

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM
THE ADMINISTRATIVE LAW COURT

Shirley C. Robinson, Administrative Law Judge

Case No. 17-ALJ-07-0441-CC
Case No. 17-ALJ-07-0444-CC
Appellate Case No. 2020-001072

RECEIVED

Apr 12 2021

SC Court of Appeals

Trident Medical Center, LLC d/b/a Trident Medical
Center and Summerville Medical Center,.....

Petitioner/
Respondent,

v.

South Carolina Department of Health and Environmental
Control and Medical University Hospital Authority d/b/a
MUSC Health Emergency Services,.....

Respondents,

Of Whom, Medical University Hospital Authority d/b/a
MUSC Health Emergency Services is

Appellant.

CareAlliance Health Services, d/b/a Roper St. Francis
Healthcare, Roper Hospital, Inc., Bon Secours-St.
Francis Xavier Hospital, Inc., Roper Mount Pleasant
Hospital and Roper St. Francis Berkeley Hospital, ...

Petitioner/
Respondent,

v.

South Carolina Department of Health and Environmental
Control and Medical University Hospital Authority d/b/a
MUSC Health Emergency Services,.....

Respondents,

Of Whom, Medical University Hospital Authority d/b/a
MUSC Health Emergency Services is

Appellant.

**RECORD ON APPEAL
VOLUME 2**

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Pleasant Hospital and Roper St. Francis Berkeley
Hospital*

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STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Trident Medical Center, LLC, d/b/a	)	
Trident Medical Center and	)	
Summerville Medical Center,	)	
	)	
Petitioners,	)	
	)	
v.		Docket No.:
		17-ALJ-07-0441-CC
South Carolina Department of	)	
Health and Environmental Control	)	
and Medical University Hospital	)	
Authority, d/b/a MUSC Health	)	
Emergency Services,	)	
	)	
Respondents.	)	
-----	)	
CareAlliance Health Services, d/b/a	)	
Roper St. Francis Healthcare,	)	
Roper Hospital, Inc., Bon Secours-	)	
St. Francis Xavier Hospital, Inc.,	)	
Roper Mount Pleasant Hospital and	)	
Roper St. Francis	)	
Berkeley Hospital,	)	
	)	
Petitioners,	)	
	)	
v.		Docket No.:
		17-ALJ-07-0444-CC
South Carolina Department of	)	
	)	
Health and Environmental Control	)	
and Medical University Hospital	)	
Authority, d/b/a MUSC Health	)	
Emergency Services,	)	
	)	
Respondents.	)	
-----	)	

ADMINISTRATIVE HEARING



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ADMINISTRATIVE HEARING

Monday, July 22, 2019
10:34 a.m. - 7:31 p.m.
Tuesday, July 23, 2019
9:08 a.m. - 3:15 p.m.
Wednesday, July 24, 2019
9:02 a.m. - 4:57 p.m.
Thursday, July 25, 2019
9:17 a.m. - 4:15 p.m.
Friday, July 26, 2019
9:10 a.m. - 3:15 p.m.
Monday, July 29, 2019
10:06 a.m. - 4:47 p.m.
Tuesday, July 30, 2019
11:38 a.m. - 5:05 p.m.
Wednesday, July 31, 2019
9:39 a.m. - 3:28 p.m.
Thursday, August 1, 2019
9:07 a.m. - 4:15 p.m.
Friday, August 2, 2019
9:07 a.m. - 1:38 p.m.

The Hearing before the Honorable Shirley Robinson was taken at the Edgar A. Brown Building, 1205 Pendleton Street, Suite 224, Columbia, South Carolina, on the 22nd day of July through the 2nd day of August, 2019 before Nadine A. Garrett and Travis McLeod, Court Reporters and Notary Public in and for the State of South Carolina.



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(The index for this hearing is located in a separate document.)

STIPULATIONS

It is stipulated and agreed that this hearing is being taken pursuant to the rules of the Administrative Law Judge Division and the South Carolina Rules of Civil Procedure.



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TMC, ET AL. V. SC DHEC, ET AL.

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(All Exhibits were marked prior to the hearing.)

DAY ONE - JULY 22, 2019

CALL TO ORDER:

THE COURT: Okay. If everyone is prepared to begin, I am going to go ahead and call the hearing to order.

This case involves consolidated matters involving Trident Medical Center. And Trident filed its -- the docket number that's been assigned to Trident is 17-ALJ-07-0441, as the Petitioner. The second Petitioner is Roper St. Francis. The docket number assigned to that case is 17-ALJ-07-0433. I'm sorry. I'm looking at one of the cases that has actually gone away. The second case, the Roper St. Francis, that docket number is 17-ALJ-07-0444. Okay. And I am going to -- I'm not going to -- first, let me go back to the Respondent. The Respondent in each of these cases is the MUSC and the South Carolina Department of Health and Environmental Control.

And because we've got so many attorneys that's representing the parties, I'm going to let the attorneys introduce themselves and for the record state which petitioner they're



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1 appearing on behalf of.

2 And this is a -- the matter that's being
3 contested is the CON that was approved by the
4 Department and issued to MUSC.

5 And if everyone is ready, we are going to
6 begin -- let's begin with Trident.

7 **MR. THOMAS:** Your Honor, Will Thomas for Trident
8 Medical Center.

9 **THE COURT:** Okay.

10 **MR. SUMMER:** David Summer for Trident Medical
11 Center, Your Honor.

12 **THE COURT:** Okay. Very good.

13 **MS. HOLLINGSWORTH:** Good morning, Your Honor.
14 Jennifer Hollingsworth on behalf of Roper St.
15 Francis Healthcare.

16 **MS. GLOBER:** Emily Globber, Roper St. Francis.

17 **THE COURT:** Okay. Thank you all. Okay. Here we've
18 got DHEC.

19 **MS. BIGGERS:** Ashley Biggers for the South Carolina
20 Department of Health and Environmental Control.

21 **MR. DAYHUFF:** Travis Dayhuff for MUSC.

22 **MR. WESTBROOK:** Daniel Westbrook for MUSC.

23 **THE COURT:** Okay. Now, before we begin with opening
24 statements, are there any matters that we need
25 to address initially?



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1 **MS. HOLLINGSWORTH:** Yes, Your Honor. We did have
2 objections to exhibit designations that I think
3 we've submitted. I believe we'd be prepared to
4 -- we consulted on the objections last Friday,
5 but were unable to resolve them, so those would
6 be given to The Court to decide.

7 **THE COURT:** Okay.

8 **MR. WESTBROOK:** Yes, Your Honor.

9 **MR. THOMAS:** Same here.

10 **THE COURT:** Okay.

11 **PRELIMINARY MATTERS:**

12 **MR. DAYHUFF:** Your Honor, we have one other pre-
13 trial issue, I suppose. And it's one that we
14 agree upon. Dr. Greg Hall is an MUSC witness
15 and he is unable to testify in the regular
16 order in MUSC's case, due to travel and work.
17 Dr. Hall is here today. Trident and Roper and
18 DHEC have kindly consented that he could go
19 first if The Court approves Dr. Hall offering
20 his testimony out of order.

21 **THE COURT:** Okay.

22 **MR. DAYHUFF:** So, we would ask you to approve that
23 and let him be the first witness up after, I
24 suppose, these motions and opening.

25 **THE COURT:** Okay. If we don't have any objections



1 to that ---

2 **MR. THOMAS:** No objection, Your Honor.

3 **THE COURT:** We'll hear his testimony initially,
4 then.

5 Okay. I have reviewed the motions on the
6 discovery matters. And, Ms. Hollingsworth, I'm
7 going to hear from you first.

8 **MOTION - BY MS. HOLLINGSWORTH:**

9 **MS. HOLLINGSWORTH:** Thank you, Your Honor. And I do
10 -- I believe that Trident does join in that
11 motion that we have filed. But what we have
12 filed is a request under Rule 23 of this
13 Court's rules related to really the ongoing
14 difficulties that have been revealed through
15 discovery, even truly upon the eve of trial.
16 So we provided and filed with The Court a
17 motion for an adverse disposition under Rule
18 23, both as to failure to comply on the part of
19 MUSC with this Court's Order from April of
20 2019, as well as, I believe it's subsection B
21 of the Rule, which just addresses the discovery
22 rules, the rules of procedure more generally.
23 And what we've provided to The Court in
24 briefing with the initial motion and then with
25 some further supplement this morning after we



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1 heard from MUSC in reply on Friday, is that,
2 contrary to really the expectations of anyone,
3 there are a number of documents that were not
4 disclosed by MUSC in discovery.

5 As The Court is familiar, we've had an
6 active contested issue related to discovery
7 really since January. The Court heard
8 substantive motions on this issue I believe in
9 February or March that culminated in your April
10 Order. And in that Order you ordered that all
11 parties immediately supplement their discovery
12 and continue to supplement timely all
13 discovery. What we learned following the
14 receipt of documents through third parties,
15 that we had to come to this Court to get
16 permission to do, because MUSC objected to us
17 doing that third-party discovery, is we have
18 learned that there are many documents related
19 both to the original project that was proposed
20 to the Department back in the spring and summer
21 of 2017, through and including documents
22 related to the changes in the new project
23 that's proposed now on Main Street in
24 Summerville. And so what we've provided to The
25 Court is various discussions and indexes of



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1 where we find actual examples by date, by name
2 of who got it, who sent it, and then what
3 information it would be responsive to.

4 In reviewing MUSC's response to our motion
5 back on Friday, MUSC's position was they
6 certainly acknowledge that -- as to all three
7 third-party entities, Intuitive Health, Equity
8 LLC, and HFPP, which is Health Facilities
9 Planning Partners, MUSC acknowledges in each
10 instance that the productions that we received
11 within the last week disclosed documents that
12 should have been produced in discovery. And
13 MUSC's possession is -- or position was they
14 were unclear whether this was due to oversight
15 or more likely because MUSC does not have
16 possession of those pages. MUSC acknowledges
17 at minimum that there were 89 pages that were
18 not produced by them related to the Intuitive
19 entity. There were 45 pages not produced by
20 MUSC that related to HFPP. And there were 212
21 documents produced by Equity that were not
22 provided to us. There are more documents than
23 that, Your Honor, but I think MUSC takes the
24 position they've determined that those
25 documents are not responsive. With respect, we



1 do disagree.

2 We've provided The Court in our brief this
3 morning the exact request for production, both
4 from our original -- well, primarily from our
5 original discovery that we were served last
6 summer, to which all of these documents would
7 be responsive, including documents sent to or
8 received from any consultant used on either the
9 original project or the current project. And,
10 Your Honor, all three of these entities that
11 we've just walked through are consultants.
12 They are entities that MUSC worked with in
13 various capacities, either on the application -
14 - the project and the application that was
15 provided to the Department or the more recent
16 project that we learned of as of January of
17 this year.

18 And in fact, Your Honor, I point out, and
19 MUSC also acknowledges, there are at least
20 three spreadsheets that we know of we still
21 don't have, because Intuitive has not provided
22 them in response to the subpoena and this
23 Court's Order directing that we be entitled to
24 engage in discovery, Intuitive taking the
25 position that the data that they received from



1 MUSC was proprietary, as in MUSC's proprietary
2 data, which we don't think that that's a valid
3 ground to be raised by Intuitive when they've
4 received the data. MUSC acknowledges that
5 Intuitive still has documents they haven't
6 produced and MUSC hasn't produced that data.

7 So, we would submit, Your Honor, even as
8 we stand here today, there is an acknowledgment
9 that there are -- there are data files that are
10 in the possession of a third party, who now
11 apparently has no role in the project, but no
12 one's producing that to these Petitioners,
13 whose entire contested case is addressing
14 whether or not the Department's action in
15 approving the CON application was appropriate.

