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 III

(CCRFF 965-1481)

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e. Factual Evidence Is Inconsistent With Dr. Haas-Wilson's Bargaining Theory

i. Dr. Haas-Wilson's Bargaining Theory Is Not Grounded In Theory Or Common Sense

965. Dr. Haas-Wilson's theory of competitive harm is based on bargaining theory in general. She opines that {[redacted]}. (Haas-Wilson, Tr. 2469; Haas-Wilson, Tr. 2759-60, *in camera*). Dr. Haas-Wilson, however, did not provide any real details of her bargaining model. (Noether, Tr. 5979).

Response to Finding No. 965:

The finding is incorrect. Dr. Haas-Wilson explains in detail her bargaining theory and the way in which it is applicable to hospital competition. (Haas-Wilson, Tr. 2469-73). She explains that in bargaining, the next best alternative to coming to an agreement will determine the outcome of the bargaining. (Haas-Wilson, Tr. 2470-72). After the merger the next best alternative to reaching an agreement with ENH was less desirable because a managed care organization could not use Highland Park hospital as part of a network to replace ENH. (Haas-Wilson, Tr. 2472-73). Dr. Haas-Wilson shows that her theory is consistent with the academic economic literature that applies bargaining theory to the analysis of hospital mergers. (Haas-Wilson, Tr. 2469-70, 2473-76). Dr. Haas-Wilson showed that her theory is consistent with the experiences of the managed care organizations. (Haas-Wilson, Tr. 2477-79).

966. When explaining her bargaining theory, Dr. Haas-Wilson relied on an article by Town and Vistnes, which suggested that a "hospital's incremental value to the plan is a function of the plan's opportunity cost of turning to the next-best alternative network that excludes the hospital." (Noether, Tr. 5984; Haas-Wilson, Tr. 2475-76). This embodies the concept that "closeness of substitution of different networks with and without a particular hospital in question are important in informing about the bargaining leverage that each party brings to the table." (Noether, Tr. 5984).

Response to Finding No. 966:

The finding is incomplete. Dr. Haas-Wilson explained that under bargaining theory, while a "hospital's incremental value to the plan is a function of the plan's opportunity cost of turning to the next-best alternative network that excludes the hospital," this does not require that two hospitals must be each other's closest competitor in order for a merger of the two hospitals to create or enhance market power. (Haas-Wilson, Tr. 2476). What matters is whether a merger would alter the bargaining positions of the hospital and managed care organizations by changing the alternative networks available to the managed care organization. (Haas-Wilson, Tr. 2469-70).

967. The Town and Vistnes article is inconsistent with Dr. Haas-Wilson's claim that her bargaining theory does not require that Evanston Hospital and HPH to be each other's closest competitors before the Merger from the perspective of either patients or MCOs. (Haas-Wilson, Tr. 2476). Dr. Noether explained that HPH and Evanston Hospital each had much closer hospital competitors, thus establishing that the combination of Evanston Hospital and HPH would have little effect on MCO bargaining dynamics. (Noether, Tr. 5985).

Response to Finding No. 967:

The finding is incorrect, moreover, the cited source does not say what Respondent's finding claims. The Town and Vistnes article states that a "hospital's incremental value to the plan is a function of the plan's opportunity cost of turning to the next-best alternative network that excludes the hospital." Nowhere does the Town and Vistnes article state that the two hospitals could not have closer competitors. (*See* Haas-Wilson, Tr. 2469-73, 2475-76).

968. { [redacted] } (Haas-Wilson, Tr. 2798, *in camera*).

{ } (Haas-Wilson, Tr. 2799, *in camera*). { } (Haas-Wilson, Tr. 2772, *in camera*).

Response to Finding No. 968:

The finding is irrelevant. As Dr. Haas Wilson explained, it was not necessary under bargaining theory for HPH and Evanston Hospital to be each others closest competitor in either the first or second stage of competition between hospitals, for the merger of Evanston and Highland Park to change the market power available to the merged entity by changing the next best alternative network available to managed care plans. (Haas-Wilson, Tr. 2476).

969. Dr. Haas-Wilson's bargaining theory also lacks common sense for several reasons. { } (Haas-Wilson, Tr. 2758, *in camera*). { } (Haas-Wilson, Tr. 2759, *in camera*).

Response to Finding No. 969:

Respondent cites no support for the first sentence of this finding. There is no basis for the claim Dr. Haas-Wilson's bargaining theory lacks common sense. The first citation merely states a truism that whenever there is a merger without new entry the choices to consumers will be reduced. The second citation merely states another truism that not all such reduction in choices will reduce competition. Think of a merger between two wheat farmers in the same geographic market where consumers now have one less wheat farmer to buy from, but the reduction in competition is insignificant. Dr. Haas-

Wilson did not rely on those two propositions to reach her conclusion that the merger created or enhanced market power. Instead Dr. Haas-Wilson conducted a scientific inquiry into the nature of the post merger pricing and only after that inquiry did she conclude that the merger was anticompetitive. (Haas-Wilson, Tr. 2657-58).

970. { } (Haas-Wilson, Tr. 2759-60, *in camera*).

Response to Finding No. 970:

The finding is irrelevant. There is no basis in the record for finding it necessary to measure the increase in bargaining power from the merger to support Dr. Haas-Wilson's testimony. { } (*See* Haas-Wilson, Tr. 2622-2637, *in camera*).

971. { } (Haas-Wilson, Tr. 2784, *in camera*).

Response to Finding No. 971:

The finding is irrelevant. There is no basis in the record for finding it necessary to determine a "magic number" of payer representatives who needed to testify consistent with her theory to support Dr. Haas-Wilson's testimony. The number of payer witnesses called to testify at trial is a decision made by Complaint Counsel with due regard to the desire to avoid unnecessary duplication of testimony at trial.

972. {

} (Haas-Wilson, Tr. 2803-04, *in camera*). {

} (Haas-Wilson, Tr. 2807-08, *in camera*).

Response to Finding No. 972:

The cited source does not say what Respondent's finding claims in the first sentence. Dr. Haas Wilson did rely on pertinent information in reaching her conclusion that the merger enhanced the market power of ENH and that ENH exercised that market power. *See* CCFF 373-391 for a description of the pricing data that Dr. Haas-Wilson relied upon. Dr. Haas-Wilson also relied upon economic theory and literature, (*See, e.g.*, Haas-Wilson, Tr. 2473-74), testimony by payers, (*See, e.g.*, Haas Wilson, Tr. 2476-79), { } (*See, e.g.*, Haas-Wilson, Tr. 2638-43, 2738-40, *in camera*). All the information that Dr. Haas-Wilson relied on was pertinent.

Nor is there any evidence in the record that Dr. Haas-Wilson ignored any pertinent information. While Respondents attempted to demonstrate that Dr. Haas-Wilson did not explore every conceivable source of information there was about the merger and the hospital market in Chicago a review of the testimony they cite, fails to show any information that Dr. Haas-Wilson overlooked in reaching her conclusions.

973. In short, Dr. Haas-Wilson did not tie the evidence of post-Merger price increases to any other evidence, and she did not explain the variation in price increases across MCOs. (Noether, Tr. 5983).

Response to Finding No. 973:

The finding is incorrect. Dr. Haas-Wilson did tie the evidence of the post merger

price increases into other evidence. She did this in several ways. First, she tied the evidence of the post merger price increase into other data to eliminate other explanations of the price increase besides market power. { } (*See, e.g.*, Haas-Wilson, Tr. 2607-2608, 2610-2615 *in camera*). Second, she tied the evidence of the post merger price increase into the economic literature on hospital merger. (*See, e.g.*, Haas-Wilson, Tr. 2475-76). Third, she tied the evidence of the post merger price increase into testimony of the payers in this case. (*See, e.g.*, Haas-Wilson, Tr.2476-79). Fourth, she tied the evidence of the post merger price increase into the testimony and documents from the Respondents. (*See, e.g.*, Haas-Wilson, Tr. 2738-39).

ii. Dr. Haas-Wilson's Bargaining Theory Does Not Apply Here Because MCOs Did Not Play Evanston Hospital And HPH Off Each Other Before The Merger

974. To support her bargaining theory, Dr. Haas-Wilson relied on the testimony of Ballengee from PHCS that, before the Merger, she viewed HPH and Evanston Hospital as competitors and that having both hospitals available "allowed [PHCS] to feel comfortable in working the negotiation." (Haas-Wilson, Tr. 2478). { } (Haas-Wilson, Tr. 2778, 2789 *in camera*). { } (Haas-Wilson, Tr. 2778, *in camera*). As discussed below, however, the record evidence does not corroborate Ballengee's testimony.

<u>Response to Finding No. 974:</u>

The fourth line of the finding, which has neither a citation to the record or a cross reference to any of Respondent's other findings is incorrect. Respondent cites no support for this finding. This is contrary to the judge's April 6, 2005 Order, Order on Post Trial

Briefs, stating that each proposed finding shall have a valid and correct cite to the record.

975. PHCS did not play Evanston Hospital off HPH during negotiations before the Merger. (Ballengee, Tr. 170). {[redacted]} (Haas-Wilson, Tr. 2780-81, *in camera*; Ballengee, Tr. 170).

Response to Finding No. 975:

The finding is irrelevant. On the very next page after the testimony cited here, Ms. Ballengee explained why during negotiations she never explicitly used the existence of Highland Park or Evanston against the other. She believed that everybody was aware of the competitive nature of the two hospitals. (Ballengee, Tr. 171).

Ms. Ballengee's testimony is a textbook example of how bargaining theory works in the North Shore. Prior to the merger, PHCS developed its negotiating strategy with Highland Park and Evanston armed with the knowledge that "we had an alternative facility that we could market within our network if, in fact, the rates were not considered to be appropriate ... we viewed Highland Park and Evanston as competitors, and it was pretty well accepted within the North Shore area and the community there that they functioned as competitors. . . . So, it was pretty well assumed that we could have one or the other hospitals in the network." (Ballengee, Tr. 166. *See* Ballengee, Tr. 166-67 (PHCS "could choose between the two [hospitals] and work them against each other" because they were "competitors" prior to the merger); Ballengee, Tr. 170 (As a result of pre-merger negotiations, PHCS obtained lower prices than Evanston was demanding because PHCS "had a competitive environment between the two hospitals" and "could trade one off for the other.")).

{ } (Ballengee, Tr. 246, *in camera*; CX 46 at 1, *in camera*).

Notwithstanding the "significantly higher" rates proposed by ENH, the fact that "the elimination of Evanston and Highland Park financially would be the best overall in impacting [PHCS's] costs," and the fact that PHCS had 72 other hospitals in its network, PHCS reached the conclusion that it needed to retain ENH in its network. (Ballengee, Tr. 154, 179, 185). The merger eliminated PHCS's "alternative facility." (Ballengee, Tr. 166).

Nowhere in Dr. Haas-Wilson's testimony does she say that managed care organizations need to "play" one hospital off against the other for her theory to be valid. (*See* Haas-Wilson, Tr. 2476). This is simply a straw man, without substance created by the Respondents so that they can knock it down. However, it is irrelevant to Dr. Haas-Wilson's theory and empirical work.

976. { } (Haas-Wilson, Tr. 2817, *in camera*; RX 2030, *in camera*).

Response to Finding No. 976:

Respondent's finding is incorrect. The cited source does not say what Respondent's finding claims. {

} (Haas-Wilson, Tr. 2817-18, *in camera*). {

}

Further, Ms. Ballengee's own testimony in this matter is the best evidence of PHCS's views of the pre-merger environment. Her testimony confirms that PHCS viewed Evanston and Highland Park as alternatives to each other prior to the merger. (Ballengee, Tr. 166. *See* CCRFF 975).

977. { } (Mendonsa, Tr. 562-63, *in camera*). { } (Mendonsa, Tr. 568, *in camera*).

Response to Finding No. 977:

The finding is irrelevant. { } (Mendonsa, Tr. 530, *in camera*). { } (Mendonsa, Tr. 569, *in camera*). { } (Mendonsa, Tr. 520, *in camera*).

With respect to the second sentence of the finding, Respondents distort the record. The exchange between Mr. Mendonsa and counsel was:

{

}

(Mendonsa, Tr. 568 *in camera*)

With respect to the first sentence of the finding Respondents also fail to provide the full testimonial record:

{

}

(Mendonsa, Tr. 562-63 *in camera* (emphasis added).

978. { } (Holt-Darcy, Tr. 1594, *in camera*). { } (Holt-Darcy, Tr. 1593-94, *in camera*). { } (Holt-Darcy, Tr. 1513, *in camera*).

Response to Finding No. 978:

Respondent's finding is irrelevant. { } (Holt-Darcy, Tr. 1603, *in*

camera).

{ (Holt-Darcy, Tr. 1513 *in camera* (emphasis added)),

} (Holt-Darcy, Tr. 1517-8, *in camera*).

{

} (Holt-Darcy, Tr. 1518-9, *in camera*).

979. Great West also did not play one hospital off another to get better rates. (Dorsey, Tr. 1470-71). That has "never been a negotiating strategy" during Dorsey's tenure at the company, and he never approved that strategy for anyone on his team. (Dorsey, Tr. 1470-71).

Response to Finding No. 979:

Respondent's finding is irrelevant. One Health (Great West) representatives testified that prior to the merger, Highland Park was Evanston's "main competitor." (Neary, Tr. 600-02). Both hospitals "drew patients from the same general area" and offered "comparable" services. (Neary, Tr. 601-02). Post-merger, One Health knew that "we were not in a strong negotiating position" because "Evanston had purchased their main competitor," Highland Park. (Neary, Tr. 600-01). This is just as bargaining theory would predict; the elimination of the alternative weakened the health plan's bargaining position. (Haas-Wilson, Tr. 2472). One Health terminated ENH for a short period of time. (Neary, Tr. 610-11; Hillebrand, Tr. 1707-08, 1898; CX 5062 at 1). After learning by natural experiment that it would lose customers if it did not have ENH in its network,

One Health re-approached the negotiating table with ENH knowing that they "were not in a strong negotiating position" because there were no alternatives to which One Health could turn. "We knew that we had to get a contract with the hospital . . . essentially regardless of what the ultimate price was." (Neary, Tr. 618-19).

Nowhere in Dr. Haas-Wilson's testimony does she say that managed care organizations need to "play" one hospital off against the other for her theory to be valid. (*See* Haas-Wilson, Tr. 2476). This is simply a straw man, without substance created by the Respondents so that they can nock it down. However, it is irrelevant to Dr. Haas-Wilson's theory and empirical work.

980. {[redacted]} (Haas-Wilson, Tr. 2788-89, 2793, *in camera*).

Response to Finding No. 980:

The statement about Preferred Plan is from a deposition that was not in evidence. Counsel for Respondent merely used it to refresh Dr. Haas-Wilson's memory, but failed to ask Dr. Haas-Wilson if it refreshed her recollection, so it has no evidentiary value.

In any event, the finding is irrelevant. Dr. Haas-Wilson testified that Preferred Plan's testimony is not inconsistent with the testimony that Dr. Haas-Wilson was relying on. Nowhere in Dr. Haas-Wilson's testimony does she say that managed care organizations need to "play" one hospital off against the other. (*See* Haas-Wilson, Tr. 2476). This is simply a straw man, without substance created by the Respondents so that they can nock it down. However, it is irrelevant to Dr. Haas-Wilson's theory and empirical work.

981. {[redacted]
[redacted]} (Haas-Wilson, 2796-98, *in camera*).

Response to Finding No. 981:

Respondent misstates the record. Dr. Haas-Wilson never answered any question with regard to Humana's testimony on this point. There is no evidence in the record at all on this issue at this point in the transcript.

Nowhere in Dr. Haas-Wilson's testimony does she say that managed care organizations need to "play" one hospital off against the other for her theory to be valid. (*See* Haas-Wilson, Tr. 2476). This is simply a straw man, without substance created by the Respondents so that they can nock it down. However, it is irrelevant to Dr. Haas-Wilson's theory and empirical work.

982. Moreover, before the Merger, HPH had contracts with virtually all MCOs, with perhaps one or two exceptions. (Newton, Tr. 457). And HPH was never excluded from managed care contracts because of Evanston Hospital (other than Humana's Staff model product). (Newton, Tr. 457).

Response to Finding No. 982:

The finding is irrelevant. So long as both hospitals were pricing competitively pre-merger, there was no reason for a health plan to exclude one from its network.

The record shows that Highland Park considered Evanston to be a competitor prior to the merger. Mr. Newton was "routinely concerned" about being excluded from a health plan's network and was "informed or told by the managed care company" that "if you're not in the network, we've got other hospitals that will fill that bill." (Newton, Tr. 303. *See also* Spaeth, Tr. 2173 (Mr. Spaeth testified that if Highland Park had attempted to raise its price prior to the merger and been excluded from a health plan's network in

favor of Evanston, that would have had a very negative effect on Highland Park.); Spaeth, Tr. 2172-73, 2178-79 (Highland Park executives knew that the hospital could not sustain a strategy in which it would lose contracts or be eliminated from a health plan's network.). *See also* Newton, Tr. 303 ("If we're looking for a particular price or a particular term in the contract that they would find not acceptable, the risk of trying to push that would be that we could be excluded from the panel."). The threat of being eliminated in favor of Evanston hospital had the pro-competitive effect of making Highland Park "somewhat constrained in its pricing contract negotiations." (Newton, Tr. 303-04). Numerous Highland Park documents confirm that Highland Park felt competitive pressure from Evanston. (*See* CX 1879 at 3-4 ("Stop competing with each other."); CX 4 at 1 (Highland Park did not want to "d[o] battle with one another" in "a common battle ground"); CX 1868 at 3 ("Within the hospital's core, competition is mainly from Lake Forest and Evanston.")).

983. Evanston Hospital's presence, or the presence of any other hospital, in a MCO's network did not make it more difficult for HPH to gain price increases from that MCO before the Merger. (Spaeth, Tr. 2176). If a MCO decided not to accept HPH's price proposals, HPH simply would either lower its prices or walk away from the MCO. (Spaeth, Tr. 2176).

Response to Finding No. 983:

The finding is irrelevant. The assertion that, if an MCO did not accept HPH's price proposals, HPH would lower its prices or not contract with the MCO is completely beside the point. The issue is what would make an MCO decide not to accept HPH's price proposals. There are two types of evidence on that issue, both pointing to the importance of the existence of an independent Evanston Hospital to keep HPH's prices in

check. {███ ████████████████████████████} (Ballengee, Tr. 167 (When Evanston and Highland Park were separate entities, PHCS could use one hospital and not the other. "If, in fact, the negotiation and the rates were not going well at one hospital . . ., we had the alternative."); Mendonsa, Tr. 530 ({████████████████████ ██ ██}), *in camera*); Holt-Darcy, Tr. 1518-19 ({████████████████████████ ███ ███ ███}), *in camera*).

{██ ███████████████████████████} (Chan, Tr. 819-21, *in camera*; Spaeth, Tr. 2201-02, 2172-73, 2178). {███████████████████████████████ ███ ██ ████████████████████████████} (Baker, Tr. 4739, *in camera*, Haas-Wilson, Tr. 2729, 2731-32, *in camera*).

The only reasonable conclusion from this evidence is that the existence of Evanston Hospital as an independent alternative to Highland Park that a managed care organization could include in its network did affect the prices that HPH could charge.

iii. Dr. Haas-Wilson's Bargaining Theory Does Not Apply Here Because She Admits That A Network Without ENH Would Still Be Marketable

984. { [redacted] } (Haas-Wilson, Tr. 2762, *in camera*).

Response to Finding No. 984:

The finding is irrelevant. Respondents have created a straw man, without substance or applicability to Dr. Haas-Wilson's testimony. Nowhere does Dr. Haas-Wilson say that a network with ENH could never be marketable. Dr. Haas-Wilson applied bargaining theory to the negotiations between hospitals and managed care organizations. Under bargaining theory the outcome of the bargaining between the hospital and the managed care organization will depend on the bargaining position of each participant. The bargaining position of a party is determined by the value of the next best alternative available to that party. (Haas-Wilson, Tr. 2469-72). If the merger changed the next best alternative for a managed care organization so that the next best alternative to reaching a contract with Evanston was less desirable, the managed care organization will be in a worse bargaining position and ENH would be in a better bargaining position post merger. (Haas-Wilson, Tr.2472-73). Nowhere does Dr. Haas-Wilson say that the network without ENH must not be marketable, only that it be less desirable to the managed care organization than the network the managed care organization could have had pre-merger if it did not reach an agreement with Evanston Hospital.

In fact, the only managed care organization that sought to market its network

without ENH was One Health. *See* CCFF 1101-77 for the complete story of One Health's post merger negotiations with ENH. One Health found that its network was not marketable without ENH and had to obtain a contract with ENH. (CCFF 1152-58).

985. { } (Haas-Wilson, Tr. 2762, *in camera*). { } (Haas-Wilson, Tr. 2763-64, *in camera*).

Response to Finding No. 985:

The finding is incomplete and misleading. The finding is incomplete because the marketability of the network would depend upon the desirability of the coverage of the network. Both extensive networks and low premiums are desirable traits for health insurance products. However there is a tradeoff between the two. (Haas-Wilson, Tr. 2462). One Health, the only managed care organization that attempted to take that tradeoff and market a network without ENH found that it could not. (CCFF 1152-58).

986. { } (Haas-Wilson, Tr. 2765-66, *in camera*). { } (Haas-Wilson, Tr. 2766, *in camera*).

Response to Finding No. 986:

The finding is irrelevant. The issues that Dr. Haas-Wilson was asked to address was whether the merger created or enhanced market power and whether ENH exercised that market power. (Haas-Wilson, Tr. 2448-49). There is no evidence in the record to even suggest that it was necessary for Dr. Haas-Wilson to reach her conclusion to measure the decrease in premium necessary to market a post-merger network without ENH.

987. { } (Haas-Wilson, Tr. 2766, *in camera*). { } (Haas-Wilson, Tr. 2768, *in camera*). { } (Haas-Wilson, Tr. 2769-70, *in camera*).

Response to Finding No. 987:

Complaint Counsel have no specific response.

988. { } (Haas-Wilson, Tr. 2773, *in camera*). { }. (Haas-Wilson, Tr. 2773, *in camera*).

Response to Finding No. 988:

This finding is incomplete and misleading. Dr. Haas-Wilson made clear in her testimony that a pre-merger network which did not have Evanston and Glenbrook Hospital could have had Highland Park Hospital in the network. After the merger that alternative, of having Highland Park but not Evanston and Glenbrook was no longer available. (Haas-Wilson, Tr. 2472-2473).

iv. Dr. Haas-Wilson's Bargaining Theory Does Not Apply Here Because There Was Little Selective Contracting In The Chicago Area

989. Dr. Haas-Wilson's bargaining theory is based on the concept of selective contracting. (Haas-Wilson, Tr. 2457-59). Selective contracting is where MCOs contract with a limited number of hospitals rather than all the hospitals in an area and use their bargaining ability to steer volume to the contracted hospitals, thus inducing price competition among hospitals. (Noether, Tr. 5980-81).

Response to Finding No. 989:

Respondent's finding is incomplete. In selective contracting, the ability of the

health plan to exclude a hospital from its network is a powerful tool and defines each side's bargaining position. (Haas-Wilson, Tr. 2470. *See also* Noether, Tr. 6189). When a health plan is putting together its provider network, if one hospital is asking for what appears to be a particularly high and unreasonable price, the health plan will look at its alternatives. (Haas-Wilson, Tr. 2470). Health plans will seek to put together an attractive network for potential buyers, while at the same time keeping premiums (i.e. the prices at which it sells its products) low. (Haas-Wilson, Tr. 2457).

990. In the absence of selective contracting, a MCO attempts to have all hospitals in their networks and, as a consequence, the MCO would not have the same bargaining leverage it would have had if it engaged in selective contracting. (Noether, Tr. 5981).

Response to Finding No. 990:

Respondent's finding is incomplete. The fact that a health plan may "attempt" to have all hospitals in its network does not mean that the health plan will reach a bargain over price with every hospital and include every hospital in its network. (*See* Haas-Wilson, Tr. 2457-58). Selective contracting is prevalent when "different insurance companies have different numbers of affiliated hospitals," even in a situation where the health plan only excludes a few hospitals from its network. (*See* Haas-Wilson, Tr. 2459-60).

991. There was never much selective contracting in the Chicago area. (Noether, Tr. 5981). An analysis of the size of various managed care networks in the Chicago area shows that all MCO networks are very large and fairly inclusive. This supports the conclusion that MCOs contract with the vast majority of hospitals in the Chicago area. (Noether, Tr. 5982 (*describing* DX 7045)).

Response to Finding No. 991:

Respondent's finding is incorrect. There is no requirement that a health plan

exclude many hospitals for selective contracting to be prevalent. (*See* Haas-Wilson, Tr. 2459-60). Second, health plan testimony demonstrates that selective contracting is very prevalent in the Chicago area. (*See* Neary, Tr. 587-88 (Before the merger, One Health's selectivity in choosing hospitals for its network forced hospitals to compete harder for the health plan's business.); Mendonsa, Tr. 484, 485, 491 (Aetna contracts with about 88 out of a total of 100 hospitals in the Chicago area. Network composition is "critically vital" to Aetna's ability to market a network to employers. Aetna has to have the "discounts so [it] can have the right pricing," and "the proper access to get the business."); Ballengee, Tr. 154-56 (PHCS has 75 hospitals in its network in the Chicago area. When PHCS weighs whether or not to exclude a hospital, it takes into account other hospitals and "comparability or some degree of parity of rates."); Holt-Darcy, Tr. 1420 (UniCare had roughly 90-96 hospitals in the Chicago area in its network. Unicare considers "geographic need, . . . marketing needs" and "access" when developing its network.); Foucre, Tr. 881, 884-85 (There were approximately 98 hospitals in United's network at the end of 2002. For a health plan to market and sell a hospital network, the geographic location of the hospitals is important for two reasons: (1) a consumer's "primary decision-making factor in selecting a hospital is very often the location of the hospital and the distance they have to travel to seek services," and (2) ensuring an adequate network compared to their competitors in the geographies of where decision-makers of key employers reside is also important.)).

The record is replete with examples of health plans terminating hospitals that did not meet their network requirements. {

} (Mendonsa, Tr. 568-569, *in camera*). Similarly, in the late 1990s, PHCS eliminated the University of Chicago from its network when the hospital refused to lower its rates. (Ballengee, Tr. 155, 189-90). Similarly, United terminated the eight hospitals in the Advocate system in 2002 when the system no longer met United's network needs. (Foucre, Tr. 931-32). In these situations, the health plans were able to exclude hospitals because they could create viable, marketable networks with alternative providers. In contrast, One Health terminated ENH because it believed the merged entity's 2000 price increases to be "excessive" but was forced to return to the negotiating table – in a weakened negotiating position – because it could not market its network without the ENH hospitals. (Neary, Tr. 609-11, 615-19).

Respondent's findings recognize that there is selective contracting in the Chicago area. (*See* RFF 149 ({ }), *in camera*; RFF 178 (United terminated 8 hospitals between 2000 and 2002)).

992. This analysis further indicates that, in the Chicago area, HMO and PPO networks are about the same size. (Noether, Tr. 5982). For example, { } (Holt-Darcy, Tr. 1584-85, *in camera*). Traditionally, in a market where there was more selective contracting, HMOs would be smaller than PPOs. (Noether, Tr. 5982).

Response to Finding No. 992:

(*See* CCRFF 991 (discussing the fact that selective contracting is prevalent in the Chicago area)).

993. There are 80 to 90 hospitals in the Chicago area, excluding VA hospitals, pediatric hospitals and private psychological institutions. (Ballengee, Tr. 154). PHCS has 75 of these hospitals in its network in the Chicago area. (Ballengee, Tr. 154).

Response to Finding No. 993:

Respondent's finding is incomplete and misleading. Even contracting with 75 hospitals, PHCS excluded hospitals because their rates were too high relative to comparable hospitals. (Ballengee, Tr. 189-90.) When PHCS evaluates whether to exclude a hospital from its network, it looks at other hospitals to see if they will give PHCS the access that its clients want to the services they are looking for. (Ballengee, Tr. 155). Location plays a role in that evaluation. (Ballengee, Tr. 155-156). For example, Ms. Ballengee testified that, prior to the merger, if negotiations with Evanston or Highland Park were not going well, PHCS could have chosen to include only one of the two hospitals in its network before the merger and worked them against each other. PHCS' strategy centered on the fact that it could have eliminated one of the hospitals from the network and utilized the other as the alternative hospital. (Ballengee, Tr. 166-67; Haas-Wilson, Tr. 2477-79).

PHCS also engaged in selective contracting when it decided to drop the University of Chicago. (Ballengee, Tr. 155-56, 189-90.). Because it had good substitutes, PHCS used its bargaining position to avoid the higher prices and eliminated the University of Chicago from its network. (Ballengee, Tr.189-90 (Comparing the University of Chicago against Northwestern, Loyola, and Rush Presbyterian but not Evanston).

994. {

} (Holt-Darcy, Tr. 1583-84, *in camera*). In fact, { } (Holt-Darcy, Tr. 1584, *in camera*).

Response to Finding No. 994:

Respondent's finding is incomplete and misleading. Unicare includes the hospitals in its network that will cover its "geographic need, . . . marketing needs" and "access" requirements. (Holt-Darcy, Tr. 1420). { } (Holt-Darcy, Tr. 1518-9, *in camera*). { } (Holt-Darcy, Tr. 1517-8, *in camera*).

v. Pertinent Documents Do Not Support Dr. Haas-Wilson's Bargaining Theory

995. Complaint Counsel may rely on documents from the files of ENH and Bain that refer to the term "leverage" to support Dr. Haas-Wilson's bargaining theory.

Response to Finding No. 995:

Complaint Counsel have no specific response.

996. Bain used the term "leverage" in some of its consulting materials. The word "leverage" as used in the Bain documents means "position." (RX 2047 at 34, 39 (Ogden, Dep.); CX 74 at 22; RX 1786 at BAIN 17641). { } (RX 2047 at 29 (Ogden, Dep.); CX 1991 at 2, *in camera*). Bain advised ENH that it "should recognize its position and not be afraid to ask to be paid fair market value" for its services. (RX 2047 at 39-40 (Ogden, Dep.)).

Response to Finding No. 996:

Respondent's finding is incomplete and misleading. The various, thin and after the fact meanings Respondents ascribe to the word "leverage" as used by Bain in its merger integration presentations defies the plain text of the presentations. Bain consistently advised ENH that ENH's "negotiating leverage [with health plans] should increase with increased scale." (CX 74 at 22). To read "negotiating leverage" in this context to mean anything else besides "bargaining position" or "negotiating strength" is contrary to the clear meaning of the words. Indeed, Bain emphasized ENH's "marketplace position" and conveyed that "with the Highland Park merger, ENH now commands a 55% market share." (CX 1607 at 5).

Likewise, Bain advised ENH that ENH had "significant leverage" with health plans because the combined ENH/HPH entity would be the largest in admissions volume in the Chicago area. (CX 74 at 15). In the PHCS action plan, Bain advised ENH that it had "the required leverage to gain PHCS's agreement to improved terms" because PHCS was heavily reliant on the combined ENH/HP entity, with ENH/HP constituting "over 30% of [PHCS] North Shore admissions." (CX 67 at 39).

Indeed, ENH itself understood that Bain's use of the term "leverage" incorporated the concept of bargaining power in contract negotiations with health plans. (Hillebrand, Tr. 1801-02). In a December 1999 presentation to Standard and Poor's, ENH emphasized that it had "negotiating strength as a combined system of 3 hospitals" over managed care. (RX 704 at ENH HJ 001645).

997. {[redacted]} (Noether, Tr. 6106-07, *in camera*). {[redacted]} (Noether, Tr. 6107, *in camera*).

Response to Finding No. 997:

Respondent's finding is incomplete, misleading and irrelevant. As described in CCRFF 996, Bain utilized the word "leverage" in its merger integration advice to mean "strength" or "bargaining position." (*See* CCRFF 996). Whether and how Bain utilized leverage in other contexts is irrelevant. Indeed, Respondent claims that in RFF 996 that the term "leverage" had two different meanings. (*See* RFF 996).

Respondent's sole source for this finding is the testimony of Dr. Noether. Dr. Noether was qualified as an expert in this case in the fields of "industrial organization economics, with particular emphasis in healthcare economics and antitrust" (Noether, Tr. 5899). She did not draft the documents in question or work for Bain.

998. {[redacted]} (RX 2047 at 65 (Ogden, Dep.); RX 1786 at BAIN 17641; Hillebrand Tr. 2014-15; Noether, Tr. 6107, *in camera*). After the Merger integration project was completed, Bain worked on a cost reduction project for ENH. (RX 2047 at 62 (Ogden, Dep.)). Bain discovered that ENH was not good at negotiating contracts across the board, and developed a "vendor strategy," which recommended that ENH approach vendor contracting in a systematic way. (RX 2047 at 62-63 (Ogden, Dep.)). Bain examined ENH's contracts with large national suppliers of medical products, and found that ENH's contracting practices in this area were "haphazard." (RX 2047 at 63 (Ogden, Dep.)). Bain's advice "looked very much like what we said on the contracting side: to be more systematic about it, to do our homework, to get everybody together in a room, we laid out a process for them going forward." (RX 2047 at 63-66 (Ogden, Dep.); RX 1786; Hillebrand, Tr. 2016-17). Bain thus advised that ENH look at its "leverage" and hospital suppliers' "leverage" when entering negotiations with the hospital suppliers. (RX 1786 at BAIN 17641). Hillebrand understood that Bain was using "leverage" to mean "strengthen the position" to purchase supplies. (RX 1786 at BAIN 17641; Hillebrand, Tr. 2016-17).

Response to Finding No. 998:

Respondent's finding is incomplete, misleading and irrelevant. As described in CCRFF 996, Bain utilized the word "leverage" in its merger integration advice to mean "strength" or "bargaining position." (*See* CCRFF 996). Whether and how Bain utilized leverage in other contexts is irrelevant.

999. Bain did not advise ENH that the Merger resulted in market power. HPH was really a non-issue to MCOs. So the "leverage" that ENH had with MCOs after the Merger was a function of where they had been paid before the Merger, and ENH's position as a major-sized hospital (even without HPH). (RX 2047 at 41 (Ogden, Dep.)).

Response to Finding No. 999:

Respondent's finding is misleading and incomplete. The merger made a difference in renegotiation results. { [redacted] } (CX 1991 at 3, *in camera*). These price increases were in keeping with Bain's advice. As described in CCRFF 996, Bain utilized the word "leverage" in its merger integration advice to mean "strength" or "bargaining position." (*See* CCRFF 996).

Respondent's finding that "HPH was really a non-issue to MCOs" was directly contradicted by the health plan witnesses. Testimony from health plan representatives established that the broader geographic coverage of the combined Evanston-HPH entity had a significant impact on the negotiating dynamic. Health plans no longer had the option of combining either Evanston or Highland Park with another hospital to provide coverage for the crucial North Shore area. (*See* CCFF 969, 999-1015, 1030 (United

experience); CCFF 1080-84 (PHCS experience); CCFF 1152-62 (One Health experience); CCFF 1204-10 (Aetna experience); CCFF 1281-88 (Unicare experience)).

1000. Similarly, the term "leverage" as used in ENH documents does not mean market power. Neaman defined his use of the term "leverage" to mean the "ability to succeed." (Neaman, Tr. 958).

Response to Finding No. 1000:

Respondent's finding is incomplete, misleading and contradicted by the record evidence. Mr. Neaman's self-serving testimony on his use of the term "leverage" is not credible, is on its face nonsensical, and is contradicted by numerous documents and supporting testimony. { }

(CX 1566 at 9; Neaman, Tr. 1138, *in camera*). Mr. Hillebrand admitted that the phrase "increase market leverage" includes the potential to get higher prices from health plans and to increase bargaining power. (Hillebrand, Tr. 1790-91, 1801-02, 1811-12; CX 394 at 3; CX 2070 at 3). In a May 2000 planning document, ENH recognized that achieving "a leadership position (#1 or #2) and significant market share (>30%)" even in small market areas, "increases contracting leverage with health plans and employers." (CX 86 at 2-3). (*See also* CCFF 1451-1461 (ENH after the fact explanations of the use of term leverage are factually implausible)).

1001. Complaint Counsel also places undue reliance on the term "indispensable" used in some ENH documents. HPH hoped to become "indispensable" to the market by improving its quality of care, not from a market power perspective. (RX 367 at ENH DR 4205). For example, the Lakeland Finance Committee's August 18, 1998, Managed Care Review stated that one of HPH's goals was to "[i]ncrease patient satisfaction and patient loyalty to the hospital and the

physicians making [Highland Park Healthcare, Inc.] indispensable to any major player in the managed care market." (RX 367 at ENH DR 4205).

Response to Finding No. 1001:

Respondent's finding is contradicted by other record evidence. Evanston's repeated use of the term, "indispensable," was clearly in some instances in the market power context. For example, part of the "market influence" goal in the NH North proposed merger was to "capture 30-40% of key health plans" and achieve a level of "indispensability." (CX 394 at 13). Evanston also had a quality goal separate and apart from "market influence." NH North was to differentiate itself with "superior outcomes" and "best physicians." (CX 394 at 13). As a central pillar of its merger strategy, Evanston was to become "indispensable" to health plans through increased market share and market power.

1002. { } (Noether, Tr. 6107-08, *in camera*; CX 7, 8, 9 and 10). { } (Noether, Tr. 6107, *in camera*). As Hillebrand explained, ENH achieved the price increases noted in these documents precisely because in 1999-2000 Evanston Hospital/ ENH realized it was not being fairly compensated by many purchasers of care for its clinical services. (Hillebrand, Tr. 2026).

Response to Finding No. 1002:

Respondent's finding is only relevant if its learning about demand hypothesis is correct. As Complaint Counsel set forth in their original findings, the learning about demand excuse is implausible. (*See* CCFF 1972-2031). { } (*See* CCFF

1983-2015, *in camera*). {

} (Ballengee, Tr. 166-69, 171; Mendonsa, Tr. 530, *in camera*).

3. Empirical Analysis Of Price *Changes* Does Not Show That The Merger Conferred Market Power

a. Professor Baker Measured The Relative, Non-Quality-Adjusted Post-Merger Price Changes In The Reasonable Range Of 9-12%

1003. { } (Baker, Tr. 4617-19, 4795-96, *in camera*).

Response to Finding No. 1003:

This proposed finding is incomplete and misleading. { } (Baker, Tr. 4617-4619 (emphasis added), *in camera*). With respect to whether that is in a "reasonable range as the section heading suggests, Complaint Counsel contrasts that to the 5% price increase generally used in the determination of whether a merger should be challenged under the Merger Guidelines.

1004. { } (Baker, Tr. 4619-20, 4646, 4795-96, *in camera*; Haas-Wilson, Tr. 2637, *in camera*).

Response to Finding No. 1004:

This proposed finding is incomplete and misleading. { } (Baker, Tr. 4619-20 (emphasis added), *in camera*).

{ } (Baker, Tr. 4796-97, *in camera*).

1005. { } (Baker, Tr. 4631, *in camera*). { } (Baker, Tr. 4631, *in camera*).

Response to Finding No. 1005:

This proposed finding is incorrect and misleading. Although economic theory does not predict that decreases in outpatient services prices would lead to increases in inpatient service prices, Dr. Haas-Wilson analyzed the possibility that a MCO might be willing to pay higher prices for inpatient services if they were getting outpatient services at a lower price. (Haas-Wilson, Tr. 2487-88). { }

(Haas-Wilson, Tr. 2607-08, *in camera*). {

} (Haas-Wilson Tr. 2614-15, *in camera*; *see also* CCFF 600-608).

Dr. Baker himself found that outpatient prices increased more at ENH relative to his control group than inpatient prices. (CCRFF 1004).

In any event, Dr. Baker, the sole source cited for this finding, lacked credibility. (*See* CCFF 1742-1762).

1006. { } (Baker, Tr. 4642, *in camera*). { } (Baker, Tr. 4642-43, *in camera*).

Response to Finding No. 1006:

Complaint Counsel have no specific response.

1007. { } (Baker, Tr. 4621, 4740, *in camera*). { } (Baker, Tr. 4637-38, 4755, *in camera*).

Response to Finding No. 1007:

Complaint Counsel have no specific response.

1008. { } (Baker, Tr. 4628-29, *in camera*).

Response to Finding No. 1008:

The finding is misleading. {

} (Amended Glossary of Terms at 4, April 22, 2005).

{

} (Amended Glossary of Terms at 4, 6, 9, April 22, 2005)

{

}

The finding is irrelevant. All the results Dr. Haas-Wilson testified to at trial were reimbursement per case.

In any event, the sole source for this proposed finding is Dr. Baker, who lacked credibility. (*See* CCFF 1742-1762).

1009. { } (Baker, Tr. 4633, *in camera*). { } (Baker, Tr. 4633, *in camera*).

Response to Finding No. 1009:

The sole source for this proposed finding is Dr. Baker, who lacked credibility. (*See* CCFF 1742-1762). { } (Baker, Tr. 4633, *in camera*).

} (Baker, Tr. 4633, *in camera*).

{ } (CCFF 497-502).

1010. { } (Baker, Tr. 4635, *in camera*). { } (Baker, Tr. 4635, *in camera*).

Response to Finding No. 1010:

This proposed finding is incomplete and misleading. } (*See, e.g.,* Mendonsa, Tr. 547, *in camera*. *See also* Chan, Tr. 672). } (Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*; CCFF 466). { } (*See generally* Haas-Wilson, Tr. 2511-13, *in camera*).

The finding is also irrelevant. { } (CCFF 497-502).

In any event, the sole source for this proposed finding is Dr. Baker, who lacked credibility. (*See* CCFF 1742-1762).

1011. { } (Baker, Tr. 4648, *in camera*).

Response to Finding No. 1011:

This proposed finding is incorrect. { } (CCFF 497-502; 1742-1762). Such actions lead to the conclusion that Dr. Baker lacked credibility. (*See* CCFF 1742-1762).

b. Problems With Available Data Render Professor Baker's Price Estimates Conservative

1012. { } (Baker, Tr. 4621-22, *in camera*). { } (Baker, Tr. 4622, *in camera*).

Response to Finding No. 1012:

The finding is misleading. {

} (Baker, Tr. 4739, 4786-87, *in camera*; RX 2040 at 4, *in camera*). { } (*See* CCFF1742-1762). { }

The finding is not supported by the citations. The first sentence does not say what Respondent claims Dr. Baker said. { } (Baker, Tr. 4622, *in camera, emphasis added*).

This proposed finding is incomplete. {] (CX 6279 at 19, *in camera*; CCFF 683-691). }

(Baker, Tr. 4622, *in camera*). {

} (Baker, Tr. 4627, *in camera*).

In any event, the sole source for this proposed finding is Dr. Baker, who lacked credibility. (*See* CCFF 1742-1762).

1013. { } (Baker, Tr. 4625-26, *in camera*). { } (Baker, Tr. 4628, *in camera*).

Response to Finding No. 1013:

This proposed finding is irrelevant. { } (Baker, Tr. 4642-43, *in camera*). { } (*See* Baker, Tr. 4643-44, *in camera*).

