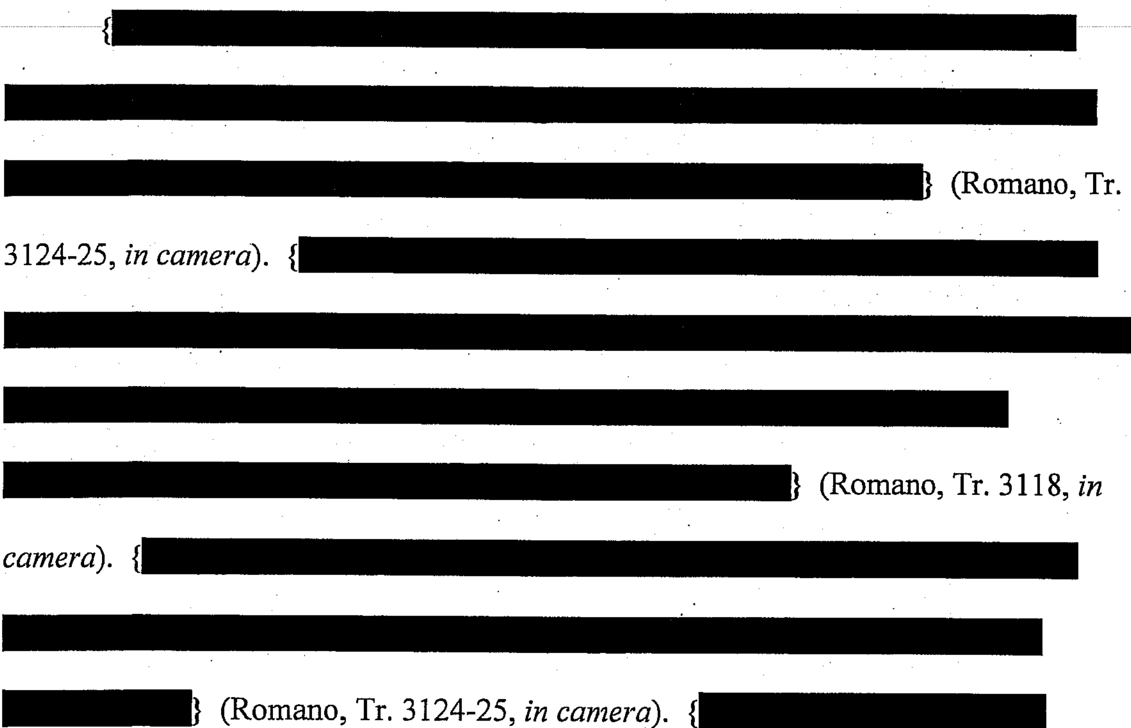
Response to Finding No. 1858:

Although Respondent asserts that it implemented a pneumatic tube system at HPH after the merger, there is no evidence showing to what extent that change might have affected patient care at HPH. In addition, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

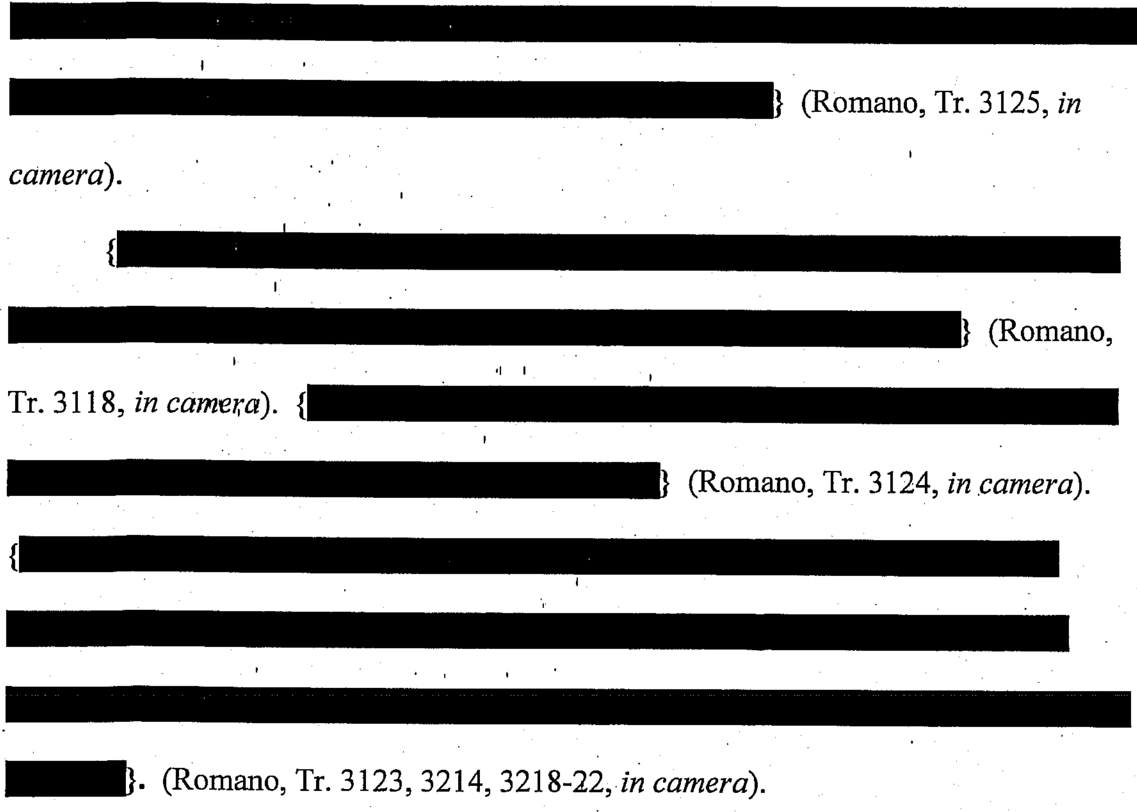
(2) ENH Brought Its Academic Focus On Pathology To HPH.

1859. As an academic hospital, Evanston Hospital brings an academic focus to pathology. (Victor, Tr. 3634). Before the Merger, HPH did not have an academic focus. (Victor, Tr. 3635).

<u>Response to Finding No. 1859:</u>



{ } (Romano, Tr. 3124-25, *in camera*). { } (Romano, Tr. 3118, *in camera*). { } (Romano, Tr. 3124-25, *in camera*). {



} (Romano, Tr. 3125, *in camera*).

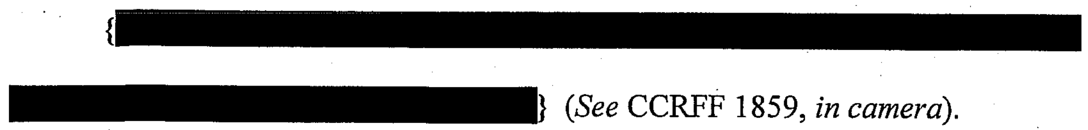
{ } (Romano, Tr. 3118, *in camera*). { } (Romano, Tr. 3124, *in camera*).

{ }. (Romano, Tr. 3123, 3214, 3218-22, *in camera*).

In addition, various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

1860. An academic focus is beneficial to pathology because those doing the teaching maintain their expertise and their knowledge in a field of specialization, and it requires individuals who are committed to only one specialty. (Victor, Tr. 3635).

Response to Finding No. 1860:

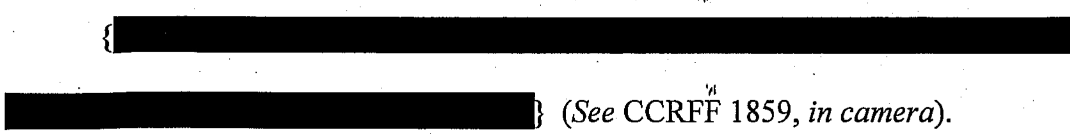


{ } (*See* CCRFF 1859, *in camera*).

1861. The academic focus at Evanston Hospital benefits the laboratory work done at HPH because the laboratory directors at Evanston Hospital provide their specialized expertise for laboratory testing and also provide expertise when consulting with physicians. (Victor, Tr.

3635).

Response to Finding No. 1861:



(*See* CCRFF 1859, *in camera*).

(3) On-Site Testing Has Substantial Advantages Over Outsourcing

1862. Performing tests on-site rather than outsourcing them has at least two advantages with respect to quality of care: (1) turnaround times are improved and routine results can be provided to physicians or placed in the patient's chart more rapidly; and (2) clinicians can have direct conversations with people in the laboratory about results that are coming from the laboratory. (Victor, Tr. 3599). It is important for clinicians to communicate with the laboratory staff in situations where it is necessary to correlate the clinical situation that the physician is facing with the laboratory result. (Victor, Tr. 3599-600).

Response to Finding No. 1862:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(4) ENH Realized Substantial Cost Savings From The Dissolution of CML

1863. As a result of closing down the CML laboratory, HPH had a savings in operating costs of $2.5 million. (O'Brien, Tr. 3510). HPH continued to see roughly a $2 million savings annually from the dissolution. (O'Brien, Tr. 3510).

Response to Finding No. 1863:

Various evidence supports the view that changes to HPH's lab did not significantly improve quality. (*See* CCRFF 1796). Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have

made such changes in the absence of the merger. (*See* CCRFF 1811). In addition, Complaint Counsel notes that none of these alleged savings appear to have been passed on to consumers, as prices have risen after the merger. (Haas Wilson, Tr. 2500-01).

1864. Before ENH took over the HPH Lab, HPH's cost per test was approximately $18. (Victor, Tr. 3637). ENH lowered HPH's cost per test to approximately $10 per test. (Victor, Tr. 3637).

Response to Finding No. 1864:

Various evidence also supports the view that the changes in HPH's lab were not merger specific because HPH would have made such changes in the absence of the merger. (*See* CCRFF 1811).

(5) HPH Pathologists Now Engage in Teaching Activities

1865. Pathologists at HPH are responsible for teaching residents at Evanston Hospital. (Victor, Tr. 3589-90). Pathologists at HPH also give didactic lectures – lectures which are focused on a specific topic – to the residents at Evanston Hospital. (Victor, Tr. 3590).

Response to Finding No. 1865:

{

} (*See* CCRFF 1859, *in camera*).

f. The Merger Resulted In Structural And Service Improvements To The HPH Emergency Department

i. Overview

1866. ENH improved both the physical layout and service components of HPH's ED after the Merger. (Chassin, Tr. 5333).

Response to Finding No. 1866:

{

} (Harris, Tr. 4283-84; Romano, Tr. 3109-10, *in camera*). {

} (Romano, Tr. 3109-10, *in camera*). Dr. Harris, ENH's medical director of the emergency department at HPH, did not see or was not aware of any (1) studies that compared clinical outcomes of patients who used the HPH emergency room prior to the renovations with the clinical outcomes after the renovation, (Harris, Tr. 4283), (2) data that compared HPH's emergency room pre-merger and post-merger turn-around times, the turn-around times of fast-track patients, or the amount of time it took a patient to get an EKG, (Harris, Tr. 4283-84), or (3) instance in which a patient transferred from HPH prior to the merger had a worse clinical outcome because of the transfer. (Harris, Tr. 4287-88).

In addition, HPH already had a good emergency department before the merger. (Newton, Tr. 394). For example, before the merger, quality in the Highland Park Hospital emergency department was monitored to make sure it was at a level the department felt was acceptable for its internal standards and any area-wide standards. (Harris, Tr. 4209). Prior to the merger, Highland Park Hospital also had a formal QA/QI program which measured the quality of care offered at Highland Park Hospital's emergency room. In fact, the emergency room had a variety of indicators to monitor performance. (Harris, Tr. 4264-65). One indicator of Highland Park Hospital's emergency room pre-merger QI program was turn-around time, which is the time from

when the patient comes into the door until the time the patient leaves, is transferred, or admitted. (Harris, Tr. 4266). HPH also made improvements to the emergency room pre-merger. Around 1995 or 1996, the Highland Park Hospital emergency department instituted changes to expedite the treatment of patients with minor injuries and illness. This was the fast-track program. The fast-track program reduced the turn-around time for patients. (Harris, Tr. 4266). Implementing the fast-track program pre-merger and adding physician assistants to the emergency department by 1997 were significant improvements to the department. (Harris, Tr. 4267).

The facility and equipment changes made in connection with emergency care at HPH after the merger are structural changes. (Romano, Tr. 2986-87). Structural measures are enabling factors that provide the conditions under which care is delivered. (Romano, Tr. 2988). Structural measures are insufficient by themselves to measure quality because they tell us very little about the care that is actually provided to patients. (Romano, Tr. 2988).

1867. The total cost of the structural changes in the ED was $5.3 million. (O'Brien, Tr. 3488). The ED staffing changes cost well over a million dollars. (Harris, Tr. 4234).

Response to Finding No. 1867:

The renovation of the emergency department at HPH would have been made by HPH without the merger. In fact, HPH was already planning to renovate and expand its Emergency Department before the merger. (Newton, Tr. 394; Harris, Tr. 4289-90; CX 98 at 2 ("overall plans for major reconstruction")). HPH brought in an architect in the fall of 1998 to discuss expansion of the emergency room at the hospital. (Harris, Tr. 4290).

HPH routinely made capital investments to upgrade and improve its facilities prior to the merger. (Newton, Tr. 383). For example, Highland Park's 1999-2003 Financial Plan set forth a "long range capital budget" that included $43 million for "strategic initiatives and master plan items," including "ambulatory, assisted living and facility expansion." The plan also set aside $65 million for "[h]ospital construction, routine capital and information technology" investments, and a small amount for Lakeland Health Ventures. (Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2). The total planned investments for the time period therefore amounted to $108 million. Expert testimony also confirms that {[redacted]} (Romano, Tr. 3111, *in camera*). {[redacted]} (Romano, Tr. 3112, *in camera*). Thus, the changes in physical facilities and staffing levels were not merger specific.

In addition, the facility and equipment changes made in connection with emergency care at HPH after the merger are structural changes. (Romano, Tr. 2986-87). Structural measures are enabling factors that provide the conditions under which care is delivered. (Romano, Tr. 2988). Structural measures are insufficient by themselves to measure quality because they tell us very little about the care that is actually provided to patients. (Romano, Tr. 2988).

1868. Emergency medicine is the area of medicine that deals with acute episodic care. (Harris, Tr. 4201). Approximately 20-30% of HPH's ED patients are admitted to the hospital. (Harris, Tr. 4213).

Response to Finding No. 1868:

Complaint Counsel have no specific response.

1869. Responsibility for monitoring quality of care in the ED at HPH before the Merger rested with Dr. Bruce Harris, the nursing director, the quality improvement department, and administration. (Harris, Tr. 4208-09).

Response to Finding No. 1869:

Complaint Counsel have no specific response.

1870. Dr. Harris, who testified at trial, is the HPH ED Medical Director and is employed by the ENH Medical Group as an emergency medicine physician at ENH. (Harris, Tr. 4201-02). Dr. Harris is a staff physician and has served as the HPH Medical Director since 1997. (Harris, Tr. 4202). Dr. Harris has practiced continually at HPH since 1985 and has been an emergency physician for almost 20 years. (Harris, Tr. 4213).

Response to Finding No. 1870:

Complaint Counsel have no specific response.

1871. Dr. Harris monitored quality of care at HPH's ED through conversations with patients and nurses, by handling complaints, by being physically present in the ED on a daily basis and by tracking several indicators. (Harris, Tr. 4208). Quality in the HPH ED was monitored to determine whether HPH was performing at a level that was acceptable for internal standards as well as any area-wide standards. (Harris, Tr. 4209, 4266).

Response to Finding No. 1871:

Complaint Counsel have no specific response.

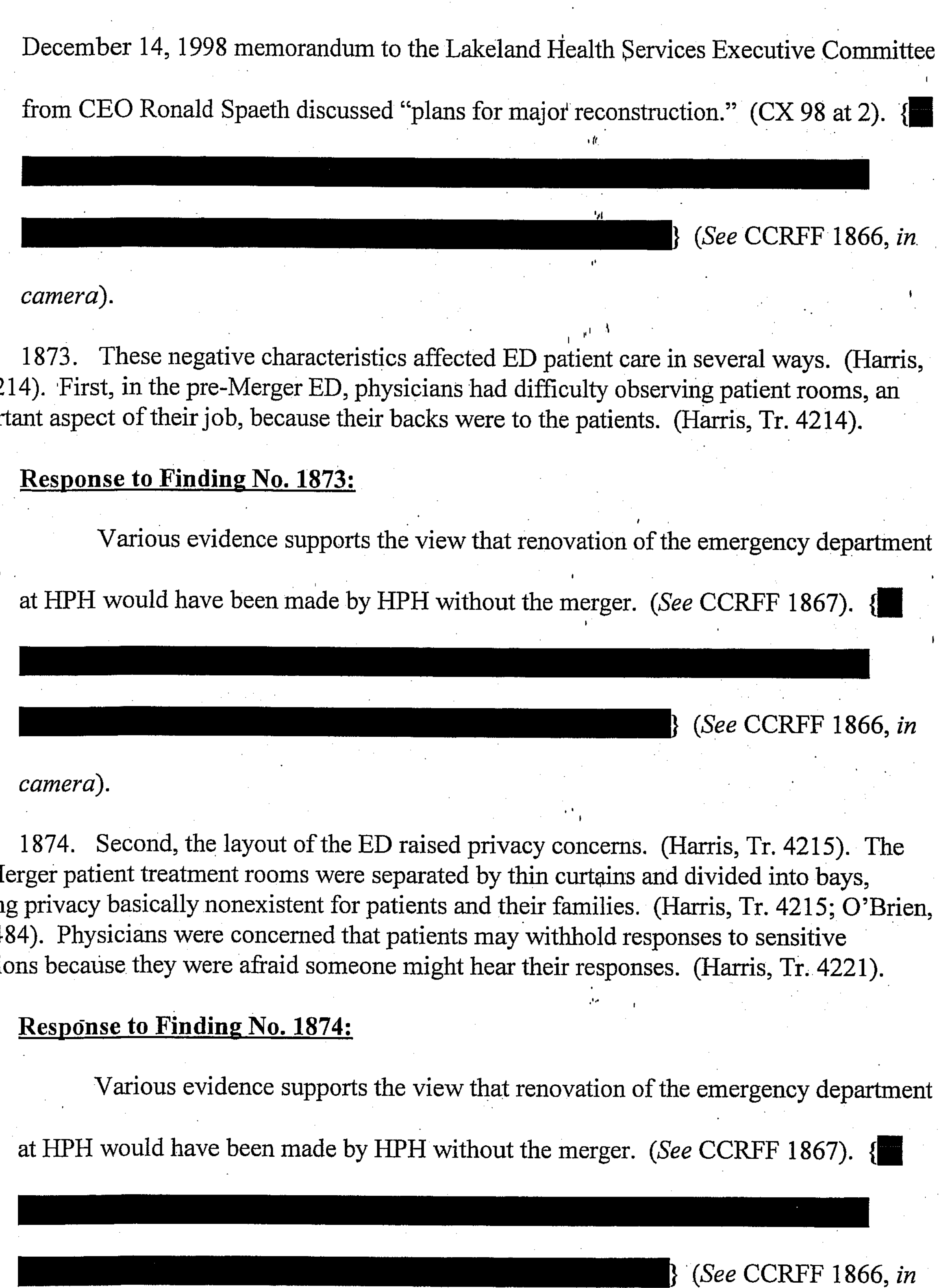
ii. HPH's Pre-Merger ED Needed Improvement

(1) HPH's ED Facilities Were Inadequate Before The Merger

1872. Before the Merger, HPH's ED was cluttered, cramped, non-private, non-ergonomic, poorly laid out and unattractive. (Harris, Tr. 4214).

Response to Finding No. 1872:

Various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867). A



December 14, 1998 memorandum to the Lakeland Health Services Executive Committee from CEO Ronald Spaeth discussed "plans for major reconstruction." (CX 98 at 2). { } (*See* CCRFF 1866, *in camera*).

1873. These negative characteristics affected ED patient care in several ways. (Harris, Tr. 4214). First, in the pre-Merger ED, physicians had difficulty observing patient rooms, an important aspect of their job, because their backs were to the patients. (Harris, Tr. 4214).

Response to Finding No. 1873:

Various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867). { } (*See* CCRFF 1866, *in camera*).

1874. Second, the layout of the ED raised privacy concerns. (Harris, Tr. 4215). The pre-Merger patient treatment rooms were separated by thin curtains and divided into bays, making privacy basically nonexistent for patients and their families. (Harris, Tr. 4215; O'Brien, Tr. 3484). Physicians were concerned that patients may withhold responses to sensitive questions because they were afraid someone might hear their responses. (Harris, Tr. 4221).

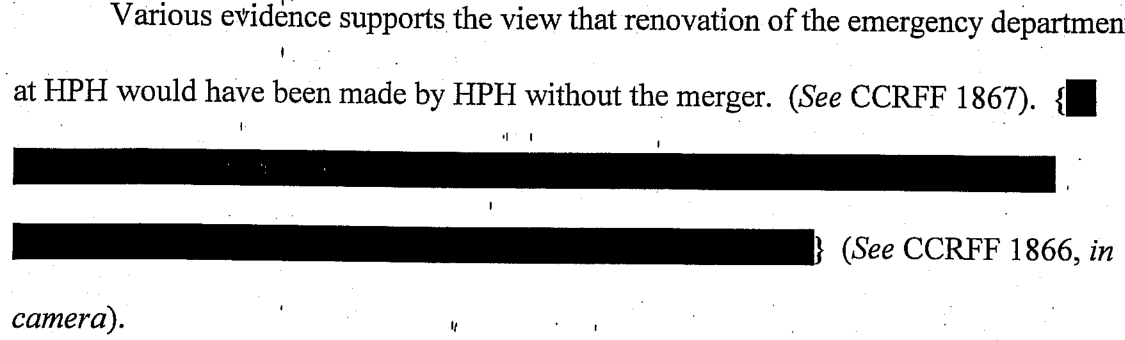
Response to Finding No. 1874:

Various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867). { } (*See* CCRFF 1866, *in camera*).

1875. Third, the registration area consisted only of a desk jutting out into a hall. (Harris, Tr. 4226). This area could only accommodate one patient or family group at a time and it did not afford any privacy. (Harris, Tr. 4226).