16 And so, Your Honor, we just think
17 particularly in light of your Order of April,
18 where you deny the discovery motion related to
19 the earlier conduct and you ordered the parties
20 to turn everything over -- and in fact, in the
21 briefing, Your Honor, related to that motion,
22 MUSC said to this Court, as of February 1, 2019
23 we have produced everything that we have. I
24 submit, Your Honor, we now know from the
25 documents received from these three entities



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1 that that is not accurate. That is not true.
2 There are other documents. There continue to
3 be documents responsive to the questions we
4 asked in discovery that we don't have. And I
5 think, Your Honor, we certainly submit that
6 that is a violation of your Order. And so Rule
7 23 looks specifically at adverse dispositions
8 or other mechanisms by which The Court can
9 address what we believe is well documented, are
10 failure to submit pieces of discovery by MUSC.
11 And certainly, I think, Trident has additional
12 information related to that, because Trident
13 did have the expense of going to Texas and
14 facilitating that deposition of Intuitive and
15 learning the additional information that we
16 have there.

17 And so we do ask The Court to consider
18 this motion under Rule 23 of your Court's rules
19 and determine adversely to MUSC that this
20 contested case proceeding should be ended with
21 an adverse disposition.

22 **THE COURT:** Thank you.

23 **MR. THOMAS:** Trident joins in on that motion, Your
24 Honor, just for the record.

25 **THE COURT:** Okay.



1 MOTION - BY MR. WESTBROOK:

2 **MR. WESTBROOK:** Your Honor, just give me a second
3 please. May it please The Court. I'm Dan
4 Westbrook. I'm here on behalf of MUSC. These
5 are serious allegations and so I'm going to
6 take some time with my argument, if that's all
7 right.

8 I want to start off, though, by quoting
9 from your Order issued on Friday denying the
10 summary judgement motion filed by Trident, the
11 latest summary judgement motions filed by
12 Trident. One of the arguments that Trident
13 made for summary judgement was based on the
14 same allegations that Ms. Hollingsworth just
15 talked about, discovery abuse. And your Order
16 concluded with this short paragraph, the
17 parties undoubtedly dispute whether any
18 discovery abuses occurred giving rise to a
19 factual issue. Until The Court hears
20 additional evidence in this case, it cannot
21 make a determination as to the alleged abuses,
22 and whether Trident -- and I would submit also
23 Roper-- has been substantially and irreversibly
24 prejudiced. As indicated in this Court's order
25 of April 11th, 2019, The Court reserves the



1 right to make determinations as to any
2 discovery abuses that occurred, their impact on
3 the parties, and sanctions as appropriate. I
4 would submit, Your Honor -- I'm sorry, that's
5 the end of your quote. I'm going back to my
6 argument now.

7 I'm going to address as fully as I can
8 right now Ms. Hollingsworth's allegations about
9 discovery abuse and Trident's. But I would
10 submit that over the course of this trial you
11 are going to need to hear evidence about
12 discovery. And you will hear evidence about
13 discovery. And I would ask you to consider the
14 same reasoning that you gave in the -- in
15 denying Trident's summary judgement motion that
16 I just quoted from and withhold your decision
17 on discovery abuse until after the trial.

18 Having said that, I want to go through and
19 tell you what our position is. And our --
20 MUSC's position is not, as characterized by Ms.
21 Hollingsworth, that we acknowledge anything.
22 So let me go through in some detail what our
23 position is. And I'm going to take this --
24 this centers around three different third
25 parties, as you know; Intuitive Health, Health



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1 Facilities Planning Partners, which for short
2 I'm going to take HFPP -- that's almost as hard
3 to say as Health Facilities Planning Partners,
4 but I'm going to try to say HFPP -- and a third
5 non-party called Equity, LLC. So I'd like to
6 talk about those three in order, please.

7 First, let's go with Intuitive.
8 Intuitive, as Your Honor probably knows, is a
9 Texas consulting company that MUSC had a lot of
10 discussions with over the course of several
11 months and who ultimately made a proposal to
12 MUSC, which MUSC rejected. So that Intuitive,
13 as Ms. Hollingsworth I believe just said, just
14 acknowledged, no role in the current project.
15 That's Intuitive. So that's who Intuitive is.

16 Let me ask our litigation support
17 consultation -- I should have introduced him
18 earlier, Mr. Dan Bupp, who is sitting on the
19 far side over there. Dan, if you would put up
20 what we've labeled as DM-9. This is just a
21 demonstrative exhibit. We're not offering it
22 into evidence. DM-9, please, Dan, if you could
23 put it on the screen. Oh, I'm sorry. We need
24 to get the technology switched on. Tia, could
25 you do that? Thank you.



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1 All right, DM-9. So Intuitive, in
2 response to the Trident subpoena, produced 474
3 pages. In his letter to The Court a few days
4 ago, Mr. Summer rounded that up to 500. That's
5 okay. It's close enough, 474 pages. Of those
6 474 pages, 254 of those pages were emails.

7 Now, as Your Honor may recall, we had an
8 agreement. The parties had an agreement in
9 this case not to produce emails. That's an
10 agreement that we've had with Trident for many
11 cases in the last few years. Mr. Thomas and I
12 worked that out quite a few years ago, and
13 agreed that emails are a pain to deal with.
14 They -- it takes a lot of man hours to review
15 them. And to save our clients money, we would
16 not go -- do discovery of emails. That was the
17 agreement. And that's the agreement that we
18 had in this case. So 254 of those 474 pages
19 were emails that we had -- were under no
20 obligation to produce.

21 One hundred and six pages were duplicates.
22 I would submit that it doesn't make any sense
23 to produce two copies of the same thing. So,
24 we didn't produce duplicates.

25 Twenty-five pages of those documents were



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1 produced by MUSC. Let me just add -- qualify
2 that. At least 25 of those pages were produced
3 by MUSC. We haven't -- this is a lot to review
4 and we haven't completed our review yet. But
5 at this point we know that at least 25 of those
6 474 pages were produced. That leaves 89 pages.
7 And our demonstrative up here is a little
8 misleading. And it says -- in the category
9 column it says documents not produced by MUSC.
10 And if you look over there quickly, it says 89.
11 No, it's not 89 documents. It's 89 pages. As
12 you see, that's in the column of number of
13 pages. I don't know how many documents that
14 is. So 89 pages were -- that were in
15 Intuitive's production had not been produced by
16 MUSC that maybe should have been produced by
17 MUSC. But I'm not conceding that, because
18 we've got to look at those 89 pages. We're not
19 sure whether those 89 pages were responsive or
20 not to their documents. We're not sure really
21 what those mean exactly until we do a further
22 review. And Mr. Levitt will be prepared to
23 testify about that when he takes the stand
24 later this week or early next week.

25 Let's look at DM-2, Dan, break this down



1 a little bit further. So this is just, by bar
2 graph, shows what we j --st, the chart that we
3 just looked through. So those are the 25 pages
4 that MUSC produced, 106 pages of duplicates,
5 254 of emails, and 89 pages that we know that
6 MUSC didn't produce. Whether MUSC should have
7 produced them or not or how many of those
8 pages, we're not sure at this point.

9 Let's look at DM-13, Dan. I thought this
10 quote was interesting from the Intuitive
11 deposition the other day. And it's interesting
12 in respect to those 89 pages. The deposition
13 -- the 30(b)(6) deposition of Intuitive that
14 Mr. Summer took a few days ago, the Intuitive
15 representative was a guy named Tom Herrmann,
16 who was the CEO of Intuitive. And at one
17 point, in response to one of Mr. Summer's
18 questions, he said -- I'm just going to read
19 the highlighted part into the record -- "we do
20 a whole lot of different iterations internally"
21 -- and I guess I'll read more than the
22 highlighted -- "and then share them internally
23 and they never make it to the client. So it's
24 very possible that some of these never went to
25 the client at all." Now, in this case the



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1 client he's talking about is MUSC. Or he's
2 talking generally about all of his clients.
3 But he was viewing MUSC as his client.

4 So, what we have -- and this was in
5 particular to a question that was sort of a
6 marketing piece about -- what's the company --
7 Intuitive, a marketing document of about, I
8 don't know, maybe 15 or so pages that they had
9 apparently sent to us. And it reappeared in
10 different iterations throughout the documents
11 that Intuitive requested. For example, there
12 was 15 pages the first time and then a few
13 months later apparently there was another one
14 that had slight revisions to it and then
15 another one that had -- later on that had other
16 revisions to it. And what he was saying is, we
17 make different iterations or different versions
18 of the same document, but these different
19 iterations never make it to the client. So
20 it's very possible that some of these never
21 went to the client, MUSC, at all. So we need
22 time to go back and look at those 89 pages and
23 see if we really got those. I don't know that
24 we did. So I do know that my client has
25 checked its file and produced everything they



1 thought was responsive to that. So at most
2 there are 89 pages from Intuitive that MUSC did
3 not produce. Whether they should have produced
4 it or not, at this point I think is still an
5 open question.

6 Let me go now -- as I said, I'm afraid
7 this is going to take some time, because we
8 take these allegations seriously. In addition
9 to the documents they produced, Intuitive
10 withheld producing some documents in response
11 to this subpoena. They withheld -- they chose
12 not to produce three spreadsheets that MUSC had
13 sent them. Now, I want to make it clear that
14 they chose to do that. I believe Mr. Herrmann
15 made this clear at his deposition. They didn't
16 consult with us. They didn't even notify us
17 that they were going to do this. So this was
18 not our decision. We weren't pressuring
19 Intuitive in any way not to produce this. They
20 made the decision not to produce these three
21 spreadsheets from MUSC on the grounds that they
22 contained MUSC proprietary information.

23 Well, let's look, Dan, at DM-7 first of
24 all. This is just to sort of put things in
25 context. To Triper -- I'm so sorry. To



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1 Trident -- that's not the first thing like that
2 I'm sure I'll say this week. But to Trident
3 and Roper in this case MUSC produced over six
4 million discreet data points in response to
5 their data request, things like date, time,
6 acuity, disposition, financial class, location,
7 procedure code, and ZIP code, things like that.
8 To Intuitive and these three withheld
9 spreadsheets, it contained 424,000 -- well
10 almost 425,000, data points; visits, ZIP code,
11 acuity, financial class, charges, payments, and
12 ED staffing model. Now, of those 424,935 data
13 points, most of those MUSC had already produced
14 to Trident and Roper in response to their
15 discovery request for production. MUSC had not
16 -- the only thing out of those three
17 spreadsheets that was sent to Intuitive that
18 had not been produced during discovery was
19 information on charges, payments, and staffing.
20 And the reason those hadn't been produced, it
21 wasn't any big deal, or any kind of
22 surreptitious kind of act, it's because they
23 had not been requested by Trident or Roper in
24 their data requests.

25 Let's go to the data requests, Dan. Let's



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1 -- who are we going to put up first. Is this
2 Roper or Trident? This is Roper. All right.
3 Roper made two -- obviously both of these put
4 in a lot of discovery requests. So did MUSC.
5 And some of the requests were specifically for
6 data, the kind of thing that you have to put on
7 an Excel sheet and produce. So, Roper
8 requested all documents that show in summary
9 form without patient identifying info the
10 patient origin by ZIP code for all emergency
11 room visits for all MUSC facilities in
12 Charleston, Berkeley, and Dorchester counties
13 for 2014 through year to date, separated by
14 facility and year. We produced all of that.
15 We produced all of that. It didn't ask for
16 charge information, payment information, or
17 staffing information, so we didn't do that, but
18 we produced all of that in a big spreadsheet.