In any event, the sole source for this proposed finding is Dr. Baker, who lacked credibility. (*See* CCFF 1742-1762).

1014. { } (Baker, Tr. 4806-07, *in camera*). { } (Baker, Tr. 4807, *in camera*).

Response to Finding No. 1014:

The cited source to the first sentence does not say what Respondent's finding claims. Dr. Baker never uses the terms wide variances in his answers, merely stating that the numbers are different. Complaint Counsel attempted to introduce the underlying tables that Dr. Baker was testifying about, *but Respondents objected* and *Chief Judge McGuire upheld the Respondent's objection and refused to admit Dr. Baker's tables.* (*See* the Court's Order Denying Complaint Counsel's Motion for the Admission of Portions of Dr. Baker's Expert Reports Into Evidence dated May 10, 2005). It is impossible therefore to objectively determine whether in fact the differences yielded "wide variances."

The finding is a non sequitur. { } (*See, e.g.* CX 5001 at 4, 6, 8 (Aetna contract for pre-merger HPH); CX 5007 at 4, 7, 10 (Aetna contract for pre-merger Evanston Hospital); CX 5068 at 27 ({ }), *in camera*; CX 5070 at 28, 30 (PHCS contract for pre-merger Evanston Hospital)). Given that, there is no reason to think that the average price at Highland Park will have the same relationship to the average price at Evanston with and without obstetrics. For instance, if Highland Park charged less for maternity than Evanston, deleting the maternity cases will make Highland Park's prices seem higher relative to Evanston than if maternity cases are included. Since managed care organizations actually paid for all hospital stays of people covered by their insurance, including maternity stays, the most accurate price comparison would, of course, include all services, including maternity.

In any event, the sole source for this proposed finding is Dr. Baker, who lacked credibility. (*See* CCFF 1742-1762).

1015. { } (Baker, Tr. 4627-28, *in camera*).

Response to Finding No. 1015:

This proposed finding is irrelevant and misleading. { } (Haas-Wilson, Tr. 2518, 2524-25, *in camera*; CCFF 535-579). { } (Baker, Tr. 4640-4643, *in camera*). *See also* CCRFF 1012-1014 discussing that the claimed problems did not affect Dr. Baker's analysis.

In any event, the sole source for this proposed finding is Dr. Baker, who lacked credibility. (*See* CCFF 1742-1762).

1016. { } (Baker, Tr. 4645-46, *in camera*). {

} (Baker, Tr. 4646-47, *in camera*).

Response to Finding No. 1016:

The finding is incomplete and misleading. {

} (Haas-Wilson, Tr. 2500; Haas-Wilson, Tr. 2582-83, *in camera*).

{

} (*See* CCFF 376-380).

In any event, the sole source for this proposed finding is Dr. Baker, who lacked credibility. (*See* CCFF 1742-1762).

c. Dr. Haas-Wilson's Empirical Analysis Fails To Support The Conclusion That Post-Merger Price Changes Are The Result Of Market Power

1017. Dr. Haas-Wilson admitted that she did not use the Merger Guidelines as the theoretical basis for her empirical work in this matter. (Haas-Wilson, Tr. 2467-68).

Response to Finding No. 1017:

This proposed finding is irrelevant, incomplete and misleading. (*See* CCRFF 515 (discussing the Merger Guidelines do not provide an appropriate framework for analyzing this Merger because they are based on developing a model to estimate whether a merger will create market power in the future.)). In this case, Dr. Haas-Wilson analyzed this merger by addressing the question whether the merger did create or enhance market power. (Haas-Wilson, Tr. 2448, 2468).

1018. Dr. Haas-Wilson further admitted that she did not write her rebuttal report. (Haas-Wilson, Tr. 2449-50, 2671). Moreover, Dr. Haas-Wilson did not know who wrote the first draft of her rebuttal report. (Haas-Wilson, Tr. 2671-72). Dr. Haas-Wilson only taught one course at Smith College and was doing no other consulting work during the Fall semester, when her rebuttal report was written. (Haas-Wilson, Tr. 2672).

Response to Finding No. 1018:

This proposed finding is incomplete and misleading and irrelevant. Unlike Dr. Noether and Dr. Baker, Dr. Haas-Wilson does not have a staff of 30 consultants who assisted her in this assignment. (Haas-Wilson, Tr. 2450). Dr. Haas-Wilson makes her living as a professor at Smith College and not at a consulting firm. Dr. Haas-Wilson wrote the initial outline that was the basis for the rebuttal report, and reviewed everything that was written in that report. (Haas-Wilson, Tr. 2449-50). Her course work at Smith College and consulting work is irrelevant to this litigation.

1019. Prior the filing of the Complaint in this matter, Dr. Haas-Wilson told the FTC they "had a strong case." (Haas-Wilson, Tr. 2673).

Response to Finding No. 1019:

Complaint Counsel has no specific response.

1020. Dr. Haas-Wilson reached this conclusion before doing any analysis of the claims data, and before reviewing deposition transcripts. (Haas-Wilson Tr. 2674-75).

Response to Finding No. 1020:

Respondent mischaracterizes the testimony of Dr. Haas-Wilson. Dr. Haas-Wilson testified that she had not reached a conclusion prior to the filing of the Complaint in this matter. Instead, prior to the filing of the Complaint, she told the FTC that they "had a strong case," which was not a conclusion.

This proposed finding is also incomplete and misleading. Dr. Haas-Wilson had read and reviewed many investigational hearing transcripts in this case before she told the FTC that they "had a strong case.". (Haas-Wilson, Tr. 2675).

i. Dr. Haas-Wilson's Empirical Theory Is Flawed

1021. { } **(Haas-Wilson, Tr. 2745-46, *in camera*).**

Response to Finding No. 1021:

The finding is irrelevant and misleading. { } (Haas-Wilson, Tr. 2745-46 *in camera*). Dr. Haas-Wilson, following economic theory as a guide, developed a list of ten possible explanations for the price increase. She did not include in her list every possible explanation, but limited the list to those that economic theory suggested "would

be potential explanations for the large post-merger price increase at ENH." (Haas-Wilson, Tr. 2480-81). { } (*See generally,* Haas-Wilson, Tr. 2482-88 (discussing DX 7024).

{ } (Noether, Tr. 6239-43 *in camera*) { } (Noether, Tr. 6240-43 *in camera*).

See also CCRFF 894-923 for Complaint Counsel's reply to the effect of the personalities of the negotiators at ENH and United.

1022. { } (Haas-Wilson, Tr. 2755, *in camera*).

Response to Finding No. 1022:

This finding is irrelevant and misleading. Dr. Haas-Wilson, following economic theory as a guide, developed a list of ten possible explanations for the price increase. She did not include in her list every possible explanation, but limited the list to those that economic theory suggested "would be potential explanations for the large post-merger price increase at ENH." (Haas-Wilson, Tr. 2480-81) { } (*See generally,* Haas-Wilson, Tr. 2482-88 (discussing DX 7024). {

} (Haas-Wilson, Tr. 2755, *in camera*).

{

}

1023. {
} (Haas-Wilson, Tr. 2545-46, *in camera*). For example, Dr. Haas-Wilson did not consider the impact of mergers between MCOs on post-Merger price increases. (Haas-Wilson, Tr. 2688-89). {
} (Haas-Wilson, Tr. 2743, *in camera*; *see* Section VII.D.2.c.vii).

Response to Finding No. 1023:

This finding is irrelevant. {

} (Haas-Wilson, Tr. 2743 *in camera*).

ii. Dr. Haas-Wilson's Methodology Is Flawed

(1) Dr. Haas-Wilson Measured The Wrong Prices

1024. {
} (Haas-Wilson, Tr. 2853, *in camera*; Mendonsa, Tr. 557; Holt-Darcy, Tr. 1541, 1586-87; Hillebrand, Tr. 1861-62, 2019; RX 844 at ENH JL 2023). {
} (Haas-Wilson, Tr. 2510, *in camera*).

Response to Finding No. 1024:

This finding is incomplete and misleading. {

} (Haas-Wilson, Tr. 2510-11, 2518, *in camera*; CX 6279 at 3, *in camera*; CCFF 465, 468).

{

} (Haas-Wilson, Tr. 2510-11, *in camera*; CX 6279 at 18-19, *in camera*; CX 6282 at 6, *in camera*).

{

}

(Haas-Wilson, Tr. 2549-50, *in camera*). {

} (Haas-Wilson, Tr. 2631-35, *in camera*; CX 6279 at 20, *in camera*. *See* CCFF 643-682).

1025. {

} (Noether, Tr. 6113, *in camera*).

Response to Finding No. 1025:

This proposed finding is incorrect. {

}

(Haas-Wilson, Tr. 2451-52). {

} (Haas-Wilson, Tr. 2732-34. *See* CCFF 394-487). {

} (CX 67 at 4. *See also* CCFF 1616-1628 (discussing the product market as inpatient services.)).

{

} (Haas-Wilson, Tr. 2487-88). {

} (Haas-Wilson, Tr. 2607-08, *in camera*). {

} (Haas-Wilson Tr. 2614-15, *in camera*. *See also* CCFF 600-608, CCFF 1635-1644 ({

}).

This is consistent with the finding by Dr. Baker that relative to Dr. Noether's control group outpatient prices increased at ENH faster than inpatient prices post-merger. (*See* CCRFF 1004).

1026. {

} (Baker, Tr. 4631-32, *in camera*). {

} (Baker, Tr. 4632, *in camera*). {

} (CX 6279 at 4-5).

Response to Finding No. 1026:

The finding is irrelevant. {

} (CX 6279 at 3. *See also* CCRFF 1024).

In addition, last sentence in the finding is misleading. Dr. Haas-Wilson did not calculate the relative price increase at ENH compared to a control group unless the data source contained data on other hospitals' prices. Since the data that came from ENH either through NERA or in response to CIDs, only had data from ENH and not other hospitals, Dr. Haas Wilson could not compare the price changes relative to a control

group.

In any event, the sole source for this proposed finding is Dr. Baker, who lacked credibility. (*See* CCFF 1742-1762).

1027. { } (Haas-Wilson, Tr. 2514, *in camera*). { } (Haas-Wilson, Tr. 2839-40, *in camera*).

Response to Finding No. 1027:

The second sentence of this proposed finding is irrelevant. { } (*See* CCFF 497-502) { }

(2) Dr. Haas-Wilson Did Not Effectively Clean The Data Underlying Her Empirical Analysis

1028. { } (Haas-Wilson, Tr. 2511, *in camera*; Baker, Tr. 4635-36, *in camera*). { } (Baker, Tr. 4636-37, *in camera*).

Response to Finding No. 1028:

This finding is incorrect. {

} (*See* CCFF 497-502). {

}

{

} (CX 6279 at 7, *in camera*; CX 6279 at 11, *in camera*; CCFF 394, 398-403, 525-534).

The second half of this proposed finding does not make sense. {

}.

1029. { } (Haas-Wilson, Tr. 2853, *in camera*).

Response to Finding No. 1029:

The finding is irrelevant. This proposed finding is irrelevant and incomplete and misleading. { } (Baker, Tr. 4659, *in camera*). Thus, Dr. Haas-Wilson and Drs. Baker and Noether cleaned the data the same way.

1030. { } (Haas-Wilson, Tr. 3038, *in camera*). { } (Haas-Wilson, Tr. 3038-39, *in camera*). { } (Haas-Wilson, Tr. 3039, *in camera*). { } (Haas-Wilson, Tr. 3039, *in camera*).

Response to Finding No. 1030:

This proposed finding is irrelevant. {

} (Haas-Wilson, Tr. 2517-18, *in camera*).

(3) Dr. Haas-Wilson's Control Groups Are Not An Appropriate Basis For Measuring Relative Price Changes

1031. { } (Haas-Wilson, Tr. 2697, *in camera*). This was the case here. (Noether, Tr. 5989-90).

Response to Finding No. 1031:

This proposed finding is incorrect and misleading. { } (Haas-Wilson, Tr. 2697, *in camera*. *See also* CCFF 1814-1926 (discussing Dr. Noether selected the wrong control group.)).

The second sentence of the proposed finding is incorrect. { }

1032. {

} (Haas-Wilson, Tr. 2548, *in camera*; Noether, Tr. 5997).

Response to Finding No. 1032:

Complaint Counsel have no specific response.

1033. { } (Haas-Wilson, Tr. 2858-59, *in camera*). { } (Haas-Wilson, Tr. 2859, *in camera*).

Response to Finding No. 1033:

Complaint Counsel have no specific response.

1034. { } (Haas-Wilson, Tr. 2857, *in camera*).

Response to Finding No. 1034:

The cited source does not say what Respondent's finding claims. Dr. Haas-Wilson testified that this was only true to the extent they were important characteristics. (Haas-Wilson, Tr. 2857 *in camera*).

1035. { } (Haas-Wilson, Tr. 2859, *in camera*).

Response to Finding No. 1035:

Complaint Counsel have no specific response.

1036. { } (Haas-Wilson, Tr. 2860, *in camera*). Generally, however, under-inclusion is safer than over-inclusion because the larger the control group, the greater the risk of having hospitals that are not good comparisons. (Noether, Tr. 5997-98).

Response to Finding No. 1036:

The second sentence of the finding is incorrect. Dr. Noether's own "academic" control group that she and Dr. Baker used to compare price levels with ENH demonstrate the danger of an under-inclusive control group. Dr. Noether creates a control group that includes the most expensive hospitals in her data, (*see* CCFF 1814-1820), even though those hospitals don't look a lot like ENH. (*See* CCFF 1912-1926). Then Dr. Noether excludes hospitals that have similar characteristics to ENH, such as (1) being a major teaching hospital, (CCFF 1846-1861), (2) on average treating cases that are as complex or more complex than those treated at ENH, (CCFF 1863-1911), and/or (3) treating most of the same types of patients as ENH, *but that have lower prices than ENH.* (CCFF 1863-1911). By excluding lower priced hospitals that are similar to ENH while including higher priced hospitals that are not similar to ENH, Dr. Noether biases her control group toward higher prices. Then she and Dr. Baker compare the price levels at ENH with the price levels in Dr. Noether's "academic" control group and purport to draw conclusions.

{ } (Haas-Wilson, Tr. 2548-49, *in camera*).

1037. {

} (Haas-Wilson, Tr. 2548-49, *in camera*).

Response to Finding No. 1037:

Complaint Counsel have no specific response.

1038. { } (Noether, Tr. 5989; Noether, Tr. 6109, *in camera*). { } (Baker, Tr. 4647, *in camera*). { } (Baker, Tr. 4647, *in camera*).

Response to Finding No. 1038:

The finding is incomplete and misleading. { } Dr. Haas-Wilson's control groups give the same results as Dr. Noether's control group when studying price changes. { }

(*See* CCFF 497-502).

1039. { } (Noether, Tr. 6109, *in camera*). { } (Noether, Tr. 6110, *in camera*). { } (Noether, Tr. 6112-13, *in camera*).

Response to Finding No. 1039:

This proposed finding is incomplete and misleading. There is no evidence of any systematic bias that would make the results from using Dr. Haas-Wilson's control groups invalid.. Dr. Haas-Wilson's control groups give the same results as Dr. Noether's control group when studying price changes. { } (*See* CCFF 497-502).

1040. { } (Haas-Wilson, Tr. 2862, *in camera*). { } (Haas-Wilson, Tr. 2862, *in camera*). { } (Haas-Wilson, Tr. 2865, *in camera*).

Response to Finding No. 1040:

The first two sentences of this proposed finding is irrelevant. The finding is incomplete and misleading. { } (*See e.g.* Haas-Wilson, Tr. 2593-2595).

1041. { } (Haas-Wilson, Tr. 2864-65, *in camera*).

Response to Finding No. 1041:

Complaint Counsel have no specific response.

1042. {

} (Haas-Wilson, Tr. 2871, *in camera*).

Response to Finding No. 1042:

This proposed finding is irrelevant. {

} (Haas-Wilson, Tr. 2616, 2619-20, *in camera*).

1043. {
} (Haas-Wilson, Tr. 2871-72, *in camera*). {
}
(Haas-Wilson, Tr. 2873-74, *in camera*). {
} (Haas-Wilson, Tr. 2875, *in camera*).

Response to Finding No. 1043:

This proposed finding is irrelevant.

} (Haas-Wilson, Tr. 2549-50, *in camera*).

{

} (Haas-Wilson, Tr. 2616, 2619-20, *in camera*). Since Dr. Haas-Wilson did not select her teaching control group based on COTH membership, there was no reason for her to know how many of the hospitals in

her teaching control group met the COTH criteria.

1044. { } (Haas-Wilson, Tr. 2869-70, *in camera*; Noether, Tr. 6110-11, *in camera*). { } (Noether, Tr. 6110-11, *in camera*).

Response to Finding No. 1044:

This proposed finding is incomplete and misleading. { } (Haas-Wilson, Tr. 2616, 2619-20, *in camera*).

1045. { } (Haas-Wilson, Tr. 2870, *in camera*). { } (Haas-Wilson, Tr. 2870, *in camera*).

Response to Finding No. 1045:

This proposed finding is incomplete and misleading. { } (Haas-Wilson, Tr. 2616, 2619-20, *in camera*).

iii. Dr. Haas-Wilson's Empirical Results Are Not Consistent With A Market Power Explanation For The Price Increases At Issue

1046. { }

(Baker, Tr. 4694-95, *in camera*). { } (Baker, Tr. 4696, *in camera*).

Response to Finding No. 1046:

The first two sentences of this proposed finding are irrelevant. Respondent failed to establish the relevance of a MCO's revenues to a hospital, much less how this relates to a hospital's bargaining leverage. { } (RFF 1050 (emphasis added); Haas-Wilson, Tr. 2474, *in camera*). { } (Haas-Wilson, Tr. 2746, *in camera*). { } In any event, the sole source for this proposed finding is Dr. Baker, who lacked credibility. (*See* CCFF 1742-1762).

The last sentence of this proposed finding is incorrect. { } (CCRFF 1049).

1047. {

} (Baker, Tr. 4697, *in camera*).

Response to Finding No. 1047:

The proposed finding is incorrect. {

} (CCFF 1927-40), {}

(CCFF 1814-20).

In any case, Dr. Baker, the sole source cited in this finding, lacked credibility. (CCFF 1742-1762).

1048. {

} (Haas-Wilson, Tr. 2746-47, *in camera*).

Response to Finding No. 1048:

This finding is irrelevant and misleading. {

}

(*See* CCFF 640-651 *in camera*).

Even Respondent's own expert found price increases at ENH after the Merger.

{

} (Baker, Tr. 4621, 4642-46, 4648, *in camera*).

1049. {

} (Baker, Tr. 4695-96, *in camera*).

{

} (Baker, Tr. 4695-96, 4742-43, *in camera*).

Response to Finding No. 1049:

This proposed finding is incorrect. {

}

(Haas-Wilson, Tr. 2638-2642, *in camera*. *See also* CX 6304 at 16-17 (Livingston,

Dep.)). (Blue Cross is "such a big player, there is no way we can have any ability to negotiate with them significantly."); Neaman, Tr. 1182-1183 (ENH had less opportunity to negotiate successfully with Blue Cross/Blue Shield than other payors because Blue Cross is very large. There is little opportunity in Mr. Neaman's mind to improve ENH's position in negotiations with Blue Cross/Blue Shield).}

1050. { } (Haas-Wilson, Tr. 2747, *in camera*). { } (Haas-Wilson, Tr. 2746, *in camera*).

Response to Finding No. 1050:

This proposed finding is incomplete. { }.

Complaint Counsel have no specific response as to the remaining three sentences of the proposed finding.

1051. { **(Haas-Wilson, Tr. 2748-49, *in camera*).** } (Haas-Wilson, Tr. 2749-50, *in camera*).

Response to Finding No. 1051:

The first sentence of this proposed finding is incomplete and misleading.

{ } (Haas-Wilson, Tr. 2748-49, *in camera*). {

}

The second sentence of this proposed finding is irrelevant. {

} (Haas-Wilson, Tr. 2746, *in camera*). {

}

1052. {

} (Haas-Wilson, Tr. 2754, *in camera*; Haas-Wilson, Tr. 2748-54, *in camera*). { } (Baker, Tr. 4696, *in camera*).

Response to Finding No. 1052:

This proposed finding is incomplete and misleading. {

} (RFF 1050, *in camera*).

} (*See* CCRFF 1051 ({

}), *in camera*). {

} (Haas-Wilson, Tr. 2753, *in camera*). {

}

(CCFF 573-574, 536-551).

d. Dr. Haas-Wilson's Empirical Analysis Fails To Account For Viable Alternative Explanations For The Price Increases At Issue, Such As Learning About Demand

1053. Dr. Haas-Wilson's difference-in-differences analyses do not necessarily show that the merger resulted in market power. (Noether, 5989, 5991).

Response to Finding No. 1053:

The cited sources do not say what Respondent claims it says. Dr. Noether merely said that Dr. Haas-Wilson cannot differentiate alternative explanations, not that the difference-in-differences analyses do not show that the merger resulted in market power. (Noether, Tr. 5989, 5991).

1054. { } (Haas-Wilson, Tr. 2545-46 *in camera*). } (Haas-Wilson, Tr. 2546-47, *in camera*). { } (Haas-Wilson, Tr. 2547 *in camera*). { } (Haas-Wilson, Tr. 2547 *in camera*).

Response to Finding No. 1054:

Complaint Counsel have no specific response.

1055. { } (Haas-Wilson, Tr. 2552, *in camera*).

Response to Finding No. 1055:

Complaint Counsel have no specific response.

1056. { } (Haas-Wilson, Tr. 2615-16, *in camera*).

Response to Finding No. 1056:

Complaint Counsel have no specific response.

1057. { } (Haas-Wilson, Tr. 2822, *in camera*). { } (Haas-Wilson, Tr. 2823, *in camera*). { } (Haas-Wilson, Tr. 2823-24, *in camera*).

Response to Finding No. 1057:

Respondent mischaracterizes the testimony of Dr. Haas-Wilson in the first sentence of the proposed finding. { } (Haas-Wilson, Tr. 2822, *in camera*). Respondent again mischaracterizes the testimony of Dr. Haas-Wilson in the second sentence of the proposed finding. { } (Haas-Wilson, Tr. 2823, *in camera*).

This proposed finding is also incomplete and misleading. There was no evidence

of any such event in the record.

1058. { } (Haas-Wilson, Tr. 2830, 2832-33, *in camera*). { } (Haas-Wilson, Tr. 2832-33, *in camera*).

Response to Finding No. 1058:

This proposed finding is incomplete and misleading. { } (Haas-Wilson, Tr. 2643, *in camera*; CCFF 695). { } (CCFF 1747, *in camera*). { } (CCFF 1747, *in camera*). {

} (CCFF 1750-1760). {

} (*See* CCFF 1744-1762).

{

} (*See* CCFF 694-738; 742-745).

1059. One would have expected ENH's negotiated prices to rise above competitive levels if those prices were the result of market power from the Merger. (Noether, Tr. 5991). If, however, learning about demand explained the post-Merger price increases, one would expect ENH's prices to rise to competitive levels. (Noether, Tr. 5991). The evidence showed that, in fact, ENH's price level is "comparable to the average of several of the major teaching hospitals in the Chicago area," thus confirming the learning about demand theory. (Noether, Tr. 5992).

Response to Finding No. 1059:

This proposed finding is incorrect. First, Dr. Noether compared ENH price levels only to her own "academic" control group which was inappropriate and biased. (*See* CCFF 1814-1820). There were other major teaching hospitals in Chicago that Dr. Noether did not include at all in her control groups. Dr. Noether never compared ENH price levels to these hospitals at all. (*See* CCFF 1846-1861). There were other hospitals that were major teaching hospitals and that, on average, treated cases as sophisticated as ENH, that Dr. Noether relegated to her "community" hospital control group. Dr. Noether compared ENH price levels to these hospitals and found ENH's prices consistently above

these other hospitals. (*See* CCFF 1854-1906). Thus, Dr. Noether can only reach her conclusion by using an inappropriate and biased control group.

Thus, the learning about demand explanation itself is without merit and implausible. (*See* CCFF 1763-2031).

1060. Significantly, both Dr. Haas-Wilson's theory of enhancement and exercise of market power and the learning about demand theory predict that the merged entity will have larger price *increases* than comparison hospitals. (Noether, Tr. 5989). But Dr. Haas-Wilson, who relies exclusively on an empirical analysis of price changes, assumes that all the hospitals used in her empirical analysis, including the merging hospitals, "were in equilibrium in terms of pricing relative to what the demand for their services was based on reasonably complete information." (Noether, Tr. 5987, 5990).

Response to Finding No. 1060:

This proposed finding is incorrect. Dr. Noether attributes assumptions to Dr. Haas-Wilson that Dr. Haas Wilson did not testify to or state on the record.

1061. If the learning about demand theory were the explanation for the post-Merger price increases, then all hospitals, in particular the merging hospitals, would not have been in equilibrium before the Merger. (Noether, Tr. 5990-91).

Response to Finding No. 1061:

This proposed finding is incomplete and misleading. Dr. Noether, in her testimony, only spoke about the learning about demand explanation as it relates to ENH, not about "all hospitals" as Respondent states in its proposed finding. (Noether, Tr. 5991). In addition, the learning about demand explanation is implausible given the facts of this case. Following the merger with Highland Park, ENH possessed and exercised substantial market power, charging thousands of dollars more per case than other hospitals. ENH could not have charged those prices pre-merger. Nor is there any evidence that before the merger, ENH's pricing was in disequilibrium, with managed care

providers being charged below equilibrium prices. (*See* CCFF 1983-2030; CCRFF 1060).

1062. Consequently, without considering price *levels*, it would be impossible to reject the learning about demand theory. (Noether, Tr. 5989). An analysis of price levels allows differentiation between market power and learning about demand. (Noether, Tr. 5991). { } (Baker, Tr. 4621, *in camera*).

Response to Finding No. 1062:

This proposed finding is incorrect for several reasons. First, in the first sentence, Dr. Noether did not say that without considering price *levels*, it would be impossible to reject the learning about demand theory. (Noether, Tr. 5989). { } (Baker, Tr. 4621, *in camera*). Third, it is incorrect that an analysis of price levels allows differentiation between market power and learning about demand. { } (Haas-Wilson, Tr. 2643, *in camera*).

1063. { } (Haas-Wilson, Tr. 2834-35, *in camera*). { } (Haas-Wilson, Tr. 2835-36, *in camera*).

Response to Finding No. 1063:

This proposed finding is incomplete and incorrect. First, Respondent mischaracterizes the testimony of Dr. Haas-Wilson. { } (Haas-Wilson, Tr. 2835 (emphasis added), *in camera*). { } (*See* CCFF 694-740). { } (*See* CCFF 1763-2031).

1064. { } (Haas-Wilson, Tr. 2835, *in camera*; Noether, Tr. 5990).

Response to Finding No. 1064:

This proposed finding is incorrect for several reasons. { } (*See* CCFF 1952-1965 ({ }), *in camera*). {

} (*See* CCRFF 1059).

4. Empirical Analysis of Price *Levels* Supports Learning About Demand

a. Dr. Noether's Control Groups Are An Appropriate Basis To Compare Price Levels

i. The Criteria Used By Dr. Noether To Select Her Control Group Are Appropriate

1065. In general, Dr. Noether compared Evanston Hospital's prices before the Merger to the prices of her control group of academic control group hospitals, and then compared ENH's prices after the Merger to that same control group of academic hospitals. (Noether, Tr. 5993). { } (Baker, Tr. 4638, *in camera*).

Response to Finding No. 1065:

The finding is incomplete and misleading. The finding is incomplete because it fails to mention that the control group selected by Dr. Noether was biased and inappropriate. The selection of the 18 hospitals into Dr. Noether's control group and the division of that control group into a group of "community" and "academic" hospitals was arbitrary on the part of Dr. Noether, not based on economic literature (Noether, Tr. 6150) and she did not disclose any specific criteria for inclusion in her original group of 18 hospitals. (Noether, Tr. 6149) Dr. Noether used certain ENH documents to identify hospitals to include in her 18 hospitals but inexplicably excluded other hospitals mentioned in those same documents. (CCFF 1827-30). Dr. Noether inexplicably included other hospitals that were not mentioned in documents she relied upon in her selection. (CCFF 1831-32).

The finding is misleading to the extent that it suggests that there is some industry standard or agreement as to what constitutes a community or academic hospitals and that

Dr. Noether relied on that industry standard or agreement in classifying her 18 hospitals into a community control group and an academic control group. There is no industry standard classification of hospitals. (*See* CCRFF 99). There is no official designation as to which hospitals fall into which category. (Noether, Tr. 6155).

Dr. Noether's arbitrary selection of 18 hospitals and the arbitrary division of that group into a "community" control group and an "academic" control group led to anomalous and inexplicable results. There are hospitals that would have met Dr. Noether's criteria to be included in her academic control group that were excluded from her original 18 hospital group. (CCFF 1846-53). There are hospitals that met Dr. Noether's criteria as major teaching hospitals that were included in her "community" control group. (CCFF 1854-1862). There were hospitals that treated more complex cases than ENH that were included in the "community" control group, including some that were major teaching hospitals. (CCFF 1863-1906).

Her arbitrary division of the 18 hospitals kept the four highest priced hospitals in her academic control group. (CCFF 1818-1820). The major teaching hospitals that Dr. Noether excluded from her "academic" control group and included in her "community" control group had lower prices than ENH. (CCFF 1857, 1862) The hospitals that treated more complex cases than ENH that Dr. Noether excluded from her "academic" control group and included in her "community" control group had lower prices than ENH. (CCFF 1872, 1879, 1885, 1891, 1899, 1906).

Dr. Noether looked at price levels rather than price changes in her analysis. (Noether, Tr,. 5991). She compared price levels at ENH with price levels at her

"academic" control group. (Noether, Tr. 5993). The selection of high priced hospitals for inclusion in her "academic" control group raised the average price that she was comparing to ENH. (CCFF 1818-1820). Conversely, the exclusion of lower priced hospitals from Dr. Noether's "academic"control group also raise the average price that Dr. Noether was comparing to ENH.

1066. Dr. Noether developed her control groups by looking at various characteristics of the 18 hospitals she selected based on a review of the evidence. (Noether, Tr. 6149). Dr. Noether identified her academic control group by considering the same characteristics she considered in terms of product differentiation: (1) breadth of service; (2) size; and (3) teaching intensity. (Noether, Tr. 5993).

Response to Finding No. 1066:

The finding is incomplete and misleading. The finding is incomplete because it fails to mention that the division of the eighteen hospitals into "academic" and "community" groups was not based on economic literature (Noether, Tr. 6150). The result of Dr. Noether's groupings was that the highest prices hospitals were included in her academic control group, (*See* CCFF 1818-1820), while hospitals that, by Dr. Noether's own criteria are major teaching hospitals, such as Lewis A. Weiss (CCFF 1854-55) and St. Francis Hospital (CCFF 1858-59), and which, { } were relegated by Dr. Noether to her community hospital control group. (CCFF 1856 (Lewis A. Weiss); CCFF 1861 (St. Francis Hospital).

1067. She elected to base her control group selection on three measures because any

single measure could be subject to bias. (Noether, 6213). Several hospitals (Alexian Brothers, Louis Weiss, Northwest Community, Resurrection and St. Francis) met only one of Dr. Noether's criteria. (Noether, Tr. 6214). Case-mix index alone would not have been an effective way to select academic control group hospitals. (Noether, Tr. 6212).

Response to Finding No. 1067:

The finding is misleading for while that is what Dr. Noether testified to, there is no basis for her conclusion. Any attempt to select control groups of hospitals that are "similar" to Evanston and Highland Park requires the researcher to make arbitrary choices over the criteria with which to compare a hospital to Evanston, as well as arbitrary choices over what is the cutoff to be considered similar. (Haas-Wilson, Tr. 2550-51). There is neither a theoretical or empirical basis for making those kinds of decisions. (Haas-Wilson, Tr. 2551). Dr. Noether never identified any bias would be introduced if she included in her academic control group hospitals such as Alexian Brothers, Louis Weiss, Northwest Community, Resurrection, and St. Francis.

Alexian Brothers, with 334 staffed beds, was closer in bed size to Evanston Hospital than five of the six hospitals in Dr. Noether's academic control group. (RX 1912 at 60 (Alexian Brothers had 77 fewer beds than Evanston Hospital, the only hospital of the six in Dr. Noethers academic control group that was closer to Evanston was Loyola which had 63 more staffed beds than Evanston)). Alexian Brothers on average treated more complex cases than Evanston. (CCFF 1867-69). {

} (RX 1912 at 44, *in camera*). { } (CCFF 1872).

Louis Weiss is a major teaching hospital. (CCFF 1854-55). Louis Weiss on average treated more complex cases than Evanston. (CCFF 1873-75). { } (CCFF 1870, *in camera*). { } (CCFF 1857, *in camera*).

Northwest Community Hospital, with 356 staffed beds, was closer in bed size to Evanston Hospital than five of the six hospitals in Dr. Noether's academic control group. (RX 1912 at 60 (Northwest Community had 65 fewer beds than Evanston Hospital, the only hospital of the six in Dr. Noethers academic control group that was closer to Evanston was Loyola which had 63 more staffed beds than Evanston)). { } (CCFF 1880-82, *in camera*). { } (CCFF 1883, *in camera*), { } (RX 1912 at 44, *in camera*). The prices at Northwest Community Hospital were lower than the prices at ENH. (CCFF 1885).

Resurrection Medical Center, with 350 staffed beds was the closest hospital to

Evanston in terms of staffed beds of the eighteen on Dr. Noether's list of hospitals. (RX 1912 at 60). { } (CCFF 1886-88, *in camera*). { } (CCFF 1889, *in camera*). Dr. Noether identified Resurrection Medical Center as one the hospitals in the same geographic market as ENH, (Noether, Tr. 5928), an exercise that was intended to identify firms that are sufficiently close substitutes as to constrain each other competitively. (Noether, Tr. 6196). { } (CCFF 1891, *in camera*).

St. Francis was a major teaching hospital. (CCFF 1858-60). St. Francis, with 268 staffed beds was closer in bed size to Evanston Hospital than Rush-Presbyterian-St. Luke's Medical Center, one of the hospitals in Dr. Noether's academic control group. (RX 1912 at 60 (St. Francis had 143 fewer staffed beds than Evanston, Rush-Presbyterian-St. Luke's had 159 more staffed beds than Evanston)). { } (CCFF 1900-02, *in camera*). { } (CCFF 1903, *in camera*). Dr. Noether identified St. Francis as one the hospitals in the same geographic market as ENH, (Noether, Tr. 5928), an exercise that was intended to identify firms that are sufficiently close substitutes as to constrain each other competitively. (Noether, Tr. 6196). The prices at St. Francis were lower than the prices at ENH. (CCFF 1906).

The conclusion to be drawn from these facts is that there would be no bias by including these five hospitals in a comparison group to Evanston, but that excluding them (and their lower prices) would bias the comparison group and cause the average price of Dr. Noether's academic control group to be biased upward.

1068. Dr. Noether used the number of DRGs to measure the breadth of service. (Noether, Tr. 5994). Breadth of service is important because the range of services that hospital affects the demand for its services. (Noether, Tr. 5994). In defining her academic control group, Dr. Noether used 370 DRGs as the cut-off for measuring breadth of service. (Noether, Tr. 5994). This cut-off included the top-third of the number of DRGs list as meeting the criteria for academic hospitals. (Noether, Tr. 6164-65).

Response to Finding No. 1068:

The finding is incomplete and misleading. Dr. Noether's selected 370 as the number of DRGs by simply arraying the hospitals in her group of 18 in order of number of DRGs and then selecting the top third to have enough DRGs to be included in her academic control group. (Noether, Tr. 6164-65). There is no requirement in the healthcare literature for a hospital to offer a certain number of DRGs to be considered a teaching hospital. (Noether, Tr. 6165). The procedure Dr. Noether used does not come out of the healthcare literature. (Noether, Tr. 6166). Dr. Noether reviewed the hospitals on her list before she chose to use one-third as the cut off instead of one-quarter or one half. (Noether, Tr. 6167). Rush-Presbyterian-St. Luke's was the last hospital chosen with the fewest DRGs by Dr. Noether's procedure. (Noether, Tr. 6167-68). { [redacted] } (CCFF 1845, *in camera*).

The next hospitals in order of DRG's on her list in terms of number of DRGs

were Northwest Community and Resurrection. (DX 1912 at 60. *See* CCRFF 1067 (discussing the ways in which Northwest Community Hospital and Resurrection Medical Center were similar to Evanston Hospital)).

{ } (CCFF 1885 ({ }), *in camera*; CCFF 1891 ({ }), *in camera*). Had Northwest Community or Northwest Community and Resurrection been included in Dr. Noether's academic control group, the average price of the academic control group would have been lower than it was.

1069. Dr. Noether used the number of staffed beds to measure the size of the hospitals. (Noether, Tr. 5995). Size can reflect underlying breadth of service, it is readily observable and it is an indicator that consumers consider. (Noether, Tr. 5995-96). Dr. Noether used a cutoff of 300 beds to define an academic hospital. (Noether, Tr. 5996). Similarly, Solucient uses size, as measured by the number of beds, as one measure of a major teaching hospital. (Noether, Tr. 5996).

Response to Finding No. 1069:

The finding is incomplete and misleading. MedPAC, which is the Medicare Payment Advisory Commission, an advisory body to Congress on Medicare reimbursement, and whose definition Dr. Noether relies upon, (Noether, Tr. 5922), does not have a bed size or DRG number requirement to be considered a major teaching hospital by its criteria. (Noether, Tr. 6155).

1070. Dr. Noether used the ratio of residents to bed to measure teaching intensity. (Noether, Tr. 5994-95). Teaching intensity is a proxy for higher quality and more sophisticated services. (Noether, Tr. 5995). Patients use teaching intensity as an indicator of desirable hospitals. (Noether, Tr. 5995). In addition, teaching hospitals generally have higher costs associated with treating patients. (Noether, Tr. 5995). Dr. Noether used a cut-off of .25 residents per bed. (Noether, Tr. 5995). {

} (Noether, Tr. 6111, *in camera*).

Response to Finding No. 1070:

Complaint Counsel have no specific response.

1071. A hospital had to meet all three of Dr. Noether's criteria to be included in her academic control group. (Noether, Tr. 5999). Six hospitals, in addition to Evanston Hospital, met all three criteria. (Noether, 6000). These hospitals are: Advocate Lutheran General, Advocate Northside, Northwestern Memorial, Rush Presbyterian, Loyola and University of Chicago. (Noether, 6000).

Response to Finding No. 1071:

Complaint Counsel have no specific response.

1072. Dr. Noether classified those hospitals that did not meet all three criteria as "community hospitals." (Noether, Tr. 6000). Twelve hospitals did not meet these three criteria. (Noether, Tr. 6000).

Response to Finding No. 1072:

The finding is misleading. There is no accepted definition of what a community hospital is. (*See* CCRFF 99 (discussing the difficulty of classifying hospitals)). In fact, Dr. Noether includes in her "community hospital" group, hospitals that are considered major teaching hospital, (CCFF 1854-62), and hospitals that on average treat more complex cases than ENH. (CCFF 1863-1911).

1073. Dr. Noether also considered the views of the hospitals themselves, the views of the MCOs and the views of consultants in characterizing her control group hospitals. (Noether, Tr. 5997). Dr. Noether found that these views were consistent with her control group definition. (Noether, Tr. 6007-08).

Response to Finding No. 1073:

The first sentence of the finding is not supported by the citation. Dr. Noether does not specifically mention the views of consultants in characterizing her control groups.

(Noether, Tr. 5997).

The finding is vague, incomplete and misleading. The finding is vague and misleading because it does not identify the hospitals, MCOs, or consultants whose views Dr. Noether allegedly considers consistent with her own.

Not even Dr. Noether claimed that the MCO's considered Evanston to be equivalent the six hospitals in her academic control group. As was noted in CCRFF 99, different industry participants characterize hospitals in different ways and one must know how the industry participant is using the term before one can draw conclusions from labels. Thus one cannot draw the conclusion that the views of MCO's are consistent with Dr. Noether's academic control group.

The finding is incomplete because it does not say that MCOs testified that ENH was not comparable to four hospitals in Dr. Noether's academic control group. (*See* CCFF 1927-1940). Moreover, the finding does not say that the only document that Dr. Noether relies on to say that hospitals agree with her control groups is a document, RX 1316, from Northwestern Memorial that lists its competitors and includes three hospitals, Christ, University of Illinois, and Cook County, that are inexplicably left out of Dr. Noether's original list of 18 hospitals, and one hospital, Northwest Community, that is relegated to the "community hospital" group, despite its similarities to ENH. (Noether, Tr. 6009. *See* CCRFF 1067 (discussion of the similarities between Northwest Community and ENH)).

1074. In a 2002 Competitive Assessment document, Northwestern Memorial identified two types of competitors: tertiary/academic hospitals and "community hospitals. (Noether, Tr. 6008-09; RX 1316 at NMH 9392). Northwestern Memorial included Christ, Cook County

Hospital, ENH, Loyola, Advocate Lutheran General, Northwest Community, Rush, University of Chicago and University of Illinois in the tertiary hospital or academic medical center group. (Noether, Tr. 6009; RX 1316 at NMH 9392).

Response to Finding No. 1074:

The finding is an example of why the control groups that Dr. Noether selected are not consistent with the views of hospitals. { } (CCFF 1846 (Christ); CC 1853 (University of Illinois). *See* RX 1912 at 44 ({ }), *in camera*), and yet all three were included in the "tertiary/academic" competitor group by Northwestern Memorial in the document cited in this finding. (RX 1316 at NMH 9392). Moreover, Northwest Community was included in the list of "tertiary/academic" competitors by Northwestern Memorial, yet Dr. Noether excluded it from her academic control group and relegated it to her "community hospital" group. (CCFF 1884; RX 1316 at NMH 9392).

1075. Dr. Noether did not attempt to make her control groups inclusive of all possible comparison hospitals. (Noether, Tr. 5997, 6150). { } (Baker, Tr. 4780-81, *in camera*).

Response to Finding No. 1075:

The finding is incomplete and misleading. Dr. Noether limited the hospitals in her control groups by her arbitrary decisions. First, she arbitrarily limited her control group by selecting 18 hospitals that excluded hospitals referenced in ENH documents she relied upon in her selection (CCFF 1827-30), and by excluding hospitals

that would have been included in her academic control group if she had included them in her original group of 18 hospitals. (CCFF 1846-53). Because her arbitrary decisions led to the inclusion of the four highest priced hospitals in her "academic" group, (CCFF 1818-20), and relegation of other hospitals that were similar to ENH to her "community" group, (CCFF 1846-1906), Dr. Noether's arbitrary choices biased her results toward finding that ENH's prices were below her academic control group.

By including the highest priced hospitals in her data, and excluding other hospitals with lower prices, Dr. Noether's selection criteria biased her results toward finding that the prices at ENH did not rise above her "academic" hospitals.

The second sentence of the finding is taken out of context and is incomplete and misleading. What Dr Baker testified to was that for some purposes, an appropriate control group of comparison hospitals would only contain hospitals that constrain the pricing of ENH, that for his pricing analysis the best control group would only contain hospitals that constrained the pricing of ENH, and he admitted that he testified in his deposition that an appropriate control group of comparison hospitals probably should contain only hospitals that constrain the pricing of ENH. (Baker, Tr. 4780-81).