Response to Finding No. 1875:

Various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867). {

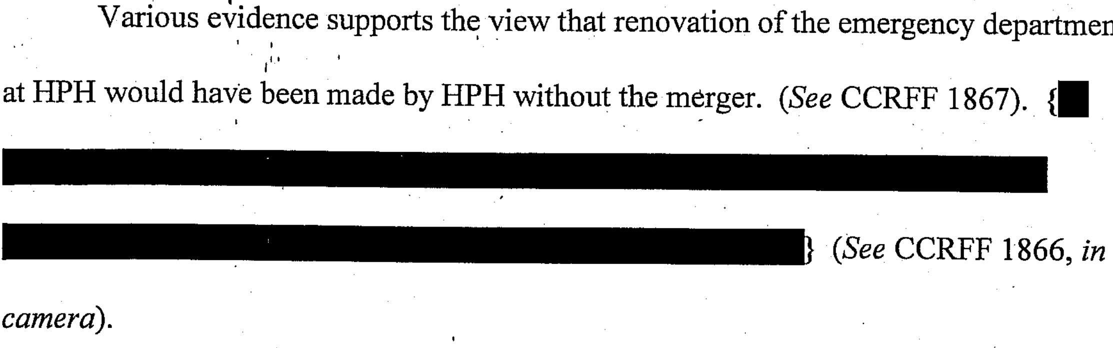


} (*See* CCRFF 1866, *in camera*).

1876. From a clinical standpoint, before the Merger, HPH did not have a decontamination room or an isolation room for patients who may have been exposed to biohazards. (O'Brien, Tr. 3484). Nor did HPH's ED have any critical care capability. (Hillebrand, Tr. 1980-81).

Response to Finding No. 1876:

Various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867). {



} (*See* CCRFF 1866, *in camera*).

1877. Before the Merger, Dr. Harris recommended to HPH management that physical improvements needed to be made to the ED. (Harris, Tr. 4248). No actions were taken or changes made pre-Merger. (Harris, Tr. 4248-49).

Response to Finding No. 1877:

This finding misstates the evidence because HPH did have plans and had taken actions before the merger. HPH was already planning to renovate and expand its

emergency department before the merger. (Newton, Tr. 394; Harris, Tr. 4289-90; CX 98 at 2 ("overall plans for major reconstruction")). HPH had even brought in an architect in the fall of 1998 to discuss expansion of the emergency room at the hospital. (Harris, Tr. 4290). It would not be unusual that such plans did not proceed in 1999 given the activities and distractions associated with the impending merger. Various other evidence also supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867). {[redacted] [redacted] [redacted]} (*See* CCRFF 1866, *in camera*).

(2) HPH Had Physician Staffing Problems Before The Merger

1878. Before the Merger, only one physician covered the ED. (Harris, Tr. 4230). This arrangement was inadequate during busy times. (Harris, Tr. 4230).

Response to Finding No. 1878:

This finding misstates the evidence. Dr. Harris clearly testified that, of course, there were times before the merger when there was more than one physician present in the emergency room. Prior to the merger, such additional coverage simply was not scheduled. (Harris, Tr. 4277). In addition, various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867). {[redacted] [redacted] [redacted]} (*See* CCRFF 1866, *in camera*).

1879. At most, HPH used moonlighting senior residents to achieve double coverage on

weekends. (Harris, Tr. 4279-80). Double coverage is a period of time when there are two emergency physicians scheduled to staff the ED. (Harris, Tr. 4232).

Response to Finding No. 1879:

If this finding means to refer to HPH pre-merger, than it misstates the evidence. The testimony of Dr. Harris refers to moonlighters who provided double coverage at HPH *after the merger*. (Harris, Tr. 4279-80). Thus, it says nothing about HPH's practices in the emergency department prior to the merger. In addition, various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867). { } (*See* CCRFF 1866, *in camera*).

1880. Dr. Harris tried to get double physician coverage in the HPH ED before the Merger. (Harris, Tr. 4230). Despite Dr. Harris's efforts, HPH never had double physician coverage before the Merger. (Harris, Tr. 4232).

Response to Finding No. 1880:

This finding misstates the evidence. Although HPH did not schedule double coverage prior to the merger, additional physician coverage was available if needed. (Harris, Tr. 4277). Dr. Harris clearly testified that, of course, there were times before the merger when there was more than one physician present in the emergency room. (Harris, Tr. 4277). In addition, various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867). { } (*See*

CCRFF 1866, *in camera*).

1881. Under HPH's pre-Merger physician staffing arrangement, if there were two critically ill patients in the HPH ED at the same time, the emergency physician had to split his or her time between both patients. (Harris, Tr. 4235).

Response to Finding No. 1881:

This finding misstates the evidence. Although HPH did not schedule double coverage prior to the merger, additional physician coverage was available if needed. (Harris, Tr. 4277). Dr. Harris clearly testified that, of course, there were times before the merger when there was more than one physician present in the emergency room. (Harris, Tr. 4277). In addition, various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867). { } (*See* CCRFF 1866, *in camera*).

1882. In addition, before the Merger, the HPH ED was responsible for responding to code blues that occurred anywhere in the hospital. (Harris, Tr. 4236). A code blue means that a patient has suffered a cardiac or a cardiopulmonary arrest. (Harris, Tr. 4236). When a physician left the ED to respond to a code blue, only the nurses were left to monitor the ED. (Harris, Tr. 4236).

Response to Finding No. 1882:

Various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867).

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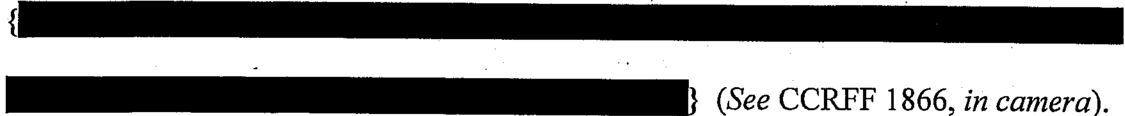

} (*See* CCRFF 1866, *in camera*).

1883. There was an incident before the Merger in the ED involving a "near miss" as a

result of the lack of double coverage. (Harris, Tr. 4236-37). Dr. Harris was finishing his shift and the physician on the next shift happened to arrive a little early. (Harris, Tr. 4237). A code blue was called in the ICU. (Harris, Tr. 4237). While Dr. Harris was responding to that code, a patient entered the ED and went into cardiac arrest. (Harris, Tr. 4237). The physician who, by chance, arrived early was able to successfully defibrillate the patient. (Harris, Tr. 4237).

Response to Finding No. 1883:

Various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867).

{ } (*See* CCRFF 1866, *in camera*).

(3) HPH's Fast Track Was Inadequate Before The Merger

1884. HPH had a Fast Track program pre-Merger. (Harris, Tr. 4246; RX 466 at ENH RS 5318). Fast Track is a program in the HPH ED designed to care for patients with minor injury or illness in a rapid manner. (Harris, Tr. 4245). This arrangement frees up the rest of the ED to care for sicker patients. (Harris, Tr. 4246).

Response to Finding No. 1884:

Complaint Counsel do not disagree.

1885. HPH's pre-Merger Fast Track consisted of a couple of beds in a room sub-divided by curtains in the Fast Track area, an area that used to be HPH's grieving room. (Harris, Tr. 4247). A storage room was converted into another patient room. (Harris, Tr. 4247).

Response to Finding No. 1885:

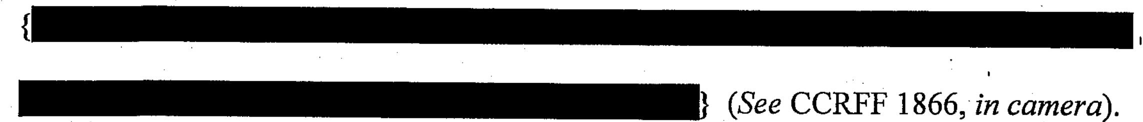
Dr. Harris, ENH's medical director for emergency care at HPH, testified that HPH's implementation of the fast track program and adding physician assistants by 1997 were significant improvements in HPH's emergency department. (Harris, Tr. 4267). In addition, various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867).

{ } (*See* CCRFF 1866, *in camera*).

1886. To staff Fast Track before the Merger, HPH hired physician assistants, also called mid-level practitioners. (Harris, Tr. 4246).

Response to Finding No. 1886:

Dr. Harris, ENH's medical director for emergency care at HPH, testified that HPH's implementation of the fast track program and adding physician assistants by 1997 were significant improvements in HPH's emergency department. (Harris, Tr. 4267). In addition, various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867).

{  } (*See* CCRFF 1866, *in camera*).

1887. The addition of the pre-Merger Fast Track was met with mixed satisfaction. (Harris, Tr. 4247). HPH was better off with it, but there were some major problems with the Fast Track program. (Harris, Tr. 4247).

Response to Finding No. 1887:

Dr. Harris, ENH's medical director for emergency care at HPH, testified that HPH's implementation of the fast track program and adding physician assistants by 1997 were significant improvements in HPH's emergency department. (Harris, Tr. 4267). In addition, various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867).

{ } (*See* CCRFF 1866, *in camera*).

1888. First, the pre-Merger HPH Fast Track area had physical limitations due to its small size. (Harris, Tr. 4247).

Response to Finding No. 1888:

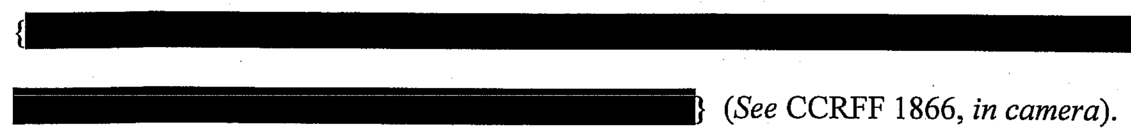
Dr. Harris, ENH's medical director for emergency care at HPH, testified that HPH's implementation of the fast track program and adding physician assistants by 1997 were significant improvements in HPH's emergency department. (Harris, Tr. 4267). In addition, various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867).

{ } (*See* CCRFF 1866, *in camera*).

1889. Second, the HPH Fast Track left HPH with no grieving room. (Harris, Tr. 4247). A grieving room is an area where the families of critically ill or deceased patients are brought so the physician can deliver bad news. (Harris, Tr. 4249). Before the Merger, physicians would have to conduct such meetings in any room they could find – *e.g.*, the nurse manager's office, the cardiac catheterization lab, or the paramedic room. (Harris, Tr. 4249).

Response to Finding No. 1889:

Dr. Harris, ENH's medical director for emergency care at HPH, testified that HPH's implementation of the fast track program and adding physician assistants in 1997 were significant improvements in HPH's emergency department. (Harris, Tr. 4267). In addition, various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867).

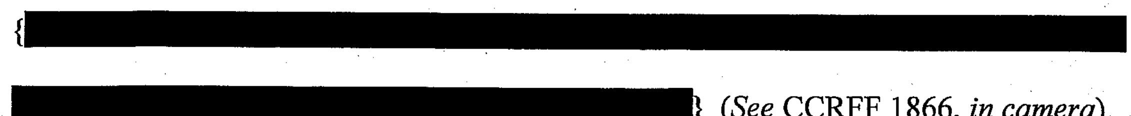

{ } (*See* CCRFF 1866, *in camera*).

1890. Third, it was possible for patients to come into the HPH ED, be seen by a physician assistant, and leave the ED without being seen by a physician. (Harris, Tr. 4247-48).

Physician assistants are good care providers, but they lack the experience of a physician. (Harris, Tr. 4248).

Response to Finding No. 1890:

Dr. Harris, ENH's medical director for emergency care at HPH, testified that HPH's implementation of the fast track program and adding physician assistants by 1997 were significant improvements in HPH's emergency department. (Harris, Tr. 4267). In addition, various evidence supports the view that renovation of the emergency department at HPH would have been made by HPH without the merger. (*See* CCRFF 1867).


{ } (*See* CCRFF 1866, *in camera*).

iii. ENH Significantly Improved The HPH ED After The Merger

1891. ENH improved quality in the HPH ED after the Merger. (Chassin, Tr. 5332). In particular, there were a number of improvements to HPH's ED after the Merger including: major facility expansion, improved physician and nurse staffing, enhancements to fast track and other improvements. (Harris, Tr. 4213-14; Newton, Tr. 470; Hillebrand, Tr. 1980-81).

Response to Finding No. 1891:

This finding essentially repeats ENH's finding 1866 and Complaint Counsel incorporate the response to that finding.

(1) ENH Substantially Expanded And Renovated The HPH ED

1892. The ED was gutted, expanded, and renovated after the Merger because the facility was extremely inadequate. (Harris, Tr. 4216; Chassin, Tr. 5333; CX 6304 at 14-15 (Livingston, Dep.)).

Response to Finding No. 1892:

This finding is misleading and incomplete. HPH was planning to renovate and expand its Emergency Department before the merger. (Newton, Tr. 394; Harris, Tr. 4289-90; CX 98 at 2 ("overall plans for major reconstruction")). These plans were in addition to the enhanced triage function and fast track plans that were actually executed pre-merger. (CX 94 at 4). In the late 1990s, HPH was making plans to expand the Emergency Department. (Newton, Tr. 394). HPH brought in an architect in the fall of 1998 to discuss expansion of the emergency room at the hospital. (Harris, Tr. 4290. *See also* CCRFF 1867).

1893. The "2001-2003 Capital Expenditure and Cash Flow Projections" called for spending $3 million to upgrade HPH's ED after the Merger. (CX 591 at 7). Construction began in or about December of 2000. (Harris, Tr. 4216; O'Brien, Tr. 3483).

Response to Finding No. 1893:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

1894. The first capital improvement ENH made at HPH was the reconstruction of the HPH ED, including the addition of an entrance for walk-in patients separate from the ambulance traffic. (Hillebrand, Tr. 1976).

Response to Finding No. 1894:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

1895. Moreover, the overall square footage of the HPH ED increased from about 7,500 square feet pre-Merger to 11,000 square feet post-Merger. (Harris, Tr. 4217). Coincident with these major improvements and expansion to the HPH ED, there was an 11.5% increase in the

volume of patients seen and treated at the ED, which is further evidence that the added capacity was utilized by, and benefited, a significant number of patients at HPH (Chassin, Tr. 5336).

Response to Finding No. 1895:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

(a) Phase I Of The HPH ED Renovation

1896. The ENH Healthcare Services Committee was a hospital Board Committee. (Harris, Tr. 4218). The Committee's primary purpose was to report on and oversee the overall clinical services at the hospital. (Harris, Tr. 4218). Dr. Harris attended committee meetings by invitation and was present at the September 14, 2001, meeting. (Harris, Tr. 4218).

Response to Finding No. 1896:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

1897. At the meeting, Dr. Harris reviewed for the Committee the enhancements and new construction in the ED at HPH (Harris, Tr. 4218-19; RX 1148 at ENH GW 271-72). Phase I of the construction, completed in September 2001, involved renovations to the major clinical areas of the ED. (Harris, Tr. 4219).

Response to Finding No. 1897:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

(i) Patient Rooms Were Redesigned

1898. State-of-the-art, patient-focused rooms were constructed as part of the Phase I renovations. (Harris, Tr. 4219-20; RX 1148 at ENH GW 271-72). HPH went from 12 to 14 beds plus an Ear, Nose and Throat ("ENT") room, and every patient room is now private, more spacious and separated by walls. (Harris, Tr. 4217, 4225; O'Brien, Tr. 3485). This redesign is important for privacy and confidentiality reasons and to meet HIPPA regulations. (O'Brien, Tr. 3485).

Response to Finding No. 1898:

Respondent's reference to HIPPA provides another example of ENH attributing a change to the merger when in fact it was merely the general adherence to changing standards of practice. HIPPA was only passed "after the merger." (O'Brien Tr. 3577). Of course ENH would have come into compliance, but so would a stand alone HPH. (*See also* CCRFF 1892, above).

1899. Patient observation by physicians and the nurses at the central station in the ED is easier because the patient treatment rooms have glass doors with curtains that can be pulled open when necessary. (Harris, Tr. 4217, 4220; O'Brien, Tr. 3485).

Response to Finding No. 1899:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

(ii) Critical Care Rooms Were Updated

1900. Critical care rooms are much larger than the old rooms, and this allows for a variety of personnel to be at a bedside during a procedure. (Harris, Tr. 4221; Hillebrand, Tr. 1980-81). The new rooms have oxygen, suction, and cardiac monitoring equipment placed in a logical location rather than scattered around the room. (Harris, Tr. 4222).

Response to Finding No. 1900:

Respondent's finding is misleading and incomplete. HPH had begun making

plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892). Additionally, there is no evidence that the size or arrangement of the critical care rooms impacted patient care at HPH before the merger.

1901. The critical care rooms are also visually more attractive and are designed to have the ability to take care of critical patients during a resuscitation. (Harris, Tr. 4221). Resuscitations are performed on patients with no heart rate or on those patients who are not breathing. (Harris, Tr. 4221-22).

Response to Finding No. 1901:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892). Additionally, it is irrelevant whether the critical care rooms are "visually more attractive." That does not impact patient care. Further, there is no evidence that resuscitations did not occur at HPH before the merger.

(iii) Isolation Rooms Were Added

1902. Isolation rooms are designed for both positive and negative air flow. (Harris, Tr. 4222). Negative air flow is used to try to prevent a patient who has an infectious disease from spreading that disease to another patient, caregiver or family member. (Harris, Tr. 4222-23). So when the door opens, air rushes in so that potential infection cannot escape from the room. (O'Brien, Tr. 3486-87). Positive air flow is used to treat patients who have low immunity who need to be protected from germs. (Harris, Tr. 4223).

Response to Finding No. 1902:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

1903. One room at HPH had been retrofitted with negative flow before the Merger. (Harris, Tr. 4223). A positive flow isolation room was installed after the Merger. (Harris, Tr. 4223; O'Brien, Tr. 3486).

Response to Finding No. 1903:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

1904. Also, a decontamination room was added, and this room is accessible from the ambulance bay and has a shower. (O'Brien, Tr. 3486-87).

Response to Finding No. 1904:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

(b) Phase II Of The HPH Renovation

1905. Phase II of the ED construction involved the non-clinical functions of the department, including the registration area, the triage room and the waiting room. (Harris, Tr. 4226; RX 1148at ENH GW 271). Phase II was completed on or before December of 2001. (Harris, Tr. 4226).

Response to Finding No. 1905:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

(i) The HPH ED Registration Area Was Made More Private

1906. After the Merger, the registration area was remodeled so that it could accommodate up to three patients or families at once. (Harris, Tr. 4226).

Response to Finding No. 1906:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

1907. Privacy screens were installed so that patient information could not be overheard by bystanders. (Harris, Tr. 4226). The new registration area was more compliant with HIPPA. (Harris, Tr. 4227).

Response to Finding No. 1907:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892). Again, HIPPA was passed after the merger so there is no reason to credit ENH with compliance efforts. (*See* CCRFF 1898).

(ii) The HPH ED Triage Area Was Significantly Expanded

1908. Post-Merger, the triage area was substantially expanded in square footage by about 300%. (Harris, Tr. 4227). New equipment was brought into the triage area, including a scale. (Harris, Tr. 4228).

Response to Finding No. 1908:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

1909. Before the Merger, the first person to see a patient walking into the ED was the registration person or a security guard and not a clinical person. (Harris, Tr. 4228). For example, before the Merger, if a patient crumped (*i.e.*, suffered a subarachnoid hemorrhage in the brain) in the registration area, there would be a delay in treatment because clinical personnel had to be called in to take care of the patient. (Harris, Tr. 4286). After the Merger, in contrast, the area was glass-windowed in, giving the triage nurse direct visual observation of both the registration areas and the waiting room areas. (Harris, Tr. 4227).

Response to Finding No. 1909:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

(iii) The HPH ED Waiting Area Was Remodeled

1910. The waiting room areas became more pleasant and roomy post-Merger. (Harris, Tr. 4228). There is now a fish tank in the area, thus providing a pleasant diversion for small children who may be waiting. (Harris, Tr. 4228-29).

Response to Finding No. 1910:

Respondent's finding is misleading and incomplete. HPH had begun making plans to renovate and expand its Emergency Department prior to the merger. (*See* CCRFF 1892).

(2) ED Physician Coverage Was Expanded Post-Merger

(i) Double Coverage At HPH's ED Improved Quality Of Care

1911. In July 2001, ENH instituted double physician coverage at HPH. (Harris, Tr. 4231, 4279). Dr. Harris was involved with this plan and met with Dr. Jeffrey Graf, the Chief of the Division of Emergency Medicine for ENH, and nursing administration about recruiting and training new physicians. (Harris, Tr. 4231).

Response to Finding No. 1911:

This change was made a year and a half after the merger and it is not as significant as ENH suggests. Before the merger, HPH would have more than one physician present in the emergency room. (Harris, Tr. 4277). Moreover, although HPH did not schedule double coverage prior to the Merger, additional physician coverage was available if

needed. (Harris, Tr. 4277).

The change was not merger specific because {[redacted]} (Romano, Tr. 3112, *in camera*).

1912. Since July 2001, because of the Merger and for the first time in HPH's history, HPH has had enhanced physician coverage with expansion to double shifts, ten hours a day. (Harris, Tr. 4229; Spaeth, Tr. 2277; Chassin, Tr. 5333).

Response to Finding No. 1912:

Respondent's finding is misleading and incomplete. This change was made a year after the merger closing and was not as significant as Respondent suggests. (*See* CCRFF 1911).

1913. This change allowed for responses to emergencies outside the ED as well as higher quality, more efficient care for patients in the ED. (Chassin, Tr. 5333).

Response to Finding No. 1913:

Respondent's finding is misleading and incomplete. {[redacted]} (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

1914. The new shift covers 11 a.m. to 9 p.m., historically the busiest hours in the HPH ED. (Harris, Tr. 4232). The double coverage cost ENH a couple million dollars. (Harris, Tr. 4233-34).

Response to Finding No. 1914:

Respondent's finding is misleading and incomplete. {[redacted]

[redacted]} (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

1915. Double coverage allows for collaboration between physicians. (Harris, Tr. 4232-33). Collaboration among physicians also occurs at conferences and educational offerings available at ENH and through the side-by-side work the physicians perform. (Harris, Tr. 4212).

Response to Finding No. 1915:

Respondent's finding is misleading and incomplete. {[redacted]

[redacted]} (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

1916. Double coverage had a positive impact on the staff physicians. (Harris, Tr. 4234). Having a second physician staffed cuts down the patient workload of each physician by 50%. (Harris, Tr. 4234). This allows each physician to spend more time with each patient and with speaking to, counseling, and educating the families. (Harris, Tr. 4234). The double coverage also allows physicians the time to do a better job of documenting their cases. (Harris, Tr. 4234).