19 They had a second data request, Roper did.
20 Let's see that. That would be their request
21 number 9. It said all documents that show in
22 summary form without patient identifying
23 information the patient origin by ZIP code of
24 all ER admissions for all MUSC facilities in
25 these three counties for 2014 through year to



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1 date, separated by facility and year. We
2 produced that information. That's what they
3 asked -- that's the data they asked for.

4 Let's go to Trident, Dan. Trident's
5 request for production number four said,
6 documents in electronic format sufficient to
7 show MUHA, that's the same as MUSC's, volume
8 for -- it's not the same, but for the purposes
9 of my argument right now it's the same --
10 volume of outpatient and inpatient discharges
11 broken out by ZIP code, 2015 through year to
12 date 2018. We produced that. Didn't ask for
13 charges, payment, or staffing.

14 Number ten. I think this is the most
15 thorough one of the requests we got. And it's
16 similar to requests that we served on them. It
17 says, number ten, for each patient served
18 through MUHA's emergency department from
19 January 1st, 2015 to the present, please
20 produce an Excel spreadsheet in native format
21 that provides the following information: Date
22 of service, type of procedures performed,
23 procedure code, patient ZIP code of residence,
24 and whether the patient was admitted as an
25 inpatient. And we produced that. Notice that



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1 it doesn't ask for charge information or
2 staffing information or payment information.

3 So one of -- the big spreadsheet that we
4 produced was Bates labeled MUSC 3919, 3919. We
5 produced this to Roper and we produced it to
6 Trident. Dan, let's put that up on the board.
7 This is a big thing that asks for a lot of
8 documents and we're not going to go through it
9 in much detail. Some of it on here I don't
10 even know what it means, but I just want to
11 walk through the columns, the different columns
12 that this has. And the column heading at the
13 top of each page, some of these abbreviations
14 I don't know what they even exactly mean. I'm
15 sure Mr. Levitt and Mr. Sullivan and Ms. Platt
16 do. But the first three columns, A, B, and C,
17 are different sorts of ID numbers. This is
18 response to the request that we just got from
19 them. Column D is the hospital admission, the
20 time of admission, followed by the discharge
21 time, the amount of hours that were spent in
22 the ED, the acuity level. The next column,
23 column H, is the acuity level. Well, columns
24 G and H are the acuity level. G is sort of the
25 number code and H is the acuity description.



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1 Column I is the arrival -- actually the arrival
2 date. The next column is the departure time.
3 K is the number of hours spent in the ED.
4 Eleven (sic) is some kind of code for the
5 disposition and then the narrative description
6 of the disposition. The account class, the
7 procedure codes, procedure names, payor, so get
8 payor mix information, the ZIP code, and the
9 fiscal year. Is that it, Dan? Any other
10 columns? This is a big spreadsheet. It's a
11 native format.

12 If you go down, you see the line items
13 there on the far left. If you go down to the
14 end, the last one, the number there is 313,815.
15 I think that would -- in terms of -- since that
16 would include the heading that I just went to,
17 there would be 300,814 points there that were
18 produced. But we did not produce charges,
19 payments -- charge information, payment
20 information, or -- what's the other one --
21 staffing data. Those three data sets we did
22 not produce, because they didn't ask us for it.
23 If they'd asked us for it, maybe we would have
24 produced it and maybe we would have objected.
25 I don't know.



1 But Intuitive -- we sent that in a
2 spreadsheet to Intuitive. I don't know why.
3 I wasn't there. But it's not that we were
4 hiding it from our opponents. It's that they
5 didn't ask for it. That's not among the data
6 sets that they requested. And now they want
7 it. I don't -- you know, I haven't really
8 talked with my client about this. I don't know
9 that we would object to this, except -- but we
10 might. I just don't know. I mean, maybe it is
11 proprietary. I don't know whether it is or
12 not. But the point is, it's a little late to
13 be asking for new discovery requests at this
14 point in time. I mean, we're in trial now. If
15 they want to charge -- excuse me?

16 **MR. THOMAS:** Oh, we were talking about the irony of
17 your statement.

18 **MR. WESTBROOK:** The irony of it. Well, the irony of
19 my opponents consulting during this argument is
20 that, if they had wanted charge information,
21 staffing information, and payment information,
22 they should have put that in their data
23 request, which they did not.

24 Let's look at DM-17, Dan. This is another
25 summary. I'm sorry. We've gone over this.



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1 Never mind. Let's go back -- let's go on to
2 HFPP.

3 The second -- the second third party that
4 was subpoenaed is a company, as I've mentioned,
5 that I'm going to call HFPP. Now, HFPP is a
6 developer and a space planner apparently and it
7 looks like they may do some sort of
8 architectural work. They were not an agent of
9 MUSC. They were not contracted with MUSC.
10 They were a broker apparently. No, I'm sorry.
11 They were not a broker. They were some sort of
12 agent for a third company that we're going to
13 talk about later called Equity, LLC.
14 Apparently Equity, LLC retained this company,
15 HFPP, who did not have a direct relationship
16 with MUSC. That's a lot of acronyms. They
17 were involved in this project while the site
18 was -- when the original site was in place.
19 Since the decision to relocate the site to
20 Summerville, HFPP, like Intuitive, has no role
21 in this case.

22 Let's look at demonstrative ten, Dan.
23 Here's -- we walked through this earlier with
24 Intuitive. I want to walk -- make the same
25 journey through HFPP. Of the 476 pages that



1 HFPP produced in response to the subpoena, 361
2 pages were emails that we were under no
3 obligation to produce. Fifty-three pages were
4 duplicates. Ten of the pages were actually
5 produced by MUSC. Seven of those pages we
6 believe were not responsive to any requests by
7 Trident or Roper. And then there were 45
8 pages, not 45 documents, but 45 pages that were
9 not produced apparently, or at least that's the
10 best of our -- no, that's not quite right.
11 Excuse me a second. There are 45 pages that
12 upon our first review apparently were not -- we
13 thought were not produced by MUSC. That totals
14 up to the 476 pages that I mentioned.

15 All right. That's DM-10. Let's go to DM-
16 3. This is a just a visual presentation of
17 what I just walked through. As you see, 45
18 pages, the blue bar there on the right, that is
19 still left without an explanation for them.

20 Let's go to DM-16, Dan. Okay. See at the
21 top, Your Honor, there are 45 pages. Again,
22 it's misleading. It's not documents not
23 produced by MUSC. It's 45 pages not produced
24 by MUSC. Now, of those, upon further review --
25 and this occurred after we filed our response



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1 the other day. Twenty one pages were
2 attachments to emails and MUSC wasn't a party
3 to the email. So if we're not copied on the
4 email, if we're not a recipient or a sender of
5 the email, there's no reason to think we got
6 the attachment. So I'm subtracting -- from
7 that 45 number, I'm subtracting 21. That
8 leaves 24 pages that we may not have produced.
9 Whether we should have produced them is still
10 in my mind an open question. That was DM-16.

11 Let's go -- I want to go to -- she didn't
12 mention it today, but I want to address
13 something that Ms. Hollingsworth mentioned in
14 her brief the other day. Let's go to HFPP
15 Bates number 93-1. Again, in the Roper brief,
16 this document, this email was discussed. And
17 this is an email from an MUSC employer --
18 employee named Carolina Cotter to an HFPP
19 employee named Georgeann Burns. "Hey
20 Georgeann- As I mentioned, I have attached the
21 summary of the MUSC ED volumes from FY 15-FY 17
22 by patient origin (through May and Annualized)
23 for our level 1-3 visits." And Ms.
24 Hollingsworth's concern in the brief that she
25 filed last week was that you produced it to



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1 Intuitive, why not produce it to us. The
2 answer is we did produce it to Roper. We did
3 produce it to Trident. It's in -- that
4 information is in that big spreadsheet, MUSC
5 3919 that I walked through a few minutes ago,
6 that I walked through the headings. These ED
7 volumes are in that spreadsheet that we
8 produced to these guys.

9 Let's look at, Dan, at HFPP 127. This is
10 a worksheet. Well, I'm going to call it a
11 worksheet anyway. I'm not sure if that's the
12 official name of it or not. And the summary
13 judgement motion, which Your Honor denied, that
14 Trident filed a few days ago, this was the
15 bombshell document that they attached to their
16 motion. This is a worksheet of -- again,
17 that's my words. I'm not sure if that's --
18 well, work plan. It says at the bottom work
19 plan. And I don't know if this is really -- I
20 haven't seen Roper talk about this, so I'm not
21 sure what their -- if this applies to their
22 motion or not. But I do know that in his
23 summary judgement motion and in his letter to
24 The Court, Mr. Summer was upset about this
25 document. And the source of the upset, as best



1 I could tell, was that this document had not
2 been produced and that it contained names of
3 various people. I think all total there were
4 about 14 names in there. And Mr. Summer, in
5 his letter to The Court, accused my expert, Mr.
6 Levitt, of misrepresenting in his -- the word
7 -- that certainly was the implication, Mr.
8 Summer. Okay. If I misread that, then I
9 appreciate that. Well, let's just -- whether
10 Mr. Summer said that or not, at his deposition,
11 Mr. Levitt said under oath that he was the
12 author of MUSC's application. In fact, he was
13 the author of MUSC's application. These people
14 on this work plan, none of them authored the
15 application. And what they did do was gather
16 information that was either submitted directly
17 to Mr. Levitt or funneled to Mr. Levitt through
18 somebody else so he could write the
19 application. That's what happened.

20 And the -- let's take a look at DM-6, Dan.
21 Here are the 14 people that were involved in
22 this process, that are identified in this work
23 plan. I just want to point out a couple of
24 names quickly. The second name on that list,
25 Georgeann Burns, is not an MUSC employee. She



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1 was with HFPP, who, as I've mentioned, was a
2 consultant for Equity. Again, these are not
3 MUSC people. She was a space planner whose
4 name appeared on there. She certainly did not
5 have any role in authoring our application.
6 The other people, as you'll see, each one of
7 these were either identified -- had been
8 identified early on, for example the first name
9 there, Ally Abernathy, is an attorney, in-house
10 attorney for MUSC, who is no longer with MUSC.
11 She left some time ago. But she was identified
12 in discovery as early as July 2018. Ms. Burns
13 was Equity's -- again, actually HFPP's space
14 planner. David Carroll spoke at the project
15 review meeting in August 2017. His name is in
16 the DHEC record. John Cooper was identified in
17 the CON application. Caroline Cotter
18 identified in the CON application back in 2017.
19 Tom Crawford was identified in discovery. I
20 could go on. I think you get the point. These
21 folks, first of all, we notified -- I mean,
22 through the CON application or through
23 discovery responses or through depositions or
24 through some place in the DHEC record, most of
25 these people were identified. Our opponents



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1 were on notice of them. We weren't trying to
2 hide their names in any way. Some of the
3 people who were not identified just had minor
4 roles. Jessica Gage, who is a wonderful person
5 and a good friend of mine, is an administrative
6 assistant. She -- all she did for this project
7 was gather documents and make appointments.
8 Andy Johanni was not a MUSC employee. Karen
9 Kumar worked at MUSC for a very short period of
10 time and had a very minor role. Eric McLean
11 was a student intern. I guess the point is
12 that we weren't trying to hide any of these
13 people. All of the people who had any degree
14 of importance or significance in working in
15 this case were identified early on. All right.
16 Let's go to DM-6. No, that is DM-6. Okay. So
17 I think that maybe takes -- that is all I want
18 to say at this point about HFPP.