1076. { } (Haas-Wilson, Tr. 2868, *in camera*). { } (Haas-Wilson, Tr. 2869, *in camera*).

Response to Finding No. 1076:

The finding is incomplete and misleading. All of the hospitals in Dr. Noether's control groups were included in Dr. Haas-Wilson's control groups, but Dr. Haas-Wilson

also included other hospitals. In her largest control group Dr. Haas-Wilson included all the general acute care hospitals in the Chicago PMSA. (Haas-Wilson, Tr. 2548) In her non-merging control group, Dr. Haas-Wilson included all the hospitals in the Chicago PMSA that were not involved in merger with another hospital between 1996 and 2002. (Haas-Wilson, Tr. 2548-49). In her teaching control group, Dr. Haas-Wilson included all the hospitals in the Chicago PMSA that were involved in some teaching activity during the study period. (Haas-Wilson, Tr. 2549). Because she did not limit her control group to high priced hospitals (or low priced hospitals), Dr. Haas-Wilson avoided introducing the bias that Dr. Noether introduced into her control group.

1077. Dr. Noether did not know the prices of the various hospitals before selecting her control group hospitals. (Noether, Tr. 6210).

Response to Finding No. 1077:

The finding, and the testimony underlying it lacks credibility. Dr. Noether testified first that her decision regarding where to cut off DRGs was "[b]ased on all of the evidence describing the hospitals . . ." (Noether, Tr. 6164-66). Only after it was brought out on her cross examination that she knew that her arbitrary decision on DRG's would include Rush-Presbyterian-St. Luke's in her academic control group, (*see* CCRFF 1068), did Dr. Noether testify that she did not know the prices of the hospitals before selecting her control group. If Dr. Noether reviewed "all the evidence describing the hospitals" how could she have missed the pricing of the hospitals? {[redacted]

[redacted]}

(CCFF 1818 *in camera*). {[redacted]

} (CCFF 1819, *in camera*).

ii. Dr. Noether's Characterization Of ENH As A Major Teaching Hospital Is Consistent With MCO Views

1078. A document authored by Ballangee at PHCS as far back as August 28, 1995, identified the Evanston Hospital Corporation, which included Glenbrook Hospital, as an "advanced teaching" hospital. (*Compare* Ballengee, Tr. 189 *with* RX 107 at GWL 859). { } (RX 773 at ENH JL 12535, *in camera*).

Response to Finding No. 1078:

The finding is incomplete. The characterization of a hospital as an teaching hospital or a tertiary hospital is different from characterizing a hospitals as appropriately being included in Dr. Noether's "academic control group." (*See* CCRFF 99). Whatever criteria PHCS used in 1995 to characterize Evanston Hospital, when Ms. Ballengee was asked directly at trial what hospitals she considered advanced teaching hospitals she listed Northwestern Memorial, Rush-Presbyterian-St. Luke's, Loyola University, University of Chicago, and University of Illinois. (Ballengee, Tr. 189). She specifically denied that ENH was an advanced teaching hospital. (Ballengee, Tr. 189).

1079. { } (Foucre, Tr. 1114, *in camera*; RX 1208 at UHCENH 3380, *in camera*; Ballengee, Tr. 212).

Response to Finding No. 1079:

The finding is misleading. The characterization of a hospital as an teaching hospital or a tertiary hospital is different from characterizing a hospital as appropriately being included in Dr. Noether's "academic control group." (*See* CCRFF 99).

{ }

(Foucre, Tr. 1114 *in camera*). { } (RX 1208 at UNCENH 3380), { } (Foucre, Tr. 1129 *in camera*). In fact, Ms. Foucre was asked which hospitals in Chicago met her definition of major teaching hospitals and she identified Loyola University Medical Center, University of Chicago, Rush Presbyterian, and Northwestern Memorial. She explicitly excluded the three ENH hospitals from that group. (Foucre, Tr. 936).

Nor did Ms. Ballengee testify that ENH was a "major academic hospital." She merely testified that ENH was affiliated with Northwestern Medical School (Ballengee, Tr. 212). When asked specifically in terms of services and quality, whether she thought ENH was comparable to Northwestern Memorial, Loyola, University of Chicago, or Rush Presbyterian, she answered no to each comparison. (Ballengee, Tr. 191-192).

iii. Dr. Haas-Wilson's Criticisms Of Dr. Noether's Control Groups Are Unfounded

1080. Dr. Haas-Wilson considers Evanston Hospital to be a teaching hospital. (Haas-Wilson, Tr. 2943). { } (Haas-Wilson, Tr. 2697-98, *in camera*) Her criticisms are addressed below.

Response to Finding No. 1080:

The finding is misleading and distorts what Dr. Haas-Wilson testified to. The characterization of a hospital as an teaching hospital is different from characterizing a hospital as appropriately being included in Dr. Noether's "academic control group." (*See* CCRFF 99). Dr. Haas-Wilson did consider ENH to be a teaching hospital and did compare ENH to other teaching hospitals in the Chicago area. (Haas-Wilson, Tr. 2943-44) When she compared the price increases at ENH to the other hospitals in the Chicago PMSA that had teaching activity, she found that ENH's post-merger price increases were larger than the other teaching hospitals in the Chicago PMSA and that the difference between the post-merger price increase at ENH and other teaching hospitals in the Chicago PMSA was statistically significant. (Haas-Wilson, Tr. 2944). { } (Haas-Wilson, Tr. 2697-98).

(1) Dr. Haas-Wilson's Sum Of Squares Measure Of Breadth Of Service Is Misleading

1081. Dr. Haas-Wilson criticized Dr. Noether's use of the number of DRGs to measure breadth of service in creating the academic control group. (Noether, Tr. 6001). Dr. Haas-Wilson proposed an alternative measure of breadth of service based on a sum of squares calculation. (Noether, Tr. 6003).

Response to Finding No. 1081:

Complaint Counsel have no specific response.

1082. { } (Haas-Wilson, Tr. 2704-05, *in camera*). { } (Haas-Wilson, Tr. 2704-05, *in camera*). { } (Haas-Wilson, Tr. 2704-05, *in camera*). {

} (Haas-Wilson, 2706 *in camera*).

Response to Finding No. 1082:

The finding is incorrect. {

} (Haas-Wilson, Tr. 2703-04 *in camera*).

1083. Dr. Haas-Wilson's measure is misleading because it places undue weight on high volume DRGs such as obstetrics. (Noether, Tr. 6004). With particular reference to obstetrics, this analysis also double-counts each obstetric encounter because Dr. Haas-Wilson counts both mother and baby. (Noether, Tr. 6004). In addition, by squaring the sums of the differences, Dr. Haas-Wilson augments the differences across hospitals. (Noether, Tr. 6005).

Response to Finding No. 1083:

The finding is incorrect. {

} (Haas-Wilson, Tr. 2703-04 *in camera*). If a hospital has a high volume DRG then its provision of services is most similar to other hospitals that have the same high volume DRGs. There is nothing misleading about that.

1084. To illustrate this mischaracterization, Dr. Noether specifically considered the sum of squared differences for both ENH and Northwestern Memorial. (Noether, Tr. 6006). Based on this analysis, Dr. Noether found that 94% of Dr. Haas-Wilson's measure of the difference between ENH and Northwestern Memorial was attributable to obstetrics patients. (Noether, Tr. 6006). Although obstetric services account for only 22 DRGs out of 520, Dr. Haas-Wilson's measure is dominated by this services line. (Noether, Tr. 6006-07). In essence, Dr. Haas-Wilson's measure really reflects the size of the obstetrics programs at various hospitals. (Noether, Tr. 6007).

Response to Finding No. 1084:

This finding is irrelevant. {

} (Haas-Wilson, Tr. 2703-04 *in camera*). If obstetrics is an service that makes up a large portion of a hospital's services, then a hospital is most similar to other hospitals for which obstetrics makes up a large portion of services.

1085. { } (Haas-Wilson, Tr. 2706, *in camera*).

Response to Finding No. 1085:

The finding is incomplete. { } (Haas-Wilson, Tr. 2706 *in camera*; CX 6282 at 7 *in camera*). { } (CX 6282 at 7-8 *in camera*).

(2) Dr. Haas-Wilson's Focus On "Quaternary Services" Is Misguided

1086. Dr. Haas-Wilson also criticizes Dr. Noether's academic control group on the ground that some of the hospitals in Dr. Noether's academic control provided "quaternary services" that are not provided by ENH. (Noether, Tr. 6001).

Response to Finding No. 1086:

The finding is incomplete. {

} (Haas-Wilson, Tr. 2698-2703 *in camera* (discussing DX 7031)).

1087. { } (Noether, Tr. 6001; Haas-Wilson, Tr. 2876, *in camera*). This definition, however, conflicts with the Complaint, which { } (Haas-Wilson, Tr. 2876, *in camera*) (emphasis added). { } (Haas-Wilson, Tr. 2882, *in camera*). { } (Haas-Wilson, Tr. 2879-80, *in camera*).

Response to Finding No. 1087:

The finding misstates the testimony of Dr. Haas-Wilson. She did not define quaternary services as extensive burn treatmeht and solid organ transplants. { } (Haas-Wilson, Tr. 2666, 2701 *in camera*). Extensive burn units and solid organ transplants were simply examples of quaternary services. Nowhere did Dr. Haas Wilson try to give a complete list of quaternary services.

The finding is also irrelevant. As with categorizations of hospitals, (*see* CCRFF 99), there is no fixed definition of categorization of care between primary, secondary, tertiary, and quaternary. (Noether, Tr. 6159 ("no universally accepted definition of primary and secondary services"), 6160 ("there is no commonly accepted, precise definition of what's a tertiary service"); Haas-Wilson, Tr. 2490 ("there is no agreed-upon list of what is tertiary and what is not tertiary"). The important fact in Dr. Haas-Wilson's

criticism of Dr. Noether's control group on this point is {[redacted]

[redacted]

[redacted]} (Haas-Wilson, Tr. 2701-02 *in camera* (discussing DX 7058)

1088. In any event, solid organ transplants and extensive burn treatments are a very small portion – .8 of 1% – of the total number of services provided at any of the academic control group hospitals. (Noether, Tr. 6002).

Response to Finding No. 1088:

The finding is irrelevant. Because quaternary services require very specific human capital, and also very specialized physical the hospitals that provide quaternary services are thought of as different than hospitals that do not. (Haas-Wilson, Tr. 2701). That Northwestern Memorial, Loyola, Rush-Presbyterian-St. Luke's, and University of Chicago are different in the types of cases they treat can be seen by the difference in case mix index at those hospitals and at ENH. (Haas-Wilson, Tr. 2699-2700 (discussing DX 7057).

1089. For example, as a percentage of total discharges, organ transplants at the University of Illinois may account for as little as eight-tenths of 1%. (Dorsey, Tr. 1473)

Response to Finding No. 1089:

The finding is irrelevant. The percentage of cases that are organ transplants is irrelevant. (*See* CCRFF 1088). Moreover, the University of Illinois is one of the hospitals that Dr. Noether arbitrarily excluded from her original group of 18 hospitals which she divided into her "academic" and "community" control groups. (*See* CCFF 1849-53). So the percentage of cases that are organ transplants at University of Illinois

irrelevant.

1090. Finally, Evanston Hospital at one point did provide extensive burn services, but elected to terminate that program because demand for these types of services was significantly lessened by the widespread use of fire detectors. (Noether, Tr. 6002-03; Hillebrand, Tr. 2009-10).

Response to Finding No. 1090:

The finding is irrelevant. Whether ENH offered some service in the past does not mean that hospitals that currently offer the service are similar to ENH today.

(3) Dr. Haas-Wilson's Criticisms Of Dr. Noether's Control Group Based On Differences In Public Perception Are Unfounded

1091. { [redacted] } (Haas-Wilson, Tr. 2709, *in camera*). In part, she relied on one year of US News & World Report rankings to highlight alleged differences in public perception. (Haas-Wilson, Tr. 2930-31).

Response to Finding No. 1091:

Complaint Counsel have no specific response.

1092. Although Dr. Haas-Wilson was aware that US News & World Report ranks hospitals based on reputation, structure and mortality, she was not aware that the reputational score was determined based solely on a survey of 150 physicians in a given specialty rather than on surveys of consumers. (Haas-Wilson, Tr. 2930.)

Response to Finding No. 1092:

The finding assumes facts that are not supported by the cited source. There is no evidence in the cited source stating on what the US News and World Report's score was based.

1093. Dr. Haas-Wilson was familiar with Health Grades, but she did not know that Health Grades listed ENH as a distinguished hospital for clinical excellence in 2003, 2004 and 2005. (Haas-Wilson, Tr. 2931).

Response to Finding No. 1093:

The finding assumes facts that are not supported by the cited source. There is no evidence in the cited source stating whether or not Health Grades listed ENH as anything.

1094. Dr. Haas-Wilson was not familiar with the Davies Award for Excellence in the Implementation of an Electronic Health Record, and was not aware that ENH had received this award. (Haas-Wilson, Tr. 2931-32).

Response to Finding No. 1094:

The finding assumes facts that are not supported by the cited source. There is no evidence in the cited source stating any facts about the Davies Award for Excellence.

1095. Dr. Haas-Wilson was familiar with a group called Solucient, and was aware of the top 100 hospital list published by Solucient. (Haas-Wilson, Tr. 2932). And she admitted that Solucient rankings would be relevant to public perception. (Haas-Wilson, Tr. 2932). But she was not aware that Solucient had classified ENH as a major teaching hospital in its rankings, or that ENH had been named to Solucient's Top100 list for the tenth time in 2005. (Haas-Wilson, Tr. 2932).

Response to Finding No. 1095:

The finding assumes facts that are not supported by the cited source. There is no evidence in the cited source stating how Solucient classified ENH or ranked ENH.

1096. Dr. Haas-Wilson was familiar with Leapfrog, but she was not aware that Leapfrog had recognized ENH for the implementation of a medical records system and for staffing its ICU with intensivists. (Haas-Wilson, Tr. 2932-33).

Response to Finding No. 1096:

The finding assumes facts that are not supported by the cited source. There is no evidence in the cited source about Leapfrog recognizing ENH for anything.

b. Dr. Noether Cleaned Pertinent MCO Data More Effectively Than Dr. Haas-Wilson.

1097. {

} (Noether, Tr. 6049-50, *in camera*).

Response to Finding No. 1097:

The finding is incorrect. The commercial payer data was available for five payers. (Haas-Wilson, Tr. 2498). In addition to the Aetna, Blue Cross, Humana, and United, data was also available from Great West. {

} (Haas-Wilson, Tr. 2576 *in camera*)

1098. {

} (Noether, Tr. 6050, *in camera*). {

} (Noether, Tr. 6050).

Response to Finding No. 1098:

This finding is incorrect. {

}

(Haas-Wilson, Tr. 2511-12 (discussing DX 7010) *in camera*). {

} (Haas-Wilson, Tr. 2574 *in camera*; CX 6282 at 5 *in camera*).

1099. {

} (Noether, Tr. 6050-51, *in camera*).

Response to Finding No. 1099:

The finding is incorrect. {

} (Noether, Tr. 6050-51 *in camera*).

1100. {█████████████████████████ } (Noether, Tr. 6051, *in camera*).

Response to Finding No. 1100:

Complaint Counsel have no specific response.

1101. {█████████████████████████ } (Noether, Tr. 6051, *in camera*).

Response to Finding No. 1101:

The finding is misleading. The commercial payer claims data had advantages to the empirical economist that other data did not. It was like "gold". (Haas-Wilson, Tr. 2496-97).

1102. {█████████████████████████ } (Noether, Tr. 6052-53, *in camera*). {█████████████████████████ } (Noether, Tr. 6053, *in camera*).

Response to Finding No. 1102:

The finding is misleading. Dr. Haas-Wilson also worked with the payer data and treated the data differently from how Dr. Noether treated it. (*See*, *e.g.* RFF 1103). Dr. Baker relied on the claims data from Dr. Noether. (Baker, Tr. 4621). {█████████████████████████ } (Haas-Wilson, Tr. 2564 (discussing DX 7022 at 2, *in camera*), *in camera*; Haas-Wilson, Tr. 2566 (discussing DX 07013 at 2, *in camera*), *in camera*; Haas-Wilson, Tr. 2569 (discussing DX 07014 at 2, *in*

camera), *in camera*; Haas-Wilson, Tr. 2571-73 (discussing DX 7020 at 2, *in camera*), *in camera*; Haas-Wilson, Tr. 2584-85 (discussing DX 7020 at 2, *in camera*), *in camera*; Haas-Wilson, Tr. 2630-31 (discussing DX 7018, *in camera*), *in camera*).

1103. { } (Noether, Tr. 6053, *in camera*). { } (Noether, Tr. 6053, *in camera*). } (Noether, Tr. 6054, *in camera*). { } (Noether, Tr. 6054, *in camera*). { } (Noether, Tr. 6054-55, *in camera*). { } (Noether, Tr. 6055, *in camera*).

Response to Finding No. 1103:

This finding is misleading. Dr. Baker relied the claims data from Dr. Noether. (Baker, Tr. 4621). Yet the calculated results from Dr. Haas-Wilson's analysis and Dr. Baker's analysis using Dr. Noether's data were consistent with one another. (*See* CCRFF 1102).

1104. { } (Noether, Tr. 6099, *in camera*).

Response to Finding No. 1104:

The finding is misleading. That may be the reason Dr. Noether elected not do regression analysis, but that reason is incorrect. { }

(Haas-Wilson, Tr. 2615-16 *in camera*). {

} (Baker, Tr. 4642, *in camera*).

1105. { } (Noether, Tr. 6099, *in camera*). { } (Noether, Tr. 6099, *in camera*). { } (Noether, Tr. 6099-6100, *in camera*).

Response to Finding No. 1105:

This finding is incorrect. Because the outpatient prices at ENH rose more than inpatient prices relative to the control group Dr. Baker used, (Baker, Tr. 4797), and { } (Dr. Haas-Wilson, Tr. 2612-15 *in camera*), there was no need to include outpatient data in a regression model to study inpatient prices. { } (Haas-Wilson, Tr. 2635-37), { }

1106. { } (Noether, Tr. 6052, *in camera*).

Response to Finding No. 1106:

What Dr. Noether actually said is { } (Dr. Noether, Tr. 6052, *in camera*).

1107. { } (Noether, Tr. 6056-6057, *in camera*).

Response to Finding No. 1107:

Complaint Counsel have no specific response.

1108. { } (Noether, Tr. 6057, *in camera*). { } (Noether, Tr. 6057, *in camera*). { }

Response to Finding No. 1108:

The finding is irrelevant. Because { }, (Baker, Tr. 4797 *in camera*), and { } (Dr. Haas-Wilson, Tr. 2612-15 *in camera*), there was no need to consider outpatient prices at all in determining the competitive effects.

The last sentence in the finding has no supporting citation.

1109. { } (Noether, Tr. 6058-59, *in camera*).

Response to Finding No. 1109:

The finding is incorrect. Dr. Noether did not consider the average reimbursement across all MCOs because she only used four MCOs. (Noether, Tr. 6049-50). Dr. Noether

never calculated the average reimbursement across all managed care organizations form the IDPH Universal Data Set. { } (Haas-Wilson, Tr. 2526-30 *in camera*).

c. Dr. Noether's Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case

1110. { } (Noether, Tr. 6060, *in camera*; RX 1912 at 73, *in camera*).

Response to Finding No. 1110:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940).

1111. { } (Noether, Tr. 6060, *in camera*; RX 1912 at 73, *in camera*). { } (Noether, Tr. 6060, *in camera*; RX 1912 at 73, *in camera*).

Response to Finding No. 1111:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). In addition, Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others

in the industry. (*See* CCRFF 99, 1065).

1112. { }

(Noether, Tr. 6060, *in camera*; RX 1912 at 73, *in camera*).

Response to Finding No. 1112:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). In addition, Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065).

1113. { (Noether, Tr. 6062, *in camera*; RX 1912 at 74, *in camera*). { } (Noether, Tr. 6062, *in camera*; RX 1912 at 74, *in camera*). { } (Noether, Tr. 6062-63, *in camera*; RX 1912 at 74, *in camera*). { } (Noether, Tr. 6062, *in camera*).

Response to Finding No. 1113:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). In addition, Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065). Moreover, the lynchpin in Dr. Noether's analysis

for including outpatient services in the same product market as inpatient services, is the claim that managed care plans trade off the prices of inpatient and outpatient services, accepting higher inpatient price for lower outpatient prices. (Noether, Tr. 5908). However { }, (Baker, Tr. 4797 *in camera*), and { } (Dr. Haas-Wilson, Tr. 2612-15 *in camera*). There is no need therefore to consider the price of outpatient services and the finding is irrelevant.

1114. { } (Noether, Tr. 6063-64, *in camera*; RX 1912 at 75, *in camera*). { } (Noether, Tr. 6063, *in camera*; RX 1912 at 75, *in camera*). { } (Noether, Tr. 6063, *in camera*; RX 1912 at 75, *in camera*).

Response to Finding No. 1114:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). In addition, Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065).

1115. { } (Noether, Tr. 6064-65, *in camera*; RX 1912 at 147, *in camera*). { } (Noether, Tr. 6065, *in camera*; RX 1912 at 147, *in camera*). {

} (Noether, Tr. 6065, *in camera*; RX 1912 at 147, *in camera*). { } (Noether, Tr. 6065, *in camera*; RX 1912 at 147, *in camera*). {

}
(Noether, Tr. 6065, *in camera*; RX 1912 at 147, *in camera*).

Response to Finding No. 1115:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). In particular, {

} (CCFF 1818-20). The impact of including these four hospitals in Dr. Noether's "academic" control group, while excluding many others that were similar in many ways to Evanston but had lower prices than ENH (CCFF 1854-1906), is obvious. With a more appropriate control group, ENH would have higher prices than the control group hospitals, which would impeach the learning about demand theory.

In addition, Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065).

1116. {
} (Noether, Tr. 6065-66, *in camera*; RX 1912 at 147, *in camera*). { }
(Noether, Tr. 6067, *in camera*; RX 1912 at 150, *in camera*). {

} (Noether, Tr. 6067, *in camera*; RX 1912 at 150, *in camera*). {
} (Noether, Tr. 6066-67, *in camera*;

RX 1912 at 150, *in camera*).

Response to Finding No. 1116:

This finding is misleading. { } (RX 1912 at 147, *in camera*).

{ } (Haas-Wilson, Tr. 2646 (discussing DX 7047). Dr. Noether never responded to that testimony by Dr. Haas-Wilson.

1117. { } (Noether, Tr. 6070). Dr. Noether's empirical findings on a payor-by-payor basis are summarized below.

Response to Finding No. 1117:

The finding is misleading. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940).

i. Aetna

1118. { } (Noether, Tr. 6094, *in camera*; RX 1912 at 70, *in camera*).

Response to Finding No. 1118:

The finding is incorrect. All of Dr. Noether's conclusions about empirical

analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940).

1119. { } (Noether, Tr. 6094, *in camera*; RX 1912 at 70, *in camera*). { } (Noether, Tr. 6095, *in camera*; RX 1912 at 70, *in camera*).

Response to Finding No. 539:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). In addition, Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065).

ii. Blue Cross

1120. { } (Noether, Tr. 6070-71, *in camera*; RX 1912 at 62, *in camera*).

Response to Finding No. 1120

The finding is misleading. While it may true that Evanston Hospital did not learn anything about Blue Cross's demand from the merger with Highland Park, the whole explanation that Evanston learned about its demand from the merger with Highland Park is spurious. (*See* CCFF 1797-2031). Moreover, all of Dr. Noether's empirical analysis on the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940).

1121. { } (Noether, Tr. 6071, 6074, *in camera*).

Response to Finding No. 1121:

The finding is incorrect. { } (Haas-Wilson, Tr. 2727-28). Moreover, all of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940).

{ } (Haas-Wilson, Tr. 2728). { }

1122. { } (Noether, Tr. 6072-73, *in camera*; RX 1912 at 34, *in camera*). { } (Noether, Tr. 6073, *in camera*; RX 1912 at 34, *in camera*).

Response to Finding No. 1122:

Complaint Counsel have no specific response.

1123. { } (Noether, Tr. 6073, *in camera*).

Response to Finding No. 1123:

The finding is misleading. { } (Haas-Wilson, Tr. 2646 (discussing DX 7047), *in camera*; Baker, Tr. 4746, *in camera*). Even just looking at the rates in the contracts that Evanston and Highland Park had premerger, in only about one-third of Evanston's pre-merger contracts were the contract rates higher at Highland Park. (Sirabian, Tr. 5717). { } (*See, e.g.* Haas-Wilson, Tr. 2535-36 (discussing DX 7009)).

1124. { } (Noether, Tr. 6074, *in camera*; Sirabian, Tr. 5707). { } (Noether, Tr. 6074, *in camera*).

Response to Finding No. 1124:

The second sentence of the finding is incorrect. Testimony by ENH's chairman explained why prices charged to Blue Cross did not increase. Blue Cross was so large and powerful in the market that ENH, could not negotiate higher prices with them. (CX

6304 at 16 (Livingston, Dep.)). {[redacted]

[redacted]} (RX 1912 at 28 *in camera*).

iii. Humana

1125. {[redacted]
[redacted]} (Noether, Tr. 6075, *in camera*; RX 1912 at 65, *in camera*).

Response to Finding No. 1125:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940).

1126. {[redacted]
[redacted]} (Noether, Tr. 6075, *in camera*; RX 1912 at 65, *in camera*).

Response to Finding No. 1126:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). In addition, Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065).

1127. {[redacted]
[redacted]} (Noether, Tr. 6075, *in camera*; RX 1912 at 65, *in camera*).

Response to Finding No. 1127:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). In addition, Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065).

1128. { } (Noether, Tr. 6076-77). { } (Noether, Tr. 6076, *in camera*).

Response to Finding No. 1128:

The cited source presents no basis for Dr. Noether's unsubstantiated opinion.

1129. { } (Noether, Tr. 6078, *in camera*). { } (Noether, Tr. 6078-79, *in camera*).

Response to Finding No. 1129:

Complaint Counsel have no specific response.

1130. { } (Noether, Tr. 6079, *in camera*). { } (Noether, Tr. 6080, *in camera*; RX 1912 at 34, *in camera*).

Response to Finding No. 1130:

The finding is misleading. {

} (Haas-Wilson, Tr. 2646 (discussing DX 7047) *in camera*; Baker, Tr. 4746 *in camera*).

iv. United

1131. { } (Noether, Tr. 6081, *in camera*; RX 1912 at 68, *in camera*).

<u>Response to Finding No. 1131:</u>

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). The finding is also inconsistent with the calculations of Dr. Baker. { } (Baker, Tr. 4736-38 *in camera*) { } (Haas-Wilson, Tr. 2731-32 (discussing 07062 at 3) *in camera*).

1132. { } (Noether, Tr. 6081, *in camera*; RX 1912 at 68, *in camera*).

<u>Response to Finding No. 1132:</u>

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an

inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, the finding is inconsistent with the calculations done by Dr. Baker. { } (Baker, Tr. 4736-38 *in camera*) { } (Baker, Tr. 4739 *in camera*)

1133. { } (Noether, Tr. 6081, *in camera*). { } (Noether, Tr. 6082, *in camera*). { } (Noether, Tr. 6082-83, *in camera*; RX 1912 at 129, *in camera*). { } (Noether, Tr. 6082-83, *in camera*; RX 1912 at 129, *in camera*).

Response to Finding No. 1133:

The finding is incorrect. Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065). The eclectic group of opinions by Dr. Noether in this finding illustrate some of the problems with the whole approach that Dr. Noether and Dr. Baker took in attempting to refute Dr. Haas-Wilson by looking at price levels rather than price changes. Dr. Haas-Wilson chose to look at price changes rather than price levels. As she explained her reasons, she recognized that

hospitals offer differentiated products, the prices of which can vary for any number of reasons. (Haas-Wilson, Tr. 2492). Dr. Noether agreed that hospitals were offering a differentiated product, (Noether, Tr. 5910), but rejected the use of price changes to instead look at price levels. (Noether, Tr. 5987). However, when Dr. Noether and Dr. Baker examine price levels they get results that were inconvenient for their theories.

Putting aside the fact that Dr. Noether's "academic" control group is inappropriate because it is biased to contain the highest priced hospitals, while excluding other hospitals that are comparable to ENH, (*See* CCFF 1814-1940), { } (Baker, Tr.4739 *in camera*). Thus Dr. Noether and Dr. Baker search for ways to explain this apparent problem with their theory. { } (Noether, Tr. 6082-83, *in camera*; RX 1912 at 129, *in camera*), and that { } (Noether, Tr. 6082-83, *in camera*; RX 1912 at 129, *in camera*). But it was just this { } that led Dr. Haas-Wilson to explain that the appropriate methodology was to use price changes rather than price levels in the first place. (Haas-Wilson, Tr. 2492).

1134. { } (Noether, Tr. 6084, *in camera*; RX 1912 at 69, *in camera*). {

} (Noether, Tr. 6084, *in camera*; RX 1912 at 69, *in camera*).

Response to Finding No. 1134:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). In addition, Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065). { } (Baker, Tr. 4739 *in camera*)

1135. { } (Noether, Tr. 6085, *in camera*; RX 1912 at 128, *in camera*). { } (Noether, Tr. 6085, *in camera*; RX 1912 at 128, *in camera*).

Response to Finding No. 1135:

The finding is incorrect. All of Dr. Noether's conclusions about empirical analysis confirming the learning about demand theory are invalid because she relied on an inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). In addition, Dr. Noether's use of the terms "community" and "academic" to describe her two control groups are meaningless. Her use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065). {

} (Baker, Tr. 4739 *in camera*)

1136. { } (Noether, Tr. 6093, *in camera*). { } (Noether, Tr. 6093-94, 6098, *in camera*).

Response to Finding No. 1136:

The finding is incorrect. Under a bargaining theory the negotiations over price are determined by the relative bargaining position of the two parties, which depends upon the alternatives available to each party. (Haas-Wilson, Tr. 2469-70). While, everything else being constant, a larger payor would have a better bargaining position than a smaller payor, (Haas-Wilson, Tr. 2753), in fact, not everything else is constant. For example, the payers vary by the extent to which are marketing their healthcare plans by offering wider or narrower networks. (Haas-Wilson, Tr. 2458-60 (discussing DX 7045)). Moreover, in discussing the changes in pricing post-merger, the managed care plans varied by their starting points. They had different contractual arrangements premerger with Evanston and Highland Park. A payer with a lower initial price faced the possibility of a larger price increase than a payer that had a higher initial price. For example, if a payor was paying 50% of charges, the largest theoretical price increase that payor could get was a 100% price increase up to 100% of charges. If a payor that was paying 80% of charges, the largest theoretical price increase that payor could get was a 25% price increase up to 100% of charges. It is therefore overly simplistic to say that {

}

d. **Professor Baker's Empirical Analysis Confirms That The Learning About Demand Theory Applies In This Case**

1137. { } (Baker, Tr. 4638-39, 4662, *in camera*).

<u>Response to Finding No. 1137:</u>

The finding is misleading. Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group; he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, since Dr. Baker simply used Dr. Noether's "academic" and "community" groups, the use of the terms "community" and "academic" to describe the two control groups are meaningless. Dr. Noether's use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065). Moreover, Dr. Baker lacked credibility. (CCFF 1742-62).

1138. { } (Baker, Tr. 4656-57, *in camera*). { } (Baker, Tr. 4657-58, *in camera*).

<u>Response to Finding No. 1138:</u>

The finding is misleading. Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, Dr. Baker lacked credibility. (CCFF 1742-62).

1139. { } (Baker, Tr. 4667-8, *in camera*). { } (Baker, Tr. 4669, *in camera*). { } (Baker, Tr. 4669, *in camera*).

Response to Finding No. 1139:

The finding is misleading. Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, Dr. Baker lacked credibility. (CCFF 1742-62).

1140. { } (Baker, Tr. 4633, *in camera*). { } (Baker, Tr. 4633, *in camera*).

Response to Finding No. 1140:

The finding is misleading. Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940).

In addition, Dr. Baker's tests would not explain the price increases at Highland Park Hospital. The reason to have control groups is to have hospitals that experience similar cost and demand shocks to ENH. (Baker, Tr. 4638). Dr. Baker recognized that Highland Park and Evanston had different characteristics pre-merger and because of that one should have hospitals in the control group that are like both hospitals. (Baker, Tr. 4639). [REDACTED]

[REDACTED]

[REDACTED]} (RX 1912 at 60 *in camera*). Moreover, Dr. Baker lacked credibility. (CCFF 1742-62).

1141. {[REDACTED]
[REDACTED]} (Baker, Tr. 4618, 4807, *in camera*).

Response to Finding No. 1141:

Complaint Counsel had no specific response.

1142. {[REDACTED]
[REDACTED]

} (Baker, Tr. 4662-63, *in camera*).
{
} (Baker, Tr. 4730, *in camera*).

Response to Finding No. 1142:

The finding is misleading. {

} (Baker, Tr. 4688-89 *in camera* (emphasis added)).

} (Baker, Tr. 4710-11 *in camera*; CCFF 1750-52). {

} (CCFF 1753-58). {

} (CCFF 1761-62) Moreover, Dr. Baker lacks credibility. (CCFF 1742-62).

Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940).

1143. { } (Baker, Tr. 4685, *in camera*). } (Baker, Tr. 4663, *in camera*). { } (Baker, Tr. 4663, *in camera*).

Response to Finding No. 1143:

The finding is misleading. (*See* CCRFF 1142). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940).

1144. { } (Baker, Tr. 4641, *in camera*). { } (Baker, Tr. 4665-66, 4738, *in camera*).

Response to Finding No. 1144:

The finding is misleading. (*See* CCRFF 1142). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

Dr. Baker did not select the hospitals that went into the "academic" control group

and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940).

1145. { } (Baker, Tr. 4642, 4660, *in camera*).

Response to Finding No. 1145:

The finding is irrelevant. { } (Baker, Tr. 4797 *in camera*). There is therefore no reason to measure combined outpatient and inpatient prices.

1146. { } (Baker, Tr. 4660, *in camera*).

Response to Finding No. 1146:

The finding is irrelevant. Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF

1814-1940). Any data problems Dr. Baker had are therefore irrelevant.

1147. { } (Baker, Tr. 4666-67, *in camera*).

Response to Finding No. 1147:

The cited source does not say { } Moreover, both Dr. Baker and Dr. Noether used Dr. Noether's control groups, which are inappropriate and biased so any conclusions they draw about empirical analysis confirming the learning about demand theory are invalid. (*See* CCFF 1814-1940). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

i. The Results Of Professor Baker's Analysis Are Consistent With The Learning About Demand Theory

1148. { } (Baker, Tr. 4669-71, *in camera*).

Response to Finding No. 1148:

The finding is misleading. (*See* CCRFF 1142). Moreover Dr. Baker lacks credibility. (CCFF 1742-1762).

Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and

biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, since Dr. Baker simply used Dr. Noether's "academic" and "community" groups, the use of the terms "community" and "academic" to describe the two control groups are meaningless. Dr. Noether's use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065).

1149. { } (Baker, Tr. 4809-10, *in camera*). { } (Baker, Tr. 4810-11, *in camera*).

<u>Response to Finding No. 1149:</u>

The finding is misleading. (*See* CCRFF 1142). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, since Dr. Baker simply used Dr. Noether's "academic" and "community" groups, the use of the terms "community" and "academic" to describe the two control groups are meaningless. Dr. Noether's use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065).

1150. {[redacted] } (Baker, Tr. 4677-4800, (*explaining* DX 8047), *in camera*; Haas-Wilson, Tr. 2706, *in camera*). {[redacted] } (Baker, Tr. 4680 (*explaining* DX 8047), *in camera*).

Response to Finding No. 1150:

The finding is misleading. Even if Advocate Lutheran General were a satisfactory control group for Evanston, it would not be a satisfactory control group to explain the prices at Highland Park Hospital. (*See* CCRFF 1140).

The difference between ENH and Advocate Lutheran General, is that payers stopped contracting with Advocate Lutheran General when they could not get satisfactory terms. (*See* Foucre, Tr. 931). Payers found that they could not stop contracting with ENH. (CCFF 1133-62).

1151. {[redacted] (Baker, Tr. 4674, 4681, *in camera*).

Response to Finding No. 1151:

The finding is misleading. Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, since Dr. Baker simply used Dr. Noether's "academic" and

"community" groups, the use of the terms "community" and "academic" to describe the two control groups are meaningless. Dr. Noether's use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

1152. { } (Baker, Tr. 4674, 4681-82, 4699, *in camera*).

Response to Finding No. 1152:

The finding is misleading. Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, since Dr. Baker simply used Dr. Noether's "academic" and "community" groups, the use of the terms "community" and "academic" to describe the two control groups are meaningless. Dr. Noether's use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

{ } (Baker, Tr. 4759 *in camera*).

1153. { } (Baker, Tr. 4674, *in camera*).

Response to Finding No. 1153:

The finding is misleading. Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, since Dr. Baker simply used Dr. Noether's "academic" and "community" groups, the use of the terms "community" and "academic" to describe the two control groups are meaningless. Dr. Noether's use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

1154. { } (Baker, Tr. 4684, *in camera*). { } (Baker, Tr. 4810-11, *in camera*). { } (Baker, Tr. 4674, *in camera*).

Response to Finding No. 1154:

The finding is misleading. Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr.

Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, since Dr. Baker simply used Dr. Noether's "academic" and "community" groups, the use of the terms "community" and "academic" to describe the two control groups are meaningless. Dr. Noether's use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

1155. { } (Baker, Tr. 4671, 4811, *in camera*). { } (Baker, Tr. 4658, *in camera*).

<u>Response to Finding No. 1155:</u>

The finding is misleading. Dr. Baker did not select the hospitals that went into the "academic" control group and did not know why Dr. Noether excluded any particular hospitals from the control group, he simply took the control group Dr. Noether gave to him. (Baker, Tr. 4752-53). Therefore, all of Dr. Baker's conclusions about empirical analysis confirming the learning about demand theory are invalid because he relied on Dr. Noether's inappropriate and biased control group to compare price levels. (*See* CCFF 1814-1940). Moreover, since Dr. Baker simply used Dr. Noether's "academic" and "community" groups, the use of the terms "community" and "academic" to describe the two control groups are meaningless. Dr. Noether's use of those terms is not consistent with others in the industry. (*See* CCRFF 99, 1065). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

In fact, ENH's prices failed Dr. Baker's learning about demand tests as he set them out before he learned that his original expert report contained computational errors.

(CCFF 1744-1760: Haas-Wilson, Tr. 2721-32).

ii. Professor Baker's Empirical Analysis Overstates ENH's Post-Merger Price Increase Because That Analysis Does Not Measure Quality-Adjusted Prices

1156. { } (Baker, Tr. 4629-30, 4799, *in camera*).

Response to Finding No. 1156:

The finding is incorrect. { }

(Baker, Tr. 4799-4800). The only expert in this case that compared quality changes at ENH to a control group was Dr. Romano, Complaint Counsel's quality expert. (CCFF 2057; CCFF 2033-36; CCFF 2040). Dr. Romano found no discernible improvement at Highland Park or ENH. (Romano, Tr. 3004-05 (discussing DX 7033 at 2). Therefore there is no need to quality adjust any prices. Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

1157. Quality improvements need to be considered in evaluating competitive effects because if quality improves, the quality-adjusted price – a way of accounting for the value of quality improvements – declines. That is, a buyer gets more for its money. (Baker, Tr. 4604-06).

Response to Finding No. 1157:

The finding is misleading. In this case there is no need to quality adjust prices. (*See* CCRFF 1156). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

1158. Since ENH's quality improved after the Merger, the quality-adjusted price did not rise as much as the observed price. (Baker, Tr. 4606). If the quality-adjusted prices stayed the same or declined, consumers would be better off with the Merger – or at least not worse off – than they would have been had the Merger not happened. (Baker, Tr. 4606).

Response to Finding No. 1158:

The finding is incorrect. The relevant question is not whether quality improved at ENH, but whether quality improved at ENH relative to the control group, which it did not. (*See* CCRFF 1156). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

1159. { } (Baker, Tr. 4804-05, *in camera*).

Response to Finding No. 1159:

The finding is irrelevant. Dr. Baker gave two conflicting answers to this question. (Baker, Tr. 4749-50 *in camera*; Baker Tr. 4804-05 *in camera*). However, the relevant question is whether quality improved at ENH relative to the control group, which it did not. (*See* CCRFF 1156). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

1160. It is appropriate to quality-adjust the prices even if MCOs did not know that quality went up at ENH, because the MCOs are objectively better off. (Baker, Tr. 4607).

Response to Finding No. 1160:

The finding is incorrect. Increases in "quality" should only be considered if the customers value the increases and are willing to pay for them. (Haas-Wilson, Tr. 2545). Moreover, the relevant question is not whether quality improved at ENH, but whether quality improved at ENH relative to the control group, which it did not. (*See* CCRFF 1156). Finally, Dr. Baker lacks credibility. (CCFF 1742-62).

1161. The prices that are observed in this case, when looking at how prices changed coincident with the Merger, could not be quality-adjusted. { } (Baker, Tr. 4658, 4663-64, 4667-68, *in camera*). { } (Baker, Tr.

4658-61, 4663-64, 4667-68, *in camera*). { } (Baker, Tr. 4663-64, *in camera*).

Response to Finding No. 1161:

The finding is irrelevant. There was no need to quality adjust the prices in this case. { } (Baker, Tr. 4799-4800). The only expert in this case that compared quality changes at ENH to a control group was Dr. Romano, Complaint Counsel's quality expert. (CCFF 2057; CCFF 2033-36; CCFF 2040). Dr. Romano found no discernible improvement at Highland Park or ENH. (Romano, Tr. 3004-05 (discussing DX 7033 at 2). Therefore there is no need to quality adjust any prices. Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

1162. Dr. Haas-Wilson did not adjust the price changes that she calculated for changes in quality. Accordingly, she provided no way for this Court to determine whether the quality-adjusted price rose, even if the observed price rose. (Baker, Tr. 4607-08).

Response to Finding No. 1162:

The finding is irrelevant. In this case there is no need to quality adjust prices. (*See* CCRFF 1161). Moreover Dr. Baker lacks credibility. (CCFF 1742-62).

1163. { } (Baker, Tr. 4651, 4653, *in camera*). { } (Baker, Tr. 4811, *in camera*).

Response to Finding No. 1163:

The finding is irrelevant. Dr. Haas-Wilson relied upon Dr. Romana, the quality

expert for the Complaint Counsel. (Haas-Wilson, Tr. 2586-88). Dr. Romano found no discernible improvement at Highland Park or ENH. (Romano, Tr. 3004-05 (discussing DX 7033 at 2). Dr. Romano was the only expert in this case that compared quality changes at ENH to a control group of hospitals. (CCFF 2057; CCFF 2033-36; CCFF 2040). {Only if quality at ENH increased relative to a control group is there any need to quality adjust the prices.} (Dr. Baker, Tr. 4799-4800). Moreover, Dr. Baker lacks credibility. (CCFF 1742-62).

1164. Moreover, there is evidence that output at ENH increased after the Merger. Evidence of increased price and increased output post-Merger is consistent with an increase in quality rather than an increase in market power as a result of the Merger. (Noether, Tr. 6217-18).