Response to Finding No. 1916:

Respondent's finding is misleading and incomplete. {[redacted]

[redacted]} (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was

constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

1917. Double coverage also improved turn-around times in the HPH ED. (Harris, Tr. 4235).

Response to Finding No. 1917:

Respondent's finding is misleading and incomplete. {[redacted]} (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

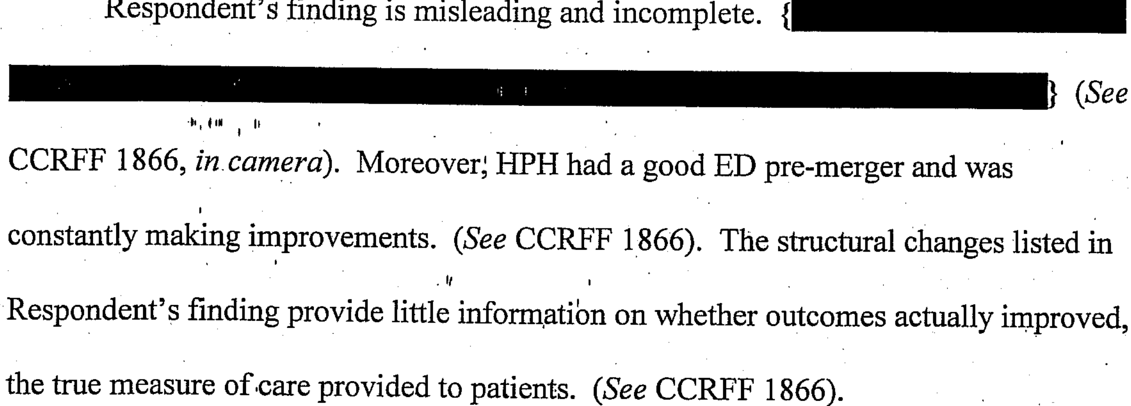
1918. Dr. Harris treated a patient who personally benefited from the double coverage. (Harris, Tr. 4233). The patient needed intubation (insertion of a tube into the windpipe to assist with breathing). (Harris, Tr. 4233). After sedation and paralysis of the patient, Dr. Harris was unable to insert the tube and called the other physician staffed in the ED to assist him with the procedure. (Harris, Tr. 4233).

Response to Finding No. 1918:

Respondent's finding is misleading and incomplete. {[redacted]} (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

1919. Dr. Harris has not had any "near misses" since the Merger. (Harris, Tr. 4237). HPH ED physicians rarely respond to codes outside the ED post-Merger. (Harris, Tr. 4237). Instead, the hospital now has an intensivist, a physician specially trained in critical care medicine, who responds to the code blues. (Harris, Tr. 4238).

Response to Finding No. 1919:



Respondent's finding is misleading and incomplete. { } (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

(ii) The Rotation Of ED Physicians At ENH Improved Quality Of Care

1920. ENH ED physicians now rotate among the three ENH hospitals. (Harris, Tr. 4210; Chassin, Tr. 5334). Rotation allows for the physicians and nurses to collaborate with a larger number of people and to keep their skills sharp. (Harris, Tr. 4210; Chassin, Tr. 5334). This is a considerable improvement in quality of care. (Chassin, Tr. 5334-35).

Response to Finding No. 1920:

Respondent's finding is misleading and incomplete. { } (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

1921. Another important result of rotation is that physicians broaden their clinical acumen because each hospital is unique. (Harris, Tr. 4211). For example, Glenbrook has a high

geriatric population, Evanston Hospital has a concentration of patients who are medically or socially indigent and HPH has a heavier pediatric emphasis. (Harris, Tr. 4211).

Response to Finding No. 1921:

This finding is misleading. It is unclear what Respondent means by "clinical acumen." Furthermore, there is no evidence that rotating through the different hospitals increases physicians' skills.

(iii) Other Staffing Changes At HPH's ED Improved Quality Of Care

1922. Changes were also made in other staffing areas. (O'Brien, Tr. 3487). An extra ED physician was added for peak hours. (O'Brien, Tr. 3488). A family medicine resident was added to rotate through the ED. (O'Brien, Tr. 3488).

Response to Finding No. 1922:

Respondent's finding is misleading and incomplete. { [redacted] } (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

1923. Pediatrician coverage in the ED improved post-Merger. (Chassin, Tr. 5336). Pre-Merger, HPH had fellows in training covering pediatrics and post-Merger there were practicing pediatricians covering the ED. (Chassin, Tr. 5336-37; RX 204, *in camera*).

Response to Finding No. 1923:

This finding is misleading. There is no evidence that pediatrician coverage in the ER improved after the merger. Highland Park Hospital had an arrangement with Children's Memorial Hospital to have advanced, specialized pediatric coverage 24 hours

a day, seven days a week. (Newton, Tr. 339)

1924. HPH now has a toxicologist on staff who is available to the ED 24 hours a day, seven days a week. (Harris, Tr. 4260). A toxicologist is a medical specialist who deals with adverse effects in patients from drugs and physical substances. (Harris, Tr. 4260). HPH did not have a toxicologist before the Merger. (Harris, Tr. 4260). The toxicologist physically sees patients, which frees up the ED physicians from having to do research on toxicology issues. (Harris, Tr. 4261).

Response to Finding No. 1924:

Respondent's finding is misleading and incomplete. { [redacted] } (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

1925. The toxicologist also brought new ideas into HPH. (Harris, Tr. 4261). For example, he discovered that in Europe, physicians were using a certain antidote to treat Tylenol and Acetaminophen overdoses that was not widely used in the United States at that time. (Harris, Tr. 4261). The toxicologist initiated use of this drug, N-acetylcysteine, at HPH. (Harris, Tr. 4261).

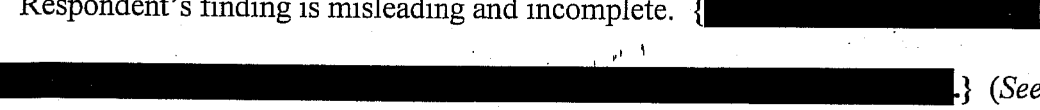
Response to Finding No. 1925:

Respondent's finding is misleading and incomplete. { [redacted] } (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

1926. Moreover, ENH implemented a crisis intervention service at HPH after the Merger. (Harris, Tr. 4262). This service provides a specially trained social worker at the hospital to assess patients with acute behavioral emergencies. (Harris, Tr. 4262; O'Brien, Tr. 3487-88). Before the Merger, the ED physician was responsible for the psychological evaluations. (Harris, Tr. 4262-63).

Response to Finding No. 1926:

Respondent's finding is misleading and incomplete. {



} (*See* CCRFF 1866, *in camera*). Moreover, HPH had a good ED pre-merger and was constantly making improvements. (*See* CCRFF 1866). The structural changes listed in Respondent's finding provide little information on whether outcomes actually improved, the true measure of care provided to patients. (*See* CCRFF 1866).

(3) ENH Improved HPH's Fast Track Design And Processes

1927. After the Merger, ENH immediately made changes to improve the HPH ED Fast Track program. (Harris, Tr. 4249; O'Brien, Tr. 3484-86).

Response to Finding No. 1927:

This finding is misleading. HPH made improvements to the emergency room before the merger. Before the merger, the HPH emergency department instituted changes to expedite the treatment of patients with minor injuries and illness. This fast-track program reduced the turn-around time for patients. (Harris, Tr. 4266). Implementing the fast-track program pre-merger and adding physician assistants to the emergency department by 1997 were significant improvements to the department. (Harris, Tr. 4267). Dr. Harris did not see or was not aware of any data that compared HPH's emergency room pre-merger and post-merger turn-around times, the turn-around times of fast-track

patients, or the amount of time it took a patient to get an EKG. (Harris, Tr. 4283-84).

1928. ENH upgraded the Fast Track program by putting it in proximity to the ED. (Chassin, Tr. 5334). Three private patient rooms were constructed for Fast Track patients that were larger than the pre-Merger rooms. (Harris, Tr. 4250; Chassin, Tr. 5333). ENH created more efficient traffic patterns with triage in Fast Track. (Chassin, Tr. 5333).

Response to Finding No. 1928:

Respondent's finding is incomplete. (*See* CCRFF 1927 (discussing HPH's pre-merger improvements to the emergency department)).

1929. An x-ray viewing area was added near the patient rooms. (Harris, Tr. 4250). In contrast, before the Merger, physicians had to walk all the way across the ED to the old view box to look at x-rays, thus wasting physician time. (Harris, Tr. 4250).

Response to Finding No. 1929:

Respondent's finding is incomplete. (*See* CCRFF 1927 (discussing HPH's pre-merger improvements to the emergency department)).

1930. In addition, ENH ensured that patients were always seen by a physician. (Harris, Tr. 4249).

Response to Finding No. 1930:

Respondent's finding is incomplete. (*See* CCRFF 1927 (discussing HPH's pre-merger improvements to the emergency department)).

(4) ENH Coordinated HPH's ED And Its Cardiac Services

1931. The HPH ED coordinates with cardiovascular services to provide emergency angioplasty. (Harris, Tr. 4240; RX 1148 at ENH GW 272). This coordination allows interventional cardiologists to perform angioplasties on patients with heart attacks. (Harris, Tr. 4240). The ability to do these cardiovascular procedures completely changed HPH's approach to treating heart attack patients. (Harris, Tr. 4240).

Response to Finding No. 1931:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1891 (no significant improvements to HPH's ED post-merger)).

1932. If HPH patients needed an angioplasty or open heart surgery before the Merger, they were transferred to a hospital with that service. (Harris, Tr. 4240-41). The first problem with the transfer situation was the delay in treatment time to a patient with a clot in an artery preventing the flow of oxygen to the heart. (Harris, Tr. 4241). The second problem was that the level of care the patient received while being transferred in an ambulance was lower than the care they received in the ED or ICU. (Harris, Tr. 4242).

Response to Finding No. 1932:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1891 (no significant improvements to HPH's ED post-merger)).

1933. Since the Merger, there have not been any situations where an HPH patient who started out in the HPH ED was transferred to another hospital because of a need for angioplasty or open heart surgery. (Harris, Tr. 4243-44).

Response to Finding No. 1933:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1891 (no significant improvements to HPH's ED post-merger)).

(5) ENH Increased Nurse Staffing In HPH's ED

1934. ENH increased nurse staffing by hiring new nurses for the ED, and this improved the efficiency and speed of caring for patients. (Chassin, Tr. 5334; Harris, Tr. 4244).

Response to Finding No. 1934:

This finding is misleading and inaccurate. There were problems with nursing turnover and high nurse vacancy rates at ENH after the merger; physicians were concerned about morale issues and how nursing turnover would affect nursing staffing and quality of care provided to patients. (RX 938 at ENHE F35 000317).

1935. A new triage nurse position was created in the HPH ED. (Harris, Tr. 4244). The

triage nurse is the first clinical person to see a patient when they present to the HPH ED. (Harris, Tr. 4244). The triage nurse's primary responsibility is to determine which patients need to be seen immediately. (Harris, Tr. 4244).

Response to Finding No. 1935:

Respondent's finding is incomplete. (*See* CCRFF 1934 (discussing problems with nursing at HPH post-merger)).

1936. The addition of the triage nurse increased the nursing services available to physicians at the bedside. (Harris, Tr. 4245). The more nurses available, the more rapidly patients are processed and observed. (Harris, Tr. 4245).

Response to Finding No. 1936:

Respondent's finding is incomplete. (*See* CCRFF 1934 (discussing problems with nursing at HPH post-merger)). Furthermore, there is no evidence that patients were processed and observed faster. {[redacted]} (Romano, Tr. 3109-10, *in camera*).

1937. ENH also hired a nurse practitioner, who is supervised by ED physicians, to attend to patients in Fast Track so they can be treated quickly and released. (O'Brien, Tr. 3486).

Response to Finding No. 1937:

Respondent's finding is incomplete. (*See* CCRFF 1934 (discussing problems with nursing at HPH post-merger)). Furthermore, there is no evidence that patients were treated and released more quickly after the merger.

1938. Some of the nurses received special training and were certified in pediatric emergency care. (O'Brien, Tr. 3487).

Response to Finding No. 1938:

Respondent's finding is incomplete. (*See* CCRFF 1934 (discussing problems with

nursing at HPH post-merger)).

(6) ENH Improved HPH's ED In Other Ways As Well

1939. ENH also improved technology in the HPH ED. (Harris, Tr. 4253-54). The addition of the cardiac monitoring system, a Pictorial Archiving Communication System ("PACS") and Epic to the ED were significant improvements. (Harris, Tr. 4254).

Response to Finding No. 1939:

This finding is misleading. (*See* CCRFF 2136 (Highland Park Hospital was considering purchasing new technology for the ED before the merger. PACS and Epic were emerging technologies at the time of the merger. Absent the merger, Highland Park would likely have followed that trend.)).

1940. Each patient room has been equipped with a standard cardiac monitoring system that is centrally monitored from the nurses' station. (O'Brien, Tr. 3487). The new cardiac monitors allow for more sophisticated measurements. (Harris, Tr. 4224). In addition, a central station at the nurses' work area allows physicians and nurses to monitor patient rhythms and vital signs from one screen in a remote area versus having to physically be in a patient room to do so. (Harris, Tr. 4223-24).

Response to Finding No. 1940:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1891 (no significant improvements to HPH's ED post-merger)).

1941. PACS is a digital x-ray system through which an ED physician can immediately see an image that was taken in radiology of an ED patient. (O'Brien, Tr. 3487). The patient does not even have to make it physically back to the ED before the physician actually sees the image. (O'Brien, Tr. 3487). PACS improved the turnaround time for making images available to HPH ED physicians. (Harris, Tr. 4254). Images are available almost immediately because they are digital. (Harris, Tr. 4255). PACS also allows physicians to pull up multiple studies to do comparisons. (Harris, Tr. 4255).

Response to Finding No. 1941:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1891 (no

significant improvements to HPH's ED post-merger)).

1942. The computerized physician order entry component of Epic (described in more depth in Section VIII.D.2.h.) has decreased transcription and dosing errors. (Harris, Tr. 4256). The system provides a warning screen if a patient has a drug allergy or there is a potential drug interaction with something the physician was going to prescribe. (Harris, Tr. 4257).

Response to Finding No. 1942:

Respondent's finding is misleading and incomplete. Epic was not deployed at HPH until January 2004, four years after the merger took place. (Wagner, Tr. 4070). There is no evidence that the merger has improved outcomes or reduced transcription errors at HPH through the deployment of Epic. (Wagner, Tr. 4065).

1943. Before Epic was installed at HPH, a physician would have to check a patient chart or ask the patient about allergies if the patient was conscious. (Harris, Tr. 4257). A physician had to rely on his own mental database to prevent drug interactions. (Harris, Tr. 4257).

Response to Finding No. 1943:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1942 (Epic instituted only in 2004 and no evidence that it improved outcomes at HPH.)).

1944. The addition of Epic also eliminated the handwriting legibility issue since everything is now electronic. (Harris, Tr. 4257-58). It also allows an ED physician to rapidly access prior clinical patient information within seconds. (Harris, Tr. 4258).

Response to Finding No. 1944:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1942 (Epic instituted only in 2004 and no evidence that it improved outcomes at HPH.)).

1945. Today, the HPH ED uses a specific module of Epic that pertains to emergency medicine. (Harris, Tr. 4259). The HPH system went live with the ED module in December of 2003. (Harris, Tr. 4259). Two ENH physicians, Dr. Mike Gillam and Dr. George del Castillo, were involved in creating that module. (Harris, Tr. 4259). HPH was the first hospital to use the ED module. (Harris, Tr. 4258-59).

Response to Finding No. 1945:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1942 (Epic instituted only in 2004 and no evidence that it improved outcomes at HPH)).

1946. Patients' clinical outcomes have been better with the addition of Epic. (Harris, Tr. 4288). For example, pre-Merger, there was a pediatric ED patient who had an abscess that needed to be drained. (Harris, Tr. 4294). A verbal order for ketamine, a sedative agent, was given by the physician. (Harris, Tr. 4294-95). The nurse inadvertently administered a substantially higher dose than what was ordered and the child was sedated more than necessary for the procedure. (Harris, Tr. 4295).

Response to Finding No. 1946:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1942 (Epic instituted only in 2004 and no evidence that it improved outcomes at HPH)).

1947. Epic automatically calculates a weight-appropriate dose. (Harris, Tr. 4295). If a physician attempts to pull out a dose that is inappropriate, Epic gives a warning, and the physician has to actively bypass the warning to administer such a dose. (Harris, Tr. 4295).

Response to Finding No. 1947:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1942 (Epic instituted only in 2004 and no evidence that it improved outcomes at HPH)).

1948. Before the Merger, Dr. Harris was not aware of any plans by HPH to purchase PACS or Epic. (Harris, Tr. 4258-59).

Response to Finding No. 1948:

Respondent's finding is misleading and incomplete. (*See* CCRFF 1942 (Epic instituted only in 2004 and no evidence that it improved outcomes at HPH)).

1949. Finally, a pneumatic tube was added to the ED and connected with the pharmacy and the laboratory after the Merger. (O'Brien, Tr. 3485). The tube expedited getting specimens and medications across the hospital. (O'Brien, Tr. 3485-86).

Response to Finding No. 1949:

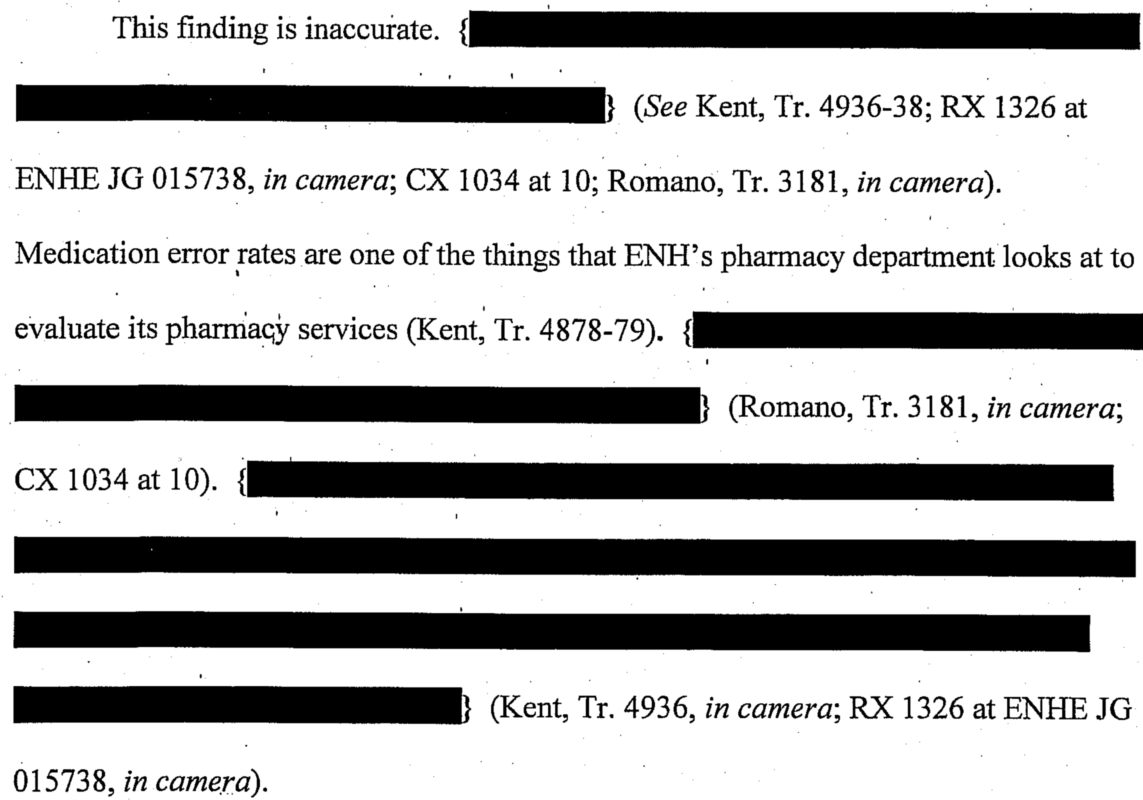
Respondent's finding is misleading and incomplete. (*See* CCRFF 1891 (no significant improvements to HPH's ED post-merger)).

g. ENH Improved Pharmacy Services At HPH Post-Merger

i. Overview

1950. ENH improved HPH's drug dispensing and clinical pharmacy services after the Merger, and these improvements had a direct impact on patient safety. (Kent, Tr. 4844; Chassin, Tr. 5354). These improvements cost at least $775,000. (Kent, Tr. 4850, 4861).

Response to Finding No. 1950:



This finding is inaccurate. { } (*See* Kent, Tr. 4936-38; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*). Medication error rates are one of the things that ENH's pharmacy department looks at to evaluate its pharmacy services (Kent, Tr. 4878-79). { } (Romano, Tr. 3181, *in camera*; CX 1034 at 10). { } (Kent, Tr. 4936, *in camera*; RX 1326 at ENHE JG 015738, *in camera*).

1951. Drug dispensing at a hospital is part of the "medication use process," which refers to the entire process of using medications in patients. This process begins with a physician writing a prescription, drug dispensing by a pharmacist, nurse administration of the medication and, finally, monitoring the effect of the drug in the patient. (Kent, Tr. 4844-45).

Response to Finding No. 1951:

Complaint Counsel have no specific response.

1952. Clinical pharmacy services consist of monitoring drug therapy, assuring that doses of medications are appropriate, and making sure that patients are responding to drug therapy as the physician intended. (Kent, Tr. 4862).

Response to Finding No. 1952:

Complaint Counsel have no specific response.

1953. Stan Kent, who testified at trial concerning the post-Merger drug dispensing and clinical pharmacy improvements at HPH, is the Assistant Vice President for Pharmacy Services at ENH. (Kent, Tr. 4839). Kent is the senior pharmacy officer in ENH and is responsible for all day-to-day operations in all pharmacy areas, as well as financial management, personnel management and the quality of pharmacy services. (Kent, Tr. 4839-40). Kent has a Master's Degree in hospital pharmacy and completed a two-year residency in hospital pharmacy administration. (Kent, Tr. 4841-42).