19 The third third party who was subpoenaed
20 is a company called Equity, LLC. Equity LLC
21 was a real -- or is a real estate broker. In
22 this case they were a broker for a company
23 called Nexton FSED, LLC. Nexton FSED, LLC was
24 the company that owned the property at the
25 original Nexton site that is no longer being



1 contemplated for this project. So Equity, LLC
2 was the broker for the real estate owner at the
3 original site. Equity, LLC, just like HFPP and
4 Intuitive, have no role whatsoever any more in
5 this project. Once the decision to relocate
6 from Nexton to Summerville was made, none of
7 these three companies have a role in this
8 project.

9 Let's look at DM-11 please. All right.
10 Equity produced the most documents of the
11 three, 966. Of those, over half, 533, were
12 emails, most of which MUSC was not a recipient
13 or a sender of. One hundred forty nine pages
14 were duplicates. Thirty one of these pages
15 were actually produced by MUSC. Forty pages
16 were not responsive to any discovery request
17 from our opponents. And, again, our original
18 count was that 212 pages had not been produced
19 by MUSC and didn't fall into any of these other
20 categories. Let's look at DM-4. Again, that's
21 just a visual presentation of what we just saw.

22 Let's move on to DM-14. As I mentioned,
23 there were 212 initially that we couldn't
24 account for. But of those 212, if you will
25 look over to this column over on my right, 71



1 of those 212 pages were attached to emails that
2 MUSC did not receive or send and was not copied
3 on. So, I think it's safe to conclude that
4 MUSC did not have those documents and therefore
5 could not produce them. That leaves 141 pages
6 that we still need to look into. Doesn't mean
7 we necessarily had them. Doesn't mean we
8 necessarily did not have them. The answer is
9 at this point I don't know how many of those
10 documents we had and I also don't know, because
11 I haven't looked at them -- had time to look at
12 them, how many were truly responsive to
13 requests that came out.

14 Dan, let's look at DM-5, which tries to
15 summarize what we've been talking about -- what
16 I've been talking about for the last -- what
17 seems like the last 90 minutes. But I'm sure
18 it seems longer than that to you guys. Third
19 party document production page counts by
20 category. Bottom of the screen you'll see
21 these three third parties produced a total of
22 a little over 1900 pages. Of those that you
23 see, over 1100 pages were emails that we,
24 pursuant to our agreement, had no duty to
25 produce. And a lot of those emails, by the



1 way, we weren't even copied on, so we didn't
2 have them. Three hundred and nine pages of
3 duplicates, 66 pages that MUSC produced, 47
4 pages that were non-responsive. That leaves
5 over on this side -- I think it was 414. It
6 leaves 254 plus 92, whatever that is. But 92
7 pages were attachments to emails to which MUSC
8 was not a party. That leaves 254 pages that at
9 this point I'm just not sure about and I need
10 time to look at those 254 pages. And Mr.
11 Levitt is planning on doing that or overseeing
12 that and will testify about that when he takes
13 the stand. I am not acknowledging at this
14 point that we should have produced 254 pages.
15 I'm not acknowledging that we should -- one
16 thing or the other. We just haven't had time
17 to examine those 254 pages. But that's
18 something we can do.

19 Let's go -- I just want to point out one
20 other thing though as well. This is a big case
21 and a lot of documents have been produced. I
22 want to show objection, a general objection,
23 that Trident made to our discovery request, to
24 all of our discovery requests. And I'm not
25 saying this is a bad objection. I don't mean to



1 make this sound like an ominous sort of thing
2 that I'm about to say. I've seen this
3 objection. It's a standard one that they use.
4 I've litigated against Trident many times and
5 this is a standard thing they use. I've seen
6 other people use -- I've used things like this
7 as well, a general objection. Trident Health
8 System objects to MUSC's Request to Produce to
9 the extent they request, quote, all documents,
10 end quote, related to, referencing, or
11 involving certain designated subject matter.
12 In some circumstances, such a request for all
13 documents is oppressive, unduly burdensome, and
14 abusive and could result in Trident Health
15 System unnecessarily producing tens of
16 thousands of pages of duplicative, redundant,
17 and immaterial information, as well as patient
18 records. In response to some of MUSC's
19 requests asking for all documents, Trident
20 Health System has produced documents sufficient
21 to fully meet the substance of MUSC's request
22 and has refrained from producing voluminous
23 reports, spreadsheets, and other data
24 compilations restating that information.

25 I don't have a problem with that



1 objection. I think that's a reasonable
2 objection. And I think what it goes to is the
3 point is, when you're in a big case with lots
4 of documents and lots of data being produced,
5 it's impossible to search every little document
6 and every person when you've got dozens of
7 people that are working on a project. You pick
8 out the main people and you get their files and
9 you put them in a central person and you do
10 your best to produce everything that you have
11 that you think is responsive. But all
12 documents, every single document, that's a
13 little unreasonable. I think Trident's right.
14 And by the way, Roper has a request that's
15 similar to that that I won't bother to put up,
16 but the language is -- the spirit of it is the
17 same.

18 Let's look at DM-1, Dan. In this case
19 MUSC in response to request for production by
20 Roper and Trident produced over 6500 pages of
21 documents. Now, that -- you see the numbers.
22 That's almost twice as much as Trident and
23 Roper combined produced. 6,526.

24 Let's look at the next demonstrative. And
25 I will say, no doubt to everyone's relief, my



1 last demonstrative. Six thousand five hundred
2 and twenty six pages we've produced. We
3 believe that 254 or fewer pages that maybe we
4 did not produce. Again, we have to go through
5 those 254 pages and make sure we haven't
6 produced them somewhere. And if we didn't
7 produce them, was there a good reason. Let's
8 assume the worst at the moment. Assuming the
9 worst, that we should have produced those 254
10 pages, you divide that 254 by 6526 that we did
11 produce, that's 96.3 percent of what we should
12 produce in a worst-case scenario that we did
13 produce. Given the spirit of Trident's and
14 Roper's all-documents rejection that I just
15 read, I don't think that's anything to be
16 ashamed of. Certainly anything that we failed
17 to produce was certainly not intentional. It
18 may have been an oversight, but I'm not ready
19 to admit that at this point.

20 Let's see, Your Honor, do I have anything
21 else at the moment? The only thing I would
22 like to do in wrapping up our argument on this
23 sanction motion is to restate quickly what I
24 said at the very beginning. Your Honor, I
25 don't think there is any proof of discovery



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1 abuse in this case. As I've produced, there's
2 plenty of evidence that a lot of documents went
3 back and forth. There's evidence that three
4 consultants, two of whom didn't have a direct
5 relationship with MUSC, produced a number of
6 documents. We need a little bit of time to
7 look at the remaining -- what is that --
8 whatever that was, any of the remaining
9 documents that we want to look at. And you'll
10 hear testimony about that over the week. And
11 I would ask The Court either to deny the motion
12 outright right now or wait and hear testimony
13 and decide at the end. Thank you.

14 **THE COURT:** Okay. Thank you, Mr. Westbrook.

15 **RESPONSE - BY MS. HOLLINGSWORTH:**

16 **MS. HOLLINGSWORTH:** Your Honor, I would like to
17 respond to the highlights and make it very
18 clear, Your Honor, that there was no need for
19 MUSC or counsel to do an analysis of data and
20 determine whether data was or wasn't responsive
21 or produced or not produced, because these
22 documents, these data files provided to be it
23 Intuitive or HFPP or Equity fall squarely
24 within requests that we made to them that say
25 all documents and other information, including



1 drafts you've given to an expert, a potential
2 expert, a consultant, or a consulting firm,
3 that does not ask anyone to do an analysis as
4 to, well, what's the nature of the document and
5 do we have it somewhere else. That would be
6 fundamentally unfair, Your Honor. That's
7 allowing that this sort of after-the-fact
8 evaluation, when the underlying -- that
9 document from the moment we served discovery,
10 Your Honor, documents -- such as the FSED CON
11 work plan dated 5/11/17, Your Honor, that's a
12 document created and used by MUSC with these
13 consultants, both Equity and HFPP, that clearly
14 walks through and describes who's responsible
15 for what with the preparation and planning for
16 the CON application. Your Honor, I don't think
17 it gets any more clear that the failure to
18 provide that document, a document apparently
19 given to HFP, who has no role now, they weren't
20 our agent, they're just this person that
21 someone else -- well, how can it be that then
22 they've provided data and documents to this
23 entity, but they have no relationship with
24 them? Just absurd, Your Honor. Of course HFP
25 was a consultant in a consultant firm. Equity



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1 is in the CON application as funding a
2 substantial part of the project that they've
3 provided to DHEC. Equity has a number of
4 documents. They did things such as the these
5 MUSC ED volumes, Your Honor. I think it's
6 highly disingenuous to take the position, well
7 don't worry because they got that data in other
8 places. Well, the data that we got in other
9 places, we did get a large data file, this six
10 million data points, that was just one of their
11 planning expert's data files. That had nothing
12 to do with what these parties asked for. They
13 provided Mr. Levitt's worksheet, as they
14 should. Nonetheless, Your Honor, when you send
15 a consultant a spreadsheet that you have
16 summarized information -- now, I point out,
17 Your Honor, it's very relevant, this
18 information is summarized and it's addressing
19 certain acuity levels. It's highly relevant to
20 this contested case. It's exceedingly
21 important to the issues that we have in this
22 Court and that we've talked about in the
23 contested case and during staff review. To
24 make the argument, well, you could have done
25 that analysis yourself is not the same thing as



1 them providing consultants data giving certain
2 types of information and summarizing certain
3 types of information. It's very relevant to
4 this contested case, Your Honor. They
5 acknowledge that they didn't produce that.

6 This idea, this suggestion -- I recognize,
7 it is difficult to do email discovery. This is
8 the first case that I've done this agreement
9 with Parker Poe and Nelson Mullins and I've
10 certainly learned a lot from doing this
11 agreement with these firms. There is a reason
12 that that agreement explicitly says that it
13 does not include documents attached to emails.
14 That's because we live in a world where a lot
15 is done electronically. You should not be
16 permitted -- and our agreement says, you can't
17 hide information and say, well, it's only
18 attached to an email and we're keeping our
19 emails from each other. Your Honor, I'd submit
20 that's flat contrary to what our agreement is.
21 And it's certainly contrary to the rules of
22 discovery and the need for disclosure.

23 We had multiple discovery requests on
24 point. You don't have to do an analysis of
25 what the data was. The suggestion that they



1 are non-responsive is just contrary on its face
2 to our discovery request. All documents and
3 other information drafted, revised, or reviewed
4 by MUSC administrators, directors, employees,
5 agents, officers related to the project. Your
6 Honor, Caroline Cotter is on almost all of
7 these documents that we're now finding. She
8 authored them. She sent them. And that is one
9 of the individuals that they identify in their
10 discovery responses as having responsibility
11 for the application. Had we known that there
12 were these documents that Ms. Cotter was
13 sending to these third-party consultants or
14 that she was authoring that described who was
15 doing what, her role would have looked much
16 different in discovery. But we didn't know
17 that. Instead, we've provided Mr. Levitt, who
18 did -- we appreciate him sitting for a
19 deposition. But when we asked him questions
20 about, well, who pulled data for you, who did
21 you work with in this department and that, he
22 tried to recall to the best of his ability,
23 Your Honor, but there's a document. There's a
24 document that tells everybody who pulled data,
25 who worked on this, who worked on that. That



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1 document should have been produced in
2 discovery, Your Honor.