Response to Finding No. 1164:

The finding is misleading and irrelevant. There are unique institutional relationships that one must understand to understand the competitive dynamics of the hospital industry. Managed care organizations are the customers of hospitals. It is in the bargaining between hospitals and managed care organizations that the hospital prices are established. (Haas-Wilson, Tr. 2456-57). However, after a managed care organization has a contract with a hospital, it is the members of the managed care organizations health plans that select which hospital they want to use, typically in consultation with their doctor. (Haas-Wilson, Tr. 2463-64). While hospitals compete for these patients, they do not compete on the basis of price. (Haas-Wilson, Tr. 2464).

This institutional relationship leads to what Dr. Elzinga called the "payer problem," individual patients who choose the hospital at which to seek services do not bear the costs of those hospital services. (CCFF 1669). Instead, it is the managed care

plan that pays for the hospital services. Thus, the person who chooses the hospital at which to obtain hospital services is not the same person who pays for those services. (CCFF 1670).

In this case, when ENH raised its prices, only one managed care plan, One Health/Great West, tried to drop the hospitals (reduce quantity). It was not successful, so it entered into a contract with ENH. (*See* CCFF 1133-1162). As such, ENH did not see a decline in the number of patients treated. This is because individual patients did directly pay the price increases that ENH charged the managed care plan. (*See* CCFF 1669-1673). When managed care plans pass on the increased cost to employers in terms of higher prices, the quantity effect would be seen at the employer/employee level where employers raised the employee's costs or dropped health insurance altogether. (*See* CCFF 145-151; CCFF 1338-1343; Mendonsa, Tr. 483-84; Dorsey, Tr. 1450).

VIII. MERGER IMPACT ON QUALITY

A. Definition And Measurement Of Healthcare Quality

1. Definition Of Quality In Healthcare

1165. Quality in healthcare is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the state of current professional knowledge. (Chassin, Tr. 5141; Romano, Tr. 3250-51).

Response to Finding No. 1165:

In findings 1165 to 1179, Respondent describes the different types of quality measures, structural, process and outcome. But Respondent's conclusion that "the problems with outcome measures are quite serious and quite severe" (RFF 1179) is inaccurate and misleading. In CCRFF 1179, Complaint Counsel explain why outcome measures, particularly when combined with process measures, are more useful than structural measures.

1166. This definition was promulgated by the Institute of Medicine ("IOM") in 1990. (Chassin, Tr. 5142; Romano, Tr. 3250). The IOM is a component of the National Academy of Sciences, and it is charged by Congress with undertaking studies in specific areas relevant to health and medicine. (Romano, Tr. 2998-99).

Response to Finding No. 1166:

For the reasons explained in CCRFF 1165, Complaint Counsel refer the court to CCRFF 1179 for an explanation why outcome measures, particularly when combined with process measures, are more useful than structural measures.

1167. This definition is generally accepted by experts as the most authoritative definition of quality. Accordingly, this definition was specifically accepted as the definition of healthcare quality by the experts for both parties in this case. (Chassin, Tr. 5143; Romano, Tr. 3251). Before IOM came up with this definition, there was no other classification that was as widely accepted as authoritative in the study of the quality of medical care. (Chassin, Tr. 5142-43).

Response to Finding No. 1167:

For the reasons explained in CCRFF 1165, Complaint Counsel refers the court to CCRFF 1179 for an explanation why outcome measures, particularly when combined with process measures, are more useful than structural measures.

1168. ENH's healthcare quality expert, Dr. Mark Chassin, was a member of the IOM committee that created and adopted the definition of quality in healthcare per a directive from Congress. (Chassin, Tr. 5142). Dr. Chassin was actively engaged in that subcommittee that debated the issues surrounding this definition and part of the committee that ultimately sanctioned the definition. (Chassin, Tr. 5142).

Response to Finding No. 1168:

Complaint Counsel have no specific response.

1169. The heart of the quality definition is the phrase "increase the likelihood of desired health outcomes." (Chassin, Tr. 5143). Quality is about reducing the risk of bad things happening, or increasing the likelihood of good things happening. (Chassin, Tr. 5143-44).

Response to Finding No. 1169:

For the reasons explained in CCRFF 1165, Complaint Counsel refer the court to CCRFF 1179 for an explanation why outcome measures, particularly when combined with process measures, are more useful than structural measures.

1170. But, "Quality" is not the same as good outcomes because, despite the best medical care, bad outcomes frequently happen to patients. (Chassin, Tr. 5144). Similarly, good outcomes may result from poor quality care, as patients are often resilient to mistakes or errors made by providers. The definition of healthcare quality reflects the balance that must be made when evaluating quality of healthcare; that is, whether the structure, process, or other means of delivering care is likely to increase the probability of good outcomes. (Chassin, Tr. 5144).

Response to Finding No. 1170:

For the reasons explained in CCRFF 1165, Complaint Counsel refer the court to CCRFF 1179 for an explanation why outcome measures, particularly when combined

with process measures, are more useful than structural measures.

2. Measuring Healthcare Quality

1171. Experts in the field of healthcare quality assessment investigate three different classes of quality measures to determine if there has been a quality improvement. The three different categories of health care quality measurement are structure, process and outcomes. (Chassin, Tr. 5144-45; Romano, Tr. 3251).

Response to Finding No. 1171:

Complaint Counsel have no specific response.

1172. Structural measures reflect specific characteristics or features of a healthcare delivery organization. Structural factors are enabling factors. They set the background. They provide the conditions under which care is delivered. (Romano, Tr, 2988). Structural measures include the physical resources put in place to deliver the processes of care – such as the beds that are available, the equipment, laboratory facilities, radiology facilities, and so forth. Structural measures also include the human resources, the specific training and the expertise of the professionals put in place to deliver the processes of care. (Romano, Tr. 2986-87, 3251; Chassin, Tr. 5145). For example, the expansion of obstetrician coverage to include nighttime coverage, even in the absence of outcome data, is a structural quality improvement. (Romano, Tr. 3251-52).

Response to Finding No. 1172:

Complaint Counsel agree with all but the last sentence of this finding. Complaint Counsel explain its position in CCRFF 1256 regarding ENH's claim to have improved quality by implementing nighttime OB physician coverage, including the lack of merger specificity of that claim. (CCRFF 1256).

1173. Processes are all the things providers do when they treat patients. Process measures reflect what health professionals actually do to diagnose and treat disease – including prescribing medications, diagnostic testing and surgical procedures. These are all parts of process in care. (Chassin, Tr. 5155; Romano, Tr. 2987).

Response to Finding No. 1173:

Complaint Counsel agree with this finding.

1174. Outcome measures reflect what ultimately happens to patients as a result of the care process: Do they leave the hospital alive? Are they disabled? Is their functional status optimized? Are they satisfied? (Romano, Tr. 2987).

Response to Finding No. 1174:

Complaint Counsel agree with this finding.

a. Strengths And Weaknesses Of Quality Measures

1175. Each one of the classes of measures described above has its uses, its strengths and its weaknesses. (Chassin, Tr. 5152).

Response to Finding No. 1175:

Complaint Counsel agree with this finding except to note that, for reasons explained in CCRFF 1179, outcome measures, particularly when combined with process measures, are more useful than structural measures.

1176. In the case of structural measures, there are typically many of them, and they are easy to gather information about. One can easily lookup the number of beds in the hospital and research the amount of training the physicians have undergone. However, structural measures are often remote from the actual outcomes. (Chassin, Tr. 5152).

Response to Finding No. 1176:

Complaint Counsel agree with this finding except to note that, for reasons explained in CCRFF 1179, outcome measures, particularly when combined with process measures, are more useful than structural measures.

1177. Process measures are readily understandable to clinicians and are very usable in quality improvement. They also have the advantage of not needing comparative data. For example, if it were known that treating hypertension is a valid measure of quality and produces good outcomes, then all of a hospital's hypertensive patients would have to be treated to their target goals. That particular hospital would not need to know how it compared to other institutions; the organization would know its goal was 100% compliance. (Chassin, Tr. 5152-53). But there are weaknesses with process measures. Clinical information in these areas are not readily available in automated data systems or routine reports. (Chassin, Tr. 5153).

Response to Finding No. 1177:

Complaint Counsel have no specific response.

1178. Outcome measures are very attractive, but they too have their strengths and weaknesses. The most attractive part of looking at outcome measures is that, by definition, an outcome is the end result – what patients and providers care about. (Chassin, Tr. 5153). The other advantage is that at least the occurrence of outcomes is readily available in some automated data systems. (Chassin, Tr. 5153). Nevertheless, despite the attractiveness of outcomes, when making a determination as to whether there has been a quality improvement, it is not always necessary to have outcome information. (Chassin, Tr. 5145). In fact, there are limitations to using outcomes in assessing healthcare quality, and outcome measures sometimes suffer from severe problems that may interfere with their usefulness in identifying the effects of hospital Mergers. (Romano, Tr. 3253).

Response to Finding No. 1178:

For reasons explained in CCRFF 1179, outcome measures, particularly when combined with process measures, are more useful than structural measures.

1179. The problems with outcome measures are quite serious and quite severe, especially when they are used to measure the quality of care at an individual hospital. (Chassin, Tr. 5153-54). Accordingly, it is necessary to have comparative data to know whether a particular outcome is good, bad, or indifferent. For example, in contrast to knowing that a hospital should treat all its hypertensive patients according to a standard, we do not know if 3% is a good mortality rate for a given procedure, or if 6% is a bad rate for another procedure when these procedures are measured in isolation. (Chassin, Tr. 5154).

Response to Finding No. 1179:

In findings 1165 to 1179, Respondent describes the different types of quality measures, structural, process and outcome. But Respondent's conclusion that "the problems with outcome measures are quite serious and quite severe" (RFF 1179) is inaccurate and misleading.

In its own business practices, ENH itself relies substantially on outcome measures. For example, in its Performance Improvement Plan for 2001, ENH defined

quality as "[t]he best possible clinical *outcomes* for our patients; [s]atisfaction for all of our many customers; [r]etention of talented staff; [s]ound financial performance." (CX 2052 at 5 (emphasis added); O'Brien, Tr. 3554-55). Patients care about what outcomes they get when they go to a hospital. (O'Brien, Tr. 3556; Chassin, Tr. 5153, 5461). ENH measures outcomes in its own quality assessments. (O'Brien, Tr. 3555-56).

{[redacted]} (Romano, Tr. 3066, *in camera*). {[redacted]} (Romano, Tr. 3066, *in camera*). {[redacted]} (Romano, Tr. 6333-34, *in camera*;. *See also,* CCFF 2122-2132).

Outcome measures are useful in measuring quality of care, particularly when they are correlated with process measures. (Romano, Tr. 2988-89). In contrast, 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).

1180. Another limitation of using outcome data to measure hospital quality is that some

outcomes occur so rarely that they are not useful as quality measures. (Romano, Tr. 3254). For example, the occurrence of neonatal mortality at a low-risk delivery service such as HPH is so rare that it would not be meaningful to compare changes in that outcome over time to evaluate quality improvements in that area. (Chassin, Tr. 5597). Further, some outcomes of medical treatment are so delayed after treatment is given that it is impossible to use them in deciding whether quality changes happened as a result of a merger. (Romano, Tr. 3254). For example, for some procedures there are so few deaths that in-hospital mortality, which is an outcome measure, is not a useful measure of quality. (Romano, Tr. 3254).

Response to Finding No. 1180:

That some outcome measures do not accurately depict a hospital's quality says nothing about the outcome measures at issue in this case.

Respondent notes that some outcomes occur too infrequently to provide an accurate measure of quality. The only specific instance of a low sample size outcome measure cited by Respondent is neonatal mortality. {[redacted]} (Romano, Tr. 3231-32, *in camera*). Thus, rather than draw any inappropriate conclusion based on a small sample, Dr. Romano forthrightly acknowledged the statistical limitations. But this finding is nevertheless important – neonatal mortality is yet another objective measure where the structural improvements touted by ENH are simply not showing up in the valid outcome data.

Respondent also notes that some mortality measures occur too long after a hospital stay to measure quality. But Respondent cites no such measure that was relied upon by Dr. Romano, and in fact, in the cited portion of the transcript, Dr. Romano

testified only that "that may be true for some procedures." (Romano, Tr. 3254). This theoretical limitation does not affect Dr. Romano's actual conclusion from the measures he used.

1181. Another important aspect in trying to use outcomes to assess hospital quality is the need to risk-adjust them. (Chassin, Tr. 5156). Risk-adjustment is the process by which all the other factors that influence patient outcomes that are independent of the treatment – such as the severity of a patient's disease, or other conditions a patient presents with – are taken into account. (Chassin, Tr. 5156; Romano, Tr. 3273).

<u>Response to Finding No. 1181:</u>

Complaint Counsel agree with this finding.

1182. Risk-adjustment is very difficult to do. It requires extremely detailed clinical information about precisely how sick the patient is and what other conditions the patient brings with him or her to the hospital. Without this information, one cannot tell whether that hospital's care has contributed to improving the outcome. (Chassin, Tr. 5156).

<u>Response to Finding No. 1182:</u>

Respondent's finding is incomplete. Risk adjustment is certainly important in drawing conclusions from outcome data, which is why Dr. Romano used risk-adjusted data in his work.

Dr. Romano is an expert in risk adjustment, having advised the U.S. Healthcare Financing Administration on risk adjustment techniques. (Romano, Tr. 2968). {[redacted]} (*See, e.g.* Romano, Tr. 3051-52 ({[redacted]}), *in camera*). {[redacted]

(Romano, Tr. 3208-09, *in camera*).

(Romano, Tr. 3208-09, *in camera*).

} (Romano, Tr. 3208-09, *in camera*).

1183. Finally, another important weakness of outcome measures is that – unlike processes or structures, which are, by and large, under the control of the provider giving care – outcomes are susceptible to a lot of influences, and many of the influences that produce certain outcomes are not under a provider's control. (Chassin, Tr. 5154; Romano, Tr. 3253-54). Therefore, it is important to sort out what part of the outcome is the responsibility of, and under the control of, the provider. (Chassin, Tr. 5154).

Response to Finding No. 1183:

For reasons explained in CCRFF 1179, outcome measures, particularly when combined with process measures, are more useful than structural measures.

1184. The difficulty in relying on outcome measures is also recognized by leading third-party organizations in the field of healthcare quality. The Joint Commission for the Accreditation of Healthcare Organizations ("Joint Commission" or "JCAHO") does not attach any weight to outcome measures of quality in the accreditation process for hospitals. (Chassin, Tr. 5156).

Response to Finding No. 1184:

This finding is inaccurate. {

} (Romano, Tr. 6333-34, *in camera*).

1185. JCAHO is the entity responsible for accrediting hospitals and certain other types of healthcare organizations in the United States. It convenes a series of expert panels to help identify appropriate quality measures for use in the accreditation process. (Romano, Tr. 2969).

Response to Finding No. 1185:

Complaint Counsel agree with this finding.

1186. Specifically, in its accreditation process, JCAHO considers and rates a hospital on approximately 1,200 explicit aspects of hospital activities, which are called elements of performance. (Chassin, Tr. 5157). None of the aspects considered in this process by JCAHO are outcome measures. Three-quarters of the elements are structural, and the remaining quarter involves process measures. (Chassin, Tr. 5157).

Response to Finding No. 1186:

Respondent's statement that "JCAHO does not attach any weight to outcome measures of quality" (RFF 1184) is inaccurate. { [redacted] } (Romano, Tr. 6333-34, *in camera*).

b. Quality Measures Must Be Valid

1187. A measure is valid if it reflects and accurately measures the concept of quality as it is defined in the IOM definition cited above. (Chassin, Tr. 5146). The tests for validity of individual structure, process and outcome measures are each unique. (Chassin, Tr. 5146).

Response to Finding No. 1187:

Respondent's general discussion of validity is irrelevant, particularly since Respondent never bothered to explain which measures used in the case were valid and which were not. Dr. Romano explained why each and every measure he relied upon was valid. Respondent's vagueness, and Complaint Counsel's precision, on this issue is explained in CCRFF 1188 below.

1188. One must examine the validity of the particular measure to determine whether it is a good measure of quality or a bad measure of quality. Therefore, just because some concept can be categorized as a structure, process, or outcome measure does not mean it is a measure that can

properly be used to evaluate healthcare quality. (Chassin, Tr. 5145-46). It follows that to employ quality measures in an accepted and accurate manner, the quality measures used should have a proven high degree of validity. (Romano, Tr. 3252).

Response to Finding No. 1188:

On the page cited by Respondent, Dr. Romano testified that to employ quality measures in an accepted and accurate manner, the quality measures used should have a proven and high degree of validity. (Romano, Tr. 3252).

The evidence is undisputed that the measures used by Dr. Romano meet that high standard. On rebuttal, Dr. Romano painstakingly went through each of the measures he used, and explained why they were valid under accepted measurements from both AHRQ and JCAHO. (*See, e.g.,* Romano, Tr. 6274-75; 6279-88).

Dr. Romano candidly explained the evidence on both sides of the question of validity, noting, for example that while the evidence connecting processes of care with outcomes relating to stroke mortality was mixed, it was still strong enough to meet AHRQ's standards for validity and inclusion. (Romano, Tr. 6281-82).

Other AHRQ measures used by Dr. Romano (decubital ulcers, failure to rescue, postoperative hip fractures, selected infections, and birth trauma) are considered valid due to the consensus among experts in the field accepting their validity. (Romano, Tr. 6283-87). In his own work, Dr. Chassin has used similar expert panels to establish by consensual validity the appropriateness of certain types of surgery. (Romano, Tr. 6284).

Dr. Romano's detailed discussion of the validity of each specific measure stands undisputed. While Dr. Chassin claimed that only six of 46 AHRQ measures were valid, he did not identify the six nor explain why the others were invalid. (Romano, Tr. 6273-

74. *See also, e.g.*, CCFF 2105-2112).

1189. An article written by Dr. Chassin, and relied on by Dr. Romano (Complaint Counsel's quality of care expert), confirms that for an outcome measure to be valid as a measure of quality, it has to be tied to a process or structure of care that can be changed to produce a desired health outcome. The relevant article written by Dr. Chassin is entitled "The Urgent Need to Improve Healthcare Quality, Institute of Medicine, National Roundtable on Healthcare Quality." It was published in The Journal of the American Medical Association ("JAMA"), a prestigious peer-reviewed medical journal. (Romano, Tr. 3252-53; Chassin, Tr. 5146).

Response to Finding No. 1189:

Respondent's general discussion of validity is irrelevant, particularly since Respondent never bothered to explain which measures used in the case were valid and which were not. Dr. Romano explained why each and every measure he relied upon was valid. Respondent's vagueness, and Complaint Counsel's precision, on this issue is explained in CCRFF 1188 above.

1190. Accordingly, for an outcome to be a valid measure of quality, it must have a proven relationship to processes or structures that can be modified so that the outcome is affected. (Chassin, Tr. 5148). If the outcome cannot be affected by a change in process or structure, then it is not a measure of quality of care because there is nothing that can be done to make the outcome better. (Chassin, Tr. 5148). For example, if an oncologist diagnoses pancreatic cancer at a late stage when it is inoperable, it is possible to measure the percent of patients who die six months from that point in treatment. That would be an outcome measure. However, there is nothing a physician can do to influence that outcome, so that would not be a valid measure of the quality of care provided to that patient. (Chassin, Tr. 5148).

Response to Finding No. 1190:

Respondent's general discussion of validity is irrelevant, particularly since Respondent never bothered to explain which measures used in the case were valid and which were not. Neither Dr. Romano nor Dr. Chassin made any meaningful use of pancreatic cancer mortality. Dr. Romano explained why each and every measure he relied upon was valid. Respondent's vagueness, and Complaint Counsel's precision, on

this issue is explained in CCRFF 1188 above.

1191. For a structural measure to be valid, it must bear a proven relationship to a desired health outcome. The same test also applies to process measures. (Chassin, Tr. 5146).

Response to Finding No. 1191:

Respondent's general discussion of validity is irrelevant, particularly since Respondent never bothered to explain which measures used in the case were valid and which were not. Dr. Romano explained why each and every measure he relied upon was valid. Respondent's vagueness, and Complaint Counsel's precision, on this issue is explained in CCRFF 1188 above.

1192. If a structural or process measure were a valid one, then an improvement in that measure would be a quality improvement even in the absence of outcome data. (Chassin, Tr. 5146-47). For example, if we know that a process like treating high blood pressure improves good outcomes, then there is no need to measure outcomes every time high blood pressure is treated. We already know that improvements in the application of adequate high blood pressure controls is an improvement in healthcare quality. (Chassin, Tr. 5147).

Response to Finding No. 1192:

Respondent's general discussion of validity is irrelevant, particularly since Respondent never bothered to explain which measures used in the case were valid and which were not. Dr. Romano explained why each and every measure he relied upon was valid. Respondent's vagueness, and Complaint Counsel's precision, on this issue is explained in CCRFF 1188 above.

1193. There are different types of evidence that may be used to establish the validity of structure, process and outcome measures. To establish a relationship between processes and outcomes, evidence from research based on randomized trials typically is required. (Chassin, Tr. 5149-50).

Response to Finding No. 1193:

Respondent's general discussion of validity is irrelevant, particularly since Respondent never bothered to explain which measures used in the case were valid and which were not. Dr. Romano explained why each and every measure he relied upon was valid. Respondent's vagueness, and Complaint Counsel's precision, on this issue is explained in CCRFF 1188 above.

1194. To establish a relationship between structural measures, several other considerations must be weighed. It is always desirable to have clinical research evidence that structural measures are valid. However, such evidence is not always available. (Chassin, Tr. 5150). In fact, Dr. Romano concedes that there are structural aspects of quality of care that could not be tested in a randomized intervention because of ethical concerns with doing so. (Romano, Tr. 3332-33).

Response to Finding No. 1194:

Respondent's general discussion of validity is irrelevant, particularly since Respondent never bothered to explain which measures used in the case were valid and which were not. Dr. Romano explained why each and every measure he relied upon was valid. Respondent's vagueness, and Complaint Counsel's precision, on this issue is explained in CCRFF 1188 below.

1195. For example, a defective defibrillator would never be installed in an emergency department as part of a randomized trial to prove that you need effective defibrillators to have quality of care in delivering shocks to the heart. (Chassin, Tr. 5150-51; Romano, Tr. 3333). Further, it would be unethical to conduct a clinical study to determine if someone who is trained as a general surgeon would conduct neurosurgery worse than someone who was trained as a neurosurgeon. Therefore, for many training and equipment issues, which are structural measures of quality, judgments must be made in the absence of outcome data generated by research. (Chassin, Tr. 5151).

Response to Finding No. 1195:

Respondent's general discussion of validity is irrelevant, particularly since

Respondent never bothered to explain which measures used in the case were valid and which were not. Dr. Romano explained why each and every measure he relied upon was valid. Respondent's vagueness, and Complaint Counsel's precision, on this issue is explained in CCRFF 1188 above.

B. Dr. Chassin Employed Accepted Methodology For The Study Of Healthcare Quality

1196. Dr. Chassin employed a multi-faceted strategy to measure the changes in structures, processes and outcomes at HPH and ENH in this case. (Chassin, Tr. 5158-59). The elements of Dr. Chassin's methodology are utilized by significant third-party organizations and state governing bodies in the field of healthcare quality. (Chassin, Tr. 5169-70, 5190-91).

Response to Finding No. 1196:

Dr. Chassin visited HPH in 2004 and used qualitative research techniques to try to determine what quality had been like five years earlier. In so doing, he adopted techniques unknown to health services research (Romano, Tr. 3021) and which were otherwise flawed in their own right. These flaws are discussed in more detail at CCRFF 1211.

1197. Dr. Chassin's strategy in approaching his assessment of whether quality of care improved at HPH in connection with the Merger was to use a variety of different sources for information, and then to prioritize areas of concern that might exist for a hospital like Evanston Hospital in preparing to merge with a community hospital like HPH. (Chassin, Tr. 5158-59). He then looked at exactly what Evanston Hospital did during the course of the Merger and thereafter. Next, he assessed the impact of all of Evanston Hospital's interventions on the quality of care that had existed before the Merger at HPH. (Chassin, Tr. 5159).

Response to Finding No. 1197:

Dr. Chassin visited HPH in 2004 and used qualitative research techniques to try to determine what quality had been like five years earlier. In so doing, he adopted techniques unknown to health services research (Romano, Tr. 3021) and which were

otherwise flawed in their own right. These flaws are discussed in more detail at CCRFF 1211.

1198. Further, to the extent Dr. Romano raised any questions in his reports about quality issues at Evanston Hospital, Dr. Chassin looked at those issues in his own assessment. (Chassin, Tr. 5579). In looking at those issues, Dr. Chassin could not find any declines in quality at Evanston Hospital pre-Merger. (Chassin, Tr. 5276, 5579).

Response to Finding No. 1198:

Dr. Chassin's conclusion regarding the lack of any decline at Evanston Hospital was wrong. (*See* CCRFF 1565).

1199. Dr. Chassin's review focused on the Merger's impact on the quality of HPH's clinical services. (Chassin, Tr. 5580). In making his assessment, Dr. Chassin considered and analyzed data from a variety of sources, including: (1) site visits made to both Evanston Hospital and HPH; (2) formal and informal interviews; (3) contemporaneous documents; (4) available outcome data, including both clinical and administrative data; and, finally (5) quantitative and qualitative analyses. (Chassin, Tr. 5159).

Response to Finding No. 1199:

Dr. Chassin explicitly limited his review to areas where alleged problems had existed pre-merger or alleged improvements were made post-merger. He therefore left out several areas and did not perform a comprehensive analysis. (CCRFF 1225).

1200. Dr. Chassin was assisted in his assessment by Dr. Elizabeth Howell, a board-certified obstetrician/gynecologist and a faculty member of the Department of Health Policy at Mount Sinai. (Chassin, Tr. 5160). Dr. Howell reviewed documents, performed literature searches, assisted with the interviews and helped to compile some of the data used in Dr. Chassin's analyses. (Chassin, Tr. 5160).

Response to Finding No. 1200:

Complaint Counsel have no specific response.

1201. Dr. Howell began the review of contemporaneous documents by identifying quality-related documents in the 36 boxes of documents produced early in discovery. (Chassin, Tr. 5160). Dr. Chassin then reviewed all of those quality-related documents and began the site

visit and interviewing processes. (Chassin, Tr. 5160). This review led to an iterative process through which Dr. Chassin made further specific requests for more documents and data and conducted additional interviews and another site visit. (Chassin, Tr. 5160-61).

Response to Finding No. 1201:

Complaint Counsel have no specific response.

1202. Dr. Chassin reviewed at least a dozen deposition transcripts before writing his expert report. (Chassin, Tr. 5161). Since writing his report, he also reviewed transcripts of physicians and witnesses, including Dr. Romano, who testified about quality issues in this case. (Chassin, Tr. 5161).

Response to Finding No. 1202:

Complaint Counsel have no specific response.

1203. Dr. Chassin conducted two, two-day site visits at HPH and ENH in June and August of 2004. (Chassin, Tr. 5169). The Joint Commission, state health departments, and professional organizations like the American College of Obstetricians and Gynecologists ("ACOG") conduct site visits as part of their assessments of hospital quality. (Chassin, Tr. 5170; Romano, Tr. 3245). Yet Dr. Romano, who admitted that site visits would have been ideal, did not conduct a site visit in this case of any relevant hospital. (Romano, Tr. 3245).

Response to Finding No. 1203:

The cited organizations conduct site visits to perform analyses of the state of quality at the time of the visit. Dr. Chassin's use of qualitative techniques to try to measure quality several years earlier is a technique unknown to health services research. (CCRFF 1211). Dr. Romano was offered the opportunity to conduct a site visit but declined that opportunity. He explained that "I really had doubts about whether I would be able to ascertain very much useful from doing a site visit in 2004 and asking questions about what things were like in 1998 or 1999. Many of the individuals who were on the front lines and providing and managing care at that time had moved on to other roles. I was also concerned that I wouldn't get an unbiased view of what actually happened,

because I would be talking to people who were themselves ENH employees." (Romano Tr. 2980).

1204. Dr. Chassin also conducted 34 formal interviews of key physicians, nurses and administrative leaders who were present at HPH or Evanston Hospital either before or after the Merger or, in some cases, both. (Chassin, Tr. 5161-62).

Response to Finding No. 1204:

Complaint Counsel note that most of these interviewees were ENH employees and most were conducted in the presence of counsel from Winston and Strawn. (CCRFF 1211).

1205. Dr. Chassin also interviewed a number of other individuals informally during his site visits, including physicians and nurses in such areas as the adolescent psychiatric unit, the ambulatory surgery unit, the cardiac catheterization lab, the emergency department ("ED") and the intensive care unit ("ICU"). (Chassin, Tr. 5162).

Response to Finding No. 1205:

Various evidence supports the view that Dr. Chassin did not follow accepted standards of qualitative research. In particular, Dr. Chassin's sampling strategy was inadequately designed to seek out alternative views or individuals having contradictory opinions. Rather, it focused largely on administrative, physician, and nursing leadership at ENH. (CCFF 2151-2155).

1206. Dr. Chassin selected all of the interview subjects. (Chassin, Tr. 5584). During his site visits, Dr. Chassin conducted informal interviews with people he met when there were no lawyers or administrators present. (Chassin, Tr. 5584).

Response to Finding No. 1206:

Various evidence supports the view that Dr. Chassin did not follow accepted standards of qualitative research. In particular, Dr. Chassin's sampling strategy was

inadequately designed to seek out alternative views or individuals having contradictory opinions. Rather, it focused largely on administrative, physician, and nursing leadership at ENH. (CCFF 2151-2155).

1207. The interviews consisted of a series of structured questions that were directed at a particular topic. (Chassin, Tr. 5163). The individuals Dr. Chassin interviewed were able to clearly describe their experiences with providing care and doing their jobs, both at the time of the interview and previously. (Chassin, Tr. 5164).

Response to Finding No. 1207:

There was an undue focus on physician and nursing leadership, as opposed to those actually "providing care." (Romano, Tr. 3015).

1208. Interviews are important in trying to gather a full picture of how a hospital functions, both currently and previously. (Chassin, Tr. 5164). Dr. Chassin utilized the interviews to determine whether there was consistency among all the different sources of information he was considering. (Chassin, Tr. 5165).

Response to Finding No. 1208:

For reasons explained in CCRFF 1203, these interviews were not particularly useful.

1209. The Joint Commission, state health departments and professional organizations like ACOG, conduct site interviews as part of their assessments of hospital quality. (Chassin, Tr. 5170; Romano, Tr. 3246-47). Nevertheless, Dr. Romano did not personally conduct any interviews of physicians or administrators relevant to the case. (Romano, Tr. 3247).

Response to Finding No. 1209:

Site visits are not used by JCAHO and others to assess quality at some historical time. (CCRFF 1211). Dr. Romano explained why such interviews would not have been useful, which explanation is quoted at length in CCRFF 1203.

1210. When possible, Dr. Chassin utilized different sources in his analysis – including interviews, document review, examination of data and site visits – to determine whether there

was consistency among all the sources of information he was considering and to see if those sources pointed in the same direction in terms of the quality assessment he was conducting. (Chassin, Tr. 5164-65, 5233). This broad range of sources led Dr. Chassin to conclude in a number of areas, for example, Ob/Gyn and nursing, that quality improved. (Chassin, Tr. 5159, 5192-93, 5233, 5236).

Response to Finding No. 1210:

Dr. Chassin's techniques were problematic for reasons explained in CCRFF 1211 below. The quality of OB/Gyn and nursing are explained in CCRFF 1276-1333 and 1385-1388, respectively.

1211. The methods used by Dr. Chassin to conduct his assessment in the changes in quality at HPH after the Merger were entirely consistent with the methods used by Dr. Chassin when he was Commissioner of Health in the State of New York. (Chassin, Tr. 5190-91).

Response to Finding No. 1211:

Dr. Chassin's research methods suffered from serious limitations that render his conclusions highly suspect. While Dr. Chassin testified on direct that his methods were consistent with methods used as New York Commissioner of Health, cross examination and Dr. Romano's testimony pointed out two fundamental flaws in his methods. First, while qualitative techniques are routinely used to measure the quality of a hospital at the time the qualitative investigation takes place, this is not what Dr. Chassin did. Instead, he visited HPH in the Summer of 2004 and tried to determine what quality had been like five or more years earlier. (Chassin Tr. 5131). Dr. Chassin could cite no instance either in the either published literature, or the practices of any expert body, of a valid technique showing how to visit a hospital at some period of time and figure out what the quality of care had been like at some period several years earlier. (Chassin, Tr. 5134-36). As Dr. Romano explained, "that would be a technique historians might use. It's not a technique

I'm familiar with in health services research." (Romano, Tr. 3021).

Second, Dr. Chassin's qualitative technique was flawed in several respects, including: (i) the failure to clearly describe his sampling strategy, (ii) the failure to formally interview people actually in the front lines of providing care, (iii) the failure to seek out alternative views or individuals having contradictory opinions, and (iv) the (typical) presence one or two attorneys from Winston & Strawn during the interviews. (Romano, Tr. 3013-16. *See also, e.g.*, CCFF 2149-2163).

C. Dr. Chassin Has Extensive Experience Evaluating And Assessing Healthcare Quality

1212. Dr. Chassin is an expert in the fields of measuring, assessing and improving quality of healthcare as well as in health services and health policy research. (Chassin, Tr. 5131).

Response to Finding No. 1212:

Complaint Counsel does not dispute that, in general, Dr. Chassin is an expert in the field of health care quality assessment. Complaint Counsel notes, however, that Dr. Chassin's resume lists his abilities in the collection and assessment of large volumes of data. (RX 1910). The use of those abilities to systematically measure outcomes, nurse vacancy rates, instances of HPH quality reviews finding problems, or any number of areas put in issue through anecdotal evidence is notably missing from the record. Although Dr. Chassin would have been qualified to do so, he did not in this case prepare any "comprehensive outcome or process analysis." (Romano, Tr. at 2991-92).

1213. Dr. Chassin is a physician employed by the Mount Sinai School of Medicine in New York City. (Chassin, Tr. 5119). He is the Edmond A. Guggenheim Professor of Health Policy, Chairman of the Department of Health Policy of the Mount Sinai Medical School, and Executive Vice President for Excellence in Patient Care at Mount Sinai Medical Center. (Chassin, Tr. 5119).

Response to Finding No. 1213:

Complaint Counsel have no specific response.

1214. As professor and chairman of the Department of Health Policy, Dr. Chassin is responsible for leading the expansion of the program in health services and health policy research. (Chassin, Tr. 5119).

Response to Finding No. 1214:

Complaint Counsel have no specific response.

1215. As the Executive Vice President, Dr. Chassin is responsible for leading clinical quality improvement throughout the medical center. (Chassin, Tr. 5120). Several medical center functions report to Dr. Chassin in his Executive Vice President role. (Chassin, Tr. 5120).

Response to Finding No. 1215:

Complaint Counsel have no specific response.

1216. The Mount Sinai Survey Center, the entity that conducts patient satisfaction surveys for inpatients and outpatients at Mount Sinai Hospital, is led by Dr. Chassin. The Six Sigma Quality Improvement Program – the vehicle that Mount Sinai uses for organizational improvement and cultural change, as well as improving business, administrative and clinical processes of care – reports to Dr. Chassin. The Cullman Institute for Patient Care, a trustee-endowed entity that focuses on improving nursing care, is overseen by Dr. Chassin. And Dr. Chassin directs the Excellence in Patient Care Initiative at Mount Sinai. (Chassin, Tr. 5120).

Response to Finding No. 1216:

Complaint Counsel have no specific response.

1217. At Mount Sinai, Dr. Chassin serves as co-chair of the quality control committee and is an elected member of the executive faculty, which is the governing body of the faculty of the medical school. (Chassin, Tr. 5120-21).

Response to Finding No. 1217:

Complaint Counsel have no specific response.

1218. Dr. Chassin completed his undergraduate studies, graduate studies and medical school studies at Harvard College. (Chassin, Tr. 5122; RX 1910 at 1). While in medical school, Dr. Chassin also attended the Kennedy School of Government at Harvard and earned a Master's

degree in Public Policy. (Chassin, Tr. 5122). After medical school, Dr. Chassin completed residency training in internal medicine at Harvard General Hospital in Los Angeles, a fellowship in health services research at the Robert Wood Johnson Foundation Clinical Scholars Program at UCLA, and then earned a Master's degree in Public Health from UCLA. (Chassin, Tr. 5122).

Response to Finding No. 1218:

Complaint Counsel have no specific response.

1219. Dr. Chassin practiced emergency medicine for 12 years. (Chassin, Tr. 5122). He is board-certified in internal medicine. (Chassin, Tr. 5123).

Response to Finding No. 1219:

Complaint Counsel have no specific response.

1220. After his research fellowship, Dr. Chassin worked for the Healthcare Finance Administration ("HCFA"), then went to the Office of Policy Analysis at HCFA, and subsequently became the Deputy Director of the Office of Professional Standards Review Organizations. (Chassin, Tr. 5123). Dr. Chassin then went to RAND Corporation, where he conducted health services research for almost ten years. (Chassin, Tr. 5123-24). After RAND, Dr. Chassin co-founded a private sector firm, Value Health Sciences, in an attempt to take some of the research methods and turn them into commercial tools to measure quality. (Chassin, Tr. 5124).

Response to Finding No. 1220:

Complaint Counsel have no specific response.

1221. From 1992-1994, Dr. Chassin was appointed by the Governor of New York as the Commissioner of Health for New York State. (Chassin, Tr. 5124). As Commissioner, he was responsible for protecting the public health, regulating and licensing delivery systems, quality investigations and investigations of physician misconduct. (Chassin, Tr. 5124-25).

Response to Finding No. 1221:

Complaint Counsel have no specific response.

1222. Over a 20-year period, Dr. Chassin has published about 90 articles in peer-reviewed literature. (Chassin, Tr. 5125). Dr. Chassin regularly reviews manuscripts for journals such as the New England Journal of Medicine and the Journal of the American Medical Association. (Chassin, Tr. 5126). Dr. Chassin lectures widely and makes presentations in the area of healthcare quality both in and outside the United States. (Chassin, Tr. 5127).

Response to Finding No. 1222:

Complaint Counsel have no specific response.

1223. Dr. Chassin was admitted into the first class of the National Academies of Science. He received the Founder's Award from the American College of Medical Quality, the Laureate Award from the American College of Physicians and the Ellwood Award from the Foundation for Accountability. (Chassin, Tr. 5127).

Response to Finding No. 1223:

Complaint Counsel have no specific response.

1224. Dr. Chassin is an elected member of the IOM. He has worked with the IOM for more than 15 years on a variety of quality of care issues. (Chassin, Tr. 5128).

Response to Finding No. 1224:

Complaint Counsel have no specific response.

1225. Dr. Chassin was retained by ENH to evaluate the effects of the Merger between Evanston and HPH, to evaluate whether any improvements that might have occurred could have occurred absent the Merger, to evaluate what would happen in the event of divestiture and to review the reports and testimony of Dr. Patrick Romano. (Chassin, Tr. 5130-31).

Response to Finding No. 1225:

Dr. Chassin was retained to "evaluate the effect of the merger" (Chassin, Tr. 5449). But his work assignment was severely limited from the outset. He did not compare quality at HPH to quality at the peer group hospitals (where price increases were lower than at ENH). (Chassin, Tr. 5448-49). And rather than take a comprehensive look at quality at the ENH system (where prices rose across the board), he limited his analysis to Highland Park Hospital. (Chassin, Tr. 5446-49).

Nor did Dr. Chassin consider all of the services provided by Highland Park Hospital. By his own admission he did not have "a listing of every single service they

provided." (Chassin, Tr. 5450-5451). Dr. Chassin only focused on areas of alleged improvement and alleged quality problems rather than the overall effect of the merger. (Chassin, Tr. 5450-5452). For example, he did not consider two "centers of excellence," the fertility clinic and the breast center. (Chassin, Tr. 5455; *See also, e.g.*, CCFF 2033-2037).

D. Overview Of Changes In Healthcare Quality At HPH As A Result Of The Merger

1226. Dr. Chassin's multi-faceted review of the quality of care at HPH and ENH led to several unmistakable, and important, conclusions. First, based on the interviews, site visits, clinical data, and documents that Dr. Chassin reviewed, a methodology utilized by third-party organizations such as the Joint Commission, the State of New York and experts in the field of health care quality, he concluded that HPH had several significant quality problems that existed before the Merger in several different service areas. (Chassin, Tr. 5138, 5169-70, 5191; Romano, Tr. 3245-47).

Response to Finding No. 1226:

Respondent's characterization of Dr. Chassin's work as a "multi-faceted review of the quality of care at HPH and *ENH*" (emphasis added) mischaracterizes the record. Dr. Chassin's assignment was to evaluate the effect of the merger on the quality of care delivered at Highland Park Hospital, one of the three ENH hospitals. (Chassin, Tr. 5130, 5449). Respondent presented no evidence showing whether or not the merger affected the quality of patient care at Evanston Hospital and Glenbrook Hospital. (Chassin, Tr. 5446-47).

While Dr. Chassin may have reached a conclusion as to "quality problems" at the pre-merger HPH, that conclusion was far from "unmistakable." Several persons and entities who, unlike Dr. Chassin, were involved in HPH pre-merger, disagreed, including:

- Mark Newton, who testified that the quality of care at Highland Park Hospital up until the year 2000 was "very good, if not excellent." (Newton, Tr. 376).
- [redacted] } (RX 412 at ENHL PK 017794, *in camera*).
- The Evanston Hospital Board of Directors, which noted at a February 23, 1999 meeting that "Highland Park Hospital is a strong community hospital." (Neaman, Tr. 1228-29; CX 874 at 5).
- Former HPH CEO Ron. Spaeth, who testified that Highland Park Hospital "was a good community hospital" before the merger. (Spaeth, Tr. 2095. *See also, e.g.,* CCFF 2295-2352).

1227. ENH addressed those problems successfully during the course of, and after, the Merger. (Chassin, Tr. 5138). Specifically, pre-Merger HPH had significant issues, including: dysfunctional obstetrics and gynecology ("Ob/Gyn") services; ineffective quality assurance programs; dysfunctional nursing culture; weak quality improvement programs; and a series of deficiencies in the physical plant that affected patient safety. (Chassin, Tr. 5191-92).

<u>Response to Finding No. 1227:</u>

{[redacted]} (Romano, Tr. 3188-89, 3226-28, 3231-32, *in camera*) {[redacted]}; (Romano, Tr. 3232-34, *in camera*) {[redacted]}; (Romano, Tr. 3127 (discussing DX 7033 at 19, *in camera*), *in camera*)

{ }; (Romano, Tr. 3136-37, *in camera* (discussing DX 441 at 70, *in camera*)) { }. { } (Romano, Tr. 3136-37, *in camera* (discussing DX 441 at 70, *in camera*)).

{ } (Romano, Tr. 3139, 3152, *in camera*). { } (Romano, Tr. 3146 (discussing CX 6296 and 6297, *in camera*), *in camera*). Based on national trends of a "move towards a more proactive stance in quality improvement," one would have expected to see HPH, which already had a good program, follow the national trend of improvement, even without the merger. (Romano, Tr. 3004).