Response to Finding No. 1953:

Complaint Counsel have no specific response.

ii. ENH Improved Drug Dispensing Services At HPH After The Merger

1954. The two most important improvements in drug dispensing services at HPH since the Merger are the addition of overnight pharmacy services and the implementation of Pyxis. (Kent, Tr. 4846; RX 1697 at ENHL PK 51635).

Response to Finding No. 1954:

This finding is inaccurate. The evidence does not show that the addition of overnight pharmacy services and Pyxis constituted "[i]mportant improvements" attributable to the merger. First, they were not necessarily "improvements" because

{[redacted]

[redacted]} (Kent, Tr. 4963, *in camera*, RX 1326 at ENHE JG

015738, *in camera*).

Second, they were not specific to the merger. {[redacted]

[redacted]

[redacted]} (Romano, Tr. 3180, *in camera*). The addition of overnight pharmacy services consisted of hiring a "third shift" pharmacist to dispense medication instead of a nurse. (Kent, Tr. 4849). But ENH, despite all its claims about high dollar improvements, did not implement this change until the Summer of 2003, three and a half years after the merger, because "it's quite expensive" to hire a third shift pharmacist. (Kent, Tr. 4849). This long delay suggests that this alleged improvement was not a direct result of the merger but rather part of the nationwide trend of increasing quality in which a stand alone HPH would have participated.

(1) ENH Added A Third-Shift Pharmacist To HPH

1955. At the time of the Merger, both Evanston Hospital and Glenbrook Hospital had hired a third (or night) shift pharmacist for at least the past 15-20 years. (Kent, Tr. 4849).

Response to Finding No. 1955:

Complaint Counsel have no specific response.

1956. HPH, however, did not have a third shift pharmacist at the time of the Merger. (Kent, Tr. 4847). {[redacted]

[redacted]} (Kent, Tr. 4942, *in camera*). Kent was concerned with pharmacist staffing at HPH at the time of the Merger because such staffing did not meet contemporary practice standards. (Kent, Tr. 4848).

Response to Finding No. 1956:

Mr. Kent testified only that a pharmacist was made available to the nurses "if they had questions or needed help." (Kent, Tr. 4848). Thus, there appears to have been no direct physician oversight, and Mr. Kent did not comment on the extent to which telephonic assistance was, or could have been available to HPH nurses pre-merger. The critical improvement claimed by ENH, adding a third shift pharmacist, was not implemented until mid 2003. (Kent, Tr. 4848-50). Complaint Counsel notes that under this state of affairs medication event rates were lower than they were after the alleged improvements were made. (*See* CCRFF 1954, above).

1957. This was a problem because nurses do not have the training required for proper drug preparation and dispensing, and there was a potential for patient harm. (Kent, Tr. 4848). Pharmacists, not nurses or physicians, should dispense drugs because pharmacists have specialized training in that activity. (Kent, Tr. 4845).

Response to Finding No. 1957:

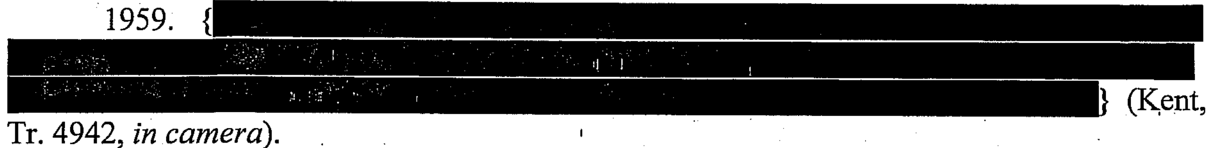
Mr. Kent commented that "pharmacists, not nurses or physicians, should dispense drugs," but nurses continued to dispense drugs, with telephonic assistance available from pharmacists in the event of question, for three and a half years post-merger. (*See* CCRFF 1956).

1958. ENH initially took steps to correct this problem at HPH by establishing a system whereby the nurses who were procuring medications from the pharmacy at night would have access to the night pharmacists at Evanston Hospital or Glenbrook Hospital if they had questions or needed help with a specific medication order or drug preparation. (Kent, Tr. 4848).

Response to Finding No. 1958

See CCRFF 1956, above (Nurses staffed the night shift at HPH pharmacy for three years after the merger). Additionally, Mr. Kent testified that a pharmacist was made available to nurses "if they had questions or needed help." (Kent. Tr. 4848). There

appears to have been no direct pharmacist oversight, and Mr. Kent did not comment on the extent to which telephonic assistance was, or could have been available to HPH premerger. The critical improvement claimed by ENH of adding a third shift did not occur until mid 2003. (Kent, Tr. 4848-50).

1959. {} (Kent, Tr. 4942, *in camera*).

Response to Finding No. 1959:

Complaint Counsel have no specific response.

1960. ENH ultimately added two third-shift pharmacists to the HPH pharmacy in 2003 at a cost of about $250,000 per year. (Kent, Tr. 4848-50).

Response to Finding No. 1960:

Complaint counsel repeats that the long time taken to implement this change calls into question its merger specificity, and that pharmacy outcome measures have deteriorated post-merger. (*See* CCRFF 1954).

1961. ENH waited until 2003 to hire a third-shift pharmacist because such staffing is a substantial expense, costing ENH $120,000-130,000 per year, per pharmacist. (Kent, Tr. 4849-50).

Response to Finding No. 1961:

A three year delay due to the relatively small outlay of $250,000 per year calls into question ENH's overall claims of having been much better financed than HPH and able to bring substantial capital and operational improvements to bear as a result. In any event, this $250,000 was easily affordable by HPH. (*See, e.g.,* CCFF 302-367).

1962. Currently, there are three shifts at the HPH pharmacy, including nighttime

coverage between the hours of 11:00 p.m. and 7:00 a.m. (Kent, Tr. 4846). ENH now has 24-hour a day on-site pharmacists at all three hospitals. (Chassin, Tr. 5355).

Response to Finding No. 1962:

Respondent presented no evidence at trial that HPH could not have done the same without the merger. In fact, Highland Park had the financial wherewithal to implement any changes to pharmacy staffing absent the merger. (*See* CCFF 335-351).

1963. Adding the third-shift pharmacist to HPH helped improve the quality of care there because it relieved the nurse supervisor from those responsibilities, provided a pharmacist professional onsite to provide pharmacy and dispensing services, and further relieved the pharmacists at Evanston Hospital and Glenbrook Hospitals from having to deal with any medication issues arising at HPH during the third shift. (Kent, Tr. 4850).

Response to Finding No. 1963:

See CCRFF 1954, above ({[redacted]

[redacted]}).

(2) ENH Added An Automated Drug Distribution System (Pyxis) To HPH

1964. At the time of the Merger, HPH used a traditional unit dose cart exchange system to distribute medications. Under this system, medication cards that hold cassettes of 15 to 20 drawers, each drawer being labeled for an individual patient, were filled in the pharmacy with a supply of medications to last 24-hours. (Kent, Tr. 4856). The drawers in these units are supposed to be locked, but often they were not. (Kent, Tr. 4856).

Response to Finding No. 1964:

This finding is misleading. The evidence does not show that the change in the drug distribution system at HPH constituted an improvement attributable to the merger. {[redacted]

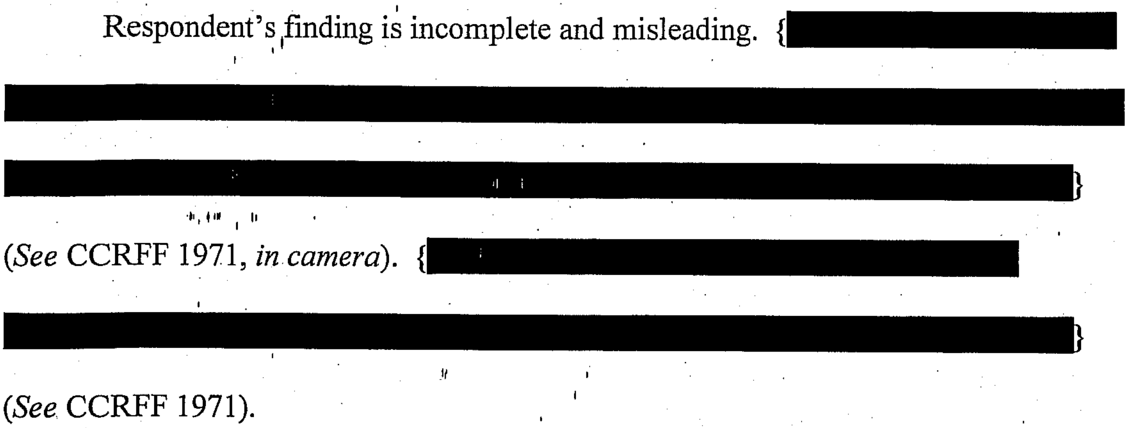
[redacted]} (Kent, Tr. 4936, *in camera*, RX 1326 at ENHE JG 015738, *in camera*).

1965. During the time the cart exchange system was in place at HPH, there were

problems with doses being lost and not making it to that patient's drawer, and there were problems with patients missing doses as well. (Kent, Tr. 4859).

Response to Finding No. 1965:

Respondent's finding is incomplete and misleading. {



}

(*See* CCRFF 1971, *in camera*). {

}

(*See* CCRFF 1971).

1966. The traditional unit dose cart exchange system in place at HPH at the time of the Merger was inefficient, in that many of the drug doses had to be returned to the pharmacy, credited back to patients' accounts and then re-shelved. (Kent, Tr. 4857).

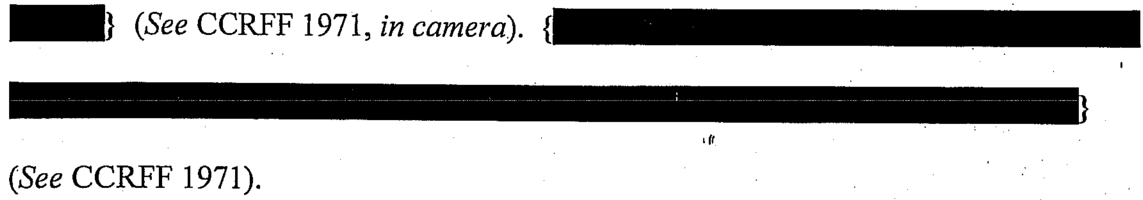
Response to Finding No. 1966:

While Respondent claims that the prior HPH practice was "inefficient," it has presented no evidence that elimination of this inefficiency has resulted in lower prices being passed on to the consumer. To the contrary, prices have gone up. (*See, e.g,* CCFF 392-404).

1967. In terms of patient care, this older distribution system was a concern because discontinued medications continued to reside in the cart and there was a chance that nurses could accidentally administer a medication that was no longer current for a particular patient. (Kent, Tr. 4857-58).

Response to Finding No. 1967:

Respondent's finding is incomplete and misleading. {



} (*See* CCRFF 1971, *in camera*). {

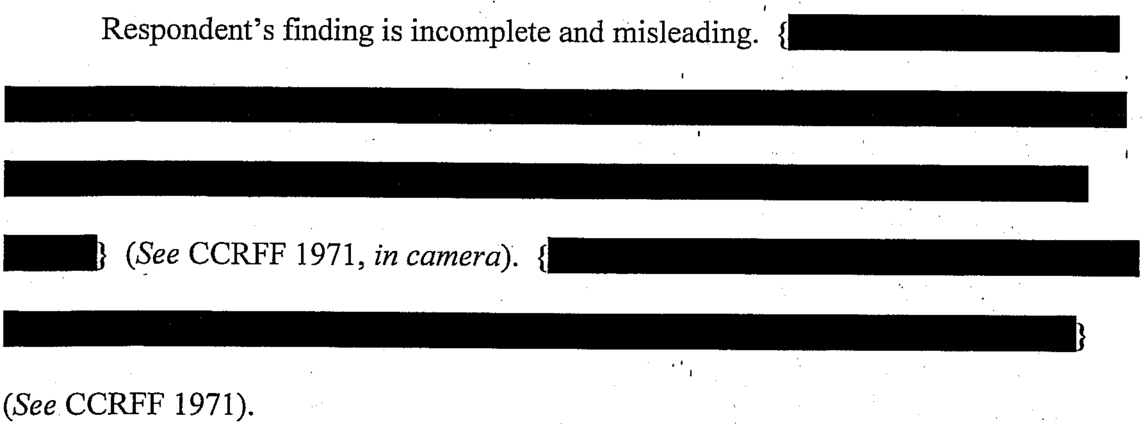
}

(*See* CCRFF 1971).

1968. At the time of the Merger, the medication use process at HPH required physicians to handwrite orders on paper. (Kent, Tr. 4858). Those orders would typically be faxed to the pharmacy and would sometimes get lost, which would require pharmacist time to locate the order. (Kent, Tr. 4858). A pharmacist then would have to enter the order, generate a label and a technician, in turn, would have to procure the medication, label it, and manually deliver it to the floor for administration by the nurse. (Kent, Tr. 4858-59). This HPH medication use process at the time of the Merger took between two to four hours. (Kent, Tr. 4859).

Response to Finding No. 1968:

Respondent's finding is incomplete and misleading. {



} (*See* CCRFF 1971, *in camera*). {

}

(*See* CCRFF 1971).

1969. While investigating the state of pharmacy services at HPH at the time of Merger, Kent expected that HPH would have made more extensive use of automation in the drug distribution process. (Kent, Tr. 4859). Kent's expectations about the level of pharmacy services that should have been in place at HPH at the time of the Merger were based upon his experience with pharmacy practice standards, which he has become familiar with through his membership in the American Society of Health System Pharmacists ("ASHP") and from visiting hospitals throughout the country, including community hospitals. (Kent, Tr. 4859).

Response to Finding No. 1969:

This finding is misleading. HPH's practice cannot have been far out of line with prevailing standards since ENH itself had only implemented Pyxis sometime in 1998, at most two years before the merger. (Kent Tr. 4860. *See also* CCRFF 1971; CCFF 2279-

2281).

1970. Since 1998, Evanston and Glenbrook Hospitals had been using an automated drug distribution product called Pyxis, which is a machine that interfaces with pharmacies. (Kent, Tr. 4860).

Response to Finding No. 1970:

Respondent's finding is incomplete and misleading. {

} (*See* CCRFF 1971, *in camera*). {

}

(*See* CCRFF 1971).

1971. Pyxis is an automated drug dispensing system, and each unit contains locked drawers with medications that are accessible via a touch screen. (Kent, Tr. 4851). Pyxis machines improve the efficiency and safety of drug distribution and overall help to improve care for patients. (Kent, Tr. 4851; Chassin, Tr. 5355-56). Specifically, Pyxis gives hospitals more control of medications because they are stored in an electronically accessible device and, in addition, provide medications in a more timely manner than traditional dispensing systems. (Kent, Tr. 4851-52).

Response to Finding No. 1971:

This finding is misleading. {

} (*See* Kent, Tr. 4936; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*). Medication error rates are one of the things that ENH's pharmacy department looks at to evaluate its pharmacy services (Kent, Tr. 4878-79). {

} (Romano, Tr. 3181,

in camera; CX 1034 at 10). {

} (Kent, Tr. 4936, *in camera*; RX 1326 at ENHE JG 015738, *in camera*). {

} (Romano, Tr. 3180, *in camera*). Equipment for a Pyxis system of drug distribution is not expensive for a hospital, around $20,000 per machine. (Newton, Tr. 397, 399)

1972. Kent was involved in the decision to install Pyxis at Evanston and Glenbrook Hospitals in 1998, a decision that was made to improve the manner in which medications were distributed and dispensed. (Kent, Tr. 4860).

Response to Finding No. 1972:

Respondent's finding is incomplete and misleading. {

} (*See* CCRFF 1971, *in camera*). {

}

(*See* CCRFF 1971).

1973. ENH decided to install Pyxis machines at HPH after the Merger for those same reasons. (Kent, Tr. 4860-61).

Response to Finding No. 1973:

Respondent's finding is incomplete and misleading. {

} (*See* CCRFF 1971, *in camera*). {

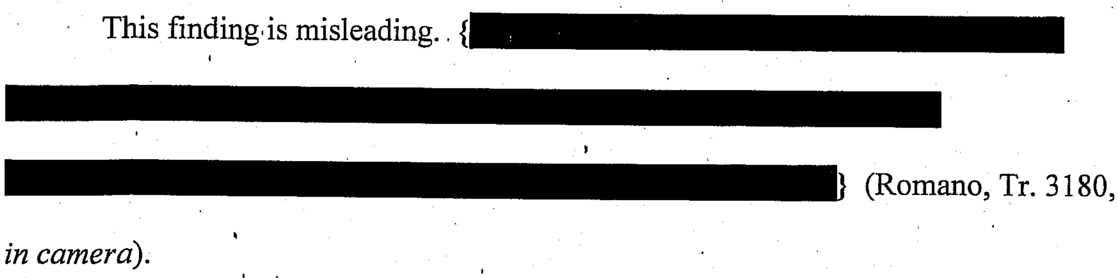
}

(*See* CCRFF 1971).

1974. ENH installed approximately twenty Pyxis machines at HPH in the first year of the Merger, 2000. (Kent, Tr. 4854-55). Pyxis machines were installed at HPH in all of the inpatient care units where there was any substantial medication use, as well as some ancillary areas. (Kent, Tr. 4855).

Response to Finding No. 1974:

This finding is misleading. {



} (Romano, Tr. 3180, *in camera*).

1975. About 85% of medication doses used on patients at ENH are currently available from Pyxis machines. (Kent, Tr. 4852).

Response to Finding No. 1975:

Complaint Counsel have no specific response.

1976. Pyxis helps ENH prevent potential medication errors insofar as it only makes available to nurses medications that have been ordered specifically for that patient. (Kent, Tr. 4852). In addition, the implementation of Pyxis machines gave ENH better control of medications, and medications are now available in a more timely fashion. (Kent, Tr. 4861).

Response to Finding No. 1976:

{

} (Romano, Tr. 3181, *in camera*; CX 1034 at 10; *see also* CCRFF 1971).

1977. Since the installation of Pyxis machines at HPH, the medication use process begins with a physician ordering a medication through Epic (discussed in Section VIII.D.2.h), the order is then sent to the pharmacy, and finally, an electronic message is sent to the relevant Pyxis machine to authorize the distribution of particular medication for a particular patient. (Kent, Tr. 4853-54). A nurse then signs into a Pyxis machine using a bio-identification – in the form of a fingerprint – to authorize access to the Pyxis unit and retrieve the medication for distribution to the patient. (Kent, Tr. 4854). The entire medication use process using Epic and Pyxis machines takes only a few minutes. (Kent, Tr. 4854).

Response to Finding No. 1977:

This finding is misleading. Like the installation of Pyxis, the installation of Epic is not specific to the merger. *See* CCRFF 1999-2127 (re Epic) and CCRFF 1954, above (Pyxis is not merger specific).

1978. Installing Pyxis drug dispensing machines across an entire hospital would cost $1-2 million. (Spaeth, Tr. 2292).

Response to Finding No. 1978:

Many hospitals have recently installed Pyxis, and the $1-2 million amount was within HPH's pre-merger capital budget. (*See* CCRFF 1954; Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2 (discussing $65 million capital budget)).

iii. ENH Added Clinical Pharmacy Services At HPH After The Merger

1979. At the time of the Merger, there were not any clinical pharmacy services provided to patients at HPH in any organized or substantive way. (Kent, Tr. 4863). Services were purely reactive to a physician who might call with a question about drug therapy. (Kent, Tr. 4863). Moreover, at the time of the Merger, pharmacists at HPH were not really involved in patient care. (Kent, Tr. 4864).

Response to Finding No. 1979:

This finding is misleading. Mr. Kent first observed the HPH pharmacy operations on January 1, 2000. (Kent, Tr. 4863). The trend to involve pharmacists more directly in patient care was only beginning in the late 1990s, and at that time HPH had plans to follow that trend and move to a more decentralized operation. (Newton, Tr. 397-99). Moreover, as discussed above, the decentralization planned by HPH pre-merger, and implemented by ENH post-merger did not bring about a decrease in the key outcome measure, medication error rates. (*See* CCRFF 1954).

1980. After the Merger, ENH changed this practice by substantively involving pharmacists in clinical activities at HPH. (Kent, Tr. 4864-65; RX 1697 at ENHL PK 51636). For example, ENH implemented decentralized pharmacists, pharmacist clinical rounds, pharmacokinetic drug monitoring, and also added an ICU pharmacist, an infectious disease pharmacist, and a medication safety pharmacist, all at HPH. (Kent, Tr. 4864-65).

Response to Finding No. 1980:

Respondent's finding is misleading and incomplete. At the time of the merger, HPH had plans to move to a more decentralized operation. (*See* CCRFF 1979).

1981. Decentralized pharmacists are pharmacists who practice at the patient care unit level and thus are in a position to directly answer questions by physicians and nurses, to educate patients, and to more closely monitor drug therapy. (Kent, Tr. 4865). Decentralized pharmacists at HPH also provide the following services to medical and surgical units at HPH including: medication verification; computer order entry; monitoring of efficacy and toxicity of high-risk medications; dose checking renal eliminated medication; providing drug information services; evaluating medication distribution issues; and providing education services. (RX 1099 at ENHE F35 341).

Response to Finding No. 1981:

This finding accurately describes the function of decentralized pharmacists, a trend that began in the late 1990s and that HPH planned to follow before agreeing to the merger. (Newton, Tr. 397, 399).

1982. The decentralization of pharmacists at HPH allowed them to more closely manage drug therapy, teach nurses about how to monitor the patients and help patients learn about their medications. (Kent, Tr. 4865-66).

Response to Finding No. 1982:

Respondent's finding is misleading and incomplete. At the time of the merger, HPH had plans to move to a more decentralized operation. (*See* CCRFF 1979).