3 And again, I will submit, we were in very
4 heated motion practice in your Court just a few
5 months ago on issues just like this. Surely
6 that the result of your decision would have
7 necessitated we should do a review and make
8 sure that we've pulled all the information that
9 we have, including perhaps maybe Ms. Cotter's
10 file. Mr. Levitt is copied on some of these
11 documents, Your Honor. We don't have them in
12 Mr. Levitt's file. So this suggestion that
13 they did what they could, but it's hard to
14 figure out who to look for documents from, I
15 would submit, Your Honor, again, it's just --
16 that may be the case, that's not the case here,
17 because we're talking about individuals who
18 were known and disclosed by MUSC as working on
19 the application. They're documents, documents
20 that they authored, documents that they
21 received, should have been produced in response
22 to these discovery requests.

23 Now, this -- also Your Honor this idea
24 that we were given -- I think the numbers were
25 something in the nature of 6,000 documents by



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1 MUSC. And, as you'll hear in a little bit as
2 we talk about the objections, until July 12th,
3 your deadline to produce -- or to provide
4 designations, the actual document total from
5 MUSC was 4800 documents. They produced 1700
6 pages of documents to us about ten days ago.
7 If you look at the 4800 documents we actually
8 got in discovery throughout -- even through
9 supplementing and I believe even through May or
10 June, about 2,000 pages of that was just copies
11 of CON files. So this suggestion, Your Honor,
12 that they have just produced massive and
13 massive amounts of information to us and maybe
14 they just missed a couple, I think, Your Honor,
15 it misses the forest for the trees, because
16 that's not the circumstance that we have. And
17 so, with respect, this idea that, well, it's
18 not a big deal, it's only 254 pages, and don't
19 worry, we're going to have our expert look at
20 it over the next week or so while we're here
21 arguing our case, meaning I don't have the
22 ability to devote the next week to reviewing
23 the 1900 pages of documents that we had to get
24 from third parties, because I'm here in your
25 Court, Your Honor, having to present my case



1 and start questioning other witnesses. Just
2 one more way in which we're entirely prejudice
3 in this posture. We had to go get these
4 documents from third parties because it was
5 clear that we weren't being told everything.
6 And we had a right to know both the nature of
7 what and why they submitted the application
8 they did and the circumstances around the
9 changes to it. How else are we supposed to
10 present even the substantial change case to
11 Your Honor if we are not able to inquire into
12 both, well, why did you want 15,000 square feet
13 back in May of 2017? Well, why is 10,000
14 square feet okay today? That's relevant, Your
15 Honor, to figure out whether or not it's
16 substantial. There's a number of documents.
17 There's all sorts of communications that talk
18 about the floor plan and the site schematic,
19 none of that stuff that we've had, Your Honor.
20 And to be frank, I don't even really understand
21 what Intuitive has or doesn't have, because I
22 had to attend by telephone, Mr. Summer had to
23 fly to Texas to get that information, and we're
24 just working as fast as we can with the time
25 that we have. But I was also dealing with the



1 1700-page production that I got on July 12th.

2 So, I just submit, Your Honor, that -- and
3 I think it's very clearly laid out in our brief
4 -- that there is no argument that certain
5 documents were non-responsive. Every document
6 provided to any of those three entities in any
7 way related to the Berkeley County project,
8 Your Honor, that was responsive. As simple as
9 it's a document that you gave to a consultant
10 or it's a document that your people prepared
11 and provided. So the suggestion, Your Honor,
12 that we get to keep culling that down and maybe
13 we'll cull it down even further, we've got
14 another week and Mr. Levitt will testify to it,
15 I think, Your Honor, that just really -- it's
16 just layering the difficulties that we face and
17 just the prejudice of this position that we're
18 now starting trial and there's 1900 pages of
19 documents that even we haven't had the chance
20 to really review and understand.

21 So I'd submit, Your Honor, it's clear from
22 our briefing that the documents were
23 responsive, that the documents were relevant,
24 and there's just no valid, good-faith reason
25 that they weren't produced to us honestly at



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1 all, because MUSC still hasn't produced these.
2 These are documents that we've now gotten
3 through significant and expensive third-party
4 discovery. Thank you, Your Honor.

5 **THE COURT:** Ms. Hollingsworth, I hear your argument
6 and I do appreciate the seriousness of the
7 allegations about the discovery abuses by MUSC.
8 But at this time I'm still not prepared or
9 ready to make a ruling on that and determine
10 what, if any, ramifications that's going to
11 mean for MUSC. But I do -- I will be listening
12 to the testimony carefully and will make some
13 determination on that as we go along. Thank
14 you.

15 **MR. SUMMER:** Might I ask one question.

16 **THE COURT:** Sure.

17 **MR. SUMMER:** If Mr. Levitt is going to do some kind
18 of review of documents and provide some
19 testimony that we don't know anything about,
20 I'd like the opportunity for us to be able to
21 depose him one night this week, so we can know
22 what he's going to testify about. This notion
23 of Perry Mason and gotcha the next day I don't
24 think is fair. If The Court's not inclined to
25 give a short continuance in order for us to



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1 wade through this information -- and you add
2 together the 1700 pages that were new that we
3 never saw that we just got from MUSC, plus the
4 1900 pages we've gotten over the last ten days,
5 we're talking close to 4,000 pages worth of
6 material that we're reviewing at night trying
7 to understand where the target is. And so at
8 a minimum I would want the opportunity during
9 the evening to depose Mr. Levitt before he
10 springs testimony on us we haven't seen before.

11 **THE COURT:** I think that's reasonable.

12 **MR. SUMMER:** Thank you.

13 **THE COURT:** Okay. And my -- I don't want to -- I'm
14 very opposed to and I'm just not going to grant
15 a continuance because this is a '17, a 19 -- I
16 mean, 2017 case. And we've really got to get
17 this resolved. Mr. Westbrook?

18 **MR. WESTBROOK:** That's all right. I was just going
19 to say, Your Honor, just a couple of things.
20 Since you've already ruled, I'm not going to
21 hold off my criticism -- or disagreements,
22 excuse me, with Ms. Hollingsworth, a number of
23 statements she said, we'll hold off on that.

24 As far as the deposition that Mr. Summer's
25 proposed, we don't have an objection to that.



1 I think that's fair as long as it's limited to
2 what he's -- any testimony he's going to be
3 presenting.

4 I do want to clarify. The 1700 pages that
5 we produced, a great bulk of that is in
6 reference to earlier -- CON applications of
7 which, as you know, CON application is a lot of
8 pages. The only pages we're going to be
9 focused on are the needs sections, which is ten
10 or 12 pages. And there are also applications
11 that Mr. Summer, I believe, and his experts
12 already have. But at any rate, that's -- we
13 don't oppose the idea of the limited
14 deposition.

15 **THE COURT:** Okay. That being said, I think we can
16 get started with opening statements at this
17 point. And we'll begin with Roper.

18 **MS. HOLLINGSWORTH:** Your Honor, so there are
19 objections to evidence that the parties were
20 not able to resolve. So that we have -- I
21 think there are some briefs that have been
22 submitted, but the parties would need to
23 address with you designations made. Certainly
24 I guess the alternative being that you would
25 hear them as we went through. But the parties



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1 did consult and we certainly do have objections
2 to information ...

3 **THE COURT:** You didn't resolve any of the ...

4 **MR. THOMAS:** We did not.

5 **MS. HOLLINGSWORTH:** But we did resolve some things.
6 Dr. Hall by agreement. You know, we've tried
7 Your Honor. And I don't think that -- it's
8 actually just very narrow issues. It may apply
9 to several documents, but they are isolated
10 reasons. And whatever The Court, you know,
11 wants to do, we can -- we will, of course,
12 comply with. But we did want to let you know
13 that.

14 **THE COURT:** Yeah. I'm going to address those as we
15 go along.

16 **MS. HOLLINGSWORTH:** Okay. Your Honor, could we
17 maybe just take two minutes to set up the
18 PowerPoint? And then another agreement, Your
19 Honor, we made, if it pleases The Court. We
20 were going to limit our opening discussions to
21 20 minutes or less.

22 **MR. DAYHUFF:** That's correct.

23 **THE COURT:** Okay. Less would be great. Okay. How
24 much time do you need?

25 **MS. HOLLINGSWORTH:** Just a couple of minutes. We're



1 just swapping over.

2 **THE COURT:** Okay. Very good.

3 **(Off the Record)**

4 **THE COURT:** Okay. Ms. Hollingsworth, you can begin.

5 **OPENING STATEMENT - BY MS. HOLLINGSWORTH:**

6 **MS. HOLLINGSWORTH:** Thank you, Your Honor. May it
7 please The Court. We have the CareAlliance
8 Health Services, does business as Roper St.
9 Francis Healthcare, and our hospitals in the
10 Tri-County area, which is Roper Hospital
11 downtown, Bon Secours-St. Francis West of the
12 Ashley, the Mt. Pleasant Hospital, and then
13 Roper Berkeley Hospital is under construction
14 and will be open in just a few months. We
15 appreciate the Court's time. We know this will
16 be a long, hopefully less than, two weeks, but
17 I will work as quickly as I can. I will beat
18 the time frame that we discussed and agreed to,
19 but we just wanted to give The Court a brief
20 overview of what it is we believe the case that
21 is before you and the argument certainly that
22 we, as Petitioners, have in evaluating and
23 challenging the decision of the Department of
24 Health and Environmental Control to approve a
25 Certificate of Need application filed by



1 Medical University Hospital Authority. I think
2 in my slides I refer to them as MUHA. It goes
3 back and forth, Your Honor, so I will do my
4 best to stay consistent.

5 But our position, overarching position,
6 Your Honor, is the Department erred in
7 approving the CON application, as it was only
8 supported by a desire of the Medical University
9 to increase its market share in an area that it
10 doesn't currently serve in a meaningful way, in
11 an area, Your Honor, that the evidence will
12 show is already well served by other providers
13 of emergency services.

14 So we always start with the purpose of the
15 Certificate of Need program. We have the
16 program, we have the legislative determinations
17 of why this program is important. And they
18 need to be followed, Your Honor. And they are
19 to promote cost containment. And that's what
20 the legislature has said. One of the four
21 guiding reasons for the approval or the denial
22 of a project that requires Certificate of Need
23 review.

24 It's also to prevent the unnecessary
25 duplication, Your Honor, of health facilities



1 and services. So this looks not only at any
2 particular type of facility, Your Honor, it's
3 also looking at the services that an applicant
4 is proposing to provide. Ans so we submit that
5 it's an important component of our challenge
6 here that the approval actually is contrary to
7 this purpose. It does not prevent this
8 unnecessary duplication.

9 The third purpose of the Certificate of
10 Need program, of course, is to guide the
11 establishing of health facilities and services
12 to best serve public needs. Your Honor, this
13 component, this purpose, speaks directly to the
14 idea of clustering and the concept of not
15 clustering services in any particular area.
16 And that will be an important issue for you as
17 we go through this contested case.

18 And finally, it's to ensure that there are
19 high-quality services provided in the health
20 facilities in this state. I believe you have
21 in your courtroom all very highly qualified
22 providers of healthcare services, but I think
23 every one of them will agree that there are
24 times where you start compromising quality when
25 you so impact utilization and volumes that --



1 certainly specifically in cath programs and
2 cardiac services, there are absolutely times
3 and needs in which, when we do too much and we
4 go too far, that we add the risk that our
5 services and the quality can be impacted.

6 So in thinking about that, Your Honor, we
7 believe that it's important to remind all of us
8 that the Department may not issue a Certificate
9 of Need unless that application complies with
10 the South Carolina Health Plan, project review
11 criteria, and other regulations. So, in
12 addition to the CON Act, we also have the
13 project review criteria that are in part
14 discussed in the Health Plan. They're also
15 fully set forth in the Department's Regulation.
16 And there are other provisions within the
17 Department's Regulation at 61-15 that are
18 important to a review of Certificate of Need
19 project.