With regard to physical plant, ENH offered no testimony that any physical plant deficiencies ever affected patient care pre-merger. While ENH did make several capital investments post-merger, HPH was financially capable, without the merger, of continuing its practice of continually investing in upgrades in services and physical plant and equipment. (*See, e.g.,* Newton, Tr. 383-84; CCFF 302-367).

1228. Second, in addition to remedying deficiencies, ENH also made substantial improvements in quality in a number of other clinical service areas after the Merger. (Chassin, Tr. 5138). Most of those improvements required ENH to integrate its clinical and management systems and import or export its collaborative multidisciplinary culture to change the way clinical care was delivered at HPH. (Chassin, Tr. 5138-29). The vast majority of those improvements could not have been achieved without a Merger. (Chassin, Tr. 5139).

Response to Finding No. 1228:

See CCRFF 1229 for a discussion of some of the key problems with ENH's claims of quality improvements.

1229. The sixteen areas in which there were substantial quality improvements include: (1) Ob/Gyn; (2) quality assurance; (3) nursing; (4) quality improvement; (5) physical plant; (6) cardiac surgery; (7) interventional cardiology; (8) intensive care; (9) emergency care; (10) psychiatry; (11) laboratory medicine/pathology; (12) pharmacy; (13) radiology and radiation medicine; (14) electronic medical records (Epic); (15) oncology; and (16) the skills of the physician staff, as a result of the medical integration with ENH and its academic programs. (Chassin, Tr. 5140-41).

Response to Finding No. 1229:

{[redacted]} (Romano, Tr. 3054, *in camera*).

In other areas, there was "no discernable improvement." (Romano, Tr. 3005). And even in areas where there was some structural improvement, for the most part, there was no evidence that "patients actually benefitted in terms of improved outcomes . . ." (Romano, Tr. 3008).

Even in the case of the structural improvements that had taken place five years

after the merger, most could have been implemented without the merger. For example, ENH and HPH actually contracted to jointly develop a cardiac surgery facility in April 1999, before the parties had agreed to merge. (Rosengart, Tr. 4527-29, 4531; CX 2094). {[redacted] } (Romano, Tr. 3180, *in camera*).

Notably absent from ENH's list of 16 areas of improvement is heart attack care. In White Papers submitted to the Bureau of Competition ENH claimed an improvement in heart attack care, prompting Dr. Romano to study that area. (Romano, Tr. 3009-10). Dr. Romano found "evidence of deterioration in both process and outcome measures [administration of critical reperfusion therapies and mortality], which increases our confidence in the truth of those findings because of the linkage between process and outcome measures." (Romano, Tr. 3007). In the cited list of 16 areas, ENH no longer lists heart attack care as an area of improvement. ENH has "buried" a discussion of heart attack care in its discussion of quality improvement (RFF 1482-1511) but as discussed in CCRFF 1490, ENH ignores three key measures (mortality, administration, and timeliness of reperfussion) of heart attack care and as discussed throughout that section exaggerates the measures it does discuss (aspirin and beta blockers).

This contraction of the claimed areas of improvement follows a major expansion. Dr. Chassin characterized the White Paper submitted to the Bureau of Competition as full of "inconsistencies, incompletenesses and inaccuracies," (Chassin, Tr. 5461) and, in his expert report, added several areas of care to the list. (Romano, Tr. 3009-10). Following

this expansion, the list has now shrunk, with the removal of the critical area of heart attack care.

1230. Many of these improvements were brought about through a substantial infusion of capital to upgrade aging, defective and outmoded equipment and facilities, and to increase accessibility to expanded clinical services delivered in key areas. Specifically, ENH allocated more than $165 million in capital funds to be invested in the infrastructure and health care delivery systems at HPH. (Hillebrand, Tr. 1976-77; Neaman, Tr. 1250).

Response to Finding No. 1230:

While ENH made several capital improvements at HPH following the merger, the evidence showed that HPH would have been fully capable of making appropriate improvements after the merger. Prior to the merger, Highland Park Hospital routinely made capital improvements to upgrade and improve the facilities. (Newton, Tr. 383-84). Highland Park continued to plan to make capital improvements just prior to the merger. In 1999, Highland Park Hospital's long-range capital budget was projected to be over $100 million in investments, which would have been funded by operating earnings and cash and investments. (Newton, Tr. 431). Highland Park's financial health is described in more detail at CCFF 302-367.

1231. { } (Romano, Tr. 3332-33, 3390-93, 3327, 3308-09, 3317-18; Romano Tr. 3067-68, 3109-11, 3160-61, 3178-79, 3194-98, 3228-29, *in camera*).

Response to Finding No. 1231:

This finding is misleading. {

} (RFF 1231, *in camera*). {

} (Romano, Tr. 3093, *in camera*).

Respondent further cites Dr. Romano's testimony for the proposition that nursing "improved in some manner at HPH." (RFF 1231). {

} (Romano, Tr. 3136, *in camera*). {

} (Romano, Tr. 3232-34, *in camera*).

Dr. Romano's testimony in the other areas listed was similar. {

} (Romano, Tr. 3005, 3008; Romano, Tr. 3054, *in camera*).

1232. Finally, as discussed in more depth in Section X.A., any divestiture of HPH would erode a number of the quality improvements achieved through the Merger. (Chassin, Tr. 5139).

Response to Finding No. 1232:

To the extent any improvements have taken place – as one would expect from

national and Illinois trends and HPH's strong pre-merger organization – a divestiture would be unlikely to erode them. (*See, e.g.*, Romano, Tr. 2998, 3003-04 (discussing national trend); Newton, Tr. 377, 291-92 (discussing some pre-merger areas of strength)). {[redacted]} (Romano, Tr. 3075, *in camera*). {[redacted]} (Romano, Tr. 3075, *in camera*). (*See also* CCFF 2560 (noting that proposed order would require that HPH retain improvements)).

{[redacted]} (Romano, Tr. 3193, *in camera*). These conclusions are discussed in more detail in Section X.A. below.

a. The Merger Improved Quality Of Care In HPH's Ob/Gyn Department

i. Overview

1233. One of the quality problem areas that existed at HPH before the Merger was Ob/Gyn services. (Chassin, Tr. 5191; Spaeth, Tr. 2249). ENH's improvements to HPH's Department of Ob/Gyn – including new obstetric practice protocols, improved physician discipline, physician and nurse teamwork – are all quality improvements at HPH resulting from the Merger. (Chassin, Tr. 5208).

Response to Finding No. 1233:

This finding is misleading and incomplete. HPH had a strong Ob/Gyn department

before the merger. (*See* CCFF 2188-2201). Pre-merger HPH had a comprehensive obstetrics program, and also had relationships with a perinatal network and advanced pediatric coverage. (Newton, Tr. 389). One of Respondent's witnesses, Dr. Silver, Chairman of ENH's Ob/Gyn Department, stated that there were good physicians in pre-merger HPH's OB department. (Silver, Tr. 3831). ENH's outside consultant, Bain, described HPH's OB and neonatology facilities as "excellent" in a report dated January 6, 2000, just days after the merger was consummated. (CX 1998 at 11). The 1998 ACOG report commended HPH's changes in nursing leadership as making it more likely for HPH to establish a center of excellence for women's and children's services. (RX 324 at ENHL PK 029763). { } (CX 6265 at 25, *in camera*). { } (CX 6265 at 20, *in camera*). { } (RX 324 at ENH PK 029706, *in camera*).

{

} (Romano, Tr. 3188-89, 3224, 3226-28, 3230-32, *in camera*. *See also* CCFF 2089-2097). {

} (Romano, Tr. 3127 (discussing DX 7033 at 19, *in camera*), *in camera*; CCFF 2143).

1234. ENH improved these Ob/Gyn services afterthe Merger at a cost of more than $750,000, annually. (Silver, Tr. 3782-83, 3848-49).

Response to Finding No. 1234:

This finding is irrelevant. Complaint Counsel do not disagree the ENH's changes to HPH's OB department may cost $750,000 annually, but Respondent has never shown why HPH needed to merge, and merge with ENH in particular, to make such expenditures. (*See* CCFF 2440-2443 for information on HPH's financial wherewithal to make such expenditures).

1235. Evanston Hospital is the high-risk obstetric center within ENH, meaning that the vast majority of at-risk mothers mothers-to-be are cared for at Evanston Hospital. (Silver, Tr. 3771; Krasner, Tr. 3695-96). Obstetric services are provided at Evanston Hospital and HPH, while the gynecologic services are available at all three ENH hospital campuses. (Silver, Tr. 3770).

Response to Finding No. 1235:

Complaint Counsel do not disagree.

1236. HPH generally cares for less risky obstetric patients, both before and after the Merger. (Silver, Tr. 3773; Krasner, Tr. 3695-96). ENH obstetricians generally admit their higher risk obstetric patients directly to Evanston Hospital. (Silver, Tr. 3773-74).

Response to Finding No. 1236:

This finding is incomplete. Before the merger, HPH's fetal diagnostic center was staffed by perinatologists who specialized in high-risk pregnancies. (Krasner, Tr. 3750). These perinatologists were from Evanston Hospital, and they were still able to provide services at HPH without a merger. (Krasner, Tr. 3750).

1237. Obstetrical care was (and is) delivered at HPH through the Family Birthing Center. The HPH Family Birthing Center is a Labor, Delivery, Recovery and Postpartum ("LDRP") unit. (Krasner, Tr. 3695, 3698). In this unit, mothers in labor are admitted to a room and remain in that room throughout their hospital stay until discharged. (Krasner, Tr. 3698). Typically, LDRP is only used at community hospitals that have a volume of fewer than 2,500 deliveries per year. (Krasner, Tr. 3698).

Response to Finding No. 1237:

Complaint Counsel do not disagree but notes that the American College of Obstetricians and Gynecologists ("ACOG") praised HPH's 16 labor delivery recovery postpartum ("LDRP") rooms and their facilities prior to the merger. {[redacted]} (RX 324 at ENH PK 029706, *in camera*).

1238. Evanston Hospital does not have a LDRP area due to the fact that its delivery volume is far too large and the physical space required to operate as an LDRP unit on that scale is enormous. (Krasner, Tr. 3698). Moreover, because Evanston Hospital was and is a Level Three hospital, which cares for the most complex obstetrical cases, using LDRP would not be an effective utilization of staff, as care for complex cases requires highly specialized staffing not used in the LDRP setting. (Krasner, Tr. 3698-99). LDRP does not affect quality of care. It is a marketing tool that is simply a choice made by the hospital for a model of care. (Krasner, Tr. 3699). That said, it was not a good marketing tool at HPH. It did not increase birth volume at all at HPH. (Krasner, Tr. 3699-700).

Response to Finding No. 1238:

This finding is irrelevant as to the discussion regarding HPH's quality of care before and after the merger. For a discussion on that topic *see* CCRFF 1237. It should also be mentioned that the LDRP was an innovative program developed by HPH as a part of its "Centers of Excellence" for women's health. (Newton, Tr. 291-93). HPH's LDRP was one of the first concepts approved by the State of Illinois for single-room maternity care. (Newton, Tr. 293).

1239. Dr. Chassin's assessment of improvements in HPH's labor and delivery services since the Merger was based on interviews of physicians and nursing staff, as well as a 1998 contemporaneous review by an external body, ACOG, that codified and collated the problems that existed in the obstetrical service. (Chassin, Tr. 5192-93). In addition, Dr. Chassin interviewed several physicians, including Drs. Hirsch and Hansfield as well as nurses Heidi Krasner and Karen Mayer concerning the Ob/Gyn services at HPH pre-Merger. (Chassin, Tr. 5194). Dr. Chassin's review was also based upon his site visit to HPH. (Chassin, Tr. 5159).

Response to Finding No. 1239:

Respondent's finding is incomplete. (*See* CCRFF 1196-1211 for a detailed discussion on the flaws of Dr. Chassin's methodology, particularly his interviews). The ACOG report provides a good example of the flaws in Dr. Chassin's non-systematic, anecdotal application of his qualitative methodology. That report was the most frequently cited source in Dr. Chassin's report, with over 30 citations, but Dr. Chassin left out the numerous commendations of HPH's OB/Gyn department in that report, such as that HPH's efforts at improvement were likely to improve physician nurse relationships with time. (Chassin Tr. 5481-83).

Notably absent from this list of the materials relied upon by Dr. Chassin is the 1999 report by the Chicago Hospital Risk Pooling Program ("CHRPP"), { [redacted]

[redacted] }

(CX 6265, *in camera*). {

} (CX 6265 at 25, *in camera*).

1240. Dr. Chassin also relied on the trial testimony of Dr. Silver, who is the ENH Chairman of the Department of Ob/Gyn. (Chassin, Tr. 5161; Silver, Tr. 3767). Dr. Silver attended medical school at Northwestern University and completed his residency and fellowship training in Ob/Gyn and maternal fetal medicine, respectively. Dr. Silver is Board certified in Ob/Gyn with a subspecialty certification in maternal fetal medicine. (Silver, Tr. 3759-60). Dr. Silver began working at Evanston Hospital in 1987, and has been employed by Evanston Hospital and, subsequently, ENH, continually since that time. (Silver, Tr. 3760-61). He became the Director of the Division of Maternal/Fetal Medicine from 1994 through 2001, which involves the care and consultation of the high-risk obstetric patient, for example, women with multiple or complex pregnancies. (Silver, Tr. 3763-64).

<u>Response to Finding No. 1240:</u>

Complaint Counsel do not disagree but notes that almost all of the alleged improvements are attributed to the efforts of Dr. Silver, who took over as Chairman of OB/Gyn in the spring of 2001. (Silver, Tr. 3768, 3841). Thus, at the earliest, the improvements attributed to him took at least a year and a quarter. By comparison, it took HPH about the same time to implement the numerous improvements noted by CHRPP. (RX 324, *in camera* (}); CX 6265, *in camera* ({ })). There is every reason to expect that HPH's trend of improvement would have continued for the year and a quarter it took Dr. Silver to act, and beyond.

1241. As Department Chairman, Dr. Silver is responsible for the provision of clinical care in the department, the academic activities of the department and the conduct of the professional staff who work in the department. (Silver, Tr. 3768). In addition, he is responsible for quality improvement activities that relate to physicians in the department. (Silver, Tr. 3769).

Response to Finding No. 1241:

Complaint Counsel do not disagree.

1242. In addition, as Chairman of the ENH Ob/Gyn Department, Dr. Silver is directly responsible for the review of physician practice and reacting to and adjudicating any quality assurance issues that arise. Before the Merger, however, he would not have had any such responsibility for obstetricians at HPH. (Silver, Tr. 3776).

Response to Finding No. 1242:

Complaint Counsel do not disagree.

1243. Dr. Silver's time as Department Chairman is divided among clinical responsibilities, teaching activities and administrative duties. (Silver, Tr. 3762-63). He has a clinical practice, performs consultations, delivers babies and supervises residents and students in the delivery and care of patients. (Silver, Tr. 3764). Dr. Silver also is a member of the Ob/Gyn Department's executive committee, which is comprised of a mixture of employed and independent physicians. (Silver, Tr. 3764-65).

Response to Finding No. 1243:

Complaint Counsel do not disagree.

ii. Evanston Hospital Had A Relationship With HPH Before The Merger Through The Illinois Perinatal Network

1244. Although Dr. Silver did not work at HPH before the Merger, he became familiar with HPH's pre-Merger Ob/Gyn practice through Evanston Hospital's involvement in the Illinois Perinatal Network, through which regional hospitals are required to transfer their high-risk mothers to Evanston Hospital for care. (Silver, Tr. 3771, 3774; Krasner, Tr. 3696).

Response to Finding No. 1244:

Complaint Counsel do not disagree.

1245. The State of Illinois has organized the provision of perinatal care based upon a system of central hospitals with services that are matched to the acuity of the patients they serve, such that high-risk expectant mothers are cared for at hospitals with that capability, including Evanston Hospital. (Silver, Tr. 3772). Other Chicago hospitals designated by the state as high-risk centers include Loyola, University of Chicago, Northwestern Memorial and Advocate Lutheran General. (Krasner, Tr. 3696).

Response to Finding No. 1245:

Complaint Counsel do not disagree.

1246. Dr. Silver, as the Division Director of Maternal Fetal Medicine at Evanston Hospital before the Merger, got to know a majority of the practitioners at HPH through the Illinois Perinatal Network. (Silver, Tr. 3774). The relationship through the Illinois Perinatal Network, before the Merger, was extremely circumscribed, however, and it was limited to quarterly state-mandated meetings to review select obstetric cases, as well as limited consultation on high-risk cases referred to Evanston Hospital. (Silver, Tr. 3774-75). { } (RX 324 at ENHL PK 29714, *in camera*).

Response to Finding No. 1246:

This finding is incomplete. HPH took many of the recommendations and criticisms in the ACOG report cited, RX 324, and made improvements based on them. (*See* CCRFF 1233). { } (CX 6265 at 25, *in camera*).

1247. Before the Merger, therefore, Dr. Silver was not responsible for the conduct of the professional staff at HPH. He had no obligation through the Illinois Perinatal Network to oversee the quality assurance with respect to obstetricians in practice at HPH. (Silver, Tr. 3775-76).

Response to Finding No. 1247:

Complaint Counsel do not disagree.

1248. There was never any formal affiliation or joint venture between ENH or HPH before the Merger with respect to obstetrical services. (Krasner, Tr. 3697). The only relationship

between Evanston Hospital and HPH before the Merger was that Evanston Hospital was a state-designated Regional Perinatal Center for HPH. As a Level Two hospital, HPH sent its high-risk expectant mothers to Evanston Hospital, a Level Three hospital, for care. That relationship continues today. (Krasner, Tr. 3696-97).

Response to Finding No. 1248:

This finding is incomplete. Before the merger, HPH's fetal diagnostic center was staffed by Evanston Hospital perinatologists who specialized in high-risk pregnancies. (Krasner, Tr. 3750).

iii. HPH Ob/Gyn Department Had Serious Problems Before The Merger

1249. { } (Chassin, Tr. 5196; RX 324 at ENHL PK 29708-11, *in camera*; Silver, Tr. 3782).

Response to Finding No. 1249:

This finding is misleading and inaccurate. Before the merger, HPH had a "very good" comprehensive obstetrics program with fine physicians. (Newton, Tr. 389; Silver, Tr. 3831; CCRFF 1233; CCFF 2188-2201). HPH also had relationships with a perinatal network and advanced pediatric coverage. (Newton, Tr. 389). { }

(Newton, Tr. 511, *in camera*). Before the merger, physician-nurse relationships and collegiality improved remarkably. (CCRFF 1368-1384).

{

} (CCRFF 1246). {

} (Romano, Tr. 3154-55, *in camera*). (*See also* CCFF 2211-2226 and CCRFF 1420-1441 for more information on HPH's effective pre-merger quality assurance activities hospital-wide). HPH did discipline problematic physicians before the merger. (Newton, Tr. 381-383). {

} (Silver, Tr. 3929-39, *in camera*; RX 2034, *in camera*).

1250. The obstetrics area at HPH before the Merger stood out as a major problem area because a third of all admissions to HPH pre-Merger were admissions of women about to have a delivery. (Chassin, Tr. 5196). The pre-Merger problems with this service combined to create unsafe situations in a critical care area, labor and delivery, that placed mothers and babies at risk of adverse outcomes because they were unable to function in a highly effective way. (Chassin, Tr. 5197).

Response to Finding No. 1250:

Certainly OB/Gyn was a major part of HPH's pre-merger activities. Dr. Chassin's testimony that a series of problems created "unsafe situations" was both wrong (for reasons described in detail elsewhere) and premised upon a state of affairs existing in May 1998, a year and a half before the merger. Immediately after testifying to alleged "unsafe situations," Dr. Chassin was asked whether "any of these problems [were] identified in the ACOG report" and responded "yes, almost all of them were." (Chassin Tr. 5197). Respondent's counsel then placed the ACOG report on the screen and Dr. Chassin explained what he saw as a "very clear message throughout the ACOG report" regarding certain problems. (Chassin, Tr. 5197).

Throughout the findings both above and below, Complaint Counsel explains in detail the selective and biased picture painted by Respondent of the ACOG report. (*See, e.g.*, CCRFF 1239 (noting failure to cite ACOG finding that physician nurse relationships likely to improve with time); CCRFF 1237 (noting ACOG praise for Ob/Gyn physical facilities)). But regardless of whether Dr. Chassin accurately characterized it, that report was based on April and May 1998 site visits, and many of the concerns identified had been addressed by the CHRPP visit a year and a quarter later and would have continued to be addressed, absent the merger, during the time it took ENH to act. By Dr. Chassin's own admission, the "unsafe situations" he claims to have existed in fact existed only in 1998. {

}

(CX 6265 at 25, *in camera*. *See also* CCRFF 1233 and 1249 (information on the quality of pre-merger HPH's OB/Gyn services), CCFF 2089-2097 (information on the lack of significant improvement in outcomes relating to OB/Gyn services)).

1251. Because HPH's Ob/Gyn leadership and department were not able to resolve internally the problems with the hospital's Ob/Gyn care, HPH asked ACOG experts to come to HPH and help implement the appropriate standards of care. (Spaeth, Tr. 2114-15, 2249).

Response to Finding No. 1251:

This finding is misleading and incomplete. {

} (RFF 1439). {

} (CCRFF 1439).

{

} (RX 324 at ENHL PK 029763, *in camera*; RX 365 at ENHRS003456, *in camera*).

1252. {

} (Chassin, Tr. 5221; RX 324 at ENHL PK 29708, *in camera*; RX 208 at ENHL PK 17285). *See* Section VIII.D.1.c.ii.

Response to Finding No. 1252:

Complaint Counsel do not disagree.

1253. The ACOG report was a thoroughly done, top to bottom, east to west review by expert Ob/Gyns looking at every aspect of the Ob/Gyn services at HPH. (Chassin, Tr. 5193).

Response to Finding No. 1253:

Complaint Counsel agrees that the ACOG report was comprehensive without necessarily adopting the specific descriptive phrases used by Dr. Chassin.

1254. {
}
(Romano, Tr. 3390; RX 324, *in camera* at ENHL PK 29709).

Response to Finding No. 1254:

This finding is incomplete. (*See* CCRFF 1233, 1344 and 1423 (information on HPH's pre-merger improvements following the ACOG report). *See also* CCFF 2174-2176, 2198).

1255. The information in the ACOG report was corroborated by other sources of information. (Chassin, Tr. 5198; RX 208 at ENHL PK 17285). ACOG also identified problems with interpretation of fetal monitoring strips as an area for improvement. (RX 1770 at ENHL PK 55180).

Response to Finding No. 1255:

This finding is misleading and incomplete. One of the exhibits cited, RX 208, is a pre-merger HPH medical staff departmental report produced in 1997, that not only shows HPH's identification of problems in quality and adverse events, but the corrective action recommended to improve quality. For example, the report describes an incident of a physician being unresponsive to nurses' requests to examine a newborn, how that physician was dealt with by the Pediatric MCEC, and the resulting "minimization" of the recurrence of this problem; in addition, the document describes how the OB MCEC successfully got a physician to adopt new surgical criteria in order to reduce the excessive number of hysteroscopies and laparoscopies he was performing. (RX 208 at ENHL PK 17285).

After the ACOG report was issued, but before the merger, HPH increased nurse education relating to fetal monitoring in order to improve interpretation of fetal monitoring strips. (Krasner, Tr. 3754). { } (Neaman, Tr. 1399, *in camera*; Silver, Tr. 3932, *in camera*). { } (Silver, Tr. 3932, *in camera*).

This is not to say that Evanston Hospital's quality of care was substandard but rather to emphasize that it will always be possible in any major health care institution to

find a document discussing possibilities for improvement. Quality should be judged by a systematic review, and quality at some historical time can only be judged by comprehensive quantitative data, not anecdotes from documents. (*See, e.g.,* Romano Tr. 3021 (Chassin historical techniques unknown to health services research)).

(1) HPH Had Insufficient Obstetrician Coverage Before The Merger

1256. A lack of in-house nighttime coverage at HPH before the Merger clearly constituted inadequate labor and delivery service. (Silver, Tr. 3782). The lack of such coverage was an issue with regard to quality of care because physicians were not always able to respond to emergencies as quickly as necessary. HPH had to rely on a good Samaritan act by a physician who happened to be in the area if nighttime coverage were needed in the labor and delivery unit. (Krasner, Tr. 3737).

Response to Finding No. 1256:

This finding is misleading. Ms. Krasner did not testify that "HPH had to rely on a good Samaritan act by a physician who happened to be in the area if nighttime coverage were needed in the labor and delivery unit." (*See* Krasner, Tr. 3737). First, the addition of in-house nighttime coverage after the merger apparently did not significantly impact important outcomes related to OB/Gyn. (CCRFF 1233). It should also be noted that ENH operated the OB/Gyn department at HPH without in-house physician coverage from the time of the merger, January 1, 2000 to the summer of 2001. (Silver, Tr. 3841-42).

{ }

(Newton, Tr. 511, *in camera*; CCRFF 1249). {

} (Romano, Tr. 3132, *in camera*).

In addition, Respondent has not explained how in-house OB physician coverage is merger-specific. If HPH were a stand-alone entity, it could simply pay $150,000 per year to maintain an in-house OB physician coverage program. (Silver, Tr. 3864. *See also* CCFF 2440-2443 (discussing pre-merger HPH's financial wherewithal to make such expenditures)). There has been a trend toward in-house physician coverage in hospital OB/Gyn departments in the region around ENH. (Silver, Tr. 3841). After HPH implemented in-house physician coverage in its obstetrics department, other Lake County hospitals such as Lake Forest Hospital, Condell Medical Center, and Victory Memorial Hospital also implemented in-house physician coverage in their OB/Gyn departments. (Silver, Tr. 3791).

(2) HPH's Ob/Gyn Department Had Poor Nurse/Physician Teamwork Before The Merger

1257. { } (Chassin, Tr. 5197; RX 324 at ENHL PK 29773, *in camera*). { } (Chassin, Tr. 5197-98; RX 324 at ENHL PK 29773, *in camera*).

Response to Finding No. 1257:

This finding is incomplete and misleading. (*See* CCRFF 1368-1384 for a detailed discussion on the improvements to the relationship between the nurses and physicians enjoyed by HPH before the merger below; *see* CCRFF 1360-1367 for a detailed discussion on the training of nurses at pre-merger HPH to make them critical participants

in delivering high quality patient care). (*See also* RX 324 at ENHL PK 029769, *in camera* ({ }).

1258. { } (RX 324 at ENHL PK 29754, *in camera*). { } (RX 324 at ENHL PK 29754, *in camera*).

Response to Finding No. 1258:

This finding is incomplete and misleading. (*See* CCRFF 1368-1384 (regarding improvements HPH made to professional relationships between nurses and physicians in the Family Birthing Center before the merger)).

1259. { } (Chassin, Tr. 5198; RX 324 at ENHL PK 29773, *in camera*). This constituted evidence of dysfunction in Ob/Gyn services at HPH. (Chassin, Tr. 5198).

Response to Finding No. 1259:

This finding is incomplete and misleading. (*See* CCRFF 1368-1384 (regarding improvements HPH made to professional relationships between nurses and physicians before the merger, particularly after the issuance of the ACOG report in 1998)).

1260. The characteristics of the Ob/Gyn services at HPH pre-Merger directly related to patient safety because effective teamwork is essential on the labor and delivery unit to provide safe care to patients. (Chassin, Tr. 5200). When communication processes are poor, sharing of critical information often is delayed and, in labor and delivery minutes, this can mean the difference between a healthy baby and an unhealthy baby. (Chassin, Tr. 5200).

Response to Finding No. 1260:

Complaint Counsel do not disagree. (*But see* CCRFF 1368-1384 (regarding improvements HPH made to professional relationships and communication between nurses and physicians in the Family Birthing Center before the merger). *See also* CCFF 2089-2097 for more information on HPH's performance on key outcomes related to obstetrical and gynecological care both before and after the merger)).

1261. The Joint Commission has published information for hospitals detailing how communication problems were the major root cause of infant injury and, in hospitals experiencing these problems, bad organizational culture, ineffective communication and teamwork, as well as intimidating behavior of the kind described by Heidi Krasner were important causes of those adverse events. (Chassin, Tr. 5202). *See* Section VIII.D.1.b.ii, *supra*.

Response to Finding No. 1261:

This finding is incomplete and misleading. (*See* CCRFF 1368-1384 below for the improvements HPH made to professional relationships, communication and teamwork between nurses and physicians in the Family Birthing Center before the merger).

1262. { [redacted] } (RX 324 at ENHL PK 29710, *in camera*).

Response to Finding No. 1262:

This finding is incomplete and misleading. *See* CCRFF 1368-1384 (regarding improvements HPH made to professional relationships, communication and teamwork between nurses and physicians in the Family Birthing Center before the merger).

(3) HPH Lacked Effective Obstetrical Leadership Before The Merger

1263. Effective hospital leadership is essential to improving quality of care, use of clinical practice guidelines, teaching and coaching staff as well as supporting quality patient care, treatment and services. (RX 2006 at 251).

Response to Finding No. 1263:

Complaint Counsel do not disagree.

1264. The Joint Commission includes several dimensions of hospital leadership as part of the standards upon which hospitals are judged. (RX 2006 at 251-54). HPH lacked effective nurse and physician leadership in obstetrics pre-Merger under the Joint Commission Standards. (Chassin, Tr. 5202-03).

Response to Finding No. 1264:

This finding is misleading and inaccurate. First, it should be noted that pre-merger HPH performed exceptionally well on JCAHO surveys. (CX 96 at 1; Spaeth, Tr. 2149; Neaman, Tr. 1198; Newton, Tr. 388). { } (RX 324 at ENHL PK 029763, *in camera*). Even Respondent's own main witness on OB issues, Dr. Silver, stated that HPH had a good OB physicians before the merger. (Silver, Tr. 3831).

{ } (CX 6265 at 25, *in camera*). { } (CX 6265 at 21, *in camera*).

1265. The lack of an effective chain of command – an identified leadership structure – was one of the biggest problems that was not solved until Dr. Silver was able to partner with Krasner to create an effective chain of command. (Chassin, Tr. 5603). { } (Romano, Tr. 3157, *in camera*). The chain of command at HPH pre-Merger was rarely utilized and did not work. (Krasner, Tr. 3708-10). { } (Romano, Tr.

3157; RX 324 at ENHL PK 029769-70, *in camera*).

Response to Finding No. 1265:

This finding is misleading and inaccurate. {

} (CX 6265 at 18, 21, *in camera*; Romano, Tr. 3158, *in camera*; Krasner, Tr. 3876, *in camera*).

Dr. Silver's revisions to the chain of command policy were not formalized in a clinical protocol until June 1, 2002, about a year after he began his role at HPH. (RX 1416 at ENHL PK 054590).

1266. Dr. Chassin also reviewed a 1999 report of HPH's obstetrical service by the Chicago Risk Pooling Project ("CHRPP"), HPH's malpractice carrier. (Chassin, Tr. 5193). In contrast to the ACOG report, the CHRPP report was an attempt by the malpractice carrier to look at certain areas related to malpractice risk. (Chassin, Tr. 5193). There were no physicians on CHRPP's review team and it was a much more superficial review, and was carried out for very different purposes, than the ACOG review. (Chassin, Tr. 5194).

Response to Finding No. 1266:

This finding is misleading. {

} (CX 6265 at 4, *in camera*; Chassin, Tr. 5194). {

} (CX 6265 at 5, *in camera*).

1267. While the CHRPP report acknowledged the existence of a chain of command policy at HPH, it did not, however, comment on the degree to which HPH's chain of command policy was, in fact, implemented or working effectively such that it was actually protecting patients. (Chassin, Tr. 5602-03).

Response to Finding No. 1267:

This finding is misleading and inaccurate. {

} (CX 6265 at 21, *in camera*).

1268. The ACOG report contains statements addressing the professional relationships between nurses and physicians, indicating that they were "likely to improve." (RX 324 at ENHL PK 29773). However, following that statement is a recommendation for the exertion of effective leadership on the department chairman and the nurse manager to create a functioning obstetrics unit. (Chassin, Tr. 5588). But that did not happen until after the Merger with the emergence of Dr. Silver as an effective physician leader partner for the obstetrics nursing service. (Chassin, Tr. 5588).

Response to Finding No. 1268:

This finding is misleading and inaccurate. (*See* CCRFF 1264-1267 (discussing improvements in HPH leadership before the merger)). ENH again is touting a claimed leadership improvement that took place a year and a quarter after the merger when there is every indication that HPH had diligently implemented many of the ACOG recommendations during the year and a quarter between that report and the 1999 CHRPP report, and would have continued to improve.

(4) There Were Inappropriate Procedures In HPH's Ob/Gyn Department Before The Merger

1269. { }(Chassin, Tr. 5203; RX 324 at ENHL PK 29730-47, *in camera*).

Response to Finding No. 1269:

This finding is misleading and incomplete. Pre-merger HPH disciplined problematic physicians and aggressively dealt with adverse events. (CCRFF 1420-1427). For example, the OB quality review committee successfully made a physician to adopt new surgical criteria in order to reduce the excessive number of hysteroscopies and laparoscopies he was performing . (RX 208 at ENHL PK 17285). { } (Silver, Tr. 3929-30, *in camera*; RX 2034, *in camera*).

1270. In addition, there were problems with respect to two categories of inappropriate procedures in labor and delivery at HPH before the Merger. (Krasner, Tr. 3714-16). One was termination of pregnancy at inappropriately late stages of pregnancy, and the other concerned inductions of labor. (Silver, Tr. 3797-98; Krasner, Tr. 3714-16).

Response to Finding No. 1270:

This finding is incomplete and misleading. ENH allowed the termination of pregnancies at inappropriately late stages at HPH until 2001, more than a year after the merger. (Silver 3857-58).

1271. Before the Merger, physicians at HPH performed a procedure in the emergency room called a Dilation and Curettage, which is performed in response to a failing pregnancy. (Silver, Tr. 3793-94; Krasner, Tr. 3715-16). An emergency room is an inappropriate location to perform this procedure because there is inadequate pain relief from anesthesiologists, an inadequate level of patient privacy and a lack of maternal support services that would otherwise be available in the operating room setting. (Silver, Tr. 3793).

Response to Finding No. 1271:

This finding is incomplete and misleading. ENH allowed physicians to perform

D&Cs in the emergency room at HPH until 2001, more than a year after the merger.

(Silver, Tr. 3781, 3857-58).

1272. For the second trimester abortions, there was a concern that the physician involved in this practice was misleading the staff by giving incorrect gestational age of the fetus and performing abortions beyond the point at which one would condone a pregnancy termination. (Silver, Tr. 3798-99). The concern regarding this issue has many dimensions, not the least of which was that the procedure may not have been proper from a medical perspective. (Silver, Tr. 3799).

Response to Finding No. 1272:

This finding is incomplete and misleading. (*See* CCRFF 1270).

1273. The fact that physicians performed tubal ligations or inductions for no medical reason at HPH before the Merger was memorialized in the 1999 CHRPP report.'"'. In November 1999, CHRPP cited HPH for use of slang language in its medical records. (Krasner, Tr. 3717-19; RX 657 at ENHL PK 29821). Specifically, CHRPP cited HPH for the term "gestaphobia," which it found in HPH's medical records. (Krasner, Tr. 3717-19; RX 657 at ENHL PK 29821). "Gestaphobia" was a term that a physician at HPH used before the Merger as a reason to schedule an induction. (Krasner, Tr. 3719-20). The non-medical slang term was known to mean that the patient no longer wished to be pregnant. (Krasner, Tr. 3719-20). Inductions, however, should only be performed for a medically valid reason, and "gestaphobia" is not a proper justification. Moreover, it is unquestioned that slang terminology should not be found in patients' medical charts. Nevertheless, the term "gestaphobia" was frequently used in medical charts and the physician who used it was never disciplined at HPH before the Merger. Indeed, the problem continued up and until the Merger. (Krasner, Tr. 3719-20).

Response to Finding No. 1273:

Respondent cites no support for this finding's sentence that the CHRPP report memorialized that physicians performed tubal litigations or inductions for no medical reason at HPH before the merger. 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. The cite to the CHRPP report only critiques HPH physicians for using the term "gestaphobia" as a diagnosis on the patients' medical chart, but there is no reference

to a physician deciding to perform any operative procedure based on that diagnosis, or that diagnosis alone.

This citation also demonstrates the fallacies in Respondent's anecdotal methodology. Recognizing that the CHRPP report documents great strides made by HPH, in RFF 1266 above, Respondent seeks to discredit that report, claiming that it was not as thorough as the ACOG report. But in this finding Respondent relies upon the CHRPP report because it makes a negative statement about HPH. Complaint counsel respectfully submits that a thorough reading of both documents, RX 324 (ACOG) and CX 6265 (CHRPP) paints a picture of HPH making changes pre-merger at the same or an even faster rate than ENH made them post-merger.

1274. Another concern was the practice of inducing labor based on social or personal factors, rather than a medical indication. (Silver, Tr. 3800-01). This practice may have resulted in unnecessary complications. For example, babies who had to be admitted to special care nurseries or transferred because of respiratory distress might not have had to undergo these procedures if the induction were properly-timed or not performed altogether. (Silver, Tr. 3801).

Response to Finding No. 1274:

Complaint Counsel have no specific response.

1275. This practice of inappropriate inductions existed at HPH before the Merger, and Dr. Silver was aware of it because he was contacted about this issue at Evanston Hospital through his role in the Illinois Perinatal Network. (Silver, Tr. 3801). Before the Merger, however, Dr. Silver could not take any action against this practice because he had no authority over HPH physicians. (Silver, Tr. 3802).

Response to Finding No. 1275:

This finding is incomplete. It ignores evidence of other medical practices which Respondent now says were inappropriate that continued at HPH's OB department long after ENH took over management of the hospital. (CCRFF 1270-1272).

iv. ENH Improved Quality Of Care At HPH's Ob/Gyn Department After The Merger

(1) ENH Expanded Obstetrician Coverage At HPH After The Merger

1276. In 2001, shortly after becoming Chairman of the Ob/Gyn Department, Dr. Silver made a definitive response to the problem of inadequate nighttime obstetrician coverage in HPH's labor and delivery unit. (Silver, Tr. 3779).

Response to Finding No. 1276:

Complaint Counsel do not disagree. As Complaint Counsel stated earlier, ENH ran the HPH OB department without in-house OB coverage for almost a year and a half. (*See* CCRFF 1256). The change was made as there was a trend in favor of in-house coverage across the country. (*See* CCRFF 1256).

1277. ENH, under Dr. Silver's leadership, implemented in-house nighttime and weekend coverage by obstetricians at HPH. (Chassin, Tr. 5204). The expanded obstetrician coverage at HPH improved quality of Ob/Gyn care by having trained physicians in the hospital at night and on weekends to respond to emergencies on the labor and delivery floor. (Chassin, Tr. 5204). In-house obstetric coverage was a substantial improvement over the pre-Merger coverage by physicians at HPH who lived nearby. (Chassin, Tr. 5586).

Response to Finding No. 1277:

ENH made this change only after almost a year and a half, and it was consistent with national trends. (*See* CCRFF 1256 ({[redacted]}), *in camera*).

1278. ENH implemented the in-house coverage program at the HPH campus because it was an issue of safety for women. (Silver, Tr. 3785).

Response to Finding No. 1278:

This finding is misleading. (*See* CCRFF 1256 ({

}), *in camera*).

Significant adverse events occurred at ENH's Evanston Hospital despite its having in-house OB physician coverage. {

} (Neaman, Tr. 1399, *in camera*; Silver, Tr. 3932, *in camera*). {

} (Silver, Tr. 3932, *in camera*). {

} (Silver, Tr. 3933, *in camera*).

1279. To effectuate this change, Dr. Silver made presentations to the Department's members, to the Department Executive Committee and, eventually, to the ENH administration for its support. (Silver, Tr. 3782-83). Dr. Silver had to obtain financial support from the ENH administration to enact the obstetrician coverage, an investment of $150,000 annually. (Silver, Tr. 3783; RX 988). This money was to be used for an additional stipend to be paid to participating physicians. (Silver, Tr. 3779-80).

Response to Finding No. 1279:

Complaint Counsel do not disagree, but notes that HPH could have afforded this amount without the merger. (*See* CCFF 2440-2443).

1280. The in-house coverage is provided by a full-time attending obstetrician who is physically present at HPH from 10:00 p.m. to 7:00 a.m. during the weekdays. (Silver, Tr. 3783; Krasner, Tr. 3736-37). Some regional hospitals staff their in-house obstetrician coverage with residents in training, but ENH provides coverage with attendings, who have finished their medical training and who are more experienced than residents. (Silver, Tr. 3783-85). During the weekends, the obstetrician is in-house at HPH 24 hours a day. (Silver, Tr. 3784).

Response to Finding No. 1280:

Complaint Counsel do not disagree.

1281. The nighttime obstetrician is available to respond in the case of an emergency, to perform an emergency Caesarean section and to provide consultations to nursing staff for any patient emergency. (Silver, Tr. 3783). Evanston Hospital had a similar in-house physician coverage program before the Merger. (Silver, Tr. 3784-86). In addition, some of the obstetricians based at Evanston Hospital have taken part in the in-house coverage at the HPH campus since the Merger. (Silver, Tr. 3784).

Response to Finding No. 1281:

This finding is inaccurate. The in-house coverage program did not begin at HPH until the spring of 2001, so obstetricians based at Evanston could not have taken part in the in-house coverage at HPH since the merger. (*See* CCRFF 1256. *See also* CCRFF 1278 above and CCRFF 1439 (information on problems the OB department at Evanston Hospital despite having an established in-house OB physician coverage program)).

1282. The obstetrician coverage at Evanston Hospital is 24 hours per day, 7 days per week, in part, because there is an obligation to train the medical students and residents who take part in the teaching program there. (Silver, Tr. 3785-86). For as long as Dr. Silver has worked at Evanston Hospital it has had in-house obstetrician coverage. (Silver, Tr. 3786).

Response to Finding No. 1282:

Complaint Counsel have no specific response.

1283. The obstetrician coverage program at HPH after the Merger was not typical of a community hospital at the time that program was instituted. (Silver, Tr. 3786). Indeed, HPH was the first hospital in Lake County to have in-house obstetrician coverage. (Silver, Tr. 3791). ENH implemented in-house coverage at HPH before Lake Forest, Condell and Victory Memorial Hospitals established their respective in-house coverage programs. (Silver, Tr. 3791).

Response to Finding No. 1283:

Complaint Counsel do not disagree. In fact, this finding supports Complaint Counsel's view that the obstetrician coverage program was not merger specific: the hospitals mentioned did not merge with ENH or any other entity to create the program. (*See* CCRFF 1256).

1284. The in-house obstetrician program has been very successful and has benefited many patients. (Silver, Tr. 3787). ENH compiles statistics on the utilization of the in-house coverage program and, for calendar year 2004, approximately 200 women at both HPH and Evanston Hospital had urgent or emergent care provided by the in-house obstetrician. (Silver, Tr. 3787). In addition, those are not the only documented uses of in-house coverage, there are many other instances when the in-house obstetrician has been contacted by nursing personnel for consultations on fetal heart tracings and other things. (Silver, Tr. 3787).