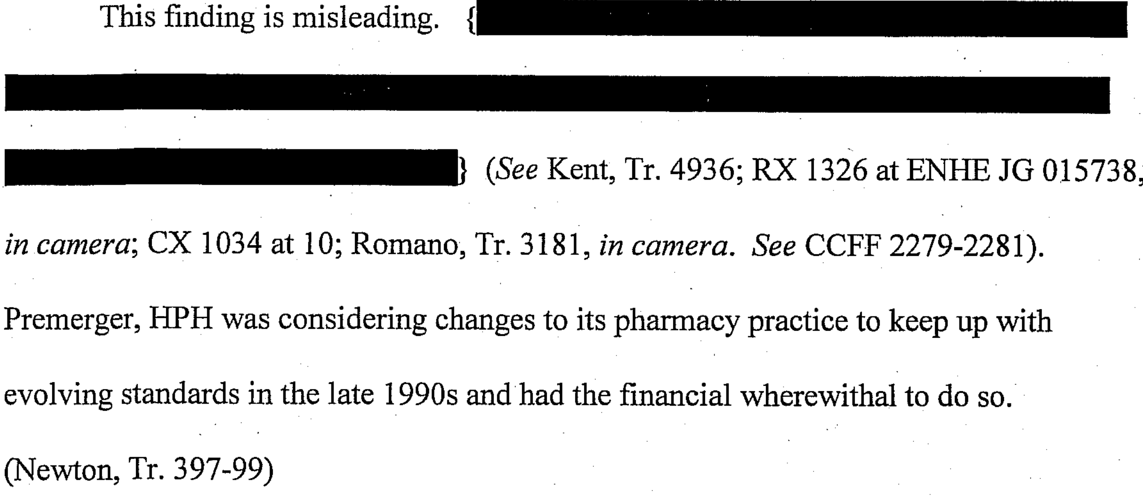
1983. The pharmacists at HPH were not decentralized at the time of the Merger, and ENH added this improvement by the end of 2000. (Kent, Tr. 4865).

Response to Finding No. 1983:

Respondent's finding is misleading and incomplete. At the time of the merger, HPH had plans to move to a more decentralized operation. (*See* CCRFF 1979).

1984. Pharmacists also took part in clinical rounds, which involve a multidisciplinary team going on rounds from one patient's room to another, a process that greatly improves drug therapy for patients. (Kent, Tr. 4866). Pharmacist involvement in multidisciplinary rounds began towards the end of 2000 at HPH. (Kent, Tr. 4866; RX 1697 at ENHL PK 51635-36). It has been proven in medical literature that adding pharmacists to the multi-disciplinary rounds in the ICU dramatically reduces medication errors and reduces preventable injuries from medications. (Chassin, Tr. 5328, 5356).

Response to Finding No. 1984:



This finding is misleading. { } (*See* Kent, Tr. 4936; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*. *See* CCFF 2279-2281). Premerger, HPH was considering changes to its pharmacy practice to keep up with evolving standards in the late 1990s and had the financial wherewithal to do so. (Newton, Tr. 397-99)

1985. ENH also implemented an ICU pharmacist at HPH. (Kent, Tr. 4866). An ICU pharmacist is a specialized, decentralized pharmacist focusing on intensive care patients. (Kent, Tr. 4866-67; RX 1697 at ENHL PK 51635). HPH did not have an ICU pharmacist at the time of the Merger. (Kent, Tr. 4866-67). ENH implemented the ICU pharmacist position at HPH toward the end of 2000. (Kent, Tr. 4867).

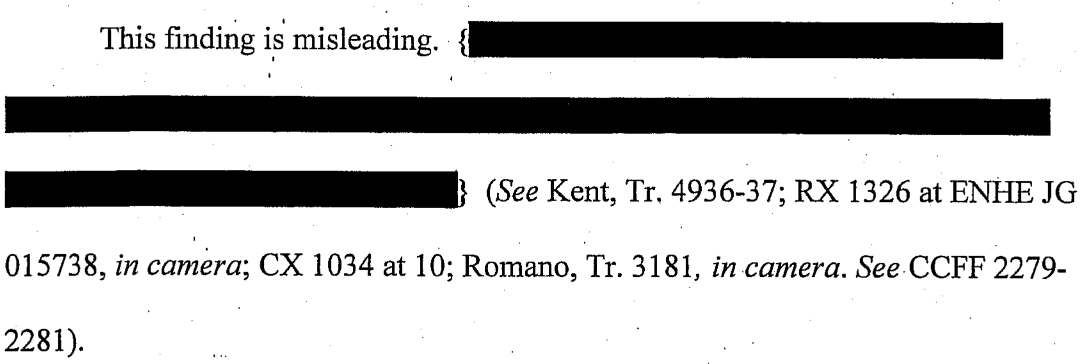
Response to Finding No. 1985:

This finding is misleading. { }

(*See* Kent, Tr. 4936-37; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*. *See* CCFF 2279-2281).

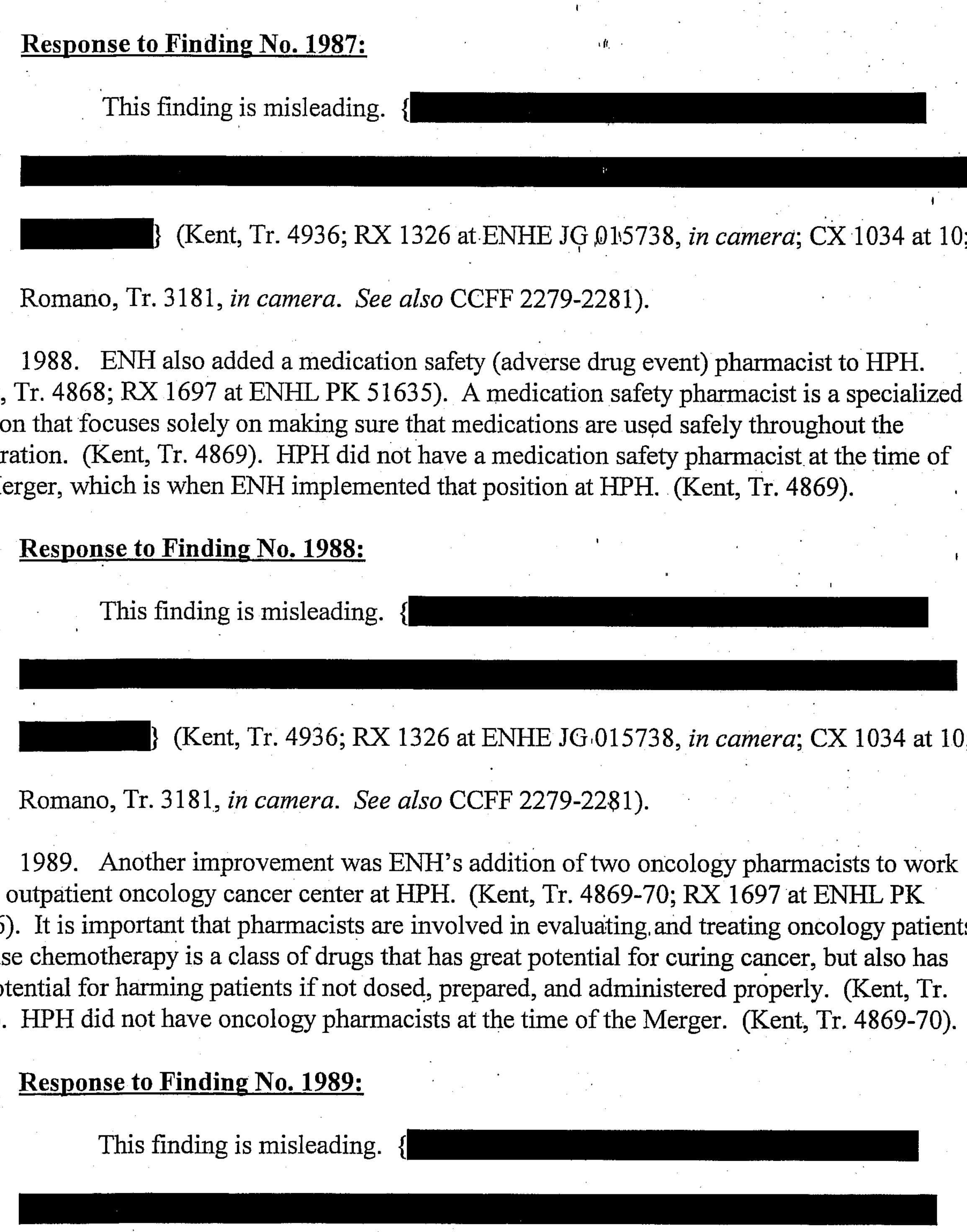
1986. ENH also implemented pharmacokinetic drug monitoring at HPH after the Merger. (Kent, Tr. 4867; RX 1697 at ENHL PK 51635). Pharmacokinetics involves the study of serum levels in the blood. (Kent, Tr. 4867). This is important because, for certain medications, if a serum level gets too high, it could cause toxicity or other problems or, if the serum level is too low, the drug may not be effective. (Kent, Tr. 4867). The addition of pharmacokinetic drug monitoring has improved pharmacy services at HPH because now physicians can rely on pharmacists to help come up with the most appropriate dose of medication for patients. (Kent, Tr. 4867-68). HPH did not have pharmacokinetic drug monitoring at the time of the Merger. (Kent, Tr. 4867).

Response to Finding No. 1986:



This finding is misleading. { } (*See* Kent, Tr. 4936-37; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*. *See* CCFF 2279-2281).

1987. ENH also added an infectious disease pharmacist at HPH after the Merger. (Kent, Tr. 4868; RX 1697 at ENHL PK 51635). An infectious disease pharmacist is someone who has specialized training and experience in the proper use of antibiotics and who monitors laboratory and microbiology reports on a daily basis to ensure that all the patients are on the correct antibiotic for their infection. (Kent, Tr. 4868). HPH did not have an infectious disease



pharmacist at the time of the Merger, which is when ENH began that service at HPH. (Kent, Tr. 4868).

Response to Finding No. 1987:

This finding is misleading. { } (Kent, Tr. 4936; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*. *See also* CCFF 2279-2281).

1988. ENH also added a medication safety (adverse drug event) pharmacist to HPH. (Kent, Tr. 4868; RX 1697 at ENHL PK 51635). A medication safety pharmacist is a specialized position that focuses solely on making sure that medications are used safely throughout the corporation. (Kent, Tr. 4869). HPH did not have a medication safety pharmacist at the time of the Merger, which is when ENH implemented that position at HPH. (Kent, Tr. 4869).

Response to Finding No. 1988:

This finding is misleading. { } (Kent, Tr. 4936; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*. *See also* CCFF 2279-2281).

1989. Another improvement was ENH's addition of two oncology pharmacists to work in the outpatient oncology cancer center at HPH. (Kent, Tr. 4869-70; RX 1697 at ENHL PK 51636). It is important that pharmacists are involved in evaluating and treating oncology patients because chemotherapy is a class of drugs that has great potential for curing cancer, but also has the potential for harming patients if not dosed, prepared, and administered properly. (Kent, Tr. 4869). HPH did not have oncology pharmacists at the time of the Merger. (Kent, Tr. 4869-70).

Response to Finding No. 1989:

This finding is misleading. { } (Kent, Tr. 4936; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10;

Romano, Tr. 3181, *in camera*. *See also* CCFF 2279-2281).

1990. ENH also implemented a code team pharmacist at HPH after the Merger. (Kent, Tr. 4870; RX 1697 at ENHL PK 51636). A code team pharmacist assists with preparing and administering medications on the floor when a patient codes (*i.e.*, has an emergency). (Kent, Tr. 4870). HPH did not have a code team pharmacist at the time of the Merger. (Kent, Tr. 4870).

Response to Finding No. 1990:

This finding is misleading. {[redacted]

[redacted]

[redacted]} (*See* Kent, Tr. 4963; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*. *See also* CCFF 2279-2281).

1991. Currently, there are 14 pharmacists at HPH compared to 10 pharmacists at the time of the Merger. (Kent, Tr. 4871).

Response to Finding No. 1991:

This finding is misleading. {[redacted]

[redacted]

[redacted]} (*See* Kent, Tr. 4936; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*. *See also* CCFF 2279-2281).

iv. HPH's Institute For Safe Medication Practices Surveys Confirm That ENH's Enhancements To HPH's Pharmacy Services Have Improved Quality Of Care

1992. ENH conducted a medication safety assessment survey at HPH in 2000 that was prepared by the Institute for Safe Medication Practices ("ISMP"). (Kent, Tr. 4871). The ISMP is the premier organization promulgating patient safety with respect to medication errors. (Chassin, Tr. 5356). The organization is a non-profit entity founded more than 20 years ago and is the leading authority in how to provide medication safely in hospitals. (Chassin, Tr. 5356-57).

Response to Finding No. 1992:

ENH's discussion of the ISMP survey responses leaves out several important points. First, the survey explicitly noted that "the self assessment characteristics should NOT be thought of as minimum standards of practice and in fact in some cases represent innovative practices not widely implemented." (RX 1029 at ENHL PK 051639). As discussed above, standards of pharmacy practice were changing, and HPH had specific plans to keep up to date with those changes. (Newton Tr. 397-99). There is every reason to expect that, on its own, Highland Park would have followed through and improved its score by 2004. (CCFF 335-351).

In fact Mr. Newton's testimony is confirmed by the HPH 2000 score. One category is for items "discussed but not implemented," as to which there were 12 at HPH in 2000, down to 6 in 2004. (RX 1029 at ENHL PK 051638). This confirms that HPH was aware of changing standards of practice and planning to follow them – but was bought by ENH at the time these plans were in progress.

Moreover, much of the discussion above applies to the ISMP survey. That survey measures items such as automated drug distribution systems and decentralized practice. (RX 1029). As noted above, those changes would likely have happened without the merger. (CCRFF 1954).

Pre-merger, HPH was considering changes to its pharmacy practice to keep up with evolving standards in the late 1990s and had the financial wherewithal to do so. (Newton, Tr. 397-99).

1993. ISMP administered the survey, containing about 200 items, by sending questionnaires to all hospitals, who then completed and returned the surveys to ISMP. (Kent, Tr. 4871-72). The purpose of the survey was to provide hospitals with a checklist that they could use

to assess the extent to which they were employing the safe medication practices that ISMP had compiled over time from research and literature to protect patients from medication errors. (Kent, Tr. 4872; Chassin, Tr. 5357). The survey results were a quantitative measure that gave hospitals a chance to know where they were on the spectrum of safety as of 2000. (Chassin, Tr. 5357).

Response to Finding No. 1993:

See CCRFF 1992 (ENH's discussion of ISMP survey responses leaves out several important points).

1994. There have been two ISMP surveys, one in 2000 and the second in 2004. (Kent, Tr. 4871-72; Chassin, Tr. 5357). The responses to the ISMP surveys are submitted electronically and then the ISMP staff compiles the results to arrive at a rating. (Kent, Tr. 4873). Kent assembled a group of pharmacists and nurses at ENH to determine their compliance with each item on the ISMP survey. (Kent, Tr. 4873).

Response to Finding No. 1994:

See CCRFF 1992 (ENH's discussion of ISMP survey responses leaves out several important points).

1995. ENH sought to be 100% accurate when completing the survey because the ISMP survey was to be used as a tool to make improvements in the medication use process. (Kent, Tr. 4873).

Response to Finding No. 1995:

See CCRFF 1992 (ENH's discussion of ISMP survey responses leaves out several important points).

1996. The results of the 2000 ISMP survey were that Evanston and Glenbrook Hospitals had achieved 80% and 81% compliance ratings, respectively, or scores in the top two ratings in the survey while, in contrast, HPH had a rating of 70%. (Kent, Tr. 4875; RX 1029 at ENHL PK 51640). Indeed, in July 2000, barely 50% of the ISMP's recommended safe medication practices were fully implemented in all units of HPH. (Chassin, Tr. 5358). The 2000 ISMP survey thus revealed that there was room to make improvements in pharmacy services at HPH. (Kent, Tr. 4875).

Response to Finding No. 1996:

Respondent's finding is incomplete and misleading. {

} (*See* CCRFF 1950, *in camera*). Moreover, ENH's discussion of the ISMP survey leaves out several important points. (*See* CCRFF 1992).

1997. By 2004, HPH was almost 90% compliant with all the items identified in the ISMP survey, a rating that was consistent with ratings for both Evanston and Glenbrook Hospitals during the same period. (Kent, Tr. 4876; RX 1029 at ENHL PK 51638).

Response to Finding No. 1997:

Respondent's finding is incomplete and misleading. {

} (*See* CCRFF 1950, *in camera*). Moreover, ENH's discussion of the ISMP survey leaves out several important points. (*See* CCRFF 1992).

1998. The ISMP surveys reflect a substantial improvement in compliance with ISMP's medication safety recommendations, most notably at HPH. (Kent, Tr. 4876; RX 1029 at ENHL PK 51638). This is a dramatic quantified improvement in the quality of medication safety. (Chassin, Tr. 5358)

Response to Finding No. 1998:

Respondent's finding is incomplete and misleading. {

} (*See* CCRFF 1950, *in camera*). Moreover, ENH's discussion of the ISMP survey leaves out several important points. (*See* CCRFF 1992).

h. ENH's Deployment Of Epic At HPH Dramatically Improved The Quality Of Care

i. Overview

1999. According to the Institute of Medicine ("IOM"), the development of an information technology ("IT") infrastructure has enormous potential to improve the safety, quality and efficiency of health care in the United States. (RX 1423 at 6). The availability of complete patient health information at the point of care delivery, together with clinical decision support systems ("CDSS") such as those for medication order entry, can prevent many errors and events from occurring. (RX 1423 at 6).

Response to Finding No. 1999:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2001 (explaining why the implementation of the EPIC information technology system after the merger was not merger specific)).

2000. The Federal Government has endorsed and expanded this view, establishing a national initiative to develop a universally accessible electronic healthcare record for all citizens within 10 years. (Wagner, Tr. 3957).

Response to Finding No. 2000:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2001 (explaining why the implementation of the EPIC information technology system after the merger was not merger specific)).

2001. In 2001, the President of ENH made ENH's top priority the implementation of a paperless, patient-centric health record with true computerized physician order entry ("CPOE"). (RX 1425 at ENHE F22 1394; RX 1839 at ENH GW 3520). ENH selected Epic in June 2001 as the system most able to meet this goal, and ENH began the long process of implementing Epic in all three of its hospitals, its faculty practice medical group outpatient offices and all affiliated physician offices that wished to participate. (Wagner, Tr. 3965-66, 3968-74).

Response to Finding No. 2001:

This finding is correct and vividly demonstrates why the claimed "improvement"

through implementation of Epic is not merger specific. In March 2001, a year and a quarter after the merger, and well after prices had been increased through the exercise of market power, ENH made the decision to implement an electronic medical records system across all three ENH hospitals, including Highland Park. (RX 1425 at ENHE F22 1395).

The decision of ENH to purchase the Epic system was influenced by the public recommendations of the Institute of Medicine and Leapfrog Group. (Wagner, Tr. 4066; RX 1117 at ENH GW 003511). Other hospitals have purchased the Epic electronic medical record system. (Wagner, Tr. 4066-67). Other hospitals in the Chicago area have purchased an integrated medical record system similar to Epic's. (Wagner, Tr. 4067). Northwestern Memorial Hospital purchased the same Epic system as ENH. (Wagner, Tr. 4068). Other community hospitals have purchased an electronic medical record system. (Wagner, Tr. 4067). Northwest Community Hospital, a stand-alone community hospital in the Chicago area , is considering purchasing an electronic medical record system from McKesson. (Wagner, Tr. 4068-69).

All ENH was doing, consistent with other hospitals across the country and in Illinois, was keeping up with the evolving state of medical care. (*See, e.g.* Romano, Tr. 2998, 3003-04 (noting general trend of improving quality nationwide)). {

} (Romano, Tr. 3161, *in camera*).

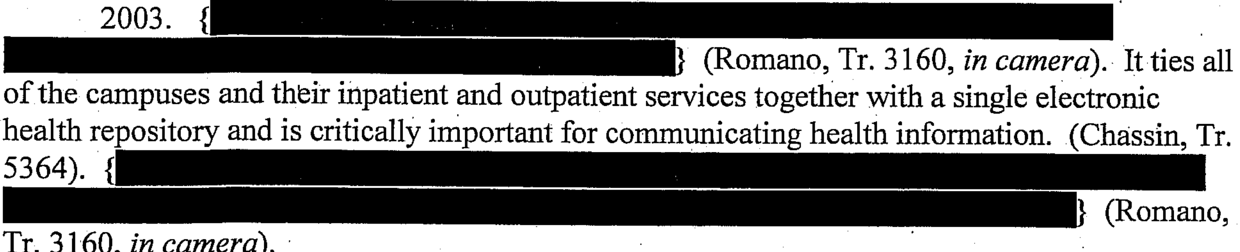
{

} (Romano, Tr. 3162, *in camera*}.

2002. Epic was first deployed in January 2003 and was fully implemented across all ENH sites and all ENH faculty practice outpatient offices by April 2004. (Wagner Tr. 3976; Neaman, Tr. 1251).

Response to Finding No. 2002:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2004 (explaining why the implementation of EPIC after the merger was not merger specific)). In addition, the timing of the Epic rollout – no earlier than four years after the merger – reinforces the conclusion that the claimed improvement is not merger specific. (*See* CCRFF 2001).



2003. { } (Romano, Tr. 3160, *in camera*). It ties all of the campuses and their inpatient and outpatient services together with a single electronic health repository and is critically important for communicating health information. (Chassin, Tr. 5364). { } (Romano, Tr. 3160, *in camera*).

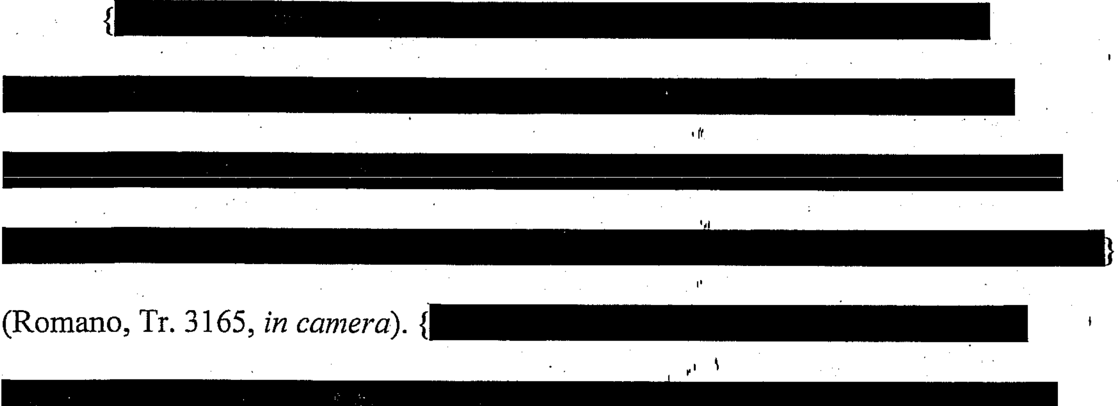
Response to Finding No. 2003:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2004 (explaining why the implementation of EPIC after the merger was not merger specific)).