20 So a brief overview, Your Honor, of what
21 our contested case is about, is we believe, and
22 the evidence will show you, that the
23 application, be it the application provided to
24 the Department and reviewed, or the project as
25 it stands today, does not comply with the South



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1 Carolina Health Plan, both with regard to
2 Standard 6 in the Health Plan and Standard 2 in
3 the Health Plan.

4 We also believe that the project does not
5 comply with the project review criteria to
6 include community need. Community need was not
7 demonstrated by the applicant and the evidence
8 will show us does not exist. There are no
9 capacity constraints that would support adding
10 more emergency service capacity in the proposed
11 service area. Approval of the project
12 unnecessarily duplicates those services and
13 facilities in the area that MUSC desires to put
14 this new facility. We believe that the
15 utilization projections used in the
16 application, and I guess would still be used in
17 this Court, are unreasonable and that they're
18 contrary to fact and expert witness testimony
19 that you're going to hear in this contested
20 case. The project does not further the needs
21 of medically underserved groups. It doesn't
22 consider more effective alternatives and
23 alternatives that would absolutely further cost
24 containment. That's not the project that you
25 have in front of you. It also doesn't



1 represent a balanced distribution of services.
2 And I'm sure in all the CON case you have,
3 there will be lots of maps, lots of maps and
4 lots of charts and you'll see some here in a
5 minute. But certainly, I think, Your Honor,
6 you'll see that the evidence reflects that
7 there will not be a balanced distribution of
8 emergency services in this proposed area. And
9 finally, certainly, adverse impact is an
10 important consideration and a consideration
11 that we don't think was adequately considered
12 and certainly not the right decision made,
13 because the approval of this project will
14 adversely impact the providers in the service
15 area, not only on utilization volumes, but it
16 is a very real concern that the staffing
17 resources in this area are not sufficient to
18 add another new provider in this area of the
19 Tri-county.

20 So we also think, Your Honor, that the
21 evidence will show you that approval of this
22 application violates the CON act and the
23 regulations. And the issue that you've already
24 heard a good bit about and you'll now receive
25 the evidence that I think you told us several



1 times is very important to you, that there have
2 been substantial and material changes such
3 that, when you look at the Regulations and you
4 look at the law, the application has so changed
5 that there is, in fact, a new project. And the
6 regulations require that the application
7 approved by the Department, it just doesn't
8 exist anymore, so there needs to be a new
9 application, because we have a new project,
10 Your Honor. That's something that we'll talk
11 about when we talk about substantial change.

12 In terms of the Health Plan, Standard 6 of
13 the Plan requires the applicant to demonstrate
14 need for the service and document where the
15 patients for the proposed service will come
16 from and why they are not being adequately
17 served by the existing services in the area.
18 And, Your Honor, we submit that, even the
19 answer provided to the Department in the CON
20 application does not meet the requirement for
21 the Standard. There's nothing in the CON
22 application, nothing in this answer or
23 elsewhere that addresses that the patients that
24 MUSC is desiring to serve are not adequately
25 served by the existing resources. In fact,



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1 there's no discussion of the existing
2 resources, of capacity, capacity both current
3 and pending, previously-approved capacity, none
4 of those things were evaluated. And, Your
5 Honor, I'd submit that when we get to the point
6 of looking at the decision and the results of
7 the Department's review, we would submit that
8 similarly those things were not considered. So
9 that evidence we will bring to you over the
10 next couple of weeks. That, Your Honor, is
11 Standard 6.

12 You've heard about Standard 2 in an
13 earlier briefing and we will, again, raise that
14 issue and whether or not the approval of this
15 application complied with Standard 2 of the
16 Health Plan.

17 Some maps that you'll see and hear
18 testimony about, Your Honor, include a lot of
19 information related to the service area that
20 the Medical University proposes to serve and
21 more recently will hear about the proposed
22 service area as evaluated by the consultant,
23 Intuitive Health, the consultant that we've
24 been told over the last few months is the
25 driving force behind the decision to change and



1 relocate the project. And we'll hear evidence
2 and information regarding what Intuitive
3 Health, the reasons behind their proposals that
4 MUSC has adopted and how they compare or
5 contrast to the information in the Certificate
6 of Need application. Certainly when you look
7 at the proposed service area that is included
8 in the CON application, it's a three-county
9 service area, Your Honor. And everyone I
10 believe that you'll hear from will tell you
11 that that is not a reasonable and appropriate
12 service area for a freestanding emergency
13 department. And so that will be a significant
14 point of contention as we go through this
15 contested case.

16 Here's another map, Your Honor, going to
17 the point of whether or not there are existing
18 and sufficient capacity and resources for
19 freestanding emergency services. You'll hear
20 testimony, you'll receive evidence regarding
21 who all is in the area, what ability or what
22 capacity do they have to provide freestanding
23 emergency services and hospital-based emergency
24 services, and whether or how the Department
25 evaluated that capacity and considered those



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1 issues when looking at need and making the
2 determination that this service was needed.
3 Because we would submit, Your Honor, that what
4 you'll show and when you hear from the
5 witnesses, that's simply not the case. As you
6 can see, there are a number of providers within
7 a very small radius of where the Medical
8 University desires to put this project. Such
9 a small area that the dots just run together,
10 so it's hard to even tell who is where. But
11 what you'll see in the information you'll have
12 is there are a lot of providers, there's a lot
13 of capacity. There is not any need.

14 The providers you will hear about, Your
15 Honor, that are in the proposed service area
16 either already providing those services or
17 previously approved by the Department before
18 and at times long before the submission of this
19 CON application would include providers within
20 just a couple miles, upwards to where the
21 Medical University is located down on the
22 peninsula. So, for example, we have my client,
23 Roper St. Francis Berkeley Hospital. We've
24 been working on that hospital for a very long
25 time, Your Honor. We tried that case over



1 seven years ago, I believe. We continued to
2 support and protect that approval all the way
3 through the Supreme Court. We received our
4 Certificate of Need in January of 2016. And we
5 are opening the doors of that hospital in just
6 a couple of months. And, Your Honor, I would
7 submit that the absence of any evaluation or
8 consideration of Roper Berkeley Hospital in the
9 review and approval of this project is
10 absolutely a reason for this Court to consider
11 the de novo information and make the
12 determination that that error requires reversal
13 of the approval, regardless of that the project
14 looks like or wherever it's located.

15 Similarly, Your Honor, Summerville and
16 Trident Medical Center are very close to where
17 it is that this application -- the original
18 application or the current project -- we'll
19 figure that out at some point -- they're within
20 six and seven miles away, Your Honor. They're
21 very close. And the Department had previously
22 approved and both of those hospitals have
23 invested substantial sums of money and are
24 continuing to invest substantial sums of money
25 to treat this very population that is drawing



1 the Medical University to the area.

2 We also have multiple freestanding
3 emergency departments already in the area.
4 There are two freestanding emergency
5 departments in Berkeley County, in Moncks
6 Corner. And there are two freestanding
7 emergency departments right in North
8 Charleston, as you'll see Centre Pointe
9 Emergency and Roper Hospital Diagnostic
10 Northwoods, within ten and 15 miles of where it
11 is the Medical University desires to put their
12 project. And so, Your Honor, I submit that
13 when you hear the information and the evidence,
14 you'll see that there is more than sufficient
15 capacity. There are more than enough
16 providers. There is not a need for additional
17 emergency services capacity.

18 One of the things you'll hear a lot about
19 too, Your Honor, is evaluating this from a 20-
20 mile radius. There is provision in the Plan
21 that we have that is in effect now and was in
22 effect as of three days after MUSC filed their
23 application that is relevant to this
24 evaluation. So you will receive evidence,
25 you'll hear from expert witnesses, and we'll



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1 talk a lot about, well, how much can
2 freestanding emergency departments do in terms
3 of volume. What about hospital-based
4 departments? All of those things, all of that
5 information will be available to you through
6 fact and expert and document evidence. And,
7 Your Honor, we believe you'll find that there
8 is a tremendous amount of capacity in the
9 service area. There's not a need for
10 additional emergency services capacity.

11 As I just alluded to, the State Health
12 Plan, the South Carolina Health Plan in effect
13 at the time the application was filed -- so of
14 course this was the application to put a
15 freestanding ED in the Nexton Planned Unit
16 Development, that was filed three days before
17 the 2017-2018 application was implemented. So
18 the 2017 -- I'm sorry, 2017-2018 Health Plan.
19 So of course that Health Plan had been
20 circulated and had been in draft form and the
21 enactment date was known. And so this -- the
22 application, again, for the Nexton location for
23 a freestanding emergency department was filed
24 three days prior to that date. So that is the
25 2015 Health Plan in effect on the date of



1 filing. Three days later you have the 2017-
2 2018 Health Plan. That's been the Health Plan
3 that was in effect throughout the Department's
4 review and at the time the decision was
5 rendered. And then subsequently where we stand
6 today, Your Honor, we are under the 2018-2019
7 South Carolina Health Plan.

8 And I think it's significant because the
9 Department's regulation and the CON Act
10 specifically discuss what Health Plan do you
11 look at, which one applies. And The Court and
12 the Department must consider the Health Plan in
13 effect at that time -- the time an application
14 is filed. But, Your Honor, they also have the
15 discretion, you have the discretion, to
16 consider the current Health Plan at the time
17 you're rendering a decision, as does the
18 Department. I think it's important here, Your
19 Honor, that at the time that the Medical
20 University changed the project and selected a
21 new location and selected a new scope and
22 services and all of the things that have
23 changed, that was the 2017-2018 Health Plan and
24 I would submit that is a reason to consider
25 that Health Plan in evaluating the project that



1 we're here addressing in your court room.

2 And the reason I mentioned that
3 specifically is, in that Health Plan the
4 standards for freestanding emergency services
5 changed just slightly. They number differently
6 and there is added I think goes to what was
7 Standard 6, but the language has changed a
8 little bit and now what the Health Plan says --
9 and this is an applicant for freestanding
10 emergency services, Your Honor -- "The
11 applicant must demonstrate need for this
12 service by documenting capacity constraints
13 within existing emergency departments in the
14 service area and/or travel time of greater than
15 15 minutes to an existing emergency department
16 in the service area." And so, again, even just
17 this small snapshot of information, you see
18 that we have multiple emergency departments
19 well within that time frame with significant
20 capacity to provide these services. And I'd
21 submit, Your Honor, never have we seen any
22 documentation of capacity constraints by the
23 Medical University for any of the providers in
24 the service area. That has always been a gap.
25 And I believe it's because, Your Honor, the



1 evidence you will receive instead is that there
2 is plenty of capacity and there are no capacity
3 constraints in this service area.

4 So, for the 15-minute drive time that's
5 discussed, what this map represents, Your
6 Honor, is the coloring of the map uses the
7 service area proposed by the applicant. That's
8 what the applicant is proposing as the areas
9 from which they will draw or redirect patients,
10 forming the analysis. And that overlay, Your
11 Honor, shows you what is in fact a 15-minute
12 drive time. So, as you can see and as you'll
13 hear from fact and expert witnesses, the
14 proposed service area and the scope from which
15 Medical University draws in order to support
16 the utilization, would say, Your Honor, it's
17 unreasonably broad and it's illogical when
18 you're thinking about freestanding emergency
19 services. That's not the type of service area
20 you'll find in freestanding emergency services.