Response to Finding No. 1284:

This finding is irrelevant. ENH provides no evidence that these women could not have been appropriately treated by an on call or other physician if there had not been in house coverage. { }

(CCRFF 1233, *in camera*). (*See also* CCRFF 1256 (in-house OB coverage program is not merger specific); CCRFF 1278, 1439 (Evanston's OB department experience problems despite having an established in-house OB physician coverage program)).

1285. In addition, the data that ENH has concerning this program is objective evidence of improvements in quality of care for Ob/Gyn patients at HPH. (Silver, Tr. 3866-67). The fact that, for 2004, 200 women whose deliveries would have gone unattended by an attending

physician were, in fact, attended – some at HPH, some at Evanston Hospital – is objective data that quality of care has been improved. (Silver, Tr. 3854).

Response to Finding 1285:

This finding is irrelevant. ENH provides no evidence that these women could not have been appropriately treated by an on call or other physician if in house coverage had not been implemented. { }

(CCRFF 1233, *in camera*). (*See also* CCRFF 1256 (in-house OB coverage program is not merger specific); CCRFF 1278, 1439 (Evanston's OB department experience problems despite having an established in-house OB physician coverage program)).

1286. Emergencies occur in the delivery process and having in-house physician coverage for that service is critical to patient care. The obstetrician coverage provided by physicians who live nearby HPH was inferior to the in-house coverage currently in place at that campus. (Silver, Tr. 3788).

Response to Finding No. 1286:

This finding is misleading and irrelevant. { } (CCRFF 1233 ({ }). *See also* CCRFF 1278 and CCRFF 1439 ({ }). *See also* CCRFF 1256 (information on why the in-house OB coverage

program is not merger specific).

1287. { } (Chassin, Tr. 5585; RX 657 at ENHL PK 29812, *in camera*; RX 324 at ENHL PK 29709, *in camera*). { } (RX 657 at ENHL PK 29812, *in camera*; Chassin, Tr. 5585; Romano, Tr. 3390).

Response to Finding No. 1287:

This finding is incomplete. { } **(RX 657 at ENHL PK 29812, *in camera*).** Regardless, CCRFF 1256 above explains why in-house OB coverage is not merger specific. (*See* CCRFF 1256 (HPH had the financial wherewithal to implement an in-house OB coverage program as a stand-alone entity.)).

1288. { } (Chassin, Tr. 5585; RX 658 at ENH RS 7482, *in camera*). These CHRPP bonuses are done by category so that it is possible to get a bonus or premium reduction in one category but not in others. (Chassin, Tr. 5585). { } (Chassin, Tr. 5585-86; RX 658 at ENH RS 7482).

Response to Finding No. 1288:

Complaint Counsel do not disagree.

1289. { } (RX 657 at ENHL PK 29809, *in camera*). { } (RX 657 at ENHL PK 29809, *in camera*). { } (RX 324 at ENHL PK 29709, *in camera*).

Response to Finding No. 1289:

{ } (RX 657 at ENHL PK 29812, *in camera*).

1290. The implementation of in-house coverage had a positive influence on the nursing staff at HPH by helping them to be more confident in providing patient care. In addition, nurses had the opportunity to consult with physicians who were present in the hospital during the nighttime. (Silver, Tr. 3790).

Response to Finding No. 1290:

This finding is incomplete and irrelevant. { } (CCRFF 1344-1348, *in camera*, 1360-1384). The in-house coverage is not merger specific. (CCRFF 1256).

1291. The lack of available nighttime obstetrical coverage increases the risk of adverse outcomes, which is, by definition, a quality problem. (Chassin, Tr. 5586).

Response to Finding No. 1291:

This finding is misleading and irrelevant. (*See* CCRFF 1233, 1256 ({ }), *in camera*).

1292. Dr. Romano concedes that the expansion of obstetrician coverage to include in-house coverage during the nighttime would be a structural quality improvement. (Romano, Tr. 3389-90). Dr. Romano could reach the conclusion that nighttime obstetrician coverage was a

structural quality improvement even in the absence of outcome data. (Romano, Tr. 3390).

Response to Finding No. 1292:

This finding is misleading and irrelevant. (*See* CCRFF 1233, 1256 ({

}), *in camera*).

(2) ENH Improved HPH's Nurse/Physician Teamwork After The Merger

1293. After the Merger, and through ENH's addition of full-time clinical department chairman, ENH corrected the problems of inadequate physician leadership in HPH's labor and delivery unit and, as a result, improved the nurse and physician teamwork. (Chassin, Tr. 5204-05). *See* Section VIII.D.1.a.iv, *infra*.

Response to Finding No. 1293:

This finding is misleading and irrelevant. HPH's selection of its clinical department chairmen from among the private practitioners as opposed to a full-time chair, did not present a problem for assuring quality of care. (Newton, Tr. 378-80). {

} (Romano, Tr. 3133, *in camera*).

1294. An important improvement to HPH's Ob/Gyn was the creation of multidisciplinary clinical care, which physicians, nurses and all of the participants in the obstetric service worked together as a team to reduce the risks of the adverse outcomes that existed before the Merger. (Chassin, Tr. 5206). Reducing the risk of an adverse outcome is a quality improvement. (Chassin, Tr. 5206).

Response to Finding No. 1294:

This finding is misleading. { } (CX 6265 at 25, *in camera*).

(3) ENH Improved HPH's Ob/Gyn Leadership And Quality Assurance Program After The Merger

1295. Dr. Silver, as Chairman of the Ob/Gyn Department, is responsible for quality assurance activities, in addition to being responsible for the quality of care provided by physicians within the department. (Silver, Tr. 3792). Dr. Silver's quality of care responsibilities include looking at trends and patterns within the department for specific outcomes, both in obstetrics and gynecology. (Silver, Tr. 3821). In addition, he speaks regularly with members of the department so that they feel at ease discussing quality of care issues. (Silver, Tr. 3821). *See* Section VIII.D.1.a.iv., *supra*.

Response to Finding No. 1295:

Complaint Counsel have no specific response.

1296. Before the Merger, the department of obstetrics at HPH was particularly weak in disciplining problem physicians. (Chassin, Tr. 5207). ENH remedied this deficiency by enacting effective physician discipline to address repeated patterns of behavior that could really only be dealt with by discipline, and that was corrected after the Merger by Dr. Silver. (Chassin, Tr. 5207).

Response to Finding No. 1296:

This finding is misleading and inaccurate. (*See* CCRFF 1269 ({ }), *in camera*. *See also* CCRFF 1255).

1297. { } (Romano, Tr. 3393-94; 3450, *in camera*). { } (Romano, Tr. 3450, *in camera*).

Response to Finding No. 1297:

This finding is misleading and irrelevant. (*See* CCRFF 1255, 1296 (pre-merger HPH disciplined problematic physicians and aggressively dealt with adverse events)).

1298. Dr. Silver became Department Chairman in 2001, following an extensive national search, lasting nine months. (Silver, Tr. 3842-43). Thus, there was a short transitional period in Ob/Gyn after the Merger and before Dr. Silver's appointment. (Silver, Tr. 3842-43). However, directly after becoming Chairman, Dr. Silver implemented several improvements, including the change in expanded obstetrician coverage. (Silver, Tr. 3842).

Response to Finding No. 1298:

Complaint Counsel do not disagree as to the date of Dr. Silver's appointment, which was about a year and a quarter after the merger. None of the changes Dr. Silver implemented were merger-specific. (CCFF 2417-2425; CCRFF 1256).

1299. It was not until after the Merger when Krasner had the partnership with a strong physician leader like Dr. Silver and a strong administration that the full conversion to an effective nursing culture and effective teamwork could be created in Ob/Gyn. (Chassin, Tr. 5207). { } (Romano, Tr. 3450-51, *in camera*). { } (Romano, Tr. 3451, *in camera*).

Response to Finding No. 1299:

This finding is misleading. Mr. Newton, a former Senior Vice President at HPH, confirmed that there was no negative impact on quality due to HPH not having full-time clinical department chairs. (Newton, Tr. 279, 379-80). Also, after the merger, HPH physicians still complained about ineffective leadership under ENH management. (CX 405 at 2). In addition, Respondent has not show how installing full-time clinical

department chairs is merger specific. {

} (Romano Tr. 3132-33, 3451, *in camera*).

1300. By installing a full-time department chair, ENH corrected the problem of lack of physician leadership in obstetrics that had plagued HPH before the Merger, enabling much more evidence-based protocols to be created, a much better system of physician discipline, and Ms. Krasner then had a physician partner to work with to really create full teamwork between nurses and physicians. (Chassin, Tr. 5204-05; RX 1416 at ENHL PK 54591).

Response to Finding No. 1300:

This finding is misleading. (*See* CCRFF 1299 (ENH changes to the leadership at HPH were not merger specific, and did not ride HPH of any leadership problems). *See also* CCRFF 1368-1384 ({

}), *in camera*).

(4) ENH Addressed The Inappropriate Procedures In Ob/Gyn At HPH After The Merger

1301. After the Merger, ENH made a policy and a procedural change to require that: (1) the inappropriate Ob/Gyn procedures described above be performed in an outpatient operating room (as opposed to the emergency room); and (2) HPH make available perinatal support staff, consisting of psychologists and work workers to assist with such procedures, that was not available to patients before the Merger. (Silver, Tr. 3795).

Response to Finding No. 1301:

This finding is irrelevant and misleading. These changes are not merger specific. For example, if HPH were a stand-alone entity, it could also continue the policy of prohibiting dilation and cutterage (D&C) in the emergency room. (Silver, Tr. 3864).

D&C was still being performed in HPH's emergency room until 2001, the merger was in January 2000. (Silver, Tr. 3781, 3857-58). In addition, the perinatal support staff wasn't available at HPH until some time in 2001, when new policy prohibited D&Cs from being performed in the emergency room. (Silver, Tr. 3795-96).

1302. Soon after becoming the Ob/Gyn Department Chairman, Dr. Silver, in consultation with other HPH physicians, put an end to the practice of physicians using the emergency room at HPH to perform Dilation and Curettage. (Silver, Tr. 3778, 3781). The physicians at HPH appreciated this change and, in addition, patients benefited from this change as they were no longer subject to having this procedure performed in an inappropriate location with inappropriate support. (Silver, Tr. 3794).

Response to Finding No. 1302:

This finding is irrelevant. *See* CCRFF 1301 (discussing the fact that, due to timing and merger specificity, Findings such as this are not relevant).

1303. Similarly, after the Merger, Dr. Silver, as Department Chairman, dealt directly with physicians performing inappropriate inductions of labor and stopped that practice from occurring. (Silver, Tr. 3802, 3808). Dr. Silver relied on one of the committees in his department, the obstetrics practice committee, to develop a protocol for labor induction that would be acceptable to the department based on evidence in the literature and best practice. (Silver, Tr. 3802; RX 1416 at ENHL PK 54592-94). Further, the protocol is clear that inductions performed for purely social reasons or convenience are, as a rule, not appropriate at any gestational age. (RX 1416 at ENHL PK 54592).

Response to Finding No. 1303:

This finding is irrelevant. In terms of timing, the OB protocols were not even "published for the department," much less fully implemented, until between September 2001 to May 2004. (Silver, Tr. 3845). The finding does not offer any evidence on the

merger-specificity of this particular protocol, or any of the OB protocols. ENH did not need to invest in any equipment or construction of new facilities to publish clinical protocols for HPH physicians. (Silver, Tr. 3847-48). The induction of labor protocol was developed because it was an important subject nationwide, and it was based on evidence "in literature and best practice." (Silver, Tr. 3802, 3807).

It should also be noted that the pathways or protocols may not have that much of a positive impact on quality, due to a heterogenous patient mix. For example, complicating factors in patients may delay the various steps of a delivery pathway from being implemented. (Silver, Tr. 3839).

(5) ENH Implemented Obstetric Committee Practice Protocols At HPH After The Merger

1304. Dr. Silver created the obstetrics practice committee, which had broad membership to foster collegiality. This committee included nurses, certified nurse-midwives and physicians from all campuses. (Silver, Tr. 3802-03). Broad membership was important so that everyone in the department had a sense of ownership about the protocols and, further, so that it was not just a small hierarchy making decisions about critical aspects of patient care. (Silver, Tr. 3802-03). The protocols are designed to address a condition or subject area and develop a consensus on that subject based on the best randomized clinical trials in the literature, the standards from societies like ACOG and input from local practitioners. (Silver, Tr. 3804; RX 1416 at ENHL PK 54594).

Response to Finding No. 1304:

The finding is irrelevant. (*See* CCRFF 1303 (including information on the timing, impact, and merger specificity of OB protocol implementation)). {[redacted]} (CX 6265 at 25, *in camera*).

1305. Before the Merger, HPH may have had separate nurse and physician protocols,

but they were not as comprehensive as those created by ENH's obstetric practice committee. For example, the pre-Merger HPH protocols would not have included as exhaustive a review of the literature, and they would not have been created with input from as broad a group of participants. (Silver, Tr. 3804-05). The post-Merger protocols were designed so that everyone who was involved in a patient's care had a say in the nature of the obstetric practice at the ENH campuses. (Silver, Tr. 3805).

Response to Finding No. 1305:

This finding is misleading and irrelevant. (*See* CCRFF 1304 above for more information on nursing involvement in pre-merger HPH quality assurance, also *see* CCRFF 1368-1384 below for a discussion on collaboration between nurses and physicians both before and after the merger). { } (Romano, Tr. 3168). { } (CCFF 2242-2244, *in camera*).

1306. ENH also developed a protocol on chain of command that was unique to the department of Ob/Gyn. (Silver, Tr. 3809; RX 1416 at ENHL PK 54612-14). This was done in response to nursing concerns as well as some physicians' concerns that the chain of command was not clear-cut for some of the services provided. (Silver, Tr. 3810).

Response to Finding No. 1306:

This finding is misleading and irrelevant. (*See* CCRFF 1265 and 1267 for more information HPH's chain of command in the OB department before the merger; *see also*, CCRFF 1303 for more information on merger specificity of the OB protocols). ENH's chain of command protocol was not published until 2002. (RX 1416 at ENHL PK

054590).

1307. This protocol was developed to ensure that the input of all personnel received appropriate attention while respecting the authority of the responsible care providers. (RX 1416 at ENHL PK 54612). Dr. Silver could recall at least one instance when the chain of command was utilized and a nurse at the HPH campus contacted him concerning an inappropriate induction of labor. (Silver, Tr. 3810). Dr. Silver determined that the care was inappropriate, contacted the physician directly to ensure that he changed his plan and provided support to the nurse. (Silver, Tr. 3810-11).

Response to Finding No. 1307:

This finding is irrelevant. (*See* CCRFF 1306).

1308. The research and drafting involved in each obstetric committee practice protocol is labor-intensive, and each such protocol takes a significant amount of time to prepare. (Silver, Tr. 3865-66).

Response to Finding No. 1308:

This finding is irrelevant. (*See* CCRFF 1303 for information on the merger specificity, as well as the actual impact on quality, of the OB protocols).

1309. To address nurse/physician collaboration, ENH, under Dr. Silver's leadership as chairman of the ENH Department of Ob/Gyn, implemented a series of obstetric committee practice protocols, including a chain of command policy that was designed, in part, to facilitate communication about "clinically significant observations" among nurses and physicians. (Silver, Tr. 3809-10; RX 1416 at ENHL PK 54612-14). { } (Chassin, Tr. 5207; RX 324 at ENHL PK 29709, *in camera*). Before the Merger, HPH's obstetric protocols were outdated and did not reflect the best current thinking about obstetrical care. (Chassin, Tr. 5208).

Response to Finding No. 1309:

This finding is misleading. (*See* CCRFF 1368-1384 for a discussion on collaboration between nurses and physicians both before and after the merger). Furthermore, even before the merger, HPH was improving upon its care maps and creating new ones. (CX 95 at 3). {

} (Romano, Tr. 3168-69, *in camera*; *see also* O'Brien, Tr. 3560-62. *See also* CCRFF 1305; CCRFF 1462-1463 (discussing implementation of ENH critical pathways and comparison with pre-merger HPH care maps)).

1310. In addition, HPH's obstetric protocols pre-Merger permitted procedures to be done in unsafe, inappropriate locations, such as abortions in the ED. (Chassin, Tr. 5208). The programs did not uncover the pattern of inappropriate gynecologic surgery pre-Merger that was effectively dealt with after the Merger. (Chassin, Tr. 5208). ENH's evidence-based, multidisciplinary protocols helped get rid of that problem after the Merger and standardize care in a very high quality way. (Chassin, Tr. 5208; RX 1416).

Response to Finding No. 1310:

This finding is misleading. (*See* CCRFF 1303, 1305, and 1309 for more information on why this finding is misleading in its discussion of protocols; *see also* CCRFF 1269-1272 (describing continuation of some inappropriate practices in HPH's OB department long after ENH took over management of HPH)).

(6) ENH Introduced The Preoperative Gynecologic Surgical Review Program At HPH After The Merger

1311. { } (Silver, Tr. 3889, *in camera*). { } (Silver, Tr. 3889, *in camera*). { } (Silver, Tr. 3889, *in camera*).

Response to Finding 1311:

This finding is misleading. There is no literature supporting the link between ENH's preoperative review program and patient outcomes. It is also not possible to

compare ENH's preoperative program to any national benchmarks. (Silver, Tr. 3852). Also, Respondent has not explained how this program is merger specific. It was not necessary for ENH to construct buildings or invest in equipment to add the program to HPH. (Silver, Tr. 3847-48). If the merger had not occurred, ENH could still have implemented the preoperative review program at Evanston Hospital and Glenbrook Hospital. (Silver, Tr. 3834). It was not created due to any deficiencies at HPH. (Silver, Tr. 3833-34; *see also* CCFF 2417-2425 (discussing lack of merger-specificity of Respondent's quality claims relating to obstetrics)).

1312. { } (RX 1768 at ENHL RSL 3, *in camera*). { } (Silver, Tr. 3889, *in camera*; RX 1768 at ENHL RSL 4, *in camera*).

Response to Finding No. 1312:

Respondent's finding is incomplete and misleading. There is no literature supporting a link between the program and patient outcomes, and Respondent has not shown the program is merger-specific. (*See* CCRFF 1311).

1313. { } (Silver, Tr. 3890, *in camera*). { } (Silver, Tr. 3891, *in camera*). { } (Silver, Tr. 3895, *in camera*).

Response to Finding No. 1313:

Respondent's finding is incomplete and misleading. There is no literature

supporting a link between the program and patient outcomes, and Respondent has not shown the program is merger-specific. (*See* CCRFF 1311).

1314. { } (Silver, Tr. 3889-90, *in camera*). { } (Silver, Tr. 3890, in *camera*).

Response to Finding No. 1314:

This finding is misleading. (*See* CCRFF 1311 (explaining why Respondent's characterization of { } is misleading)).

1315. { } (Silver, Tr. 3893, *in camera*; RX 1768 at ENHL RSL 8, *in camera*). { } (Silver, Tr. 3835-36; RX 1768 at ENHL RSL 8, *in camera*). { } (Silver, Tr. 3895, *in camera*).

Response to Finding No. 1315:

Respondent's finding is incomplete and misleading. There is no literature supporting a link between the program and patient outcomes, and Respondent has not shown the program is merger-specific. (*See* CCRFF 1311).

1316. { } (Silver, Tr. 3894-95, *in camera*; RX 1768 at ENHL RSL 4, *in camera*). { } (Silver, Tr. 3895, *in camera*).

Response to Finding No. 1316:

Respondent's finding is incomplete and misleading. There is no literature supporting a link between the program and patient outcomes, and Respondent has not shown the program is merger-specific. (*See* CCRFF 1311).

1317. { }. (Silver, Tr. 3836-37; Silver, Tr. 3298, *in camera*). { } (Silver, Tr. 3898, 3917-18, *in camera*; RX 2033, *in camera*; RX 2034, *in camera*). There were no other examples in the Department of Ob/Gyn in which gynecologic surgery was done inappropriately. (Silver, Tr. 3837). *See* Section VIII.D.1.c.iii., *supra*.

Response to Finding No. 1317:

This finding is incomplete. { } (Silver, Tr. 3929, *in camera*; RX 2034, *in camera*). In addition, the finding does not refer to other inappropriate practices that occurred at HPH even after ENH took over management. (CCRFF 1269-1272).

1318. The preoperative surgical review program unambiguously improves quality of patient care. (Silver, Tr. 3852). { }. (RX 1768 at ENHL RSL 16, *in camera*). { } (Silver, Tr. 3923-24, *in camera*).

Response to Finding No. 1318:

Respondent's finding is incomplete and misleading. There is no literature supporting a link between the program and patient outcomes, and Respondent has not shown the program is merger-specific. (*See* CCRFF 1311).

1319. Dr. Silver's addition of the preoperative gynecologic surgical review program is a major quality improvement because it prevents inappropriate surgery or premature surgery before a complete workup has been provided and that was an important improvement after the Merger. (Chassin, Tr. 5206; RX 1768; RX 1769 at ENHL PK 5876).

Response to Finding No. 1319

This finding is misleading. { [redacted] } (RX 1769 at ENHL PK 5876, *in camera*).

1320. Dr. Romano agreed that the preoperative gynecologic review program instituted at HPH after the Merger would be a quality improvement if there had been evidence of such a problem before the Merger. (Romano, Tr. 3392). Dr. Romano, however, found documentary evidence that inappropriate gynecologic surgeries had been performed at HPH before the Merger. (Romano, Tr. 3392-93). Further, Dr. Romano agrees that ENH took steps to put an end to those inappropriate gynecologic surgeries at HPH after the Merger. (Romano, Tr. 3393).

Response to Finding No. 1320:

This finding is incomplete and misleading. (*See* CCRFF 1311 for a discussion on the merger specificity of the preoperative gynecological review program and its actual use and impact on quality at HPH). (*See also* CCRFF 1269-1272 for information on inappropriate surgeries and procedures at HPH post-merger).

v. Patient Outcomes In ENH's Ob/Gyn Services Are Consistent With, Or Better Than, National Benchmarks

1321. { [redacted] } (Silver, Tr. 3825; Chassin, Tr. 5419, *in camera*). { [redacted] } (Silver, Tr. 3821-22; Chassin, Tr. 5413, *in camera*).

Response to Finding No. 1321

This finding is incomplete and misleading. (*See* CCRFF 1233 and CCFF 2089-2097 for a more detailed discussion of patient outcomes relating to OB/Gyn services).

{ } (Romano, Tr. 3230-32, *in camera*). { } (Romano, Tr. 3187-88 (discussing DX 7037 at 3, *in camera*), *in camera*).

1322. There are three ways in which babies are delivered: (1) a spontaneous vaginal delivery; (2) a Cesarean delivery; and (3) an operative vaginal delivery, all of which are a kind of patient outcome. (Silver, Tr. 3811-12).

Response to Finding No. 1322:

This finding is misleading and incorrect. The methods of delivery would be more accurately described as a procedure or process, rather than an outcome, measure. (Romano, Tr. 2986-87; Silver, Tr. 3812). Dr. Silver, Respondent's own fact witness on OB issues, did not describe them as patient outcomes in the cited testimony. (Silver, Tr. 3811-12).

1323. { } (Chassin, Tr. 5416, *in camera*; Silver, Tr. 3814-15). { } (Chassin, Tr. 5416-17, *in camera*; Silver, Tr. 3812-14; RX 1416 at ENHL PK 54656).

Response to Finding No. 1323:

Complaint Counsel do not disagree.

1324. ENH implemented an operative vaginal delivery protocol, which was important to

help obstetricians at ENH select the appropriate delivery method – forceps or vacuum when performing an operative vaginal delivery. (Silver, Tr. 3815; RX 1416 at ENHL PK 54656-60).

Response to Finding No. 1324:

This finding is irrelevant. (*See* CCRFF 1303 (the OB protocols are not merger specific). *See also* CCRFF 1321 ({ }), *in camera*).

1325. Having a successful vaginal delivery is more common with forceps than with vacuum methods and, thus, the associated Cesarean section rate would be lower. (Silver, Tr. 3814). A lower Cesarean section rate benefits patients at ENH because it decreases their risk of complications and of maternal death. (Silver, Tr. 3824).

Response to Finding No. 1325:

This finding is incomplete and misleading. { } (Romano, Tr. 3187-88, *in camera*; Silver, Tr. 3814). { } (Romano, Tr. 3187-88, *in camera*; *see also* CCRFF 1321 ({ }), *in camera*).

1326. { } (Chassin, Tr. 5418, *in camera*; Silver, Tr. 3823-24 (*discussing* DX 7037-001). Both before and after the Merger, ENH has been very consistent in its performance on the Cesarean section rate, having a rate that is lower than the national trend throughout the pre- and post-Merger period. (Silver, Tr. 3824 (*discussing* DX 7037-001)).

Response to Finding No. 1326

Complaint Counsel do not disagree. (*But see* CCRFF 1321 and CCFF 2089-2097

({███

███████████████████}, *in camera*).

1327. {██
██
███
█████} (Chassin, Tr. 5418, *in camera*). {████████████████████████
██}
(Silver, Tr. 3825; Chassin, Tr. 5419, *in camera (discussing* DX 7037-002)). Physicians in the department are appropriately very selective of which patients undergo an operative vaginal delivery. (Silver, Tr. 3826).

Response to Finding No. 1327:

Complaint Counsel have no specific response. (*But see* CCRFF 1321 and CCFF

2089-2097 ({██████████████████████████████████████

██████████████████████████}, *in camera*).

1328. {██
███} (Chassin, Tr. 5419, *in camera*). {███
██
█████████████████████████████████} (Chassin, Tr. 5419, *in camera*; Silver, Tr. 3825-26). {███
██
████████████████████████████} (Chassin, Tr. 5420, *in camera*).

Response to Finding No. 1328:

This finding is incomplete and misleading. (*See* CCRFF 1321 and CCFF 2089-2097 for a more detailed discussion on HPH and ENH's performance on outcome and process measures, and how there was no improvement in key outcomes and processes of care after the merger).

1329. {██

} (RX 1769 at ENHL PK 5873, *in camera*). {

}. (RX 1769 at ENHL PK 5873, *in camera*). {

}
(RX 1769 at ENHL PK 5873, *in camera*).

Response to Finding No. 1329:

This finding is incomplete and misleading. (*See* CCRFF 1321 and CCFF 2089-2097 for a more detailed discussion on HPH and ENH's performance on outcome and process measures, and how there was no improvement in key outcomes and processes of care after the merger). {

} (RX 1769 at ENHL PK 5873, *in camera*). {

} (RX 1769 at ENHL PK 5873, *in camera*).

1330. {

} (Romano, Tr. 3228-29, *in camera*). {

} (Romano, Tr. 3228, *in camera*).

Response to Finding No. 1330:

This finding is incomplete and misleading. {

}

(Romano, Tr. 3227-28, *in camera*. *See also* CCFF 2089-2097).

1331. {

}

(Romano, Tr. 3189, *in camera* (DX 7037 at 6-9)).

Response to Finding No. 1331:

This finding is incomplete and misleading. {

} (Romano, Tr. 3188-89, *in camera*).

1332. Dr. Romano also found that perineal tear rates declined at ENH from the pre- and post-Merger periods significantly more than at ENH peer group hospitals. (Romano, Tr. 3397).

Response to Finding No. 1332:

Complaint Counsel do not disagree.

1333. {

} (Chassin, Tr. 5419-20, *in camera*). {

} (Chassin, Tr. 5420-21, *in camera*). {

} (Chassin, Tr. 5420-21, *in camera*).

Response to Finding No. 1333:

This finding is misleading. (*See* CCFF 2122-2132 for a detailed discussion on why outcome measures are important in assessing changes in quality). (*See also* CCRFF 2089-2097 for more information on HPH's performance on important outcome

measures). Furthermore, the changes instituted in HPH's OB department could have been implemented without the merger. (*See* CCFF 2417-2425).

vi. Dr. Romano's Undue Reliance On Administrative Data To Evaluate HPH's Obstetrical Service Is Invalid

1334. The indicators that Dr. Romano used to analyze obstetrical services at the ENH hospitals were not comprehensive. (Romano, Tr. 3395). Dr. Romano conceded that the indicators for birth trauma, third and fourth degree perineal lacerations, neonatal mortality and vaginal birth after a Cesarean section ("VBAC") rates are not comprehensive and overlook many important processes of care. (Romano, Tr. 3396).

Response to Finding No. 1334:

This finding is misleading and incomplete. It is more informative to rely on administrative data from the Illinois Department of Public Health ("IDPH") than strictly on interview data, a major source of Respondent's expert's analysis. (Romano, Tr. 3411). Furthermore, the indicators Dr. Romano used are considered to be valid indicators of quality by experts in the field with a strong connection to processes of care. (CCFF 2105-2108).

1335. { } (Chassin, Tr. 5414, *in camera*). { } (Chassin, Tr. 5414-15, *in camera (discussing* DX 7034A at 9-10)).

Response to Finding No. 1335:

This finding is incomplete. (*See* CCRFF 1334 for more information on the appropriateness of administrative data). {

} (Romano, Tr. 6317-18, *in camera*}.

1336. { } (Chassin, Tr. 5416, *in camera*). { } (Chassin, Tr. 5417, *in camera*).

Response to Finding No. 1336:

This finding is irrelevant. (*See* CCRFF 1334 and 1335 for information on the appropriateness of the quality indicators Dr. Romano used in his analysis).

1337. Dr. Chassin did not examine neonatal mortality because he did not find risk-adjusted data that would have allowed him to track quality in a meaningful way pre- and post-Merger. (Chassin, Tr. 5596). To obtain meaningful data would have required a large-scale chart review because administrative data by themselves do not allow one to make such judgments. (Chassin, Tr. 5596-97). Even if risk-adjusted data on neonatal mortality were available, that outcome would be very rare in a low-risk obstetric service like HPH's. Accordingly, it would be questionable whether one could make meaningful comparisons on this point pre- and post-Merger. (Chassin, Tr. 5597).

Response to Finding No. 1337:

This finding is misleading and irrelevant. Dr. Chassin indicated himself that neonatal mortality is a very important quality measure. (Chassin, Tr. 5465-66). An expert panel review led JCAHO to endorse neonatal mortality as a core measure of quality. (Romano, Tr. 6288).

b. The Merger Improved Quality Of Care In HPH's Nursing Services

i. Overview

1338. Nursing services are absolutely critical to patient care because of the increasing

complexity and severity of illnesses of hospitalized patients. (Chassin, Tr. 5230).

Response to Finding No. 1338:

Complaint Counsel do not disagree.

1339. Effective nursing services have exemplary leadership, are focused on developing autonomous nursing practices and encourage collaborative participation with physicians and other clinicians. (Chassin, Tr. 5231). Literature dating back 15 to 20 years in nursing health services research has evaluated these qualities of effective nursing and has shown that when they are present, the mortality and morbidity rates of patients are lower than in those hospitals with dysfunctional nursing services. (Chassin, Tr. 5231).

Response to Finding No. 1339:

Complaint Counsel do not disagree.

1340. ENH positively transformed the nursing service at HPH after the Merger. Nursing services improved through enhanced training, improvements in physician/nurse relationships, critical thinking and assessment skills, and improved safety. (Chassin, Tr. 5239-43; Ankin, Tr. 5070).

Response to Finding No. 1340:

Complaint Counsel agree that, just as HPH had done prior to the merger, ENH took some positive steps after the merger to continue to improve nursing services. But after the merger, there remained evidence of nursing problems, in some cases for several years. The point is not that nursing was particularly problematic either before or after the merger, but rather that an anecdotal look at the evidence, of the sort used by ENH to "prove" the existence of pre-merger nursing problems, is not particularly useful.

{ [redacted] }

(Chassin, Tr. 5480-81; CX 405 at 8; RX 924 at ENH MLN 001411; RX 900 at ENH GW 000528; RX 938 at ENHE F35 000317; RX 1347 at ENHL PK051851, *in camera*. *See*

also CCFF 2179-2185). In a post-merger letter to ENH's CEO, Linda Morris, an HPH nurse, complained that the "environment is very negative and the nursing staff is very frustrated with staffing issues of professional and support staff." (RX 924 at ENHLMN001411). She also complained that there was no nursing orientation at HPH when she started there. (RX 924 at ENHLMN001411). { } (RX 1347 at ENHL PK051851, *in camera*). Also in 2002, HPH physicians felt that the HPH nursing staff was "understaffed and underachieving." (CX 405 at 8).

Much more valuable than the anecdotal evidence noted above is a systematic comparison of different measures pre- and post-merger. { } (Romano, Tr. 3233-34, *in camera*; CCFF 2098-2101). { } (Romano, Tr. 3136-37 (discussing DX 441 at 70, *in camera*), *in camera*. *See also* CCFF 2138, 2139). The latter is particularly interesting, since Dr. Chassin agreed that patient satisfaction with nursing care is a useful measure of nursing quality. (Chassin, Tr. 5467).

1341. Heidi Krasner, who testified at trial concerning these improvements, has been a

registered nurse for 18 years. (Krasner, Tr. 3688-89). Krasner is the Clinical Coordinator for the Nursing Resource Team, the Staffing Office and IV Therapy Team for HPH. (Krasner, Tr. 3688). She has held this position since August 2004. (Krasner, Tr. 3688). Krasner, who has practiced at several hospitals across the Chicago area, was hired at HPH as the Clinical Nurse Manager for the Family Birthing Center in 1997. She was manager of the family birthing center from 1997-2001. (Krasner, Tr. 3689-91).

Response to Finding No. 1341:

Complaint Counsel do not disagree. Complaint counsel notes that Ms. Krasner was the only nurse to testify at trial about the alleged problems in nursing at the pre-merger HPH. But all parties agreed that Ms. Krasner was an outstanding nurse, who brought effective leadership to HPH's nursing staff, began to fix many of the problems she found, and stuck with her job despite challenges she claims to have found. (Krasner Tr. 3747-48). Hiring Ms. Krasner is just one example of HPH's commitment to good (and improving) nursing.

1342. As the Clinical Nurse Manager for the Family Birthing Center, Krasner was responsible for the day-to-day operations of the Birthing Center, prenatal education for parents, lactation services, nurse staffing and training for labor and delivery, and oversight of nurse-physician relationships. She was also responsible for the financial condition of the Birthing Center and the Lactation Center at HPH. She managed a total of 60 people in this capacity. (Krasner, Tr. 3691-92).

Response to Finding No. 1342:

Complaint Counsel do not disagree.

1343. Despite the fact that Krasner is no longer the Nurse Manager of the Family Birthing Center at HPH, she is still very familiar with the state of care in that unit. Her familiarity is based upon the fact that the nurses she oversees on the resource team serve in the Family Birthing Center, as well as throughout the hospital, and she maintains oversight for all of the finances of the Birthing Center. Moreover, Krasner gathers all of the health-related statistics regarding deliveries and patients who are admitted, re-admitted, or discharged from the Family Birthing Center. (Krasner, Tr. 3694-95).

Response to Finding No. 1343:

Heidi Krasner has not delivered patient care since she last worked at the HPH Family Birthing Center. Furthermore, she has no way of knowing how patient outcomes at HPH have changed since the merger. (Krasner, Tr. 3743-44).

ii. HPH's Pre-Merger Nursing Services Needed Improvement

1344. Key elements of effective nursing were absent from HPH before the Merger. (Chassin, Tr. 5232).

Response to Finding No. 1344:

This finding is inaccurate. HPH offered good nursing services before the merger, and was steadily improving in nursing before the merger. (CCFF 2166-2178). It had a "high quality nursing staff" in the 1990s before the merger. (Newton, Tr. 383. *See also* Dragon, Tr. 4403). Heidi Krasner was proud of the pre-merger improvements she made to nursing in the Family Birthing Center such as instituting cross-training and new orientation program. (Krasner, Tr. 3748-49). Ms. Krasner successfully reduced the nurse vacancy rate at the Family Birthing Center before the merger. (Krasner, Tr. 3748).

{ } (RX 324 at ENHL PK 029765, *in camera*). { } (RX 324 at ENHL PK 029764-029765, *in camera*). { } (RX 324 at ENHL PK 029769, *in camera*).

After its site visit 1998, ACOG made a series of recommendations for improvement that the hospital began to address with follow-up actions. (Newton, Tr.

390-91; Spaeth, Tr. 2116; Krasner, Tr. 3753; CX 98 at 2). Heidi Krasner helped implement some of those recommendations before the merger, which included increased fetal monitoring nurse education. (Krasner, Tr. 3753-54). {

} (Romano, Tr. 3155-56, *in camera*). {

(CCFF 2174-2176, *in camera*).

1345. Leadership did not support active involvement of nursing in multidisciplinary care. (Chassin, Tr. 5232).

Response to Finding No. 1345:

This finding is incorrect. Various sources of evidence show that before the merger HPH supported the active involvement of nursing in multidisciplinary care through cross-training. (CCRFF 1344). HPH management was generally supportive of its nurses. (Krasner, Tr. 3746-47). {

} (CX 6265 at 25, *in camera*).

1346. Analysis performed by health care providers at the time of, and before, the Merger also confirmed that the nursing culture at HPH was passive, and the nurses simply carried out

physician orders instead of being partners in care. (Chassin, Tr. 5232; RX 925 at ENHL PK 51687).

Response to Finding No. 1346:

This finding is misleading. The document criticizing nursing culture that is cited in the finding, RX 925, was actually written in August 13, 2000, commenting on ongoing problems that were obviously occurring after the merger and ENH management took over nursing at HPH. (RX 925 at ENHL PK 51687). {[redacted]} (CX 6265 at 21, *in camera*; Romano, Tr. 3158, *in camera*).

1347. Before the Merger, nursing problems were memorialized in an August 23, 2000, memorandum from Peggy King, Assistant Vice President, to Mary O'Brien, Senior Vice President. (RX 925). King identified concerns about passive nursing, the failure of nurses to practice autonomously, a punitive nursing atmosphere that inhibited accident investigation, a lack of nurse leadership support and nursing competency. (Chassin, Tr. 5235; RX 925 at ENHL PK 51687).

Response to Finding No. 1347:

RX 925 was written almost nine months after the merger. As discussed in CCRFF 1344, this document described problems that had been pro-actively identified by HPH pre-merger, and that HPH had been complimented by an outside body for addressing. That the problems still needed to be addressed nine months into ENH's leadership merely confirms that the process is an ongoing one, which started pre-merger an continued post-merger. Even Dr. Chassin characterized nursing improvements as an evolutionary process that spanned a period of years (Chassin Tr. 5478-80), and that

period of years clearly began pre-merger.

1348. Moreover, the Family Birthing Center at HPH had several major nursing service issues that paralleled the nursing problems in the rest of the hospital. (Chassin, Tr. 5232-39). The problem areas for nursing in the Family Birthing Center were focused in the areas of staffing, training and nurse-physician relationships. (Krasner, Tr. 3701).

Response to Finding No. 1348:

This finding is misleading. HPH had high quality nursing services before the merger. Ms. Krasner made significant improvements to nursing in the Family Birthing Center before the merger. (*See* CCRFF 1344).

1349. The issues concerning HPH nursing before the Merger are explored in more depth below.

Response to Finding No. 1349:

This is not a finding of fact.

(1) HPH Had Issues Concerning Nurse Recruiting, Vacancy And Turnover Rates Before The Merger

1350. {[redacted]} (Spaeth, Tr. 2247; RX 442 at ENH RS 4660, *in camera*). Specifically, pre-Merger HPH had a 13-15% nurse vacancy rate and had to fill the vacancies with temporary nurses from agencies. (Spaeth, Tr. 2247; O'Brien, Tr. 3533-34).

Response to Finding No. 1350:

This finding is misleading and irrelevant. According to Heidi Krasner, there are always nursing vacancies at hospitals. (Krasner, Tr. 3748). As a matter of fact, HPH had a high nursing vacancy rate of 11.4% in 2000, six months after the merger. (RX 900 at ENH GW 000528). In addition, physicians complained of an "understaffed" nursing staff at HPH two years after the merger. (CX 405 at 8). Even after the merger, ENH

administration was concerned with how the problems with high nursing vacancy rates and nursing turnover would effect nursing staffing and quality of care provided to patients. (RX 938 at ENHE F35 000317).

Ms. Krasner, with the approval of HPH management, successfully filled most of the nursing vacancies at HPH before the merger. (Krasner, Tr. 3748). Before the merger, HPH had a relatively low nursing vacancy rate of 6.17% in 1999. (CX 6264 at 1). {[redacted] } (O'Brien, Tr. 3672, *in camera*). {[redacted] } (Krasner, Tr. 3877, *in camera*; CX 6265 at 19, *in camera*). {[redacted] } (Newton, Tr. 509, 513, *in camera*; O'Brien, Tr. 3672, *in camera*).

1351. In 1997, there were several vacant nursing positions in the Family Birthing Center. Specifically, HPH had 7.9 Full Time Equivalent positions that were vacant and were not even posted for hire. (Krasner, Tr. 3701-02).

Response to Finding No. 1351:

This finding is misleading and irrelevant. Ms. Krasner filled most of the nursing vacancies at the Family Birthing Center after she was hired in 1997. (*See* CCRFF 1350).

1352. Physicians were concerned about the nurse vacancy rate. (O'Brien, Tr. 3531, 3533-34; RX 938 at ENHE F35 317).

Response to Finding No. 1352:

This finding is misleading. It also should be noted that the evidence cited points to concerns with the nurse vacancy rate that were present after the merger. (O'Brien, Tr. 3531, 3533-34; RX 938 at ENHE F35 317. *See also* CCRFF 1350).

1353. To decrease nurse vacancy, HPH needed to recruit and hire new nurses. However, economic realities at HPH before the Merger restricted the ability of HPH to compete in the market for nursing salaries and benefits packages. (RX 450 at ENH DR 3478). Starting salaries for Registered Nurses and Operating Room Techs were 4.8% and 7.5% below their respective markets in 1999 at HPH. (RX 450 at ENH DR 3478). And there was no merit-based reward system for nurses at HPH. (Krasner, Tr. 3702).

Response to Finding No. 1353:

The document relied upon, RX 450, demonstrates both that ENH overstates the problems of low compensation, and that HPH was aware of and addressing that problem pre-merger. While the document discusses compensation issues, it states that "the core of our problem is the lack of available candidates" in a "volatile market." (RX 450 at ENH DR 003478). The document goes on to recommend salary increases in 1999. (RX 450 at ENH DR 0034789). There is no reason to expect that HPH would not have implemented those salary increases, and done what was possible to solve the problem, in that "volatile market," had the merger not occurred. Respondent has not shown why HPH needed to merge, and at that, merge specifically with ENH to implement the internal recommendation to increase salaries. HPH was in excellent financial condition before the merger, and most likely could have made any necessary salary and benefits changes without merging with ENH. (CCFF 302-355, 2440-2443).

1354. Krasner could not cure any issues of compensation before the Merger. (Krasner, Tr. 3722). Contemporaneous documents confirm this statement was true for all of HPH nursing. (RX 450 at ENH DR 3478).

Response to Finding No. 1354:

Again, the cited document proves the opposite of what ENH says. On the page following the page cited by ENH to document the existence of the problem, it recommends salary increases in 1999 to solve that problem. (RX 450 at ENH DR 003479). This belies ENH's claim to have solved the problem only with the merger.