2004. ENH's roll-out of Epic at HPH constituted a major improvement in quality of care. (Chassin, Tr. 5363). It is a major improvement in the structure of care at ENH that increases the likelihood of desired health outcomes when the physician uses the information in ways that improve care. (Romano, Tr. 3327-29).

Response to Finding No. 2004:

This finding is inaccurate and misleading. While the roll-out of Epic may have allowed Highland Park to keep up with national quality improvement trends, it is not a "major improvement" attributable to the merger.

{}

(Romano, Tr. 3165, *in camera*). { } (CX 94 at 2). In 1997, Highland Park Hospital also revised its "Information Technology Strategic Plan" and began to implement key parts of that plan including looking for a new IT vendor. (CX 94 at 2). Prior to the merger, Highland Park Hospital was planning "to utilize the latest technology to support patient care" by exploring the use of internet technology and expanding access to information to physician offices. (CX 1908 at 20). There is no reason to believe that, had the merger not occurred, Highland Park would not have continued to improve its operations by investing in information technology, either through Epic or other appropriate systems. Epic was not fully deployed at Highland Park Hospital until January 2004. (Wagner, Tr. 4070), and Highland Park would no doubt have continued to improve information technology on its own during the four years it took ENH to roll out Epic.

In addition, there is no evidence that the merger has improved outcomes at Highland Park through the deployment of Epic. (Wagner, Tr. 4070).

2005. In fact, Complaint Counsel's quality expert uses Epic at the University of California at Davis ("U.C. Davis") and advocated for the implementation of Epic because he believed it would result in an improvement in quality. (Romano, Tr. 3326-28).

Response to Finding No. 2005:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2004 (explaining why the implementation of EPIC after the merger was not merger specific)).

2006. ENH has spent approximately $42 million on Epic to date. (Wagner, Tr. 3987-88; Neaman, Tr. 1251; Hillebrand, Tr. 1984). Approximately $14 million of the $42 million was spent to implement Epic at HPH. (Hillebrand, Tr. 1984; Neaman, Tr. 1355; O'Brien, Tr. 3523).

Response to Finding No. 2006:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2004 (explaining why the implementation of EPIC after the merger was not merger specific)). HPH was fully capable of devoting $14 million to information technology upgrades without the merger.. HPH's 1999-2003 financial plan set forth a "long range capital budget" that included $65 million for "[h]ospital construction, routine capital and information technology" investments. (CX 545 at 3; CX 1055 at 2; Newton, Tr. 430-31).

ii. Epic Integrates All Patient Information Into A Single Data Repository That Is Accessible By All Caregivers And The Patient

2007. Epic is an integrated, longitudinal health record. (Wagner, Tr. 3945). An "integrated" record is a single repository for all of the clinical information that is necessary for patient care, including physician office visits, hospital encounters, laboratory information, x-ray images, and other ancillary information that may be necessary for patient care. (Wagner, Tr. 3945-46). A "longitudinal health record" serves as a repository of information that follows the patient through his or her life. (Wagner, Tr. 3946). The term "health record" means that the patient can access and contribute to the patient's own information. (Wagner, Tr. 3945-46).

Response to Finding No. 2007:

See CCRFF 2001, above. (ENH's implementation of Epic is not unique. At the time of the merger, studies recommended the use of electronic medical records. ENH's decision to purchase Epic was influenced by these studies and was not merger specific.)

2008. Epic allows all caregivers to have access to clinical information about a patient – including hospital admissions, office visits, laboratory studies, imaging studies and information generated by other caregivers – that is secure, current, complete, legible, organized and instantly accessible. (RX 1425 at ENHE F22 1392; RX 1636 at ENHE DL 1721; RX 1677 at ENHE DL 10002-03).

Response to Finding No. 2008:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2004 (explaining why the implementation of EPIC after the merger was not merger specific)).

2009. Epic, as deployed at ENH, includes a patient portal that allows patients to review their health record, including their test results, office visits, hospital visits and communicate securely with their physician. (Wagner, Tr. 3959-60).

Response to Finding No. 2009:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2004 (explaining why the implementation of EPIC after the merger was not merger specific)).

2010. In contrast to Epic, a nonintegrated electronic medical record gives electronic access to pieces of a patient's clinical information and different data repositories, such as a hospital laboratory repository or a radiology data repository, but the data repositories cannot talk to each other. (Wagner, Tr. 3946).

Response to Finding No. 2010:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2004 (explaining why the implementation of EPIC after the merger was not merger specific)).

iii. Sources Outside Of ENH, Including The Federal Government, Have Been Calling For The Use Of Electronic Medical Records

2011. In the early 1990s, the Institute of Medicine ("IOM") issued a report identifying electronic medical records as an essential ingredient to modern healthcare. (Wagner, Tr. 3955).

Response to Finding No. 2011:

Respondent is absolutely correct that the IOM and other sources have been calling

for the implementation of "electronic medical records" systems. These calls did not prompt ENH to begin the Epic launch systemwide until March 2001. (*See* CCRFF 2001). Absent the merger, HPH would have read the same reports and devoted its ample capital resources to similar upgrades. (*See* CCRFF 2006).

2012. In the middle and late 1990s, the IOM issued a report entitled "To Err is Human," identifying unnecessary patient deaths in hospitals as a result of poor order transmission or misinterpretation. (Wagner, Tr. 3955).

Response to Finding No. 2012:

Complaint Counsel have no specific response.

2013. The IOM issued another report about two years later entitled "Crossing the Quality Chasm," which further identified the electronic medical record as an essential ingredient to raising quality and making the quality of healthcare more uniform across the country. (Wagner, Tr. 3955-56).

Response to Finding No. 2013:

See CCRFF 2011, above. Moreover, ENH's reliance on a source published after the merger further reinforces the conclusion that EPI's implementation was not merger specific and was merely part of a national trend. (*See* CCRFF 2001).

2014. In the 1990s, an organization called Leapfrog, a collection of large industry employers – *i.e.*, purchasers of healthcare – identified CPOE as an indicator of excellence in healthcare institutions. (Wagner, Tr. 3956).

Response to Finding No. 2014:

Respondent's finding is misleading and incomplete. HPH had access to the same public information and could have been influenced to purchase and implement Epic in the same manner. Absent the merger, HPH could have read the same reports and devoted its ample capital resources to similar upgrades. (*See* CCRFF 2011).

2015. More recently, the Federal Government has established a national initiative to develop a universally accessible electronic healthcare record for all citizens within 10 years. (Wagner, Tr. 3957). The goal is to improve the safety, quality, and efficiency of healthcare in every area of this country. (RX 1701 at 1-2). President Bush, in the January 2004 State of the Union Address, called for the widespread adoption of computerized health records to avoid dangerous medical mistakes, reduce costs and improve care. (RX 1635 at 99; RX 1677 at ENHE DL 10002)

Response to Finding No. 2015:

See CCRFF 2011, above. In addition, Respondent's reliance on a January 2004 speech by the President further reinforces the conclusion that Epic's implementation was not merger specific and was merely part of a national trend. (*See* CCRFF 2001).

2016. To accomplish the goal of a universally accessible electronic medical record, in April 2004, President Bush created an Office of National Healthcare Information Technology, which is headed by Dr. David Brailer. (Wagner, Tr. 3957; RX 1701 at 1).

Response to Finding No. 2016:

Respondent's finding is misleading and incomplete. HPH had access to the same public information and could have been influenced to purchase and implement Epic in the same manner. Absent the merger, HPH could have read the same reports and devoted its ample capital resources to similar upgrades. (*See* CCRFF 2011).

2017. The Federal Government's initiative expands the Leapfrog vision from CPOE to a patient-focused electronic medical record that includes all of the patients' medical records in one place and is accessible by all providers and the patients themselves. (Wagner, Tr. 3958).

Response to Finding No. 2017:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique.)

iv. The Sharing Of Information Is Important To Patient Care And Patient Safety

2018. The sharing of patient information is important because no single physician is the repository of all the knowledge it takes to manage a patient's well-being. (Wagner, Tr. 3960).

Patients see different physicians for different needs, and all of these physicians contribute to the patient's overall health. (Wagner, Tr. 3960).

Response to Finding No. 2018:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique.)

2019. Patient safety is enhanced when all physicians can contribute to the same body of knowledge and access the same body of knowledge, affording them complete and current information about the patient. (Wagner, Tr. 3960).

Response to Finding No. 2019:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique.)

v. ENH Made A Patient-Centric Integrated Electronic Health Record Its Top Priority And Chose Epic Because It Was Best Suited To Accomplish This Goal

2020. Initially, ENH was interested in order transmission, recovery, and result review. (Wagner, Tr. 3958). Over time, ENH's focus changed to an integrated longitudinal heath record. (Wagner, Tr. 3961; RX 1839 at ENHE GW 3520).

Response to Finding No. 2020:

See CCRFF 2001, above. (ENH's implementation of Epic is not unique. ENH's decision to purchase Epic was influenced by studies like the IOM report. Other hospitals also purchased Epic.)

2021. Before Epic, ENH had elements of a medical record in place through a vendor called McKesson HBOC, but the record was not integrated. (Wagner, Tr. 3962).

Response to Finding No. 2021:

Complaint Counsel have no specific response.

2022. The McKesson HBOC system was insufficient to accomplish ENH's goal because: (1) in the late 1990s, McKesson discontinued its physician documentation and order transmission capability; and (2) the McKesson HBOC system did not include support for the ambulatory world. (Wagner, Tr. 3962). The bulk of healthcare happens outside of the hospital in what is termed the ambulatory world, which includes physician offices. (Wagner, Tr. 3962).

Response to Finding No. 2022:

Complaint Counsel have no specific response.

2023. In 2001, Neaman established as ENH's number one priority the implementation of a paperless, patient-centric electronic health record with true CPOE. (RX 1425 at ENHE F22 1394; RX 1839 at ENH GW 3520). Accordingly, in February 2001, ENH began aggressively searching for a different clinical electronic medical record system. (Wagner, Tr. 3964). ENH choose Epic in June 2001 because Epic was best suited to meet ENH's ambulatory needs, and Epic had an excellent track record in dealing with physicians and responding to physicians' needs for software development and evolution. (Wagner, Tr. 3965-66; Hillebrand, Tr. 1985).

Response to Finding No. 2023:

See CCRFF 2001, above. (ENH's implementation of Epic is not unique. ENH's decision to purchase Epic was influenced by studies like the IOM report. Other hospitals also purchased Epic.)

2024. ENH purchased the following software packages from Epic: patient registration, scheduling, central data repository, inpatient documentation and order entry, outpatient documentation and order entry, a reporting engine, and a patient portal. (Wagner, Tr. 3966-67). The inpatient and outpatient packages use the same central data repository. (Wagner, Tr. 3967).

Response to Finding No. 2024

See CCRFF 2001, above (ENH's implementation of Epic is not unique. ENH's decision to purchase Epic was influenced by studies like the IOM report. Other hospitals also purchased Epic).

2025. The Epic project is focused on creating a body of information that follows and surrounds the patient. (Wagner, Tr. 3951). The goals of the Epic project include: (1) improving patient safety by eliminating problems associated with illegible orders and medication errors; (2) ensuring that physicians, clinicians, and administrators have access to the right patient data at the right time; (3) ensuring the accuracy of the information and data in the record; and (4) simplifying processes and making them consistent across the organization. (RX 1425 at ENHE F22 1394).

Response to Finding No. 2025:

See CCRFF 2001, above. (ENH's implementation of Epic is not unique. ENH's decision to purchase Epic was influenced by studies like the IOM report. Other hospitals also purchased Epic.)

vi. ENH Planned From The Outset To Deploy Epic At HPH And In Affiliate Outpatient Offices

2026. When ENH signed the contract with Epic in 2001, it decided that Epic would be deployed at all three ENH hospitals, at ENH's full time faculty practice medical group outpatient offices, and all of the affiliate outpatient physician offices that were willing to participate. (Wagner, Tr. 3967).

Response to Finding No. 2026:

See CCRFF 2001, above. (ENH's implementation of Epic is not unique. ENH's decision to purchase Epic was influenced by studies like the IOM report. Other hospitals also purchased Epic.)

vii. ENH Aggressively Deployed Epic Throughout The ENH System

(1) Initial Steps

2027. ENH was required to take several steps before deploying Epic, including workflow analysis, build, hardware deployment, training, and creating a support system. (Wagner, Tr. 3968). Moreover, all of these steps had to be taken before deploying Epic in the ENH hospitals and then repeated for each physician office that installed Epic. (Wagner, Tr. 3975-76).

Response to Finding No. 2027:

See CCRFF 2033 below. (Completion of roll-out will make it easier for Highland Park Hospital to maintain Epic after a divestiture).

(a) Workflow Analysis

2028. A workflow is an understanding of how knowledge is captured, shared, stored,

and retrieved. (Wagner, Tr. 3968). Workflows are the blueprints used in designing and building Epic. (Wagner, Tr. 3970).

Response to Finding No. 2028:

Complaint Counsel have no specific response.

2029. The workflow analysis phase, which included workflow analysis for all three ENH hospitals, began in November 2001 and lasted through April 2002. (Wagner, Tr. 3972).

Response to Finding No. 2029:

Complaint Counsel have no specific response.

(b) Build

2030. Building Epic involved configuring it with items including lists, documentation tools, orders sets, best practice alerts and health maintenance alerts. (Wagner, Tr. 3968).

Response to Finding No. 2030:

See CCRFF 2033 ({[redacted]

[redacted]}).

2031. The build phase, which included the build for all three ENH hospitals, began in April 2002 and continued aggressively until November 2002. (Wagner, Tr. 3972-73). Elements of the build that were unique to each hospital were built more proximate to the time in which each hospital went live on Epic. (Wagner, Tr. 3973). ENH continues to build Epic through the present. (Wagner, Tr. 3972-73).

Response to Finding No. 2031:

See CCRFF 2033 ({[redacted]

[redacted]}).

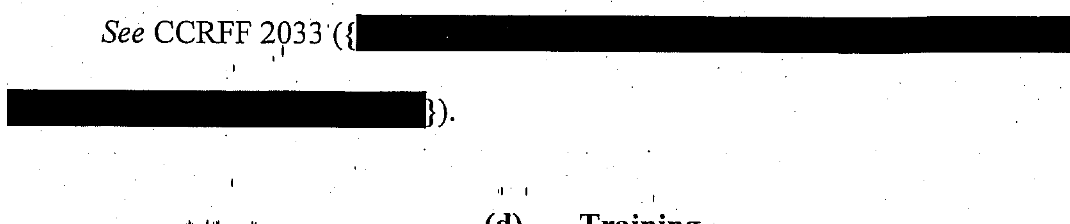
(c) Hardware Deployment

2032. The hardware deployment process for all three hospitals and ambulatory offices took place in 2002. (Wagner, Tr. 3973-74). To run Epic, ENH had to purchase a new central processor and a new network infrastructure. (Wagner, Tr. 3973). The network infrastructure

required the purchase and install of multiple access points. (Wagner, Tr. 3973). As part of the hardware deployment, ENH purchased new equipment for HPH. (Wagner, Tr. 3974).

Response to Finding No. 2032:

See CCRFF 2033 ({



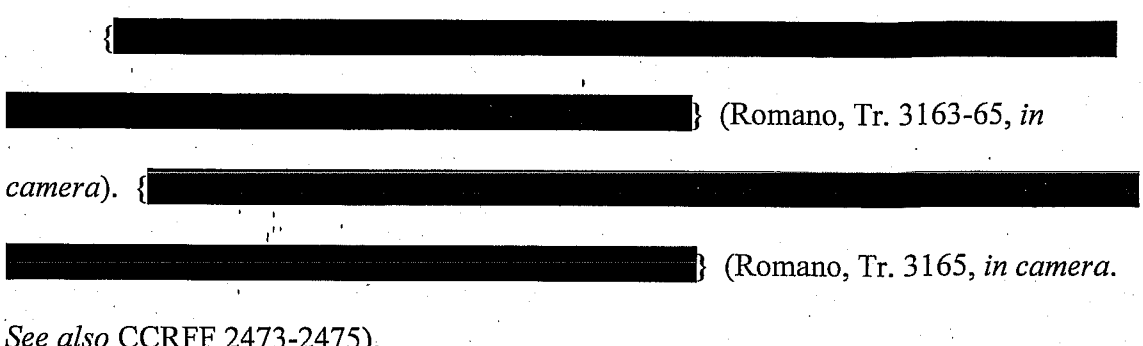
}).

(d) Training

2033. Training is required before a person is allowed to use Epic at ENH. (Wagner, Tr. 3986). For example, ENH physicians cannot admit, consult, or perform surgery unless they have completed 16 hours of Epic training. (Wagner, Tr. 3987; O'Brien, Tr. 3522). Physicians who use EPIC in their office must also take an additional four hours of training. (Wagner, Tr. 3987).

Response to Finding No. 2033:

{



} (Romano, Tr. 3163-65, *in camera*). {

} (Romano, Tr. 3165, *in camera*.

See also CCRFF 2473-2475).

2034. ENH physicians underwent Epic training that was more extensive than the training conducted by other institutions, such as U.C. Davis, because ENH has implemented more features of Epic. (Romano, Tr. 3335).

Response to Finding No. 2034:

Respondent's finding is incomplete and misleading. (*See* CCRFF 2033

({

}), *in camera*).

2035. The Human Resources Division, Training Division, of ENH set up a classroom environment and performed the training. (Wagner, Tr. 3986-87). The cost of Epic training was paid by ENH. (Wagner, Tr. 3987).

Response to Finding No. 2035:

See CCRFF 2033 ({ }).

2036. ENH trained almost 8,000 people to use Epic over the course of 119,352 training hours. (RX 1425 at ENHE F22 1402). This included 1,500 physicians and staff at HPH. (O'Brien, Tr. 3522).

Response to Finding No. 2036:

See CCRFF 2033 ({ }).

2037. Physicians, nurses, and clinicians were trained in an impeccable way to use the system, which has been a failing in many other implementations. (Chassin, Tr. 5364).

Response to Finding No. 2037:

(*See* CCRFF 2033 (It is unclear what Respondent means when it states that people "were trained in an impeccable way to use the system.")).

2038. Epic training is role-specific. (Wagner, Tr. 3986). There is different training, for example, for physicians and nurses. (Wagner, Tr. 3986). ENH has developed and used 51 different training courses. (Wagner, Tr. 3986).

Response to Finding No. 2038:

See CCRFF 2033 ({ }).

2039. Formal Epic training began in October 2002 and continued aggressively through December 2003. (Wagner, Tr. 3974). Training continues through the present. (Wagner, Tr. 3974). New physician arrivals, new nurse arrivals, new house staff arrivals and rotating medical students must be trained to use Epic. (Wagner, Tr. 3974).

Response to Finding No. 2039:

See CCRFF 2033 ({[redacted]

[redacted]}).

2040. Training in the proper use of an electronic medical record is important and a big part of the cost of such systems. (Romano, Tr. 3329). ENH has spent $7 million to date on Epic training. (Wagner, Tr. 3987-88). Moreover, when new physicians and other personnel join ENH, ENH pays for the cost of their training. (Wagner, Tr. 3987).

Response to Finding No. 2040:

See CCRFF 2033 ({[redacted]

[redacted]}).

(e) Support System

2041. ENH's support system for Epic, which supports Epic in all three hospitals, was developed contemporaneously with the installation of Epic and it is ongoing. (Wagner, Tr. 3975).

Response to Finding No. 2041:

See CCRFF 2001, above. (There is nothing unique with ENH's deployment of Epic. Epic is an emerging technology, and other hospital systems have implemented it.) Only three independent physician practices have Epic installed in their office (Wagner, Tr. 3978).

2042. As part of Epic support, ENH maintains Epic's mechanics and clinical structure, trains personnel and provides user support, and builds new order sets, practice alerts and other quality related features in Epic. (Wagner, Tr. 3975).

Response to Finding No. 2042:

Respondent's finding is incomplete and misleading. (*See* CCRFF 2033

({[redacted]

}), *in camera*).

(2) **Deployment**

2043. Epic was first deployed in a faculty practice internal medicine office in January 2003. (Wagner, Tr. 3976). The faculty practice group consists of physicians who are employed by ENH. (Wagner, Tr. 3976). Epic is mandatory for the faculty practice physicians. (Wagner, Tr. 3977).

Response to Finding No. 2043

See CCRFF 2001, above. (There is nothing unique with ENH's deployment of Epic. Epic is an emerging technology, and other hospital systems have implemented it.) Only three independent physician practices have Epic installed in their office (Wagner, Tr. 3978).

2044. Epic was deployed at Glenbrook Hospital in March 2003, Evanston Hospital in June 2003, and HPH in December 2003. (Wagner, Tr. 3976-77).

Response to Finding No. 2044:

See RFF 2002; CCRFF 2001, above. (Epic was deployed more than three years after the merger, and it is difficult to claim that the installation of Epic is directly related to the merger.)

2045. The deployment of Epic at HPH was a two step process. (O'Brien, Tr. 3521). In December 2003, ENH implemented progress notes, nursing notes and other items that were documented in a patient's chart. (O'Brien, Tr. 3521-22). In April 2004, ENH implemented CPOE across all of the inpatient and outpatient services at HPH. (O'Brien, Tr. 3522).

Response to Finding No. 2045:

Respondent's finding is incomplete and misleading. (*See* CCRFF 2001 (explaining why the implementation of Epic at HPH after the merger was not merger-

specific)).

2046. Epic was deployed in three to five faculty practice physician offices during months when there was no hospital "go live." (Wagner, Tr. 3977).

Response to Finding No. 2046:

Respondent's finding is incomplete and misleading. (*See* CCRFF 2001 (explaining why the implementation of Epic at HPH after the merger was not merger-specific)).

2047. Epic was first deployed in an affiliate office in June 2004. (Wagner, Tr. 3977).

Response to Finding No. 2047:

See CCRFF 2001, above. Only three independent physician practices have Epic installed in their office (Wagner, Tr. 3978).

2048. Three affiliated practices currently have Epic in their offices. (Wagner, Tr. 3978). ENH is continuing to expand Epic into the offices of affiliated physicians. (Hillebrand, Tr. 1984).