21 So, we believe that the evidence and
22 information will show you that the utilization
23 projections are unreasonable, that the service
24 area, as I've just discussed, is unreasonably
25 broad for the type of service and facility



1 that's being proposed. The projections made no
2 attempt to adjust for acuity or age. Didn't
3 even consider that there's a Level I trauma
4 center being used as the basis to support these
5 projections. In the application the
6 information that you have and the Department
7 had to review is just a straight utilization
8 using the downtown emergency department
9 volumes, the Medical University's adult ED,
10 their chest pain ED, and the pediatric ED. And
11 what we think The Court we hope will find
12 compelling when you hear from our experts is
13 that it's not the correct way in which to
14 evaluate, that there needs to be an adjustment
15 both for acuity and for age, and that when we
16 perform those calculations is a much, much
17 smaller shift on which the Medical University
18 couldn't even conceivably rely in supporting
19 the project.

20 Here, Your Honor, you will -- you've heard
21 a lot already about Intuitive. You've heard
22 about Intuitive from Medical University.
23 You've heard about it in affidavit testimony.
24 And you'll have heard about it today and you'll
25 hear about it some more. And what you'll find,



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1 Your Honor, is the project, as it now exists,
2 was chosen, selected with the guidance, with
3 the input, with the oversight of Intuitive
4 Health. I think we were told they were a
5 consultant firm. We know that their analysis
6 is the basis of the move. And what we know
7 from their documents is that the reason for the
8 move was to get the best financial success and
9 the greatest likelihood of investment return as
10 opposed to the Nexton Planned Unit Development
11 that was provided to the Department for review.

12 We also believe, Your Honor, it'd be
13 important to hear about the alternatives that
14 are available and that should have been
15 considered and were not considered by the
16 applicant. And that very specifically includes
17 that Shawn Jenkins Women's and Children's
18 Hospital is opening this year. It will have
19 20 treatment spaces devoted to that hospital.
20 And as a result, there is an emergency
21 department co-located directly next to the
22 adult ED that will be vacant. And so certainly
23 we submit, Your Honor, that the promotion of
24 cost-containment principles would suggest that
25 you absolutely would simply re-purpose an



1 existing ER that had spaces and treatment for
2 a substantial pediatric volume that's now going
3 across the street and use that space to
4 alleviate these alleged capacity constraints.
5 That's what the Medical University supported
6 this application on, Your Honor. They said it
7 repeated throughout their application, that the
8 reason they were doing this project was to
9 address continued growth and space constraints.
10 And it was to address challenges at the Medical
11 University. Of course, none of the language
12 was evaluating capacity constraints or
13 addressing needs in the proposed service area.
14 This project is intended to alleviate issues on
15 the medical campus downtown, on the peninsula,
16 by putting it out into the Summerville market.
17 We submit, Your Honor, what you'll hear is
18 that's simply not a reason nor does it support
19 the approval of this freestanding emergency
20 department.

21 In addressing the adverse impact issues,
22 Your Honor, what you will hear from the
23 witnesses on behalf of Petitioners, the
24 information that you'll hear and examination of
25 the Respondent's witnesses, we believe that



1 you'll have the ability to find that there will
2 be adverse impact on the providers in the area,
3 that the purpose of this application is to draw
4 patients away from providers serving the area,
5 and it's intended to draw patients from
6 population growth. What I'd submit, Your
7 Honor, is that growing population base is the
8 base on which a number of the hospitals before
9 you challenging this contested case have
10 already invested and are investing substantial
11 healthcare resources to treat them. You will
12 hear a lot about expansions in the existing
13 emergency departments. Roper Berkeley I
14 believe you'll hear described has over 153
15 million dollars in brick and mortar alone,
16 which is a drop in the bucket of the investment
17 that Roper St. Francis Healthcare has made
18 based on the growth. And to just simply
19 determine that there should be additional
20 providers without these resources coming online
21 and evaluating them, what the needs of the
22 area, Your Honor, we would submit that's not
23 health planning. That's contrary to the
24 Certificate of Need Act and the Regulations.

25 So we believe not only does it address



1 volume, as I talked about earlier, but staffing
2 resources are a real concern, Your Honor. You
3 will hear from several witnesses about the
4 shortage of nursing staff and technician staff.
5 These are specialized staff that are used in
6 these departments. And we have a lot of
7 projects already approved coming online that
8 are having difficulties that they didn't used
9 to have, because, Your Honor, there is a
10 shortage of these very skilled and qualified
11 professionals.

12 And so, Your Honor, the last issue that
13 you, again, heard a lot about and will hear
14 more about is that we believe that the
15 application -- the approval of the application
16 must be reversed because the project that
17 you'll hear about does not comply with the CON
18 Act, it does not comply with the Regulations.
19 Not only is there simply no application,
20 because what the Department reviewed has been
21 abandoned. And then what we're left with and
22 the evidence we've worked hard to compile
23 simply does not satisfy neither the Act nor the
24 Regulation, which specifically address the
25 information that must be submitted to the



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1 Department for DHEC staff review. That's
2 missing. And so certainly, Your Honor, what we
3 do know about the project is that, when you
4 look at the Regulations in sections 310 and
5 605, the changes, the amendments that have been
6 made to the project are so substantial that
7 they certainly constitute a new application and
8 they are a new project.

9 A quick summary of those changes, Your
10 Honor, just looking at the information that's
11 required in the CON application and how what
12 you're going to hear about is significantly and
13 substantially different, both as to the
14 location, as to who owns the land, what are the
15 terms of an agreement, who's the tenant. The
16 size is substantially different. We went from
17 a 22-acre parcel with three acres for the
18 freestanding emergency department. It's now
19 1.73 acres, Your Honor. It's significantly
20 smaller. We don't know anything about the
21 zoning. We have some project costs, but we
22 certainly don't have detail with regard to any
23 changes in how it will be equipped. How does
24 the change by a third smaller in size -- that
25 necessarily has some impact on equipment or



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1 other costs. We don't know anything about
2 that, Your Honor. And then what we know about
3 the project description, I'd say, Your Honor,
4 is even that is inconsistent as we stand here
5 today. So you'll hear a lot about how the
6 application the Department reviewed looks
7 significantly and materially differently from
8 what's before you to review.

9 And so we do ask The Court in this
10 contested case to reverse the Department's
11 approval, to deny the CON application to the
12 Medical University for a freestanding emergency
13 department on the basis that it does not comply
14 with the Health Plan, it does not comply with
15 the CON Regulations or the project review
16 criteria, and it violates every purpose of the
17 Certificate of Need Act. We believe that just
18 a desire to capture market share without
19 considering the community's need or lack
20 thereof and without considering providers who
21 are in the area serving and investing to add
22 and expand services, it's simply a basis by
23 which this Court should reverse the
24 Department's decision and deny the application.
25 And that is what we'll be asking you to do at



1 the end of this contested case. Thank you,
2 Your Honor.

3 **THE COURT:** Thank you. Mr. Summer.

4 **OPENING STATEMENT - BY MR. THOMAS:**

5 **MR. THOMAS:** I think we've got a do a flip switch
6 over and hopefully it'll go a bit smoother than
7 what happened last time.

8 **(Off the Record)**

9 **MR. THOMAS:** Your Honor, may it please The Court,
10 after five minutes. Today I've got with me Ms.
11 Sorram (phonetic) from Summerville Medical
12 Center. She's just administrator. I've got my
13 partner David Summer. I've got VickiLynn
14 Mitchell, my paralegal. And Dan Sullivan is
15 our healthcare expert, Your Honor.

16 One thing I want to do today is try to
17 advance this slide. Sorry, Your Honor.

18 **(Off the Record)**

19 **MR. THOMAS:** Okay. So, a little more kind of basic
20 than Ms. Hollingsworth. I just want to kind of
21 say what a freestanding ED is. It's a stand-
22 alone emergency department, Your Honor, that
23 actually operates under a hospital's license.
24 And they generally treat the lower acuity
25 patients, so it's not, you know, trauma



1 patients, folks that are having a ST-elevated
2 myocardial infarction, aka heart attack. Those
3 aren't the persons that are normally going to
4 go to a freestanding ED. And we'll talk a
5 little bit more about the levels. And we may
6 even hear from Dr. Hall today about that. But
7 for more serious cases, patients who do present
8 to a freestanding ED are generally going to be
9 transported to hospitals that could actually
10 handle that particular emergency. They'll be
11 stabilized under a law called EMTALA and then
12 they should be taken to a kind of a full-
13 service hospital.

14 Moreover, you'll hear about emergency
15 medical service protocols. They have -- you
16 know, they have procedures that say where high-
17 acuity patients need to go. So, if somebody
18 had a heart attack at, you know, Lowe's or
19 something like that, the EMS isn't going to
20 stop by the freestanding ED. Instead they're
21 going to go the hospital that can cath that
22 patient and provide the relief for, say, a
23 heart attack.

24 So Trident Medical Center, to give you
25 kind of an overview, is Trident Medical Center



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1 is off of exit 205B. It has Center Pointe, a
2 freestanding ED in North Charleston. It has
3 Moncks Corner Medical Center, which is a
4 freestanding ED up in Moncks Corner. It
5 services Central Berkeley County. It will have
6 Summerville Medical Center freestanding ED.
7 And Summerville is its sister facility that
8 operates under Trident's name. And it's -- if
9 you see the slide here, Your Honor, you see
10 Summerville freestanding ED off of exit 199 to
11 the right. That other X where it's right next
12 to North Main Street, that is MUSC's proposed
13 location, off the same exact exit -- highway
14 exit, less than a mile away, Your Honor.

15 Now, Trident Medical Center is at exit
16 205B. If you've ever gone to Charleston,
17 you've gone by exit 199 and then by Trident's
18 exit, 205B, which is six miles away. So just
19 a couple of things about Trident Medical
20 Center. It's a Joint Commission Certified
21 Stroke Center. It's an American Cardiology --
22 College of Cardiology accredited Chest Pain
23 Center. It's Joint Commission Certified for
24 Advanced Heart Failure. So when folks who
25 utilize Trident's freestanding EDs,



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1 Summerville's future freestanding ED, actually
2 present with these very serious problems, they
3 can be taken straight to Trident, which is also
4 a Level II trauma center, Your Honor. They
5 don't have to be trucked, say, 23 miles away
6 down to MUSC.

7 This is just a -- kind of a
8 representation, an image of Trident's Center
9 Pointe Emergency, freestanding emergency center
10 in North Charleston, South Carolina, which is
11 within the service area that MUSC wants to
12 serve with its freestanding ED.

13 I'm going to talk a little bit about our
14 opposition. A little bit -- a lot of it,
15 actually, overlaps with Roper's case, but
16 Trident's got to make its case before this
17 Court as well. So we're obviously opposed to
18 MUSC's project to locate whatever it is, 11.3
19 or 13.5 million dollar freestanding ED, which
20 is going to be located less than a mile away
21 from Summerville's freestanding ED off the same
22 exit. We're asking you to reverse the
23 Department's decision for a few reasons, some
24 of which you've heard and others you haven't.

25 One is that affected persons have



1 effectively been denied their due process
2 rights. It was interesting, we heard and,
3 Judge, you said we need to go ahead and try
4 this case, it's a 2017 case. Well, the 2017
5 application is a lot different than what we
6 learned about in 2019. One can even argue it's
7 actually a new case. But the fact of the
8 matter is the Medical University decided to
9 substantially change their project without
10 informing DHEC, the public, registered affected
11 persons, who obviously, as we talked about this
12 morning, we had a lot of discovery requests
13 that were ignored. Only in early 2019 did MUHA
14 produce seven or eight pages of documents,
15 which indicated the project had changed with
16 little or no detail. And so once it was made
17 aware of these changes, we feel that -- we
18 understand that the evidence is going to show
19 they had -- that some kind of meeting was had
20 with DHEC. And at that point we believe DHEC
21 should have said you need to drop, re-file this
22 new application. That didn't happen.