1355. { } (Krasner, Tr. 3702; Newton, Tr. 513-14, *in camera*). But agency nurses are not as effective with respect to patient care as nurses who are on staff. Because agency nurses are temporary, they lack institutional familiarity with the hospital, its policies, or its physicians. (Krasner, Tr. 3702-03; RX 657 at ENHL PK 029811). Further, the skill set and abilities of agency nurses are unknown before they are brought in to staff the hospital because there is no interview process in their selection. They are simply provided to the hospital through an outside temporary nursing agency. (Krasner, Tr. 3702-03).

Response to Finding No. 1355:

This finding is misleading. (*See* CCRFF 1350 ({ }), *in camera*).

1356. Hiring agency nurses is expensive, and they are difficult to find. The trend of increased reliance on agency nurses at HPH before the Merger increased the financial resources of the hospital that had to be dedicated to finding and retaining the temporary employees. For example, in 1998, the total agency nurse cost was $26,833 at HPH. However, the following year the cost increased dramatically. In just one month, January 1999, HPH spent $14,679 on agency nurse costs. (RX 450 at ENH DR 3478).

Response to Finding No. 1356:

The cited document indicates that there was a shortage of nurse applicants, and that this market reality forced HPH to rely on agency nurses, as do all hospitals. (RX 450 at ENH DR 003478).

1357. Moreover, before the Merger, there was constant turnover of nurses in the Family

Birthing Center at HPH. (Krasner, Tr. 3702, 3721-22). This constant turnover caused vacancy rates to be an ongoing problem at HPH. (Krasner, Tr. 3755).

Response to Finding No. 1357:

This finding is misleading. (*See* CCRFF 1350 ({ }), *in camera*),

1358. The turnover rate was high and getting worse at HPH pre-Merger. Specifically, in 1998, Staff Nurse turnover was 19.4% higher than the average staff turnover in 1996 and 1997 at HPH. (RX 450 at ENH DR 3478).

Response to Finding No. 1358:

This finding is misleading. (*See* CCRFF 1350 ({ }), *in camera*).

1359. The considerable turnover over time resulted in concerns regarding nurse staffing and issues regarding the quality of services being afforded to patients. (RX 938 at ENHE F35 317).

Response to Finding No. 1359:

This finding is misleading. (*See* CCRFF 1350, 1352 ({ }), *in camera*).

(2) HPH Had Issues Concerning Nurse Training Before The Merger

1360. Overall, the proper training of nurses is critical with respect to the quality of care given to patients. Anytime a nurse is not properly trained it puts patients at risk and compromises the safety of care provided at a hospital. (Krasner, Tr. 3705).

Response to Finding. No. 1360:

Complaint Counsel do not disagree.

1361. Nurses also must have critical thinking skills to be active and engaged and function at a high level when caring for patients. (Chassin, Tr. 5237). When nurses do not posses these important skills, it creates an environment in which they cannot alert physicians when adverse events are about to happen, such as when patients are starting to deteriorate. Put simply, nurses have to have critical thinking skills to function as part of an effective care-giving team. (Chassin, Tr. 5237).

Response to Finding No. 1361:

Complaint Counsel do not disagree.

1362. Nurses were not well-trained at HPH before the Merger. There were nurses without CPR certification, there was no nurse orientation program, there was no nurse training for delivering care to high-risk patients and nurses were not cross-trained. (Krasner, Tr. 3703-05).

Response to Finding No. 1362:

This finding is misleading and inaccurate. { } (RX 324 at ENHL PK 029769, *in camera*; Krasner, Tr. 3748-49). Following the ACOG report in 1998, HPH increased nurse education for fetal monitoring before the merger. (Krasner, Tr. 3753-54). { } (CX 6265 at 19, *in camera;* Krasner, Tr. 3877, *in camera. See also* CCRFF 1344-1347). Respondent's quality expert did not compare the amount of training given to nurses before the merger to the amount given after. (Chassin, Tr. 5493). After the merger, an HPH nurse complained that there was no nursing orientation when she started working at HPH under post-merger ENH management. (RX 924 at ENHLMN001411). {

} (RX 1347 at ENHL PK 0151851, *in camera*).

1363. According to documented evidence, physician leaders, quality improvement personnel and nursing leaders all commented that once the Merger occurred it became apparent that HPH nurses lacked the skills necessary to implement the collaborative treatment pathways that HPH was exposed to by ENH. (Chassin, Tr. 5236-37; RX 925 at ENHL PK 51687).

Response to Finding No. 1363:

This finding is misleading and incomplete. { } (RX 1347 at ENHL PK 0151851, *in camera*; CX 405 at 8 (complaining by HPH physicians in 2002, that nursing staff was "understaffed and underachieving")).

1364. Despite the critical need for adequate training, pre-Merger HPH's nurses lacked effective skills to handle modern aspects of patient care. There also was a lack of professionalism among the nurses in that HPH nurses did not have input into the plans for, and care given to, patients within the scope of their practice. (Chassin, Tr. 5232-33; RX 925 at ENHL PK 51688).

Response to Finding No. 1364:

This finding is misleading. (*See* CCRFF 1344, 1362 (discussing the improvements in training and skills for nurses at HPH before the merger, and criticisms of nursing skill and training at HPH after the merger)).

1365. Specifically, for Labor and Delivery at HPH to function properly, the nurses need to be able to care for the mother both in labor and in post-delivery. Cross-training allows nurses to be educated to deliver care both in labor and post-delivery. Pre-Merger, patient care was compromised because nurses were not cross-trained and HPH employed the LDRP model. (Krasner, Tr. 3704-05).

Response to Finding No. 1365:

This finding is misleading. (*See* CCRFF 1344, 1362 (discussing the improvements in training and skills for nurses at HPH before the merger, and criticisms of nursing skill and training at HPH after the merger)).

1366. There were several physician concerns regarding nurse training at HPH. (O'Brien, Tr. 3533). Physicians were concerned about nurse competency and skills in general. (O'Brien, Tr. 3533-34). Physicians did not feel that the nurses were acting as the eyes and ears for them when the physicians were away from the hospital. (O'Brien, Tr. 3534). Physicians also felt there was a lack of critical thinking and accountability among the nurses. (O'Brien, Tr. 3534).

Response to Finding No. 1366:

This finding is misleading. (*See* CCRFF 1344, 1362 (discussing the improvements in training and skills for nurses at HPH before the merger, and criticisms of nursing skill and training at HPH after the merger)). Also, the cited testimony refers to perceptions at HPH after the merger around October 2000, when Ms. O'Brien started doing her assessments of quality at HPH. (O'Brien, Tr. 3533).

1367. Physicians also were skeptical that pre-Merger HPH's nurses possessed the necessary clinical skills or competencies. Physicians stated that, as a result, nurses were unable to participate in ENH's collaborative pathway process that HPH was exposed to after the Merger. (Chassin, Tr. 5237; RX 925 at ENHL PK 51688).

Response to Finding No. 1367:

This finding is misleading. (*See* CCRFF 1344, 1362 (discussing the improvements in training and skills for nurses at HPH before the merger, and criticisms of nursing skill and training at HPH after the merger)). Also, the exhibit cited, RX 925, was created after the merger and reflects physician concerns about nurses at HPH after the merger. (RX 925 at ENHL PK 51687-516788).

(3) HPH Had Issues Concerning Nurse/Physician Relationships Before The Merger

1368. HPH had problems before the Merger with nurse/physician relationships. (Chassin, Tr. 5233).

Response to Finding No. 1368:

This finding is inaccurate and misleading. { } (CX 6265 at 21, *in camera*). { } (RX 1347 at ENHL PK 051851, *in camera*. *See also* CCRFF 1363).

1369. ACOG, which sets guidelines for care of Ob/Gyn patients, made a site visit to HPH before the Merger in September 1997 and published its findings concerning nurse/physician relationships, among other issues, in a report submitted to the hospital. (Krasner, Tr. 3732-74). This report, as well as other documents, identified problems with pre-Merger HPH nurse/physician relationships, as did interviews Dr. Chassin conducted with physicians, nurses, and employees who practiced at HPH before and/or after the Merger. (Chassin, Tr. 5233, 5236).

Response to Finding No. 1369:

This finding is misleading and incomplete. { } (RX 324 at ENHL PK 029764-029765, *in camera*). {

} (CCRFF 1368). The problems with Dr. Chassin's interviewing methodology are discussed in CCFF 2149-2163.

1370. { } (RX 324 at ENHL PK 29710, *in camera*). According to Krasner, this was an understatement. (Krasner, Tr. 3738).

Response to Finding No. 1370:

This finding is misleading and incomplete. It selectively cites from ACOG report, which also complimented HPH's pre-merger nursing department in many ways. (*See* CCRFF 1369). Moreover, HPH improved its nurse/physician relationships after the ACOG report, but before the merger. (*See* CCRFF 1368-1369).

1371. { } (Krasner, Tr. 3738; RX 324 at ENHL PK 29710, *in camera*). { } (RX 324 at ENHL PK 29754, *in camera*).

Response to Finding No. 1371:

This finding is misleading and incomplete. HPH improved its nurse/physician relationships after the ACOG report, but before the merger. (*See* CCRFF 1368-1369).

1372. Drs. Alexander, Ankin, Harris and Rosengart as well as Krasner, Mayer and O'Brien all confirmed at trial that nurse/physician relationships were not good before the Merger and improved as a result of the Merger. (Chassin, Tr. 5233; O'Brien, Tr. 3533-34; Krasner, Tr. 3705-07; RX 1445 at ENHL PK 51621).

Response to Finding No. 1372:

This finding is misleading, irrelevant, and inaccurate. Dr. Alexander did not testify at trial. (*See* CCRFF 1368-1369 (discussion on HPH's problems with

nurse/physician relationships both before and after the merger)). {

} (Ankin, Tr. 5036-96, 5103-05, *in camera*; Harris, Tr. 4201-99; 4418-28, *in camera*; Rosengart, Tr. 4435-4566; 4578-4580, *in camera*).

1373. The nursing culture at HPH was passive in that the nurses simply carried out physician orders instead of being partners in care. This passive behavior and lack of professionalism displayed by nurses at HPH before the Merger stemmed from a destructive culture and negative nurse/physician relationships. (Krasner, Tr. 3706-07).

Response to Finding No. 1373:

This finding is misleading and inaccurate. (CCRFF 1368). {

} (CX 6265 at 21, *in camera*).

1374. The punitive manner in which incidents were investigated by physicians and administration also damaged nurse/physician relationships. That punitive culture acted as a barrier to incident reporting. (Chassin, Tr. 5232-35; RX 925 at ENHL PK 51687).

Response to Finding No. 1374:

This finding is misleading and incomplete. (*See* CCRFF 1368 and 1373 discussing HPH nurse passivity before the merger. *See also* CCRFF 1444-1445 discussing adverse event reporting before the merger.)).

1375. Typically, physicians did not listen to or rely upon nurses judgments before the Merger. Nurses had no recourse when confronting a physician who was providing care in an unsafe manner. (Krasner, Tr. 3708-10).

Response to Finding No. 1375:

This finding is misleading. (*See* CCRFF 1368-1369 (discussing HPH's pre-merger improvements in nurse/physician collaboration and collegiality)).

1376. Before the Merger, the nurses and physicians in the Family Birthing Center at HPH did not work together as a team. There were no collegial relationships and no mutual respect. Physicians verbally abused nurses and had no confidence in nurses' clinical skills to manage their patients. (Krasner, Tr. 3705-06).

Response to Finding No. 1376:

This finding is misleading. (*See* CCRFF 1368-1369 (discussing HPH's pre-merger improvements in nurse/physician collaboration and collegiality)).

1377. There were no processes developed to ensure access to dispute resolution and there were no mechanisms in place for disciplinary actions. (Krasner, Tr. 3740). The HPH Department Chairs were private practitioners who were not paid by HPH. (Krasner, Tr. 3728).

Response to Finding No. 1377:

This finding is misleading and irrelevant. (*See* CCRFF 1432 (discussion on the impact of HPH's pre-merger selection of chairs). *See also* CCRFF 1424 (discussion on HPH's pre-merger discipline of physicians)).

1378. Physicians placed their own convenience above patient safety before the Merger. (Krasner, Tr. 3706).

Response to Finding No. 1378:

This finding is misleading. Ms. Krasner did not offer any specific incidents as evidence to support such a strong statement. Besides, the trial testimony of Respondent's witnesses supports the view that before the merger HPH's medical staff included good, high quality physicians with strong and positive relationships with the community. (CCFF 2311-2314).

1379. Sometimes physicians' treatment of nurses at HPH was extreme. In 1998, there was a case where a nurse was being cross-trained to scrub in the labor and delivery operating room for a Cesarean section. The nurse being trained was not moving fast enough for an HPH physician during the procedure and the physician threw the patient's placenta at the nurse. This type of behavior was typical at HPH before the Merger. (Krasner, Tr. 3713-14).

Response to Finding No. 1379:

This finding is misleading. (*See* CCRFF 1368-1369 (discussing positive nurse/physician relationships before the merger). *See also* CCRFF 1378 (discussing the professionalism of HPH's medical staff before the merger)). This is also another example of ENH's anecdotal approach. There are any number of "extreme" examples of nursing problems post-merger or at Evanston Hospital. {[redacted]} (CX 411 at 1, *in camera*). While never justifiable, such incidents, in the case of HPH, hardly speak to a need for a hospital to merge with another entity to prevent bad behavior from reoccurring. Rather, they point to a need to analyze the quality claims at issue in this case in a comprehensive and systematic, not anecdotal, way. Only Dr. Romano has done that. (*See* CCFF 2045).

1380. Physicians' conduct towards labor and delivery nurses at HPH was not typical of other hospitals such as Evanston Hospital, Lake Forest Hospital or Rush University Medical Center. It was very different from those institutions and extremely dysfunctional. (Krasner, Tr. 3689-90, 3711-12). Yet, before the Merger, there was no significant effort made in the HPH Family Birthing Center to repair nurse/physician relationships. (Krasner, Tr. 3739-40).

Response to Finding No. 1380:

This finding is inaccurate and misleading. (*See* CCRFF 1368-1369 (discussion of HPH's pre-merger efforts and successes in improving nurse/physician relationships.)).

1381. As a result, nurses in labor and delivery were very passive at HPH in the pre-Merger period. They did not have critical thinking skills and lacked professionalism. Nurses did not have enough confidence in their own skills to question a physician's judgment when they might know something was improper. All of this meant nurses were not advocating for their patients before the Merger. (Krasner, Tr. 3706-07).

Response to Finding No. 1381:

This finding is misleading. (*See* CCRFF 1368-1369, 1373-1374 (discussing

HPH's pre-merger improvements in nurse/physician collaboration, as well as increasing assertiveness among nurses in providing patient care)).

1382. This destructive nursing culture at HPH hindered teamwork critical to the quality delivery of medicines to patients in the hospital. And patient care was affected by the dysfunctional nursing culture pre-Merger. Patients are put at risk whenever nurses do not think for themselves and do not act as a patient advocate. (Krasner, Tr. 3707-08).

Response to Finding No. 1382:

This finding is misleading. (*See* CCRFF 1368-1369, 1373-1374 (discussing HPH's pre-merger improvements in nurse/physician collaboration, as well as increasing assertiveness among nurses in providing patient care)).

1383. For example, before the Merger, the HPH pharmacy had a procedure under which certain medications were automatically stopped after a fixed period of days, and if nurses and physicians did not take immediate action, the medication no longer would be delivered. The passive and unprofessional culture for nurses and the lack of teamwork between nurses, physicians and pharmacists caused the stop order practice to lead to a number of adverse events during the pre-Merger period. These events were grave compromises of good medical care and included: (1) unrecognized, inappropriate stop orders for medications leading to morbidity and transfer to specialized care; (2) wrong IV administrations; (3) inconsistency in the security of narcotics in the hospital; and (4) multiple instances of administering one patient's medications to another patient. (Chassin, Tr. 5235-36; RX 925 at ENHL PK 15687-88).

Response to Finding No. 1383:

This finding is misleading. (*See* CCRFF 1368-1369, 1373-1374 (discussing HPH's pre-merger improvements in nurse/physician collaboration, as well as increasing assertiveness among nurses in providing patient care). *See also* CCFF 2279-2282 *and* CCRFF 1950-1998 (discussion on the quality of pharmacy services at HPH before and after the merger)).

1384. Krasner was not able to solve the nurse/physician relationship issues before the Merger. (Krasner, Tr. 3722). The issues could not be solved pre-Merger because there was not a culture – throughout the hospital, through administration, or through physician leadership – that

promoted positive nurse/physician relationships. (Krasner, Tr. 3739). Solving the cultural issues at HPH with respect to nursing required a change of the hospital systems, administration and physician leadership; the support for cultural change had to be pervasive throughout the organization. (Krasner, Tr. 3739).

Response to Finding No. 1384:

This finding is misleading. (CCRFF 1368-1369, 1373-1374 (discussing HPH's pre-merger improvements in nurse/physician collaboration, as well as increasing assertiveness among nurses in providing patient care)).

iii. ENH Improved HPH's Nursing Services And Culture After The Merger

1385. The quality of nursing has dramatically improved at HPH since the Merger. (Ankin, Tr. 5070).

Response to Finding No. 1385:

This finding is inaccurate. There was no dramatic improvement in nursing at HPH after the merger. (*See* CCRFF 1340).

1386. ENH completely transformed the nursing service at HPH. Nursing services improved through enhanced training, improvements in nurse/physician relationships, critical thinking and assessment skills, and improved safety. (Chassin, Tr. 5239-43). The nursing service changed from one with a passive culture into a much more active, professional culture that learned to be full partners with physicians in providing multidisciplinary, effective care. (Chassin, Tr. 5239).

Response to Finding No. 1386:

This finding is inaccurate. Many of the structural problems HPH had in nursing pre-merger continued after the merger, under ENH management. (CCRFF 1340, 1362-1363). In addition, even before the merger, HPH's nursing culture was improving, with nurses playing a more active and beneficial role in patient care. (CCRFF 1344-1346, 1369, 1373-1374). According to Dr. Chassin, change in this area is an evolutionary

process that spanned a period of years. (Chassin Tr. 5478-80). The above cited findings make clear that this "evolution" began in earnest at pre-merger HPH and was still continuing several years into the merger.

1387. The changes in nursing culture, however, took some time to develop. (O'Brien, Tr. 3536). There were some initial improvements in the first two years after the Merger. (O'Brien, Tr. 3537; RX 900 at ENH GW 528; RX 913; RX 915; RX 916). But the significant changes in the nursing culture at HPH were instituted in the period from 2002 to 2004. (O'Brien, Tr. 3536).

Response to Finding No. 1387:

This finding is inaccurate and misleading. None of the evidence Respondent cites to in this finding points to any improved outcomes relating to nursing. *See* CCRFF 1340 (discussing outcomes and process measures, and patient satisfaction related to HPH from the time of the merger until the present). *See also* CCFF 2138; CCRFF 1362,1363 (discussion on the structural problems in HPH nursing that extended past the merger)). Even if one is to credit the structural changes claimed by ENH, ENH's admission that "significant changes" were not made until 2002-2004 proves Complaint Counsels' point that this is an ongoing process which began pre-merger. (*See* CCRFF 1388 below).

1388. For example, a 2003 memo to Mary O'Brien, President of HPH, regarding the state of inpatient nursing services at HPH details improvements in critical thinking and assessment skills, improved patient safety, reduced rates of patient misidentification and a series of other nursing improvements. (Chassin, Tr. 5242; RX 1445).

Response to Finding No. 1388:

In conceding that the changes "took some time to develop," in RFF 1387, Respondent proves Complaint Counsel's point. Respondent points to some legitimate concerns in HPH's pre-merger services, but ignores the undeniable fact that HPH was

aware of and was proactively addressing those issues pre-merger. (*See, e.g.*, CCRFF 1344-1346, 1369, 1373-1374). The pre-merger time period presented by ENH begins with Ms. Krasner's hiring in 1997 and continues to the merger on January 1, 2000, or about two and a half years. But here, and in RFF 1386, Respondent asks the Court to consider a post-merger time period of about five years, to the end of 2004. Complaint Counsel submit that ENH has, at most, continued to build on the strong and improving nursing service it acquired from HPH, and has a time period about twice as long in which to look for results.

It is also undeniable that many of the same problems continued on ENH's watch, as ENH implicitly concedes in claiming that the "significant changes" took place from 2002 to 2004, from three to five years after the merger. (*See also* CCRFF 1362 and 1363 (discussing the structural problems in HPH nursing that extended past the merger)). What ENH accomplished in nursing, as in so many other areas, was to continue to address quality issues, as HPH had previously done and as hospitals across the country were doing, for years after the merger. This proves only that quality improvements are an ongoing process, not that the merger brought about any changes that were not already happening. Even more importantly, none of the evidence Respondent cites to in this finding points to any improved outcomes relating to nursing. (*See* CCRFF 1340 (discussing outcomes and process measures, and patient satisfaction related to HPH from the time of the merger until the present; *see also* CCFF 2138).

(1) ENH Improved HPH's Nurse Recruiting, Vacancy And Turnover Rates After The Merger

1389. ENH immediately provided several nurse pay increases to address high turnover and vacancy rates at HPH. (Krasner, Tr. 3722; O'Brien, Tr. 3534; RX 822 at ENH GW 296). ENH made market adjustments for nurses at the time of the Merger, and again in October of 2000. (O'Brien, Tr. 3535).

Response to Finding No. 1389:

As explained in CCRFF 1353, the principal problem was a lack of applicants, and HPH was aware of and capable of addressing the salary issue pre-merger. (*See* CCRFF 1353. *See also* CCRFF 1350 (information on HPH's continued nurse vacancies after the merger)).

1390. ENH instituted a merit-based pay system called Levels of Practice. (RX 900 at ENH GW 529). This merit-based performance system allowed nurses to receive increases in pay for a greater commitment to the hospital and to the unit in which they worked. For example, nurses were incented for precepting and teaching, obtaining certification and performing at a higher skill level. (Krasner, Tr. 3722).

Response to Finding No. 1390:

In doing so, ENH implemented salary increases that had been recommended by, and were affordable to, HPH pre-merger. (*See* CCRFF 1353. *See also* CCRFF 1350 (information on HPH's continued nurse vacancies after the merger)). Furthermore, Respondent has not explained why HPH could not have implemented a "Levels of Practice" system without merging with ENH.

1391. ENH also implemented a strategy to retain good nurses at HPH called a clinical ladder system. (O'Brien, Tr. 3536). The clinical ladder system elevates nurses with special certifications or skills to higher pay areas. (O'Brien, Tr. 3536).

Response to Finding No. 1391:

This finding is irrelevant. (*See* CCRFF 1353. *See also* CCRFF 1350 (information on HPH's continued nurse vacancies after the merger)). Furthermore, Respondent has

not explained why HPH could not have implemented a "clinical ladder" system without merging with ENH.

1392. There was no centralized Nursing Resource team at HPH before the Merger. (Krasner, Tr. 3702, 3724). Accordingly, ENH developed a Nurse Resource Team to address staffing issues at HPH. The resource team was also on a merit-based pay system, and that system allowed the resource team to grow tremendously. Certain members of the HPH Nurse Resource Team staffs at all three hospitals in the ENH system. (Krasner, Tr. 3723-24).

Response to Finding No. 1392:

This finding is irrelevant. (*See* CCRFF 1350 (information on HPH's continued nurse vacancies after the merger, and Ms. Krasner's success in dramatically reducing the nurse vacancy rate at HPH before the merger)). Furthermore, Respondent has not explained why HPH could not have implemented a centralized Nursing Resource team without merging with ENH. Also, before the merger, HPH did have unit-based resource teams to address staffing issues. (Krasner, Tr. 3724).

1393. Today, HPH uses its extensive Nurse Resource Team and staffing office to minimize its reliance on agency nurses. The larger the resource team, the fewer agency nurses need to be used. Moreover, those nurses on the resource team are better qualified nurses to take care of patients at HPH. (Krasner, Tr. 3694).

Response to Finding No. 1393:

This finding is irrelevant. (*See* CCRFF 1392. *See also* CCRFF 1350 (discussing HPH's use of agency nurses both before and after the merger)).

1394. The ENH Nurse Staffing Office manages all the nursing resource teams throughout HPH. This office supplies and deploys nurses to all of the units throughout the hospital to assist managers in providing adequate staffing to care for patients. (Krasner, Tr. 3693-94).

Response to Finding No. 1394:

This finding is irrelevant. (*See* CCRFF 1392).

1395. As a result of the changes in compensation, staffing and the Nurse Resource Team, the nursing staff in the HPH Birthing Center is more satisfied. This enables HPH to retain more easily and recruit nurses than before the Merger. (Krasner, Tr. 3724).

Response to Finding No. 1395:

This finding is irrelevant and misleading. (*See* CCRFF 1389-1393). Also, HPH had considerable problems with nursing morale after the merger. (RX 938 at ENHE F35 000317).

1396. { } (O'Brien, Tr. 3672, *in camera*). In addition, by February 2, 2001, the nurse vacancy rate at HPH dropped to 5.8%. (RX 1032 at ENH GW 471). { } (O'Brien, Tr. 3672, *in camera*).

Response to Finding No. 1396:

This finding is misleading. (*See* CCRFF 1350 (discussing improvements in the staffing of nurses at HPH before the merger, and lingering problems in the staffing of nurses at HPH after the merger)).

(2) ENH Improved HPH's Nurse Training After The Merger

1397. ENH implemented widespread additional training for nurses across the entire HPH hospital, on regular floors and in the ICU and operating room, thus allowing the nurses to be more active and more effective clinical caregivers. (Chassin, Tr. 5239). Since the Merger, the nurses at Evanston Hospital/HPH have been under the same umbrella of nursing leadership and have been free to train throughout the system. (Rosengart, Tr. 4466).

Response to Finding No. 1397:

The cursory and anecdotal nature of the first sentence of this finding again demonstrates the problem with ENH's approach. The sole cited documentation for the existence of "widespread additional training" is Dr. Chassin's testimony that there was in

fact "widespread additional training." (Chassin Tr. 5239). There is no attempt to tabulate the number and type of training classes available pre-merger and compare them to what existed post-merger. Extensive efforts were made by HPH to augment nurse training opportunities pre-merger (CCRFF 1362), and there is no evidence that these efforts would not have continued without the merger, and no real way even to know, as of today, exactly how much training ENH is doing. Respondent also has not explained why HPH could not have given its nurses any additional training ENH may have instituted without merging with ENH.

1398. Before the Merger, nurses at HPH were very infrequently trained at Evanston Hospital. (Krasner, Tr. 3727).

Response to Finding No. 1398:

This finding is misleading and inaccurate. ENH does not explain why training at HPH or any other location besides Evanston Hospital is inferior to training at Evanston hospital. (*See also* CCRFF 1344-1345,1362 (explanation of pre-merger training that was available)).

1399. ENH also put in place a rotation system for HPH nurse managers to rotate through all three hospital campuses. (O'Brien, Tr. 3535). The rotation system helped the nurse managers gain critical skills. (O'Brien, Tr. 3535; RX 1445 at ENHL PK 51620).

Response to Finding No. 1399:

This finding is misleading and irrelevant. It is worth noting that the document purporting to memorialize this improvement, RX 1445, is dated February 2003, more than three years after the merger. HPH's skill in addressing nursing issues pre-merger leaves every reason to believe similar improvements in "critical skills" would have been

achieved absent the merger. (*See, e.g.*, CCRFF 1344-1345, 1362-1363, 1368, and 1397).

Moreover, ENH's reliance on RX 1445 belies its contention in numerous other findings, that Press Ganey scores are unreliable measures of quality. The document reports to HPH's President, Mary O'Brien, extensive information about "patient satisfaction" as measured by Press Ganey scores, indicating that Ms. O'Brien, and ENH, view Press Ganey as a useful measure of quality.

1400. After the Merger, nurses at HPH had the ability to be trained for extended periods of time at Evanston Hospital. Extended training allowed HPH nurses to build their high-risk nursery skills in Evanston Hospital's high-risk nursery. By training for extended periods at Evanston Hospital, HPH nurses could receive very focused training, be exposed to a higher volume of deliveries, attend to more complex cases and see things they could not see at HPH. HPH nurses could not build these skills by training at the lower risk HPH Family Birthing Center. (Krasner, Tr. 3725-26).

Response to Finding No. 1400:

There is no reason to believe that appropriate training opportunities would not have continued to be available to HPH nurses without the merger. (*See, e.g.*, CCRFF 1344-1345, 1362-1363, 1368, and 1397).

1401. An example of the enhanced training opportunities brought about by the Merger occurred when ENH hired a new Clinical Coordinator for the HPH Family Birthing Center. After the Merger, the new Clinical Coordinator was able to receive focused training for several months at Evanston Hospital. Before the Merger, HPH might have been able to send the coordinator to Evanston Hospital's nursery for two or three days as part of the perinatal center agreement, but beyond that, an extended opportunity was not available. (Krasner, Tr. 3725-27).

Response to Finding No. 1401:

There is no reason to believe that appropriate training opportunities would not have continued to be available to HPH nurses without the merger. (*See, e.g.*, CCRFF 1344-1345, 1362-1363, 1368, and 1397).

1402. Nurses at all levels at HPH were trained to prepare for and begin the cardiac surgery program at HPH. (RX 822 at ENH GW 296). The addition of the cardiac surgery program at HPH added considerable value to each of the nurses in the ICU. (Ankin, Tr. 5065). For example, the increased abilities of HPH nurses gained from caring for critically ill heart patients also translated to care they provide to other patients in the ICU. (Rosengart, Tr. 4483-84).

Response to Finding No. 1402:

These opportunities would like have been available without the merger, since HPH had extensive pre-merger plans to develop a cardiac surgery program without merging with ENH, thus being able to provide HPH nurses with training in caring for critically ill heart patients. (CCFF 2357-2373). The Court also found Dr. Ankin's cited testimony to be beyond the scope of the questions being asked. (Ankin, Tr. 5065).

1403. Specifically, nurses at HPH that participated in the cardiac surgery program were sent to Evanston Hospital for additional training on caring for open heart patients. (Ankin, Tr. 5064-65). In addition, all of the nurses in the HPH ICU completed an orientation to the cardiac surgery program. (RX 1445 at ENHL PK 51621).

Response to Finding No. 1403:

Respondent's finding is incomplete. (*See* CCRFF 1402 above for an explanation why this claimed improvement is not merger specific). Moreover, in the pre-merger contract in which ENH and HPH agreed to begin a cardiac surgery program without a merger, the parties agreed that HPH would pay ENH for nurse training at Evanston Hospital. (CX 2094 at 3-4). It is therefore indisputable that this claimed benefit was not merger specific.

1404. ENH provided the ICU team with two additional nurse educators, including an advanced practice nurse whose sole job is to educate the nurses on the proper use of ICU equipment. (Ankin, Tr. 5068). In addition, 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). *See* Section VIII.D.2.c.

Response to Finding No. 1404:

Respondent's finding is incomplete. (*See* CCFF 2394-2402 for information on how HPH could have implemented an intensivist program similar to the one it has now without merging with ENH. *See also* CCFF 2272-2278 for information on how the merger with ENH has not significantly improved the quality of HPH's ICU). The pre-merger HPH had sufficient funds to hire nurses for the ICU without the merger, just as it had sufficient funds to hire intensivists. (*See, e.g.,* Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2). Moreover, in the pre-merger contract in which ENH and HPH agreed to begin a cardiac surgery program without a merger, the parties agreed that HPH would pay ENH for nurse training in the ICU. (CX 2094 at 3-4). It is thus indisputable that such training did not depend upon the merger.

1405. The advanced practice nurses in the ICU at HPH provide education to other nurses daily on the proper use of medical equipment, medications and wound care. (Ankin, Tr. 5068-69). Advanced practice nurses are nurses with additional training to complete clinical assessments and writing orders. (Ankin, Tr. 5069). HPH did not have advanced practice nurses before the Merger. (Ankin, Tr. 5069). Since the Merger, ENH has added two advanced practice nurses to the HPH ICU. (Ankin, Tr. 5069-70).

Response to Finding No. 1405:

The finding is irrelevant and misleading. There is no reason why HPH could not have hired advanced practice nurses after the merger. (*See, e.g.,* Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2).

1406. One of the advanced practice nurses in the HPH ICU is a clinical advanced practice nurse who is extremely well trained in critically ill patients who is present in the HPH for 40 hours each week. (Ankin, Tr. 5070). The clinical advanced practice nurse enables the intensivists to provide better care to all patients in the HPH ICU. (Ankin, Tr. 5070).

Response to Finding No. 1406:

This finding is irrelevant and misleading. There is no reason why HPH could not have hired advanced practice nurses after the merger. (*See, e.g.*,(Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2).

1407. As of 2003, ENH physicians praised ICU nurses and the quality of care they provided to cardiac surgery patients in the ICU. (Chassin, Tr. 5242; RX 1445 at ENHL PK 51621). Further, improved critical thinking and practice of nurses at HPH were noted by physicians in the State of Nursing Inpatient Department Report. (RX 1445). For example, Dr. Rosengart was cited stating that "[p]rior complaints about quality of care to CV surgery patients now resolved." Dr. Rosengart went on to praise the nursing staff for "improved critical thinking and practice evidenced by quality assessment and resuscitation of patient on night shift." (RX 1445 at ENHL PK 51621).

Response to Finding No. 1407:

This finding, beginning "as of 2003" provides further support for ENH's concession in finding 1387 that nursing changes "took some time to develop." ENH cannot attribute to the merger the existence of good ICU nurses more than three years after the merger in light of the indisputable record that HPH was making progress at addressing nursing issues for several years before the merger. (*See, e.g.*, CCRFF 1344-1345, 1362-1363, 1368, and 1397).

(3) ENH Improved HPH's Nurse/Physician Relationships After The Merger

1408. In contrast to the pre-Merger HPH nurse/physician relationships, the nurse/physician relationships at Evanston Hospital were very collaborative. (O'Brien, Tr. 3533). Nurses were confident in their skills and physicians were confident in the nurses' skills. (O'Brien, Tr. 3533). The nurse/physician relationships at pre-Merger HPH were more of an order giver/order taker relationship, and it was difficult for nurses and physicians to interrelate. (O'Brien, Tr. 3534; Spaeth, Tr. 2291).

Response to Finding No. 1408:

This finding is inaccurate and misleading. Once again, ENH ignores the

contemporaneous evidence that HPH was not only addressing physician nurse collaboration pre-merger, but has also taken, and been recognized for having taken, substantial steps to improve it. (*See* CCRFF 1362, 1363, 1368, and 1373).

1409. Vital to the improvements in nursing services at HPH was the improved nurse/physician relationships that were enhanced in terms of communication and teamwork. HPH would not have achieved a quality improvement in nursing unless nurses were able to work collaboratively as partners with physicians and teams in the ICU, surgery, cardiology, cardiac surgery and other areas. There was a great improvement in teamwork after the Merger. (Chassin, Tr. 5239-40).

<u>Response to Finding No. 1409:</u>

This finding is inaccurate and misleading. Once again, ENH ignores the contemporaneous evidence that HPH was not only addressing physician nurse collaboration pre-merger, but has also taken, and been recognized for having taken, substantial steps to improve it. (*See* CCRFF 1362, 1363, 1368, and 1373).

1410. ENH changed the culture at HPH by altering the leadership structures in the hospital. ENH installed full-time, paid department chairs who are responsible for managing physicians within their department and addressing nurse/physician relationships, among other issues. (Krasner, Tr. 3727).

<u>Response to Finding No. 1410:</u>

This finding is inaccurate and misleading. Once again, ENH ignores the contemporaneous evidence that HPH was not only addressing physician nurse collaboration pre-merger, but has also taken, and been recognized for having taken, substantial steps to improve it. (*See* CCRFF 1362, 1363, 1368, and 1373).

1411. The Department Chairmen attend departmental meetings at HPH and are at HPH each week. Further, ENH installed Vice-Chairmen with offices at HPH. Vice-Chairs are also paid for their service in that position. (Krasner, Tr. 3730-31).

<u>Response to Finding No. 1411:</u>

Insofar as this change of governance relates to nursing, Complaint Counsel have no specific response. Complaint Counsel have noted elsewhere that the existence of paid department chairs creates its own conflict issues in the context of physician discipline. (*See* CCRFF 1432).

1412. ENH also made changes in nursing leadership at HPH after the Merger. (O'Brien, Tr. 3537; Neaman, Tr. 1354). For example, a new Vice President of Nursing was hired. (O'Brien, Tr. 3537).

Response to Finding No. 1412:

This finding is misleading. ENH's attempt to attribute to the merger this routine personnel change two and a half years later demonstrates that it quality argument and lacks credibility. Ms. O'Brien testified that in May 2002, then Vice President of Nursing, Jane Stenske, received an opportunity for career advancement, which she took, opening up the nursing spot. So ENH, according to Ms. O'Brien, hired someone new. (O'Brien Tr. 3537-38). Ms. Stenske had been hired before the merger by HPH, and she was, according to ENH's own nursing witness, Ms. Krasner, a "good hire" a "good leader" and "supportive of nursing." (Krasner Tr. 3746-47). It is difficult to see how replacing her two and a half years after the merger, because she took another job, amounted to any material improvement. It is also difficult to see how this routine personnel change can be attributed to the merger.

1413. As a result of changes made by ENH, HPH nurses and physicians now have a collegial relationship. ENH addressed the nurse/physician relationships by putting in place an ethics committee where they worked together. (O'Brien, Tr. 3535). Nurses' opinions are respected by physicians and HPH, under ENH ownership, does not tolerate physician abuse of nurses. (Krasner Tr. 3727).

Response to Finding No. 1413:

This finding is misleading. (*See* CCRFF 1368, 1379 (discussing the relationship between physicians and nurses at HPH both before and after the merger)).

c. The Merger Substantially Improved HPH's Quality Assurance Program

i. Overview

1414. { [redacted] } (Romano, Tr. 3449, *in camera*).

Response to Finding No. 1414:

Complaint Counsel do not disagree.

1415. Hospitals are responsible for operating quality assurance programs: (1) to identify and appropriately discipline poorly performing physicians, and (2) to carefully investigate adverse events and close calls to identify opportunities for improvement in hospital systems and policies for reducing the likelihood of those adverse events recurring. (Chassin, Tr. 5209-10).

Response to Finding No. 1415:

Complaint Counsel do not disagree.

1416. The pre-Merger quality assurance program at HPH was inadequate in both respects. (Chassin, Tr. 5210-11 RX 417 at ENHL PK 17695). It had a very weak structure within each of the clinical departments for performing effective peer review and identifying problem physicians, and it lacked an adequate process to discipline those physicians. (Chassin, Tr. 5210-11).

Response to Finding No. 1416:

HPH had a strong quality assurance or "QA" program before the merger. (*See* CCFF 2209-2226). It had a system in place to keep track of quality of care at the hospital. (Spaeth, Tr. 2090). Before the merger, HPH was not shy about disciplining problematic physicians. (Newton, Tr. 381-383). { [redacted] }

(Romano, Tr. 3142, *in camera*; CX 6296 at 10-22, *in camera*). {

} (*See, e.g.*, RX 204 at ENHL PK 031140, *in camera*; RX 346 at ENHL PK 024709, *in camera*; RX 414 at ENHL PK 039155, 039164, *in camera*).

One of the exhibits Respondent cites to in its finding, RX 417 ("Quality in the New Millennium"), is a good example of an aggressive internal program undertaken by pre-merger HPH to examine and improve upon its quality. (RX 417 at ENHL PK 017692-017704). Through this report, HPH self-identified problems in the quality of care it provided to patients and how to alleviate them. (RX 417 at ENHL PK 017692-017704).

1417. Because of these structural issues, the Merger was necessary to make effective improvements to HPH's quality assurance program. (Chassin, Tr. 5389). After the Merger, ENH transformed the leadership structure at HPH, thus allowing ENH to export its superior quality assurance processes to HPH (Chassin, Tr. 5389-90).

Response to Finding No. 1417:

{

} (Romano, Tr. 3142, 3151, 3158-59, *in camera*). {

} (*See, e.g.*, CX 464 at 2-3, *in camera*; CCFF 2227-2231). After the merger, HPH physicians complained about the lack of communication regarding policy, ineffective leadership, and no representation in ENH. (CX 405 at 2). As late as 2004, ENH's cardiology department was still experiencing significant organizational and leadership problems. (CX 773 at 1).

1418. Shortly after the Merger, ENH made several improvements to HPH's quality assurance program, including: (1) implementing full-time clinical department leadership; (2) instituting a mandatory bi-annual re-credentialing process for all HPH physicians; (3) improving the mechanisms for reporting and discussing adverse events and close calls; and (4) improving the physician discipline process. (Chassin, Tr. 5224-28, 5389-90).

Response to Finding No. 1418:

{ } (Romano, Tr. 3158-59, 3170-71, *in camera*). { } (Romano, Tr. 3159, *in camera*; *See also* CCRFF 1417, CCFF 2426-2429).

1419. { } (Romano, Tr. 3449-50, *in camera*). Further, Dr. Romano did not rely on administrative data to reach the conclusion that there were improvements in the quality assurance program at HPH (Romano, Tr. 3393).

Response to Finding No. 1419:

{ } (Romano, Tr. 3449, *in camera*). A more complete summary of his opinion, in which he rejects ENH's claim of "drastic improvement" is quoted in CCRFF 1420 below. (*See* CCRFF 1420). Dr. Romano also testified that Respondent has not proven that any changes to the QA program could only have occurred due to the merger. (*See* CCRFF 1417-1418). The claim that Dr. Romano did not rely on administrative data in studying HPH's quality assurance program is irrelevant. His analysis of the quality assurance claim was based upon a thorough review of the same materials as Dr. Chassin. (Romano,

Tr. 3139, 3152). In the wholly separate areas where Dr. Romano did rely on administrative data, he explained in detail why that data was both reliable and valid. (*See* CCFF 2104-2112).

ii. HPH's Quality Assurance Was Inadequate Before The Merger

1420. Before the Merger, several physician issues hindered HPH's efforts to improve the quality of care at HPH, including: poor procedural technique, poor diagnostic skills, limited knowledge of best demonstrated practices, failure to report errors and failure to question practice. (RX 417 at ENHL PK 17696).

Response to Finding No. 1420:

This finding is misleading. Respondent's citation to RX 417 strongly buttresses Dr. Romano's conclusion that HPH had both an effective and improving QA program pre-merger. (Romano, Tr. 3139, 3152). That document is in fact a major pre-merger study titled "Quality in the New Millennium at HPH" which was undertaken by HPH pre-merger. (RX 417). Studying and learning from one's mistakes is of course the whole point of quality assurance, and this document vividly demonstrates that HPH was doing so pre-merger. For further discussion HPH's pre-merger QA program *see* CCRFF 1416. (CCRFF 1416). Respondent has also failed to show that the merger was necessary for any changes and improvements to HPH's QA program. (*See* CCRFF 1417 and 1418). Moreover, the selective citation to a portion of Dr. Romano's testimony is misleading. Dr. Romano, with the assistance of a qualified nurse, reviewed the same committee meeting minutes and other materials as Dr. Chassin, and concluded that "there are documents indicating a very effective quality assurance and quality improvement process . . . On balance I cannot accept Dr. Chassin's conclusion that it was dramatically

improved after the merger." (Romano, Tr. 3139, 3152).