Response to Finding No. 2048:

See CCRFF 2001, above. Only three independent physician practices have Epic installed in their office (Wagner, Tr. 3978).

2049. Use of Epic is mandatory for affiliated physicians in the ENH hospitals. (Wagner, Tr. 3978).

Response to Finding No. 2049:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2033 ({[REDACTED]}), *in camera*).

2050. ENH has offered incentives for affiliates to adopt Epic in their offices by waiving

the $12,000 license fee. (Wagner, Tr. 3980-81).

Response to Finding No. 2050:

Respondent's finding is misleading and incomplete. (*See* CCRFF 2047 (noting the small number of ENH-affiliated physicians that have Epic installed in their offices)).

viii. The Deployment And Maintenance Of Epic Requires Tremendous Resources, And Manpower

2051. Approximately 200 people at ENH were involved in the deployment of Epic. (Wagner, Tr. 3985).

Response to Finding No. 2051:

See CCRFF 2001, above. (There is nothing unique with ENH's deployment of Epic. Epic is an emerging technology, and other hospital systems have implemented it.)

2052. The Epic system requires continuous maintenance. (Wagner, Tr. 3985). The activities required to maintain Epic include understanding, configuring, building, and training employees to use and deploy upgrades from Epic twice a year, and satisfying requests from departments and divisions for new best practice alerts, order sets, order set reminders, and care plans. (Wagner, Tr. 3985-86). ENH currently employs 75 people to maintain Epic. (Wagner, Tr. 3986).

Response to Finding No. 2052:

See CCRFF 2001, above. (There is nothing unique with ENH's deployment of Epic. Epic is an emerging technology, and other hospital systems have implemented it.)

ix. ENH Has Realized Cost Savings Through The Use Of Epic

2053. Epic produces both clinical and administrative cost savings. (Wagner, Tr. 3988). Clinical cost savings result from the reduction in duplication of tests (because the information is easily obtainable when needed) and the avoidance of adverse medication and procedural outcomes that are diminished through Epic's quality and patient safety features. (Wagner, Tr. 3988).

Response to Finding No. 2053:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.) Complaint Counsel notes further that the alleged cost savings do not appear to have been passed on to consumers, since prices have gone up across the board since the merger. (*See, e.g.*, CCFF 392-502).

2054. Administrative savings result from the cost savings in personnel required to manage paper records and the reduction in the cost of dictation or transcription. (Wagner, Tr. 3988-89). Epic has generated additional efficiencies by reducing the amount of time physicians spend looking for charts, reducing dictation costs. (RX 1698 at ENHE TH 1206).

Response to Finding No. 2054:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.). Further, any cost savings that resulted from the use of Epic were not passed on to health plans after the merger. (*See* CCFF 392-502).

x. ENH Requires Physicians To Use Epic In The ENH Hospitals

2055. It is critically important that all physicians who have privileges at HPH use Epic. (Chassin, Tr. 5366). Physician use of Epic is the linchpin of achieving the full benefit of integrated electronic health records. (Chassin, Tr. 5366).

Response to Finding No. 2055:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic). *See also* CCRFF 2004, above. (Meditech was an excellent system, and Highland Park Hospital was exploring other information systems at the time of the merger.)

2056. Accordingly, ENH has mandated that a physician cannot practice medicine at any ENH hospital, including HPH, without using Epic. (Wagner, Tr. 3982). A physician cannot enter an order at any ENH hospital without using Epic. (Wagner, Tr. 3982).

Response to Finding No. 2056:

Respondent's finding is incomplete and misleading. (*See* CCRFF 2001 (explaining why the implementation of Epic at HPH after the merger was not merger-specific)).

2057. Additionally, a physician cannot obtain or renew privileges at any ENH hospital without being trained to use Epic. (Wagner, Tr. 3982). ENH re-credentials one-quarter of its professional staff every six months. (Wagner, Tr. 3982-83).

Response to Finding No. 2057:

Respondent's finding is incomplete and misleading. (*See* CCRFF 2001 (explaining why the implementation of Epic at HPH after the merger was not merger-specific)).

2058. The adoption of CPOE improved in the quality of care at HPH because it reduces a large number of categories of medication errors. (Chassin, Tr. 5364). It is well-documented in outcome studies that the use of CPOE reduces medication errors and injuries as a result of medications, particularly when coupled with CDSS, as it was in ENH's case. (Chassin, Tr. 5364).

Response to Finding No. 2058:

See CCRFF 2004, above (improved technology is not merger specific).

xi. Epic Allows ENH Clinicians To Access Complete, Up-To-Date Patient Information From Almost Anywhere

2059. In the ENH hospitals, Epic can be accessed from anywhere there is an access terminal, including nurses stations, patient rooms, administration areas and mobile carts that can be taken into patient rooms. (Wagner, Tr. 3982).

Response to Finding No. 2059:

See CCRFF 2001, above. (There is nothing unique with ENH's deployment of Epic. Epic is an emerging technology, and other hospital systems have implemented it.)

2060. Outside of the hospital, Epic can be accessed from anywhere there is a hard connection, such as in a physician's office, or broadband Internet. (Wagner, Tr. 3983).

Response to Finding No. 2060:

See CCRFF 2001, above. (There is nothing merger specific with regard to ENH's deployment of Epic. Epic is an emerging technology, and other hospital systems have implemented it.). { [redacted] } (*See* CCRFF 2122, *in camera*).

2061. An ENH physician may access Epic via the Internet using a security code generated by a key fob. (Wagner, Tr. 3983). Almost 1,100 physicians at ENH have key fobs. (Wagner, Tr. 3983).

Response to Finding No. 2061:

See CCRFF 2001, above. (There is nothing merger specific with regard to ENH's deployment of Epic. Epic is an emerging technology, and other hospital systems have implemented it.). { [redacted] } (*See* CCRFF 2122, *in camera*).

2062. Once a physician has gained access to Epic, whether in the hospital or through the Internet, he or she sees the entire patient record – including all hospital care, laboratory care, radiology images and office visits. (Wagner, Tr. 3983-84). There is no difference between the information a physician may view accessing Epic via the Internet compared to accessing Epic in the ENH hospitals. (Wagner, Tr. 3984).

Response to Finding No. 2062:

See CCRFF 2055, above. Only three independent physician practices have Epic installed in their office. (Wagner, Tr. 3978).

2063. Affiliated physicians who do not have Epic in their offices can still access the Epic system using the Internet. (Wagner, Tr. 3984). Through the Internet, they can see the patient's entire health record, including the patient's hospital visits, office visits to Epic-enabled practices, laboratory images and ancillary services. (Wagner, Tr.3984).

Response to Finding No. 2063:

See CCRFF 2055, above. Only three independent physician practices have Epic installed in their office. (Wagner, Tr. 3978).

2064. ENH physicians currently access Epic via the Internet up to 60 times a month. (Wagner, Tr. 3984-85).

Response to Finding No. 2064:

See CCRFF 2001, above. (There is nothing merger specific with regard to ENH's deployment of Epic. Epic is an emerging technology, and other hospital systems have implemented it.) { } (*See* CCRFF 2122, *in camera*).

xii. Epic Has Dramatically Changed And Improved The Practice Of Medicine

2065. As a result of Epic, paper patient charts are no longer used in the ENH hospitals or in those physician's full time faculty practice and affiliate offices that have adopted Epic. (RX 1425 at ENHE F22 1404, 1406).

Response to Finding No. 2065:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

(1) Epic Makes Learning A Patient's Medical History Considerably Easier

2066. Before Epic, a physician would learn a patient's medical history by asking the patient. (Wagner, Tr. 4002). Patients, however, often have imperfect memory of their health history, medications and allergies. (Wagner, Tr. 4002).

Response to Finding No. 2066:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic.

Other hospital systems have deployed Epic.)

2067. Epic relieves patients of having to remember and repeat their medical information to different caregivers. (RX 1677 at ENHE DL 10004). Epic provides an organized means of keeping, retaining and reviewing a patient's medical history, family history, medication history, allergies, prior surgeries, prior office visits and prior hospitalizations. (Wagner, Tr. 4002). Moreover, the patient's medical history is current, and information is available as soon as it is entered. (Wagner, Tr. 4032).

Response to Finding No. 2067:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic.

Other hospital systems have deployed Epic.)

2068. Patients appreciate physicians having access to their complete medical information. (Wagner, Tr. 4033).

Response to Finding No. 2068:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic.

Other hospital systems have deployed Epic).

(2) Epic Makes Finding And Reading A Patient's Medical Information Substantially Easier

2069. Before Epic, physicians in the ENH system were not required to record or keep information in their files in any standardized manner. (Wagner, Tr. 4002-03). A patient's medical record was generally handwritten. (Wagner, Tr. 4003; RX 1466). Moreover, there was no standard form of shorthand that physicians used to record information in their charts. (Wagner, Tr. 4005).

Response to Finding No. 2069:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic.

Other hospital systems have deployed Epic).

2070. Epic has made information recorded in the patient's medical record easier to read because it is all typecast. (Wagner, Tr. 4003-04; RX 1466).

Response to Finding No. 2070:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic).

2071. Before the installation of Epic, a patient's medical record could span more than one volume. (Wagner, Tr. 4003). Additionally, different physicians who treated a patient would keep separate medical charts. (Wagner, Tr. 4005). As a result, the patient's health record was fragmented, and different parts were maintained at different sites of care. (Wagner, Tr. 4005-06).

Response to Finding No. 2071:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic).

2072. Epic has changed the way in which medical files are organized. (Wagner, Tr. 4003). It aggregates all of the patient's information in one location so that all caregivers can review and have access to all of the necessary information, and it presents information to the physician as he or she has a need to use it. (Wagner, Tr. 4003, 4006). Moreover, Epic causes the physician to capture and report information in specific locations where it is easily retrievable. (Wagner, Tr. 4003).

Response to Finding No. 2072:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic).

2073. The improved availability of information at the point of care such that physicians no longer need to spend as much time looking for information in consultation and prior visits is an improvement in the quality of care. (Romano, Tr. 3327).

Response to Finding No. 2073:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic).

(3) Epic Simplifies And Makes The Ordering Of Medication And Tests More Efficient

2074. Before Epic, in the hospital setting, physicians would order medication and tests

by going to the nurses' stations, finding the patient's chart, recording on paper the order to be accomplished and flagging the chart. (Wagner, Tr. 4006). In contrast, Epic allows the physician to order medication and tests by placing the order during the course of caring for the patient. (Wagner, Tr. 4008).

Response to Finding No. 2074:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic).

2075. In the hospital setting, before the arrival of Epic, nurses would know when a medication or test was ordered for a patient by seeing the flag on the patient's chart when he or she walked past the nursing station, or the unit secretary may have noted the flagged chart, pulled it, and asked the nurse to come and sign off on the order. (Wagner, Tr. 4007-08; RX 1466). In Epic, nurses learn about new orders immediately by an icon that shows up in the new orders column on their patient list on the mobile terminal the nurse carries with her. (Wagner, Tr. 4008; RX 1466).

Response to Finding No. 2075:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic).

2076. In physician offices, before the implementation of Epic, medications would be ordered on written prescriptions, which would be given to the patient. (Wagner, Tr. 4006-07). In Epic, prescriptions may be printed on a piece of paper to be taken by the patient to the pharmacy or may be transmitted directly to the pharmacy so that they are filled by the time the patient arrives. (Wagner, Tr. 4008-09).

Response to Finding No. 2076:

See CCRFF 2001, above. Only three independent physician practices have Epic installed in their office. (Wagner, Tr. 3978).

2077. Before Epic, a physician would learn the medications a patient was taking or had taken in the past by asking the patient and/or calling the patient's other physicians. (Wagner, Tr. 4007). In Epic, a physician learns the medications the patient is taking or had taken in the past by looking in the medications section of Epic, which maintains a record of current and historic medications. (Wagner, Tr. 4009).

Response to Finding No. 2077:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

2078. Before Epic, the detection of drug interactions and drug allergies depended on: (1) the prescribing physician having complete and accurate information as to what medications the patient was taking or may have taken in the past; and (2) the prescribing physician's knowledge of potential drug interactions. (Wagner, Tr. 4007). In Epic, at the time a prescription is written, Epic runs a check on drug interactions, drug/allergy interactions, drug/disease interactions, and drug/food interactions, and it presents alerts to the physician if there is an interaction. (Wagner, Tr. 4009).

Response to Finding No. 2078:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

(4) Epic Improves The Process By Which Laboratory Results Are Reported And Accessed

2079. Before Epic, in the hospital setting, the laboratory would batch and print all of that day's laboratory output and deliver it to the nursing stations. (Wagner, Tr. 4009-10). Test and laboratory results typically would be received the next morning. (Wagner, Tr. 4011). Mail reports took a week or two to be received by the physician's office. (Wagner, Tr. 4011).

Response to Finding No. 2079:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

2080. Before Epic, for tests or labs ordered in a physician's office, results would be communicated to that office either by mail or fax or a printer connected to the laboratory by modem (if the physician's office had one), which would run a print job in the middle of the night on the laboratory work that was done the previous day. (Wagner, Tr. 4010).

Response to Finding No. 2080:

Respondent's finding is incomplete and misleading. (*See* CCRFF 2001

(explaining why the implementation of Epic at HPH after the merger was not merger-specific)).

2081. In Epic, test and laboratory results are available as soon as they are resulted. (Wagner, Tr. 4012; Victor, Tr. 3593; RX 1636 at ENHE DL 1721). Before Epic, in the hospital setting, test and laboratory results were stored in the patient's paper record or in the laboratory database. (Wagner, Tr. 4011). In a physician's office, test and lab results were stored in a paper record and in the performing laboratory's database before the installation of Epic at ENH. (Wagner, Tr. 4012).

Response to Finding No. 2081:

Respondent's finding is incomplete and misleading. (*See* CCRFF 2001 (explaining why the implementation of Epic at HPH after the merger was not merger-specific)).

2082. Before Epic, if a physician were neither in the hospital nor in his or her office, the physician would access test and lab results either by calling the office and asking that the patient's chart be pulled or calling the performing laboratory to have the results read to the physician. (Wagner, Tr. 4010). There was no way for physicians at HPH to access test and laboratory results through the Internet. (Wagner, Tr. 4011). In Epic, test and laboratory results can be accessed from wherever a person has Epic access – either in the hospital, the physician's office, or anywhere there is Internet access. (Wagner, Tr. 4012-13; Victor, Tr. 3594-95; RX 1636 at ENHE DL 1721). Moreover, any clinician who has secure access to Epic can access test and laboratory results. (Wagner, Tr. 4013).

Response to Finding No. 2082:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.) Only three independent physician practices have Epic installed in their office. (Wagner, Tr. 3978).

2083. Before the installation of Epic, if a patient who had a test performed at a physician's office required hospital treatment, the hospital would not have knowledge of the results of the test that was performed in the physician's office. (Wagner, Tr. 4012). Similarly, if a patient who had a test performed in the hospital later saw a physician at her office, the physician would not have knowledge of the results of the test performed in the hospital. (Wagner, Tr. 4012). In Epic, both the hospital and the physician would have knowledge of those

test results. (Wagner, Tr. 4013).

Response to Finding No. 2083:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic).

(5) Epic Has Made Consulting With Other Physicians Much Easier

2084. Epic has changed the way physicians consult with each other by allowing the referring physician to speak with the consulting physician live and simultaneously view the same information. (Wagner, Tr. 4013).

Response to Finding No. 2084:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

(6) Epic Has Substantially Improved Laboratory Services

2085. Epic is an improvement over the previous method of reporting laboratory results because: (1) the laboratory results go into the chart virtually immediately and are immediately available to the physicians and staff treating the patient; (2) the information is stored in the same location and easily found when needed; and (3) physicians may review test results at home and make clinical decisions without having to travel to the hospital. (Victor, Tr. 3595-96).

Response to Finding No. 2085:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

2086. Epic allows laboratory results to be compared more easily to previous results because everything is present on one chart as opposed to multiple charts. (Victor, Tr. 3596).

Response to Finding No. 2086:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

2087. Additionally, to make a diagnosis, pathologists often have to look at information contained in the patient's medical record. (Victor, Tr. 3597). Before Epic, to get information about a patient's medical record, ENH pathologists would have to call physicians or members of the clinical staff to obtain the information they needed to make a diagnosis. (Victor, Tr. 3598). Epic benefits ENH pathologists because they can look up information in a patient's medical record, including a patient's medical history, x-ray data, and prior test results, without having to find the physician who treated the patient. (Victor, Tr. 3597).

Response to Finding No. 2087:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

xiii. Epic Has Numerous Safety Features That Improve The Quality Of Care

2088. Epic improves quality of care and patient safety: (1) by giving complete access to information wherever the physician needs it; and (2) through the use of built-in alerts, including heath maintenance alerts, order sets, best practice alerts and clinical pathways. (Wagner, Tr. 4015-16).

Response to Finding No. 2088:

There is no evidence that the merger has improved outcomes at Highland Park Hospital through the deployment of Epic. (Wagner, Tr. 4065. *See* CCRFF 2004).

(1) Epic Has Health Maintenance Alerts

2089. A health maintenance alert is a reminder of tests a physician may want to perform that are based on a person's age, gender and disease state, such as pap smear or a mammogram. (Wagner, Tr. 4016-17). Epic alerts the physician when the patient is due for a health maintenance test. (Wagner, Tr. 4017).

Response to Finding No. 2089:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the

time of the merger, other hospitals began implementing Epic.)

2090. Expert bodies within ENH determine what health maintenance alerts will be put into Epic based on national guidelines, and are continually adding new alerts. (Wagner, Tr. 4017).

Response to Finding No. 2090:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

(2) Epic Has Best Practice Alerts

2091. Best practice alerts are alerts of avoidable risks or risks that can be diminished by an appropriate course of care. (Wagner, Tr. 4017). Epic presents a best practice alert to the physician when avoidable risks or risks that can be diminished by an appropriate course of care are detected. (Wagner, Tr. 4018).

Response to Finding No. 2091:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

2092. Expert bodies within the departments and divisions of the ENH hospitals determine what best practice alerts are added to Epic based on national guidelines and standards, and continue to add such alerts into Epic. (Wagner, Tr. 4018).

Response to Finding No. 2092:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

(3) Epic Presents Physicians With Order Sets

2093. Order sets are collections of tests, medications and procedures that are appropriate for the management, treatment and diagnosis of a given problem. (Wagner, Tr. 4018-19). When a patient's chief complaint is entered into Epic, Epic presents the physician with order sets recommended for that chief complaint. (Wagner, Tr. 4019).

Response to Finding No. 2093:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

2094. Expert bodies within ENH determine what order sets are added to Epic based on national guidelines and standards. (Wagner, Tr. 4019). There are over 1,000 order sets built into Epic today, and ENH is continuing to add more. (Wagner, Tr. 4019; RX 1425 at ENHE F22 1419).

Response to Finding No. 2094:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

(4) Epic Facilitates The Use Of Clinical Pathways

2095. A clinical pathway is a collection of activities that need to be accomplished to handle an episode of care for a specific diagnosis in an optimal, safe manner. (Wagner, Tr. 4019). Epic facilitates the use of clinical pathways by presenting the physician with elements of the appropriate clinical pathway for the patient's diagnosis or complaint. (Wagner, Tr. 4020).

Response to Finding No. 2095:

See CCRFF 2001, above. (There is nothing unique to ENH's deployment of Epic. Other hospital systems have deployed Epic.)

2096. Multidisciplinary bodies composed of physicians, nurses, pharmacists and therapists determine which pathways are programmed into Epic. (Wagner, Tr. 4020). There are currently more than 50 pathways in place in Epic. (Wagner, Tr. 4020; RX 1425 at ENHE F22 1418).

Response to Finding No. 2096:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

(5) Epic Implements A Clinical Decision Support System

2097. A Clinical Decision Support System ("CDSS") is a broad category that refers to uses of automated data, typically to bring in information from different sources to help physicians make better decisions about prescribing medication and ordering lab tests while providing care to patients. (Chassin, Tr. 5365).

Response to Finding No. 2097:

Complaint Counsel have no specific response.

2098. There is a body of literature in the field of quality improvement that addresses CDSS systems as they relate to medication errors and improving outcomes. (Chassin, Tr. 5366). Those studies indicate that when CDSS systems are added to CPOE systems, the combination is even more effective at preventing injury from medications and medication errors than either system by itself. (Chassin, Tr. 5366).

Response to Finding No. 2098:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

2099. CDSS has been implemented in Epic through health maintenance alerts, best practice alerts, order sets and clinical pathways. (Wagner, Tr. 4021; Chassin, Tr. 5365). Other examples of clinical decision support in Epic include not allowing X-rays to be taken of female patients under a certain age unless they are first asked if they are pregnant, and not allowing medication orders to be placed if the patient's allergies have not been verified within the last year. (RX 1425 at ENHE F22 1415).

Response to Finding No. 2099:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

2100. ENH is developing and rolling out additional CDSS functions through Epic that are state-of-the-art. (Chassin, Tr. 5365).

Response to Finding No. 2100:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

(6) Epic Improves Patient Access To Their Medical Records

2101. Giving patients access to their medical records allows them to be more knowledgeable about their health problems and what medications they are on, and it is one of the Government's and Dr. Brailer's four principal goals. (Wagner, Tr. 4056-57).

Response to Finding No. 2101:

Complaint Counsel have no specific response.

2102. Patients can print the information from their medical records, including their current medications and laboratory results, from ENH's patient portal and take it with them when they visit physicians who may not be on the Epic system. (Wagner, Tr. 4056-57).

Response to Finding No. 2102:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

(7) Epic Improves Quality Of Care When There Are Drug Recalls

2103. When the drug Vioxx was recalled, within four hours ENH was able to identify and give to caregivers lists of their patients who were on or who had been on Vioxx. (Wagner, Tr. 4021).

Response to Finding No. 2103:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

2104. Before Epic, when there was a drug recall, it took one physician office six months to review all patient charts for patients who had taken the drug, and the physician was not certain he had identified all of his patients who had taken that drug. (Wagner, Tr. 4021-22).

Response to Finding No. 2104:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the

time of the merger, other hospitals began implementing Epic.)

xiv. ENH's Accomplishment In The Deployment of EPIC Is Unique

2105. No hospital system other than ENH has both employed and affiliated physicians on the same integrated electronic medical record system. (Wagner, Tr. 3985).

Response to Finding No. 2105:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.) Only three independent physician practices have Epic installed in their office. (Wagner, Tr. 3978).

2106. Dr. Ankin, for example, does not practice at any other hospital that has an electronic medical record system such as Epic. (Ankin, Tr. 5071). He recommended to Lake Forest Hospital that it adopt Epic three to four years before the Merger, but the hospital could not afford it. (Ankin, Tr. 5071-72).

Response to Finding No. 2106:

The question of whether or not Lake Forest adopted Epic is irrelevant to this case. This case is about Highland Park's merger with Evanston. *See* CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.) Furthermore, ENH did not implement Epic until several years after the merger. (*See* CCRFF 2109).

2107. ENH is the only institution in the Chicago area that has brought live 100% physician use of inpatient clinician order entry, documentation, and result review and ambulatory and inpatient use simultaneously, while also giving patients access to their own information. (Wagner, Tr. 4082).

Response to Finding No. 2107:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

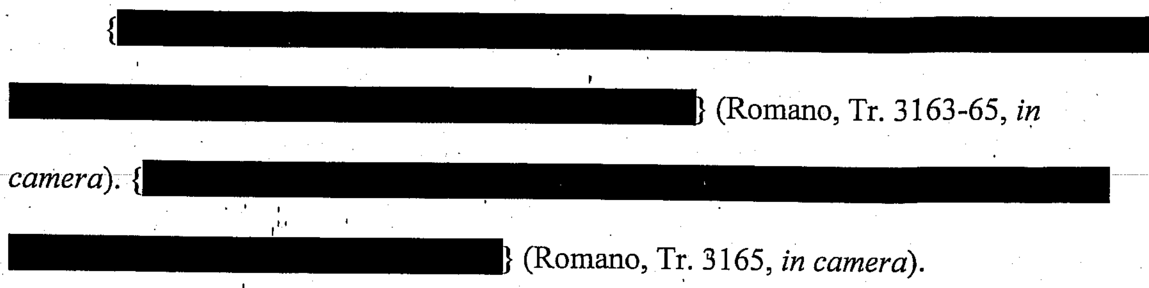
2108. ENH is the only institution in the Chicago area and in the country that has accomplished a broad and successful deployment of an integrated electronic medical record. (Wagner, Tr. 4082).

Response to Finding No. 2108:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

2109. The typical roll-out of an electronic medical record like Epic would require at least two to three years. (Romano, Tr. 3334). The depth and speed with which ENH was able to completely engage their three campuses, including both physicians and non-physicians, in the roll-out of Epic produced a much greater improvement in quality in a much shorter period of time than most, if not all, other implementations of a full electronic medical record. (Chassin, Tr. 5368).

Response to Finding No. 2109:



{ } (Romano, Tr. 3163-65, *in camera*). { } (Romano, Tr. 3165, *in camera*).

xv. ENH Has Been Recognized By Numerous Outside Sources For Its Successful Deployment Of Epic

2110. Epic Systems has used the implementation of Epic at ENH as a model and has referred other institutions to ENH. (Romano, Tr. 3329).

Response to Finding No. 2110:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.). Only three independent physician practices have Epic installed in their office. (Wagner, Tr. 3978).

2111. In 2004, ENH achieved the "Highest Value Rating" from KLAS CPOE Digest. (RX 1666; RX 1677 at ENHE DL 10003; RX 1580). This meant that based upon physician and

nurse data collected during the winter of 2003-04, ENH achieved the overall highest value for physician and nurse use across all KLAS measurements. (RX 1666).

Response to Finding No. 2111:

See CCRFF 2001, above. (It is not clear what Respondent means by "ENH achieved the overall highest value for physician and nurse use across all KLAS measurements.")

2112. Also in 2004, ENH received the Nicholas Davies Award from the Health Information Management Specialists Society for being the only institution that has universally accepted inpatient physician order entry, physician documentation, and nurse documentation by employed and non-employed physicians; has extended this capability to the ambulatory world; and has an integrated medical record. (Wagner, Tr. 3996-97; RX 1733 at 1).

Response to Finding No. 2112:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.) Only three independent physician practices have Epic installed in their office. (Wagner, Tr. 3978).

2113. In November 2004, Dr. Brailer visited ENH to recognize ENH on its achievement of having a fully deployed and integrated electronic health record universally throughout the three ENH hospitals that was used by all physicians and patient accessible. (Wagner, Tr. 3959).

Response to Finding No. 2113:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.). Only three independent physician practices have Epic installed in their office. (Wagner, Tr. 3978).

xvi. Other Academic Hospitals In The Chicago Area Are Looking To Learn From ENH's Successful Deployment Of Epic

2114. The ENH information systems staff gives presentations on ENH's deployment of Epic to other hospitals in the Chicago area, including Loyola, the University of Chicago,

Northwestern Memorial, Children's Memorial Hospital, and Advocate Health System. (Wagner, Tr. 3997). Those presentations are generally made at the request of the other hospitals because they want to understand how ENH accomplished the successful deployment of Epic in such a short time. (Wagner, Tr. 3997-98).

Response to Finding No. 2114:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

2115. Other hospitals in the Chicago area, including the University of Chicago, Loyola, Northwestern Memorial, and Children's Memorial have made site visits to ENH to study its deployment of Epic. (Wagner, Tr. 3998).

Response to Finding No. 2115:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

2116. A representative of the U.C., Davis has made a site visit to ENH to study ENH's deployment of Epic. (Wagner, Tr. 3998).

Response to Finding No. 2116:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

2117. ENH provided its Epic training materials to Loyola. (Wagner, Tr. 3999). Loyola sought to purchase ENH's Epic training materials because it is a huge effort to create the training materials, and Loyola felt they would benefit from having available to them materials that had been demonstrated to be successful. (Wagner, Tr. 3999).

Response to Finding No. 2117:

See CCRFF 2001, above. (ENH's implementation of Epic was not unique. At the time of the merger, other hospitals began implementing Epic.)

xvii. Epic Has Not Been Implemented By Community Hospitals

2118. { } (Romano, Tr. 3162, *in camera*).

Response to Finding No. 2118:

Other community hospitals have purchased an electronic medical record system. (Wagner, Tr. 4067). Northwest Community Hospital, a stand-alone community hospital in the Chicago area, is considering purchasing an electronic medical record system from McKesson. (Wagner, Tr. 4068-69). { } (Romano, Tr. 3162-63, *in camera*). The $14 million ENH claims to have spent on Epic at HPH was well within that hospital's 1999-2003 capital budget. (*See* RFF 2006 (noting $14 million spent); Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2 (describing HPH $65 million capital budget)).

2119. Indeed, no community hospital has deployed an enterprise grade electronic medical record system such as Epic. (Wagner, Tr. 3999-4000). Those hospitals smaller than HPH that are installing Epic are part of a larger hospital system. (Wagner, Tr. 4000-01).

Response to Finding No. 2119:

See CCRFF 2118, above.

2120. Moreover, the majority of community hospitals today do not have an electronic medical record that includes CPOE systems. (Romano, Tr. 3334).

Response to Finding No. 2120:

See CCRFF 2118, above.

xviii. Epic Is Far Superior To Meditech, The System Used At HPH Before The Merger

2121. Before the Merger and through February 2001, HPH used elements of an

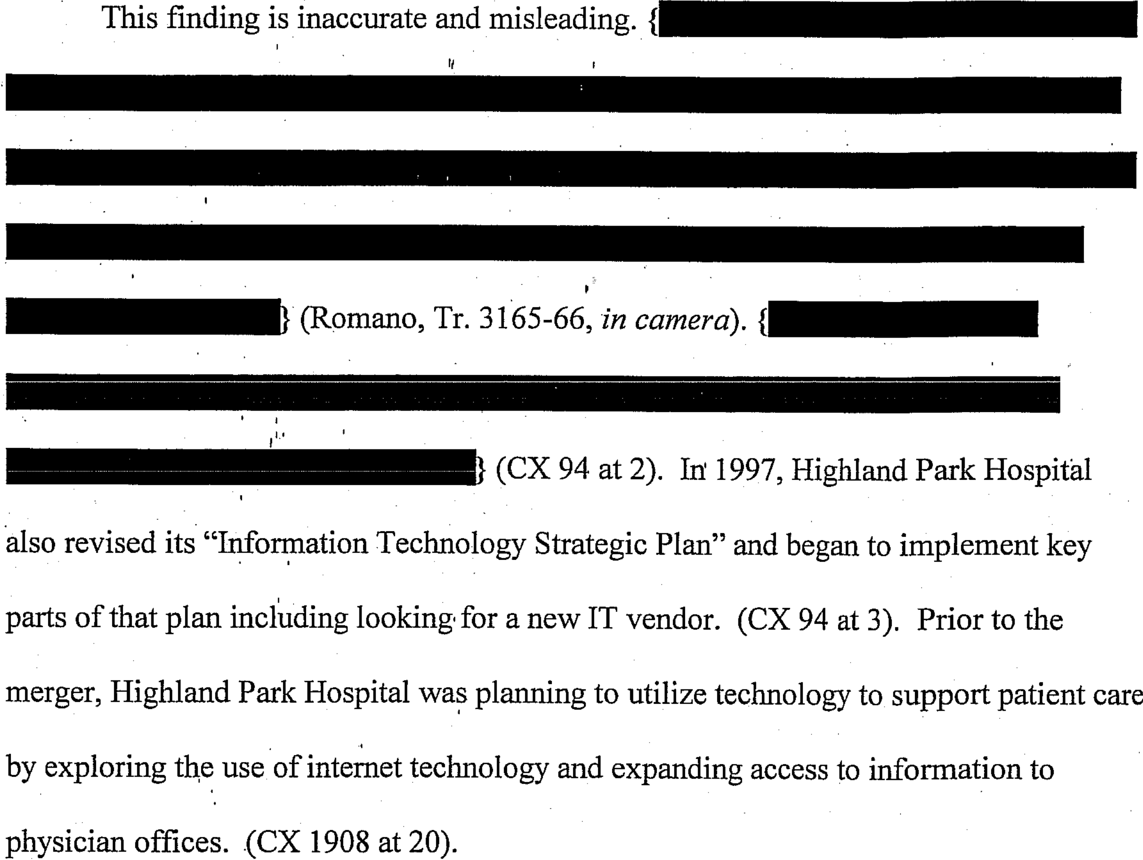
electronic medical record system called Meditech. (Wagner, Tr. 4058; O'Brien, Tr. 3520-21). Meditech integrated billing and registration functions, as well as pharmacy, lab and radiology functions. (O'Brien, Tr. 3520).

Response to Finding No. 2121:

See CCRFF 2122, below.

2122. The capabilities of Meditech as deployed at HPH pre-Merger were essentially the same as those that were available at ENH in 1985. (Wagner, Tr. 4060).

Response to Finding No. 2122:



This finding is inaccurate and misleading. { } (Romano, Tr. 3165-66, *in camera*). { } (CX 94 at 2). In 1997, Highland Park Hospital also revised its "Information Technology Strategic Plan" and began to implement key parts of that plan including looking for a new IT vendor. (CX 94 at 3). Prior to the merger, Highland Park Hospital was planning to utilize technology to support patient care by exploring the use of internet technology and expanding access to information to physician offices. (CX 1908 at 20).

There is no reason to believe that, had the merger not occurred, Highland Park would not have continued to improve its operations by investing in information technology, either through Epic or other appropriate systems. Epic was not deployed at

Highland Park Hospital until January 2004 (Wagner, Tr. 4070), and Highland Park would no doubt have continued to improve information technology on its own during the four years it took ENH to roll out Epic.

There is no evidence that the merger has improved outcomes at Highland Park through the deployment of Epic. (Wagner, Tr. 4065).

2123. Meditech could not be accessed remotely outside HPH, so it was used in conjunction with paper charts. (O'Brien, Tr. 3521). Meditech did not operate as the primary patient chart. (O'Brien, Tr. 3521).

Response to Finding No. 2123:

See CCRFF 2122, above.

2124. Meditech, as deployed at HPH, did not allow for CPOE. (Wagner, Tr. 4061). Without CPOE, it is not possible to have the clinical decision support, such as alerts and reminders, that is present in Epic as deployed by ENH. (Wagner, Tr. 4061).

Response to Finding No. 2124:

See CCRFF 2122, above.

2125. Meditech, as deployed at HPH, did not have any ambulatory or outpatient capability. (Wagner, Tr. 4061). It also did not allow patients to access their own medical records. (Wagner, Tr. 4062).

Response to Finding No. 2125:

See CCRFF 2122, above. Only three independent physician practices have Epic installed in their office. (Wagner, Tr. 3978).

2126. Before the Merger, if a patient who was discharged from HPH wanted to obtain information relating to her hospitalization, including the medications she was given during the hospital visit, she would have to request that the record be sent, and it would have taken a week or longer for the patient to receive it. (Wagner, Tr. 4062).

Response to Finding No. 2126:

See CCRFF 2122, above.

2127. Meditech, as deployed by HPH, was not a patient-focused, community-based, multi-hospital, multi-office, comprehensive, longitudinal health record. (Wagner, Tr. 4062).

Response to Finding No. 2127:

See CCRFF 2122, above.

i. The Merger Improved The Quality Of Radiology, Radiation Medicine And Nuclear Medicine At HPH

i. Overview

2128. Radiation medicine is a therapeutic department that provides very focused radiation to targeted areas. (O'Brien, Tr. 3498). Nuclear medicine is a diagnostic department that tracks isotopes injected into a patient to pick up the affinity between the radiation and things such as tumors. (O'Brien, Tr. 3498).

Response to Finding No. 2128:

Complaint Counsel have no specific response to this finding.

ii. HPH's Pre-Merger Radiology Equipment Was Antiquated And Productivity Was Lower Than It Should Have Been With Respect To Radiology Services

2129. At the time of the Merger, equipment in the Radiology Department at HPH was antiquated, had limited radiation capacity and needed to be replaced. (O'Brien, Tr. 3491; Chassin, Tr. 5359).

Response to Finding No. 2129:

This finding is misleading. Highland Park had considered purchasing new radiation technology, but had not made a decision by the time of the merger. Capital was available if the hospital wanted to purchase new radiology technology and equipment. (Newton, Tr. 400-01; Spaeth, Tr. 2137-38. *See generally* CX 545 at 3).

2130. For example, HPH had an old linear accelerator, which was purchased in the mid-1980s and located in the basement of the medical office building adjacent to the hospital.

(O'Brien, Tr. 3499-500). The old accelerator had no trade-in value, and ENH had to pay to have it removed. (O'Brien, Tr. 3500-01).

Response to Finding No. 2130:

See CCRFF 2129, above. (Highland Park Hospital was considering upgrading radiology equipment and technology at the time of the merger.)

2131. The equipment was so antiquated that, before the Merger, physicians did not send their patients to HPH for radiology services. (Chassin, Tr. 5362-63).

Response to Finding No. 2131:

See CCRFF 2129, above.

2132. At the time of the Merger, HPH performed fewer radiology exams than Glenbrook Hospital even though Glenbrook Hospital had one CT scan and HPH had two. (O'Brien, Tr. 3492-93).

Response to Finding No. 2132:

See CCRFF 2129, above. (Highland Park Hospital was considering upgrading radiology equipment and technology at the time of the merger.)

iii. ENH Made Substantial Post-Merger Improvements To Radiology And Radiation Medicine Services That Improved The Quality Of Care At HPH

(1) ENH Upgraded The Equipment And Systems At HPH And Extended Its Technology To HPH

2133. After the Merger, ENH purchased a new linear accelerator for HPH. (O'Brien, Tr. 3500). It also added two new CT scanners in HPH's radiology department, upgraded the radiation therapy equipment, and purchased a simulator. (O'Brien, Tr. 3496, 3501; Chassin, Tr. 5362-63; RX 1896 at ENHL MO 7109). A simulator is an instrument in radiation medicine that maps the location and doses for delivering radiation. (O'Brien, Tr. 3502).

Response to Finding No. 2133:

ENH does not specify the date of purchase of the linear accelerator, but at the

referenced section of the transcript, Ms. O'Brien noted that it was the "new linear accelerator in the Ambulatory Care Center." (O'Brien, Tr. 3501). The Ambulatory Care Center was not opened until February 2005, more than five years after the merger. (O'Brien, Tr. 3498). Ms. O'Brien also indicated that the simulator was purchased for the Ambulatory Care Center. (O'Brien, Tr. 3502). She was not clear with regard to the other equipment mentioned in this finding.

Consistent with the general trend of quality improvement, any hospital, HPH included, would have been expected to upgrade its equipment as appropriate during this five year period. *See* CCRFF 2129, above. (Highland Park Hospital was considering upgrading radiology equipment and technology at the time of the merger).

2134. ENH added $2.3 million of new equipment to the radiology and radiation medicine departments in 2000 and 2001, and another $4.1 million of upgraded equipment between 2002 and 2004. (O'Brien, Tr. 3496-97).

Response to Finding No. 2134:

ENH claims in this finding total capital expenditures of $6.4 million over the five year period from 2000 to 2004. There is no reason to believe HPH could not have funded the same investments from its $108 million capital budget for 1999-2003, or a subsequent capital budget including 2004. (Newton, Tr. 401, 430-31; CX 545 at 3; CX 1055 at 2; Spaeth, Tr. 2137-38).

2135. In February of 2001, ENH extended RADNET, a radiology information system that provides access to patient reports from anywhere in the ENH system, to HPH. (O'Brien, Tr. 3494). The installation of RADNET and Epic at HPH cost about $2.1 million. (O'Brien, Tr. 3496).

Response to Finding No. 2135:

See CCRFF 2134 (This investment appears to be subsumed within the $6.4 million discussed in CCRFF 2134.)

2136. In February or March of 2001, ENH improved the quality of HPH's radiology department by extending PACS, its radiology imaging system, to HPH. (O'Brien, Tr. 3494; Chassin, Tr. 5360; Spaeth, Tr. 2277, 2293). PACS is a new way of taking x-rays that does not involve film. (Chassin, Tr. 5360). As a result, the radiology department became almost film-less, reducing the chance for lost images. (O'Brien, Tr. 3495-96; RX 1233 at ENH GW 267). Additionally, turnaround time was reduced, and the images became instantly available for viewing to HPH physicians from their home, office, or anywhere they have Internet access. (O'Brien, Tr. 3495; Chassin, Tr. 5360-61; RX 1233 at ENH GW 266-267).

Response to Finding No. 2136:

This finding is misleading. Before the merger HPH was considering purchasing PACS. (Newton Tr. 401 (ENH owned HPH for a year and a quarter until it decided to make this investment in February or March 2001)). { } (Newton, Tr. 400-01; Spaeth, Tr. 2137-38, Romano, Tr. 3184-85, *in camera*. *See generally* CX 545 at 3).

2137. As of February 15, 2002, there were 70 PACS workstations in use throughout the ENH system. (RX 1233 at ENH GW 267).

Response to Finding No. 2137:

Complaint Counsel have no specific response to this finding.

2138. The IOM has determined that more immediate access to computer-based clinical information, such as laboratory and radiology results, can reduce redundancy and improve quality. (RX 1423 at 6).

Response to Finding No. 2138:

ENH leaves out of this citation a key fact which shows why the citation supports Complaint Counsel's position. The IOM report to which ENH refers, and which supports the technology investments ENH made, is dated 2003. (RX 1423 at 5-6). This is yet another example of ENH following nationwide trends of evolving quality, but claiming that they are attributable to the merger.

2139. After the Merger, ENH also added a call center for radiology at HPH to allow patients in need of radiology tests to call into the corporate system and schedule the first appointment available at any ENH hospital. (O'Brien, Tr. 3493-94). Before the Merger, the appointment scheduling system at HPH was a paper-based system. (Chassin, Tr. 5359).

Response to Finding No. 2139:

See CCRFF 2129, above. (Highland Park Hospital was considering upgrading radiology equipment and technology at the time of the merger).

(2) ENH Added Additional Radiology Staff And Improved Access To Specialists At HPH

2140. After the Merger, HPH added radiologists to improve turnaround times for reading radiology reports. (O'Brien, Tr. 3493).

Response to Finding No. 2140:

This finding is misleading. The citation does not state when the radiologists were added. There is no indication that Highland Park Hospital would not have new radiologists if the merger had not occurred. Highland Park Hospital had adequate capital to make such an improvement. (Newton, Tr. 400-01). Further, there is no evidence that adding radiologists actually improved the turnaround time for reading radiology reports or improved quality in any other way.

2141. Moreover, additional staff were added to the HPH Radiology Department, and weekend and evening hours were extended. (O'Brien, Tr. 3493).

Response to Finding No. 2141:

See CCRFF 2140, above.

2142. Before the Merger, the radiologists at HPH were generalists. (Chassin, Tr. 5362). At the time of the Merger, the radiology departments at all three campuses combined to create one department. (Chassin, Tr. 5361). All of the HPH radiologists were required to adopt a specialty, and those that did not ceased practicing at ENH. (Chassin, Tr. 5362).

Response to Finding No. 2142:

See CCRFF 2140, above.

2143. After the Merger, HPH patients had access to specialists in MRI reading, neuroradiology specialists, and specialists who only did interventional procedures in radiology. (Chassin, Tr. 5362). The addition of specialists was an important quality improvement at HPH. (Chassin, Tr. 5361-32).

Response to Finding No. 2143:

This finding is misleading. There is no evidence that Highland Park Hospital patients did not have access to these specialists before the merger.

(3) HPH Would Not Have Been Able To Make The Improvements In Radiology And Radiation Medicine Without The Merger

2144. Because the cost of installing PACS was roughly $9 million, HPH would not have been able to install the system before the Merger. (Spaeth, Tr. 2293).

Response to Finding No. 2144:

This finding misstates the witness' testimony. When asked whether HPH could have installed PACS without the merger, Mr. Spaeth responded "Again, a matter of setting a priority. My understanding was $9 million, probably not." (Spaeth Tr. 2293). Mr. Spaeth also discussed HPH's capital budget, noting that the $108 million capital

budget would have allowed HPH to "bring new programs to the hospital." (Spaeth, Tr. 2137-38). As to which programs, he stated "[n]ot all of them, but we could spend money on some of them." (Spaeth, Tr. 2138). He provided no explanation why PACS could not have been funded as a "priority." Mr. Newton testified that HPH was considering purchasing PACS and "the capital was available. It just had to be allocated there." (Newton, Tr. 401).