1421. Adverse events, including adverse drug events, were largely underreported. (RX 417 at ENHL PK 17695). {[redacted]} (Chassin, Tr. 5211; RX 417 at ENHL PK 17695-96; RX 251 at ENHL PK 17839, *in camera*).

Response to Finding No. 1421:

Pre-merger HPH had a strong QA program that actively analyzed adverse events. (*See* CCRFF 1416). Furthermore, Respondent's use of RX 251 is misleading. {[redacted]} (RX 251 at ENHL PK 17839, *in camera*). {[redacted]} (RX 251 at ENHL PK 17839, *in camera*).

1422. Even where adverse events were reported, however, HPH lacked a systematic approach for examining them and determining ways to prevent them from recurring. (Chassin, Tr. 5211; RX 417 at ENHL PK 17695). {[redacted]} (Chassin, Tr. 5211; RX 417 at ENHL PK 17695-96; RX 251 at ENHL PK 17839, *in camera*).

Response to Finding No. 1422:

This finding is misleading. Again, ENH cites to RX 417 which proves the opposite of what ENH asserts – the pre-merger study of HPH's quality assurance processes demonstrates that pre-merger HPH was studying and seeking ways to improve those processes. (RX 417). Pre-merger HPH had a strong QA program that actively analyzed adverse events and took advantage of opportunities for improvement, see

CCRFF 1416 and 1421.

Respondent's claim that "HPH had a pattern of finding no opportunities for improvement" misstates the evidence and demonstrates the lack of credibility of Respondent's position. Dr. Chassin's conclusion of a "pattern of finding no opportunities for improvement" was based on "qualitative evidence" consisting of "information that is in written minutes", which "tends to be an incomplete summary of the discussions that occurred." (Romano, Tr. 3140). Moreover, Dr. Chassin did not review the facts of the individual cases where no opportunity for improvement was identified, and therefore could not say that there was in fact some opportunity for improvement that was missed. (Chassin, Tr. 5512-13). Even after the merger, no opportunity for improvement was identified in some cases, and Dr. Chassin did not compare the number of times this happened pre-merger to see if the merger brought about a decrease. (Chassin, Tr. 5519). In at least one case pre-merger, Dr. Chassin was aware of an incident that triggered an "extensive special case review", a "root cause analysis" and a "corrective action plan." (Chassin, Tr. 5514). Finally, Dr. Chassin could not say whether there were no other such cases, pre-merger. (Chassin, Tr. 5519).

{[redacted] } (Romano, Tr. 3145, *in camera*). {[redacted] }

(Romano, Tr. 3146, *in camera*; CX 6296 at 3-6, *in camera*).

1423. { } (RX 1772 at ENHL PK 17957, *in camera*). { } (Chassin, Tr. 5222-23; RX 324 at ENHL PK 29713, *in camera*; RX 284 at ENHL PK 26594). A discussion by the board of the ACOG site visit in 1998 misrepresented the nature of that visit, given the highly critical nature of the ACOG report. (Chassin, Tr. 5212, 5215; RX 349 at ENH RS 3439). { } (Chassin, Tr. 5215-16; RX 324 at ENHL PK 29713-74, *in camera*).

Response to Finding No. 1423:

This finding is incomplete and misleading. Respondent points to examples in which the QA process at HPH before the merger produced "no opportunities for improvement" without taking into account the circumstances surrounding the event. { } (RX 1772 at ENHL PK 17957, *in camera*. *See also* CCRFF 1416, 1421-1422). As explained in CCRFF 1422 above, Dr. Chassin performed no analysis to show whether, in cases where no opportunity for improvement was identified in the minutes, there was in fact some opportunity that was missed. Nor did he compare the frequency of this occurrence pre-merger with that post-merger.

{ } (Romano, Tr. 3152-54, *in camera*). {

} (Romano, Te. 3155-56, *in camera*).

1424. There is no evidence that HPH took any formal disciplinary actions against HPH physicians before the Merger despite several clear examples of pre-Merger physician behavior at HPH that clearly merited such action. (Chassin, Tr. 5225-26).

Response to Finding No. 1424:

Pre-merger HPH was not shy about disciplining problematic physicians before the merger. (Newton, Tr. 381-383. *See also* CCRFF 1416). {

} (Silver, Tr. 3929-39, *in camera*; RX 2034, *in camera*). {

} (Romano, Tr. 3043-44, *in camera*).

1425. {

} (Harris, Tr. 4420-23, *in camera*; RX 368 at ENH RS 7055, *in camera*). {

} (Harris, Tr. 4420-21, *in camera*; RX 346 at ENHL PK 24708, *in camera*). {
.}
(Harris, Tr. 4420, *in camera*). {

} (Harris, Tr. 4420, *in camera*).

Response to Finding No. 1425:

Again, pre-merger HPH disciplined problematic physicians when necessary. (*See*

CCRFF 1416). ENH's post-merger changes have not completely eliminated practice by unqualified or problematic physicians. (*See* CCRFF 1424). Moreover, the referenced incident in fact proves the opposite of what ENH claims. While the incident itself resulted in a patient death, HPH's response was "a textbook example of how to do things right in terms of identifying opportunities for improvement." (Romano, Tr. 3146). Moreover, the incident was voluntarily reported to JCAHO. (Romano, Tr. 3150). HPH was "damned if it did and damned if it didn't" under Respondent's one-sided view of the evidence. If a review indicates no opportunities for improvement, ENH says opportunities were missed. (*See* RFF 1423). But if, as in this case, the review goes into detail about an admitted problem, ENH focuses on the underlying problem without acknowledging HPH's efforts to address it.

1426. { } (Harris, Tr. 4421, *in camera*). { } (Harris, Tr. 4421, *in camera*; RX 346 at ENHL PK 24709, *in camera*).

Response to Finding No. 1426:

This finding is incomplete and misleading. (*See* CCRFF 1425). In addition, Dr. Harris testified that HPH had made an effort to deal with the physician at issue. HPH had both reprimanded him, and asked him to "get the training that was necessary to perform the procedure" or provide for his own coverage in the future. (Harris Tr. 4423-25).

1427. { } (Harris, Tr. 4423, *in camera*). { } (Harris, Tr. 4423, *in camera*). { } (Harris, Tr. 4423, *in camera*).

Response to Finding No. 1427:

This finding is incomplete and misleading. (*See* CCRFF 1425-1426).

1428. This pattern of ineffective adverse event case reviews was widespread throughout HPH. (Chassin, Tr. 5223).

Response to Finding No. 1428:

This finding is incomplete and misleading. (*See* CCRFF 1416, 1421-1425). In the cited portion of the transcript, Dr. Chassin merely repeated his anecdotal assessment that HPH failed to identify opportunities for improvement, even though there are examples where that was clearly not the case. (*See* CCRFF 1423). Dr. Chassin never tabulated the number of times this happened pre-merger compared to post-merger, and could not say that there were in fact opportunities which were missed. (*See* CCRFF 1422).

(1) HPH's Pre-Merger Organizational Structure Hindered Quality Assurance Activities

1429. Hospital governance plays a critical role in setting the tone for effective quality assurance. (Chassin, Tr. 5211). Effective peer review and quality assurance starts with the leadership at all levels. (Chassin, Tr. 5211). For peer review and quality assurance to work well, the Board of Trustees must have a role in hearing about, encouraging, and then enforcing discipline. (Chassin, Tr. 5211). The hospital's leadership, the administrative leadership and the nursing and physician leadership must play similar roles. (Chassin, Tr. 5211).

Response to Finding No. 1429:

HPH's leadership and organization structure played a positive role in QA before the merger. Prior to the merger, HPH physicians engaged in case reviews as part of quality assurance. (Spaeth, Tr. 2090-91). In order to assure high quality of care, the board of directors would also credential and re-credential physicians based upon

recommendations from the medical executive committee and department chairman. (Newton, Tr. 381). Board members would also participate in a joint committee with medical staff leadership that would examine quality and peer review issues. (Newton, Tr. 381). { } (CX 6265 at 25, *in camera*). { } (CX 6265 at 25, *in camera;.see also* CCFF 2218-2226). It is noteworthy that in demonstrating the inaccuracies in this finding complaint counsel relies above upon the testimony of witnesses who were actually present at and participated in HPH board meetings. ENH, in contrast, relies upon the testimony of a doctor who merely reviewed minutes from meetings at which, for example, Mr. Newton was present.

1430. Before the Merger, there was a lack of effective hospital and Board leadership at HPH that prevented physician leaders from being able to enforce and evaluate conduct by other physicians. (Chassin, Tr. 5389-90). There was a lack of overarching goals set from the top down. (RX 417 at ENHL PK 17696).

Response to Finding No. 1430:

This finding is misleading, HPH as an organization and its leadership supported quality assurance. (*See* CCRFF 1429). Again, in attempting to prove that HPH was not effective in solving quality problems pre-merger, ENH cites the pre-merger "Quality in the New Millenium" study in which HPH documented a thorough study of quality issues and developed a plan to address them. (RX 417). If HPH's extensive pre-merger assessment of quality had found no problems, then ENH would say opportunities were

missed. (*See* CCRFF 1425).

1431. Before the Merger, HPH had a hospital culture of keeping adverse event discussions away from the Board of Trustees. (Chassin, Tr. 5216-17). As a result, the Board rarely, if ever, was involved either in analyzing the adverse events or helping to solve them. (Chassin, Tr. 5212, 5216-17). The documentary evidence of HPH's Board of Trustee meetings confirms an absence of sufficient discussion of quality assurance problems at the hospital Board level. (Chassin, Tr. 5212).

Response to Finding No. 1431:

This finding is misleading. HPH's leadership, at all levels, was actively involved in quality assurance. (*See* CCRFF 1429). In addition, Dr. Chassin did not interview any trustees of HPH to get their perspective on the Board's involvement in quality assurance issues at HPH before the merger. (Chassin, Tr. 5161-62). Again, it is curious that the sole witness on whom ENH relies regarding activities at HPH board meetings is its expert, rather than someone who was present.

1432. Additionally, clinical department chairman were the primary authority for evaluating and correcting physician discipline and quality assurance problems within their clinical spheres. (Chassin, Tr. 5217; Spaeth, Tr. 2253). All of the department chairmen were private practicing physicians. This arrangement placed department chairmen in the role of judging the behavior of physicians in their department with whom they worked or had a competing financial stake. (Chassin, Tr. 5218-19; Spaeth, Tr. 2252). This structure created conflicts that prevented the members of the quality assurance committee from effective peer review because, in part, they did not want to be responsible for someone losing their privileges and livelihood. (Chassin, Tr. 5219; RX 324 at ENHL PK 29713).

Response to Finding No. 1432:

This finding is irrelevant. HPH's practice of choosing clinical department chairmen from among the private practitioners on the medical staff did not present a problem for assuring quality of care. (Newton, Tr. 378-80). Physicians are professionals who go through a peer review process, so choosing chairmen among medical staff should

not make a difference as to quality of care. (Newton, Tr. 380). Most community hospitals have elected officers from the medical staff, and JCAHO has not taken a position that elected medical staff officers are adverse to quality. (Spaeth, Tr. 2315). Placing department chairs paid by the hospital in the same position, as ENH did after the merger, which creates conflict issues of its own and has caused one doctor to complain that the ENH paid department chair favors physicians affiliated with ENH. (Romano, Tr. 3133).

1433. The incentive to discipline fellow physicians was further reduced by the possibility that the disciplined physician might be elected as a department head the following year. (Spaeth, Tr. 2252). { [redacted] } (Chassin, Tr. 5218-19; RX 324 at ENHL PK 29708, *in camera*). { [redacted] } (Chassin, Tr. 5218; RX 324 at ENHL PK 29708, *in camera*).

Response to Finding No. 1433:

This finding is misleading and irrelevant. HPH's process in selecting departmental chairman did not negatively impact quality, and ENH's changes created problems of their own.. (*See* CCRFF 1432).

1434. A further problem at HPH before the Merger was that the physicians in leadership roles practiced at other hospitals, and HPH sometimes had trouble finding physicians to accept positions as department chairman. (Spaeth, Tr. 2251-52). For example, HPH's pre-Merger head of surgery, Dr. Sobinsky, practiced primarily at Lake Forest Hospital. (Spaeth, Tr. 2251).

Response to Finding No. 1434:

This finding is misleading and irrelevant. HPH's process in selecting departmental chairman did not negatively impact quality, and ENH's changes created problems of their own. (*See* CCRFF 1432).

(2) HPH's Pre-Merger Adverse Event Case Reviews Were Suboptimal

1435. Hospital quality assurance programs look carefully at adverse events, errors and close calls that do not result in adverse events to learn as much as possible about how the organization can prevent those unsafe situations or bad outcomes from recurring. (Chassin, Tr. 5219-20). HPH had no systematic method of quality assurance before the Merger, and there were several substantial barriers to clinical quality reform. (Chassin, Tr. 5220; RX 417 at ENHL PK 17695).

Response to Finding No. 1435:

HPH had a strong quality assurance program that closely analyzed adverse events for opportunities to improve quality. (CCRFF 1416, 1421-1423). Again, RX 417 is the pre-merger study that shows HPH actively seeking to improve its quality assurance processes.

1436. Numerous records and contemporaneous documents dated before the Merger identify inappropriate practices and physician misbehavior that was not dealt with and further demonstrate that HPH's pre-Merger culture prevented physicians from taking effective disciplinary action. (Chassin, Tr. 5217-18; RX 417 at ENHL PK 17696-97).

Response to Finding No. 1436:

HPH had a strong quality assurance program that closely analyzed adverse events for opportunities to improve quality, before the merger. (CCRFF 1416, 1421-1423). Before the merger, HPH disciplined problematic physicians, and ENH had problems disciplining physicians after the merger. (CCRFF 1424). Respondent is correct that Dr. Chassin made a sweeping statement about the documents he said demonstrate that HPH did not discipline physicians. But Dr. Romano, aided by a qualified nurse, reviewed all of the same documents and concluded that "[o]n balance I cannot accept Dr. Chassin's conclusion that it was dramatically improved after the merger." (Romano, Tr. 3139,

3152).

1437. { } (RX 324 at ENHL PK 29754, *in camera*). { } (Chassin, Tr. 5221-22; RX 2006 at 103; Harris, Tr. 4418, *in camera*; RX 365 at ENH RS 3454, *in camera*). { . Because HPH was required to do an adverse event case review by the Joint Commission as a result of the 1998 esophageal obstruction case, it does not reveal very much about the strengths or weaknesses of HPH's pre-Merger quality assurance program. (Chassin, Tr. 5620-21).

Response to Finding No. 1437:

This finding is misleading. HPH performed root cause analyses of adverse events. (CCRFF 1422). This incident was a "textbook example of how to do it right" and the incident was reported to JCAHO voluntarily. (Romano, Tr. 3146, 3150-51).

1438. { } (Harris, Tr. 4421, in camera; RX 365 at ENH RS 3454, *in camera*). { } (Harris, Tr. 4421, *in camera*).

Response to Finding No. 1438:

This finding is incomplete and unduly selective in terms of widely disparaging HPH's quality of care before the merger based on one incident. Before the merger, HPH routinely disciplined problematic physicians and maintained a strong and consistant QA program. (CCRFF 1416, 1421-1424).

1439. {

} (Chassin, Tr. 5221; RX 324 at ENHL PK 29708, *in camera*; RX 208 at ENHL PK 17285). In fact, the ACOG report states that ACOG was called in to do the review because a member of the HPH board of trustees was upset by a 1997 newspaper publication regarding a malpractice verdict against HPH for an incident that occurred four years earlier. (Chassin, Tr. 5587). { } (Chassin, Tr. 5221; RX 324 at ENHL PK 29710, *in camera*).

Response to Finding No. 1439:

This finding is irrelevant, the fact is that pre-merger HPH acted on the opportunity to invite specialists from ACOG to perform a site survey in order to improve quality. HPH acted on many of the recommendation ACOG made. (*See* CCRFF 1423). It should also be noted that ENH never invited ACOG to perform a site survey of HPH after the merger. (Krasner, Tr. 3752). Also, there was no evidence presented at trial of ENH inviting ACOG to perform a site survey of its Evanston Hospital after that Hospital experience some malpractice suits related OB/Gyn services. { } (Neaman, Tr. 1399, *in camera*; Silver, Tr. 3931-32, *in camera*). { } (Silver, Tr. 3932, *in camera*). { } (Silver, Tr. 3933, *in camera*). { } (Silver, Tr. 3934, *in camera*). { } (Neaman, Tr.

1401, *in camera*; Silver, Tr. 3936, *in camera*; CX 1033, *in camera*). {[redacted]

[redacted]

[redacted]

[redacted]} (Silver, Tr. 3936, *in camera*).

In addition, although Respondent claimed that it improved quality at HPH by eliminating the practice of performing D&C procedures in the emergency room, ENH allowed physicians to perform D&Cs in the emergency room at HPH from the time of the merger until after the spring of 2001. (Silver, Tr, 3781, 3857-58). ENH also allowed certain second trimester abortions to be performed in labor and deliver at HPH until at least the spring of 2001. (Silver, Tr. 3857-58).

1440. The fact that the 1998 ACOG site visit was voluntarily requested is not, by itself, a reflection of a good QA or QI process at HPH before the Merger. (Chassin, Tr. 5586-87, 5221).

Response to Finding No. 1440:

HPH's request for an ACOG site visit, and its actions on the ACOG recommendations, show an impressive committment to QA and QI. (*See* CCRFF 1423, 1439).

(3) HPH's Ob/Gyn Department Was Particularly Poor At Disciplining Problem Physicians

1441. Before the Merger, the Department of Ob/Gyn at HPH was particularly weak in disciplining physicians who had demonstrated the kinds of repeated patterns of behavior that could really only be dealt with by discipline. (Chassin, Tr. 5206-07).

Response to Finding No. 1441:

HPH disciplined problematic physicians before the merger, and ENH management

let a physician perform inappropriate gynecological surgery at HPH for over two years after the merger. (*See* CCRFF 1423; *see also* CCRFF 1439 for a discussion on serious QA problems at ENH's Ob/Gyn department).

iii. ENH Improved HPH's Quality Assurance Program Soon After The Merger

1442. After the Merger, ENH completely changed the structure of physician oversight at HPH. (Chassin, Tr. 5224). ENH replaced the part-time and private practicing physician chairs with full-time clinical chairmen, and integrated the medical staffs in each department. (Chassin, Tr. 5224-25; Neaman, Tr. 1354; Spaeth, Tr. 2253-54). The clinical chairmen are responsible for the integrated departments and physicians at HPH. (Spaeth, Tr. 2253-54).

Response to Finding No. 1442:

This finding is irrelevant. HPH's pre-merger practice of choosing its clinical department chairman had no deleterious effect on quality of care. (*See* CCRFF 1432). Also, just as there are pre-merger document to which ENH can point criticizing the leadership, there are post-merger documents in the same vein. (CX 405 at 2). And as late as 2004, ENH still experienced organizational and leadership problems in its Cardiology Department resulting in a "toxic" and dysfunctional environment. (CX 773 at 1). ENH has presented these documents in an anecdotal fashion without ever systematically tabulating the pre and post-merger occurrences.

1443. The clinical chairmen are no longer elected. Rather, they are selected following a national search and employed by ENH. (Spaeth, Tr. 2252-53). As such, they are unencumbered by the conflicts-of-interest facing the private practicing physician leaders at HPH before the Merger. (Chassin, Tr. 5391).

Response to Finding No. 1443:

This finding is irrelevant. (*See* CCRFF 1432 and 1442). Paid departmental chairs continue to be encumbered by conflicts of interest, and one physician has complained

specifically about unfair treatment – favoritism toward ENH affiliated physicians – as a result. (Romano, Tr. 3133).

(1) The Merger Improved The Reporting Of Adverse Events At HPH

1444. Before the Merger, Evanston Hospital's organizational culture encouraged the reporting of hospital errors for learning purposes. (Chassin, Tr. 5227). That culture was exported to HPH after the Merger, and over time, resulted in a positive change at HPH in the reporting of errors. (Chassin, Tr. 5227-28).

Response to Finding No. 1444:

This finding is misleading. HPH's QA program, including the reporting of errors, was steadily improving before the merger, and any subsequent improvement was more in line with a nationwide trend in improving QA rather than specific to the merger. (CCRFF 1416-1423).

1445. Contemporaneous documents from the quality assurance meetings at HPH show that HPH became more proactive in identifying and reporting errors after the Merger. (Chassin, Tr. 5228; RX 889 at ENHL PK 16485). As early as June 2000, the quality assurance committee meetings at HPH reflect HPH's new efforts to discuss and encourage the reporting of medical errors and close calls. (Chassin, Tr. 5229-30; RX 889 at ENHL PK 16485).

Response to Finding No. 1445:

This finding is misleading and incomplete. The finding reflects ongoing improvement in HPH's QA that can be traced back to before the merger, such as the apparently successful use of root cause analysis, which was also used frequently before the merger. (RX 889 at ENHL PK 16485. *See also* CCRFF 1416-1423). Again, ENH has presented no systematic analysis of the documents and asks the Court to take Dr. Chassin's word that an improvement took place – supported by a few anecdotal examples. Dr. Romano has reviewed the same documents and disagrees. (Romano, Tr.

3152).

Moreover, on the very same page of the document ENH cites in support of its claim of improved processes, RX 889 at ENHL PK 16485, there is a discussion of "Press Ganey patient satisfaction data," further demonstrating that ENH's criticisms of that data at trial are inconsistent with the business practices memorialized in documents it says are reliable for other purposes. (*See* CCRFF 2248-2268 (discussing validity of Dr. Romano's use of Press Ganey scores)).

(2) ENH's Addition Of Strong Department Leadership At HPH Helped Correct Problems With Physician Discipline

1446. { } (Chassin, Tr. 5225; RX 2033, *in camera*; RX 2034, *in camera*). { } (RX 2034 at ENHL PL 1301, *in camera*).

<u>Response to Finding No. 1446:</u>

This finding is misleading and incomplete. (*See* CCRFF 1424, 1439 and 1441 (discussing HPH's pre-merger disciplinary actions against physicians, and ENH's failings in taking appropriate disciplinary measures after the merger)).

1447. ENH's addition of department chairmen was an important step in improving the system of physician discipline at HPH, and it improved the quality in the Department of Ob/Gyn at HPH. (Chassin, Tr. 5204-05).

<u>Response to Finding No. 1447:</u>

This finding is irrelevant. (*See* CCRFF 1432, 1439 and 1442 (discussing HPH's pre-merger disciplinary actions against physicians, and ENH's failings in taking appropriate disciplinary measures after the merger; also discussing the problems with

quality at the OB/Gyn department of Evanston despite its method of choosing departmental chairmen)). It should also be pointed out that a full-time chairperson was not installed at HPH by ENH management until the spring of 2001, almost a full year and half after the merger. (Silver, Tr. 3841).

1448. Dr. Silver, the chairman of the Department of Ob/Gyn at HPH, fixed the weak disciplinary structure within the department. (Chassin, Tr. 5206-07).

Response to Finding No 1448:

Various evidence supports the view that HPH already had a strong disciplinary structure before the merger across its entire hospital. (*See* CCRFF 1416, 1424). Furthermore, the presence of a full-time clinical chairman will not in and of itself impact quality significantly. (*See* CCRFF 1432, 1439). Moreover, Dr.Silver did not begin until halfway into 2001, or a year and a half after the merger. If there was a "weak disciplinary structure," it continued for a year and a half on ENH's watch. This fact is inconsistent with ENH's claim of sweeping improvements brought about by the merger but fully consistent with Dr. Romano's conclusion that quality assurance improved at HPH based upon a gradually emerging consensus that came about with nationwide. (Romano, Tr. 3159).

1449. {[redacted]} (Silver, Tr. 3880-89, 3896-3916, *in camera*).

Response to Finding No. 1449:

This finding is misleading and irrelevant. Again, HPH disciplined physicians before the merger, and some disciplinary problems at HPH continued long after ENH

management took over following the merger. (*See* CCRFF 1424, 1448).

1450. { } (Silver, Tr. 3880-82, *in camera*). { } (Silver, Tr. 3881, *in camera*). { } (Silver, Tr. 3882-83, *in camera*). { } (Silver, Tr. 3884, *in camera*).

Response to Finding No. 1450:

This finding is irrelevant. (*See* CCRFF 1424; *See also* CCRFF 1448).

{ } (Silver Tr. 3881, *in camera*). This is exactly what ENH says Dr. Silver did, with regard to inpatient privileges, post-merger.

1451. { } (Silver, Tr. 3886, *in camera*). { } (Silver, Tr. 3886-87, *in camera*). { } (Silver, Tr. 3888-89, *in camera*).

Response to Finding No. 1451:

This finding is irrelevant. (*See* CCRFF 1424). {

} (Silver, Tr. 3886-88, *in camera*).

1452. { } (Silver, Tr. 3906-07, *in camera*). { } (Silver, Tr. 3898, 3917, *in camera*; RX 2033, *in camera*; RX 2034, *in camera*). { } (Silver, Tr. 3913-14, *in camera*). { }. (Silver, Tr. 3900-01, *in camera*).

Response to Finding No. 1452:

Respondent's finding is incomplete and misleading. { } (CCRFF 1424)

1453. { } (Silver, Tr. 3916, *in camera*). { } (Silver, Tr. 3901-02, *in camera*). { } (Silver, Tr. 3902, *in camera*).

Response to Finding No. 1453:

This finding is irrelevant and misleading. (*See* CCRFF 1424 ({ }), *in camera*).

1454. { } (Silver, Tr. 3903-04, *in camera*; RX 2033, *in camera*). {

} (RX 2033, *in camera*). { } (Silver, Tr. 3907, *in camera*).

Response to Finding No. 1454:

This finding is irrelevant and misleading. (*See* CCRFF 1424 (}), *in camera*). { }

1455. { } (Silver, Tr. 3908, *in camera*; RX 2034, *in camera*.) { } (Silver, Tr. 3908-10, *in camera*; Jones, Tr. 4191, *in camera*). { } (Jones, Tr. 4191-92, *in camera*).

Response to Finding No. 1455:

This finding is irrelevant and misleading. (*See* CCRFF 1424 ({ }), *in camera*).

1456. { } (Jones, Tr. 4192, *in camera*). {

} (Jones, Tr. 4192, *in camera*). {

} (Jones, Tr. 4192, *in camera*).

Response to Finding No. 1456:

This finding is irrelevant and misleading. (*See* CCRFF 1424 ({

}), *in camera*).

1457. {

} (Silver, Tr. 3926, *in camera*).

Response to Finding No. 1457:

This finding is irrelevant and misleading. (*See* CCRFF 1420-1424, 1439, and 1454 ({

}), *in camera*). Furthermore, there is no literature yet on the link between ENH's preoperative review program and patient outcomes. (Silver, Tr. 3852).

(3) ENH Improved The Process Of Reviewing HPH Physician Credentialing Status

1458. After the Merger, ENH introduced a periodic re-credentialing process in which HPH physicians underwent a review of their practices under which they were required to meet the credentialing requirements that have been established to maintain clinical privileges by the appropriate department chairman. (Chassin, Tr. 5226; Neaman, Tr. 1354; RX 651 at ENH MN 1536). After the Merger, several physicians at HPH were not granted re-appointment during the periodic re-credentialing process because of their failures to respond while on call. (Chassin, Tr. 5227).

Response to Finding No. 1458:

This finding is irrelevant and misleading. Before the merger, HPH would also credential and re-credential physicians based upon recommendations from the medical executive committee and department chairman, in order to assure high quality. (Newton, Tr. 381; CCRFF 1429).

1459. { }
(Chassin, Tr. 5227; RX 324 at ENHL PK 29709, *in camera*; RX 346 at ENHL PK 24708, *in camera*).

Response to Finding No. 1459:

The cited sources do not that state that physicians failure to respond while on call was a contributing factor to an obstetric malpractice case. Furthermore, Evanston Hospital recently experienced severe adverse events resulting in a malpractice suit despite having in-house OB physician coverage. (*See* CCRFF 1439).

{ } (RX 346 at ENHL PK 24708-11, *in camera*).

d. The Merger Improved HPH's Quality Improvement Program

1460. Quality improvement ("QI") is directed toward improving the quality of service

across a wide variety of measures. (Chassin, Tr. 5252). Hospitals must have QI programs that are directed proactively using data-driven methods to improve their services over time. (Chassin, Tr. 5252).

Response to Finding No. 1460:

It should be noted that the consensus in this area is fairly recent. { }

(Romano, Tr. 3159, *in camera*).

1461. To be effective, a QI program has to involve multidisciplinary approaches, which requires input from all different clinical perspectives – including physicians, nurses, pharmacists and all of the other perspectives of care. (Chassin, Tr. 5252). The QI program must also be data-driven, which requires the identification of specific measures that are valid and focus on improving those measures. (Chassin, Tr. 5252). Further, the QI program must be proactive, identifying the best opportunities for improvement across the services that the hospital offers. (Chassin, Tr. 5252-53).

Response to Finding No. 1461:

Respondent's finding is incomplete. (*See* CCRFF 1460, 1464). { } (CX 6265 at 25, *in camera*). { } (CX 6265 at 25, *in camera*).

1462. In the months immediately following the Merger, ENH made major improvements in HPH's QI program by exporting its QI program to HPH. (Chassin, Tr. 5257). { } (Romano, Tr. 3451-52, *in camera*).

Response to Finding No. 1462:

This finding is misleading. { }(Romano Tr. 3451-52, *in camera*). { } (Romano, Tr. 3139, 3152, *in camera*). { }

(Romano Tr. 3159, *in camera*).

The majority of ENH's critical pathways, a key component of its QI program, were not exported HPH until after October 2001, by August 2002 at the latest, more than two years after the merger. (RX 1357 at ENHE F42 021021). { } (Romano, Tr. 3170, *in camera*). (*See also* CCRFF 1460).

1463. These QI program improvements dramatically improved the quality of patient care at HPH. (Chassin, Tr. 5257-58; Ankin, Tr. 5055).

Response to Finding No. 1463:

This finding is not supported by any evidence. { } (Romano, Tr. 3168-69, *in camera*; *see also* O'Brien, Tr. 3560-62). (*See also* CCRFF 1305; CCRFF 1462-1463 (discussing implementation of ENH critical

pathways and comparison with pre-merger HPH care maps)). { } (Romano, Tr. 3168-70, *in camera*). { } (*See, e.g.*, CX 464 at 2-3, *in camera* ({ })).

This finding is also misleading. Respondent implies that QI program improvements at HPH would not have occurred unless HPH was acquired by ENH. { } (Romano, Tr. 3158-59, *in camera*). } (Romano, Tr. 3159, *in camera*). { } (Romano, Tr. 3159, *in camera*).

{ } (Romano, Tr. 3170-71, *in camera*). It should be noted that in developing critical pathways for HPH, ENH took into account HPH's pre-merger care maps. (CX 6286 at 4 (King, Dep.); O'Brien, Tr. 3560-61).

i. HPH's Pre-Merger QI Program Was Inadequate

1464. HPH's pre-Merger QI program suffered from several weaknesses: (1) it included several indicators that were not valid quality measures and did not use data from sources outside HPH to determine where its performance was on the scale of good, bad, or indifferent; (2) there was a lack of benchmarking and use of best demonstrated practices; (3) HPH used a care map process that was very simplistic and deficient as a means of improving care; and (4) HPH's approach to improvement was extremely limited in that it did not use evidence from adverse event investigations, or a multidisciplinary process, and had very few indicators. (Chassin, Tr. 5253-54; RX 417 at ENHL PK 17694).

Response to Finding No. 1464:

This finding is incorrect. (*See* CCRFF 1468 (describing strengths of HPH's pre-merger QI program)).

1465. { } (Chassin, Tr. 5254-55; RX 216 at ENHL PK 36980, *in camera*).

Response to Finding No. 1465:

This finding misstates the evidence. HPH tracked more measures than what is listed in RFF 1465. { } (RX 216 at ENHL PK 039675-039681, *in camera*) (*See also* CRFF 1468).

1466. HPH also had an extremely limited process for attempting to proactively improve quality of care pre-Merger. This process failed to identify the places where care needed to be improved. (Chassin, Tr. 5255; RX 417 at ENHL PK 17695). In addition, there was evidence of wide variations in applying practice standards in the treatment of certain diseases, resulting in variation in patient outcomes at HPH before the Merger. (RX 417 at ENHL PK 17695).

Response to Finding No. 1466:

This finding is incorrect. (*See* CCRFF 1468 (describing strengths of HPH's pre-

merger QI program)).

1467. {

} (Chassin, Tr. 5255; RX 216, *in camera*). HPH's pre-Merger care maps lacked valid process measures of quality, such as which medications and treatment procedures should be used, and did not result from a multidisciplinary process that included physicians and nurses developing a best approach to patient care. (Chassin, Tr. 5255-56).

Response to Finding No. 1467:

This finding is incorrect. (*See* CCRFF 1468 (describing strengths of HPH's pre-merger QI program)).

1468. Even though HPH recognized some of the limitations in its QI efforts toward the end of the pre-Merger period, there is no evidence that HPH actually improved its QI process before the Merger. (Chassin, Tr. 5256; RX 417 at ENHL PK 17695).

Response to Finding No. 1468:

This finding is false and not supported by a citation. HPH's pre-merger "Quality in the New Millennium" report, which is cited in this finding, lays out many planned initiatives for improving specific problems in quality:. (RX 417 at ENHL PK 017694-017697). It should also be noted that this report was compiled in 1999, shortly before the merger, making it unreasonable to expect the implementation of all of the suggested quality improvements by the time of the merger. Furthermore, HPH's QI program was strengthened by the" integration at a variety of levels throughout the organization." (RX 417 at ENHL PK 017693).

Even before the report, HPH engaged in aggressive QI efforts. These efforts included implementing clinical best practices through the use of care maps. (O'Brien, Tr. 3562). {

} (Romano, Tr. 3168-69, *in camera*; *see also* O'Brien, Tr. 3560-62). (*See also* CCRFF 1305; CCRFF 1462-1463 (discussing implementation of ENH critical pathways and comparison with pre-merger HPH care maps)). Even before the merger, HPH was constantly improving upon its care maps and was creating new ones. (CX 95 at 3). {

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(Romano, Tr. 2983, 3139, 3152, *in camera*). {

} (Romano, Tr. 3146 (discussing CX 6296, *in camera*, and 6297, *in camera*), *in camera*).

{

} (RX 253 at ENHL PK 031272, *in camera*; RX 442 at ENH RS 004658, *in camera*). {

} (Romano, Tr. 3142, 3146, *in camera*). Before the merger, HPH also performed case reviews by physicians which identified problem cases that would result in the hospital mentoring a physician. (Spaeth, Tr. 2090-91). In addition, prior to the merger HPH had committee made up of Board members and medical staff leadership that would look at quality issues and peer review issues. (Newton, Tr. 381).

A pre-merger strategic plan for HPH included paying closer attention to providing documentation and measurable outcomes of quality through the creation of additional clinical pathways and modifications to providing care. (Newton, Tr. 331-32; CX 1868 at 12). And while Dr. Chassin attacked pre-merger HPH for using indicators for quality that "lacking validity," ENH also used the same quality indicators to measure quality improvement. (Chassin, Tr. 5440-43).

{[REDACTED]} (Krasner, Tr. 3753-54; Romano, Tr. 3154-55, *in camera*). {[REDACTED]} (CX 6265 at 25, *in camera*).

ii. ENH Exported Its Superior Quality Improvement Processes To HPH Soon After The Merger

1469. At the time of the Merger, a team of people from the QI departments at Evanston Hospital and HPH conducted an assessment of the QI activities at HPH. (O'Brien, Tr. 3526). The team determined that there was some effort at HPH to use best practices and to make investigations of some adverse events. (O'Brien, Tr. 3526). However, the Evanston Hospital best practices were more comprehensive and contained an established set of criteria for determining when an investigation should take place after a near miss or an adverse event. (O'Brien, Tr. 3526-27).

Response to Finding No. 1469:

This finding is misleading. It assumes that before the merger Evanston Hospital's QI program was superior to HPH's. {[REDACTED]}

(Romano, Tr. 3168-69, *in camera*; *see also* O'Brien, Tr. 3560-62). (*See also* CCRFF 1305; CCRFF 1462-1463 (discussing implementation of ENH critical pathways and comparison with pre-merger HPH care maps)). It should also be noted that HPH did its own assessment of its QI process "toward the end of the pre-merger period" and determined it needed improving. (Chassin, Tr. 5256). But then the merger happened immediately afterwards, while advancements in QI were happening at hospitals across the country. (Romano, Tr. 3003-04). Based on national trends of a "move toward a more proactive stance in quality improvement," one would have expected to see HPH, which already had a good program, to follow the national trend of improvement, even without the merger. (Romano, Tr. 3004).

1470. After the Merger, ENH rapidly exported its quality assurance and QI systems to HPH by involving a large cohort of physicians in quality improvement committees and activities. (Chassin, Tr. 5375; O'Brien, Tr. 3524). The first committee was the Professional Staff Quality Improvement Committee, which is physician-led and hears reports from physician leaders related to critical pathways or other outcomes. (O'Brien, Tr. 3525). Critical pathways are best practice techniques designed to improve the efficiency of care and minimize omission and the cost of services. (Ankin, Tr. 5054-55).

Response to Finding No. 1470:

The cited sources do not support the assertion that ENH's exportation of its QA and QI systems to HPH was rapid. (*See also* CCRFF 1462).

1471. The second committee was the Subcommittee on Quality Improvement of the Board of Directors, which is responsible for setting the priorities for quality initiatives for a particular year. (O'Brien, Tr. 3524-25).

Response to Finding No. 1471:

Complaint Counsel have no specific response.

1472. Physicians at HPH were invited to participate on both committees at the invitation

of the chairman of the department. (O'Brien, Tr. 3525). Through this participation, HPH physicians began to set some of the priorities for quality improvement for all of ENH. (O'Brien, Tr. 3525).

Response to Finding No. 1472:

This finding is incomplete. HPH physicians complained after the merger about the lack of communication regarding policy and no representation at ENH. (CX 405 at 2). HPH physicians also complained about the Quality Control committee being moved out of HPH after the merger. (CX 405 at 6).

1473. Through their involvement in the development of critical pathways and review of literature to determine up-to-date treatment plans, the physicians upgraded their skills. (Chassin, Tr. 5375). These upgraded skills resulted in improved quality for patients because physician training is a structural issue that improved processes used to take care of patients. (Chassin, Tr. 5375).

Response to Finding No. 1473:

This finding is incorrect. (*See* CCRFF 1463 and 1468 for a discussion on HPH's quality improvement process before the merger). *See also* CCRFF 1469 for information on the merger specificity of ENH's changes to QI at HPH)).

1474. After the Merger, the nurses in ENH's QI Department also collected data and communicated with physicians at HPH so that the physicians could make decisions about changing practices. (O'Brien, Tr. 3527).

Response to Finding No. 1474:

Nurses also participated in QI activities at HPH before the merger. (*See* CCRFF 1461).

1475. {[redacted]} (Chassin, Tr. 5257; RX 869; RX 1776; RX 348 at 2, *in camera*). Further, ENH's critical pathways contain numerous process measures of quality designed to improve patient outcomes, and they employ many best practices from other sources to generate a proactive approach to quality improvement.

(Chassin, Tr. 5257). {[redacted]}
(Chassin, Tr. 5258; RX 1326 at ENHE JG 15730, *in camera*).

Response to Finding No. 1475:

{[redacted]} (Romano, Tr. 3169, *in camera*. *See* CCRFF 1463, 1468 and 1469 ({[redacted]}), *in camera*).

1476. One of the priorities of the Subcommittee on Quality Improvement of the Board of Directors at ENH in the year 2000 was to align HPH care maps with ENH's clinical pathways, with input from physicians at all three ENH hospitals. (O'Brien, Tr. 3528; RX 869). An example of such alignment can be seen in the area of acute myocardial infarction. (O'Brien, Tr. 3528).

Response to Finding No. 1476:

Complaint Counsel have no specific response.

1477. In 2000, Evanston Hospital had 57 multidisciplinary critical pathways, and it formulated a very detailed plan for rolling those out in such a way that would teach HPH its multidisciplinary model of QI. (Chassin, Tr. 5257-58; RX 869; RX 1775; RX 1776; RX 1683). The action plan set forth a strategy for identifying interdisciplinary team members, educating staff and establishing a support system for implementation. (RX 1776).

Response to Finding No. 1477:

This finding is misleading in that it implies that the HPH care maps were scrapped in favor of the ENH critical pathways. In fact, ENH incorporated some preexisting HPH care maps. (O'Brien, Tr. 3560-61). As one of the cited documents notes, the goal was to "integrate Highland Park Hospital's Care Maps with the Evanston Northwestern

Healthcare Critical Pathway system." (RX 869 at ENHE F35 321).

1478. ENH implemented the first critical pathways at HPH as early as March 2000. (RX 889 at ENHL PK 16483). Between January 2000 and October 2001, ENH implemented 15 new pathways. (RX 1357 at ENHE F42 21020-21). By August 2002, ENH had introduced a total of 33 new critical pathways to HPH. (RX 1357 at ENHE F42 21020-21).

Response to Finding No. 1478:

As noted in CCRFF 1477 above, the pathway integration project took the best from both HPH and ENH. (*See* CCRFF 1462 and 1468 ({ }), *in camera*).

1479. The intensivists at HPH also implemented critical care pathways at HPH post-Merger. (Ankin, Tr. 5054-55; RX 1084 at ENHL MA 5). Before the Merger, HPH had three pathways used in intensive care. (Ankin, Tr. 5055). Since the Merger, the development of pathways has been greatly increased, and it is easier for the intensivist team to develop new pathways. (Ankin, Tr. 5055).

Response to Finding No. 1479:

Respondent did not offer any evidence on how the intensivists have improved mortality rates at HPH post-merger. (Ankin, Tr. 5090-91). (*See also* CCRFF 1462,1463, 1468, and 1469).

1480. The new critical pathway guidelines implemented by ENH after the Merger contain information that was lacking in the HPH care maps, including a variance-tracking tool, a physician ordering sheet, a documentation tool and an educational piece with options delineated for physicians. (RX 869).

Response to Finding No. 1480:

This finding is incorrect. (*See* CCRFF 1462, 1463 for a discussion on the strengths of HPH's quality improvement process pre- merger). {

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(Romano, Tr. 3168-69, *in camera*).

iii. Data From HPH's Pre-Merger Care Maps Cannot Be Used To Assess Quality Improvements At HPH Post-Merger

1481. It is not possible to learn anything about changes in quality of care at HPH after the Merger by comparing the pre-Merger data available through HPH's care maps with the available data from critical pathways at Evanston Hospital because length of stay and cost per case are not particularly related to quality of care. (Chassin, Tr. 5258-59). For example, data related to the pathway integration project – which reported number of cases, average length of stay, variable cost per case, case mix index and age across procedures and conditions – would not be useful in drawing any conclusions about changes in quality of care at HPH before and after the Merger. (Chassin, Tr. 5259-63).

Response to Finding No. 1481:

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} (Romano, Tr. 3168-69, *in camera*).