23 So just to give you a little flavor of
24 what goes into a new application and what they
25 would have had to done to inform the public,



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1 when you file a CON application under the CON
2 Act and its Regulations, you first have to file
3 a notice in the paper telling everybody what
4 you're doing. It says where your project's
5 going to be located, what it is and how much
6 it's going to cost. They didn't have to do
7 that when they changed their location. Also,
8 once the application's received by the
9 Department, notice goes -- it is published in
10 a South Carolina State Register. And everybody
11 who wants to review that publication gets to
12 find out that MUSC has a new project that was
13 once at Nexton, it's now at exit 199. It's
14 different. It's smaller. The duration for
15 this project is much less as well. And I'll
16 talk a little bit about that in a bit. But and
17 then after that, after it's been deemed
18 accepted for filing, DHEC reviews the
19 application and then they publish again in the
20 State Register. They let the public know that
21 this application has now been deemed complete
22 and affected persons now may write a letter in
23 opposition to the project. Well, that didn't
24 happen here either. The public was not
25 informed that the application was deemed



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1 complete, because the application that was
2 deemed complete was at Nexton.

3 So, as I've mentioned here, affected
4 persons would have been put on notice of the
5 changes in scope, which I thought Ms.
6 Hollingsworth did a great job there, location,
7 which we've talked a lot about, duration. It
8 was represented that this -- that the Nexton
9 project, the freestanding ED, was actually
10 going to close down upon the opening of the
11 MUSC hospital four or five miles away. But we
12 don't know if that's the case anymore. And the
13 cost of course changed. They went from maybe
14 13 million to 11.

15 So, Your Honor -- so one of the issues
16 here, Your Honor, and you've heard about this,
17 is there now have been multiple iterations of
18 the project with the last being disclosed three
19 weeks ago, just three weeks before the trial,
20 on July 2nd. So there was the original
21 project, which was the Nexton project. They
22 said they were going to have a CDU, which was
23 going to be located in the area with a variety
24 of ancillary services that their patients would
25 be able to take advantage of. They talked



1 about a helipad for very critical patients
2 who'd then be quickly ferried downtown. It was
3 going to be 15,000 square feet, a lot larger
4 than the current footprint. And then February
5 19th, 2019, MUSC's CEO, Pat Cawley, stated in
6 a sworn affidavit that the project would be a
7 hybrid FSED with this urgent care center within
8 the four walls. And don't take it from me.
9 Here's the exact paragraph from his affidavit,
10 which he says another project change to the --
11 another change to the project that MUSC intends
12 to make is to provide urgent care services,
13 which are not subject to CON requirements, and
14 that is a very important line, in the same
15 building as the FED. Many people who come to
16 an emergency department do not need emergency
17 services, only emergent (sic) care services.
18 Then he goes on to say that they will not --
19 that the payors will be billed for urgent care
20 services, not freestanding ED services. So we
21 were under that impression for a while, Your
22 Honor.

23 And then just three weeks ago we get an
24 email, that -- remember, you heard Mr.
25 Westbrook say many, many times earlier this



1 morning we have an agreement not to produce
2 emails. But yet they oddly produced this one.
3 And it said that nothing has changed in the
4 nature or types of service that will be
5 performed at this freestanding ED and
6 everything remains consistent with our CON
7 application. And I would say, if nothing's
8 changed, then aren't we talking about the
9 Nexton project? Aren't we talking about a
10 15,000 square foot project with a CDU and a
11 helipad?

12 Now, as Ms. Hollingsworth alluded to, we
13 believe that the project was substantially
14 changed. And although this is a de novo
15 review, and you hear a lot about that, it's
16 supposed to be a de novo review of the
17 freestanding project -- freestanding ED project
18 that DHEC reviewed located at Nexton, not of a
19 new in a new location with a different scope of
20 services. And de novo's never, you know,
21 provided a party with a license to just change
22 wholesale their project and especially these
23 changes that we weren't told about until 2019,
24 until the very last minute, Your Honor.

25 So, we also received thousands of new



1 documents on the eve of trial. And we believe
2 that's per se discovery abuse and there's not
3 really a question of fact there.

4 We also believe -- and we've raised this
5 in our motion. I understand it was denied,
6 Your Honor, but that's because you belief
7 there's still an issue of fact here. And we
8 believe that the project appears to be managed
9 by an illegal entity. And not declared by us,
10 but by the Administrative Law Court, Judge
11 Funderburk's Order. He found MUSC SV,
12 Strategic Ventures, which was founded to be
13 ultra vires. It's a very well-thought-out, I
14 thought a well-reasoned Order. And what's
15 interesting about it is that two of the key
16 provisions in this case, i.e. where the
17 project's going to be located, and where -- and
18 the land lease for the project were decided by
19 MUSC Strategic Ventures. Now, we would argue
20 that allowing MUHA now to simply come in and
21 say, well, it's not going to be MUSC SV
22 anymore, it's going to be different party.
23 That is prejudicial to Trident Roper because we
24 don't get discovery on that. We don't know who
25 the new party's going to be, what their



1 financial abilities are, what they're able to
2 do. So we're going to learn -- I guess, if The
3 Court believes that MUSC Strategic Ventures is
4 an ultra vires entity, we're going to learn for
5 the first time who the new entity's going to
6 be. So, you know, we don't believe the
7 Petitioner should be forced to conduct
8 discovery on the fly and during the trial.

9 Now, getting into kind of the project
10 review criteria of the case, Your Honor, we
11 believe, like Roper, that it doesn't comply
12 with Standard 6. And I thought Ms.
13 HOLLingsworth did a good job there. You know,
14 what MUSC failed to do in its application and
15 otherwise, in any of the future submissions to
16 DHEC, is it never said why the services already
17 there aren't adequate to serve patients who are
18 in need of emergency services. What you're
19 going to hear a lot about is, well, there are
20 patients that go downtown, they come to us.
21 But they don't have to, right, Your Honor?
22 That's not a requirement. If they have
23 emergency services, such as the type that are
24 going to be treated at a freestanding ED -- and
25 you'll hear about this. These are mainly the



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1 Level IVs and V patients, non-critical. You
2 know, some urgent, but, you know, these are
3 things that MUSC, first of all, has no
4 experience in even providing. They don't have
5 a freestanding ED. But these are things that
6 are already being done by Trident and Roper in
7 the exact service area where they're proposing.

8 So there will be, Your Honor, 167, by our
9 calculations, ED treatment rooms or spaces
10 within MUHA's freestanding purported service
11 area -- freestanding ED purported service area
12 capable of treating, we believe conservatively,
13 334,000 visits annually. And we don't think
14 that MUSC needs to spend 12 million dollars of
15 state money that it really doesn't have and
16 that maybe, based on what we've heard and I
17 think what The Court's going to hear from an
18 evidentiary standpoint, it ought to put that
19 money into its ED downtown, which sounds like
20 it's not a very efficient operation.

21 And this is the slide just showing all the
22 different emergency services available within
23 MUHA's freestanding ED proposed site. There
24 are eight such emergency departments within
25 their service area that they purport that



1 they're going to serve. Eight.

2 Your Honor, we maintain that -- Trident
3 maintains that it doesn't comply with the State
4 Health Plan. There's obviously no community
5 need, given the number of resources that are
6 already there. It doesn't contain cost. It
7 certainly unnecessarily duplicates services of
8 a freestanding ED less than a mile away. It
9 doesn't meaningfully benefit medically
10 underserved patients. There's no problems with
11 access to medically underserved patients. And
12 the project does not appear to be financially
13 feasible for MUSC.

14 And Ms. Hollingsworth talked about the
15 purposes of the CON Act; cost containment, not
16 duplicating services, making sure that there
17 are available health resources of high quality.
18 And that, of course, is The Court's starting
19 point. And the other controlling statute is, of
20 course, Ms. Hollingsworth mentioned as well, is
21 that, you know, The Court must find that the
22 application itself complies with the State
23 Health Plan. The applicable one in this case
24 is 2015, but we, like Roper, believe that The
25 Court should take notice, as it can under the



1 statute, of the later published State Health
2 Plans.

3 So, with respect to the project review
4 criteria, Your Honor -- and I'm not going to
5 talk about the -- I do want to talk about the
6 standard in the 2015 plan again -- is that you
7 have to demonstrate that the proposed service
8 -- where the patients are going to come from
9 and why they're not being adequately served by
10 existing services in the area. And that's just
11 a huge part. And MUSC didn't even reference
12 that in its original CON application, didn't
13 even talk about the existing services in its
14 service area. And of course, as Ms.
15 Hollingsworth explained, you have the 2017-2018
16 Plan. And they talk about to this travel time
17 greater than 15 minutes to an existing
18 emergency department in the area and capacity
19 constraints. That's going to be 360,000 visits
20 worth of capacity in that service area, Your
21 Honor. So, it's rife with ED bays. And this
22 is just a listing that the 167 treatment rooms
23 -- or areas that will be capable of treating
24 334,000 visits per year that will be online
25 when MUSC opens up. And the Trident ones are



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1 Trident Medical Center, Summerville Medical
2 Center, Center Pointe, and Moncks Corner
3 Medical Center, which are all there and all
4 told have over 100 ED bays. Excuse me, Your
5 Honor.

6 So, I want to talk a little bit, Your
7 Honor, about some of the -- some compliance
8 with the individual PRCs, the project review
9 criteria. What's very interesting to us is
10 that MUSC produced documents showing that its
11 own analysis indicate, from a market scorecard,
12 that Mt. Pleasant was the number one spot for
13 them. Second place was Goose Creek. And third
14 place was another ZIP code in Mt. Pleasant.
15 And they chose to ignore all three of those,
16 Your Honor. So, we believe that Intuitive
17 somehow convinced them to go to the new
18 location and change the way they're going to be
19 configured because of some of the reasons that
20 have already been mentioned in Roper's opening.

21 We don't believe, given that all of the
22 resources available, that MUSC can make a
23 reasonable argument about a lack of access to
24 these services. As I've said already, their
25 proposed service area is probably one of the



1 most heavily concentrated areas of ED services
2 in the state of South Carolina. And what's
3 interesting, Your Honor, back to their
4 scorecard, Mt. Pleasant -- that Mt. Pleasant
5 area, which is now the fourth largest city in
6 South Carolina -- doesn't have a freestanding
7 ED. Nor does West Ashley. Nor does James
8 Island, although Trident applied for one in
9 James Island as well.

10 I also want to talk about financial
11 feasibility. MUSC's own documents indicate
12 financial feasibility issues. They -- since
13 they've applied for this case, they've
14 purchased 137 million dollars worth of
15 hospitals. They've got bond debt related to
16 their 400 million dollar Children's Hospital.
17 They've got massive pension debt and an overall
18 liability position of two billion dollars. And
19 they have a negative net position on their
20 balance sheet of 640 -- actually, I was wrong,
21 that was a typo. It's 661 million dollars.
22 That's straight from their financial report,
23 Your Honor. The total net position negative
24 661 million dollars.

25 Now, as I've already said, what we expect



1 to hear from MUSC is that they're just going to
2 treat their own patients. And that would be
3 great if that were the standard in the State
4 Health Plan that this Court must review and
5 apply in this case. We don't fault them for
6 wanting to treat their own patients, but that
7 is not the standard. The standard is, what are
8 the existing resources available in the area?
9 And the resources available in the area are
10 rife, they're myriad, they can -- there's more
11 than enough ED resources to go around for any
12 patients who need, especially the low-acuity
13 care type that MUSC is going to offer at its
14 freestanding ED.

15 We believe that once you hear the
16 evidence, you're going to see that this is a
17 market-share play. This is for MUSC to capture
18 more market share in the Berkeley area in order
19 to potentially feed its hospital that it wants
20 to build there in the future. This is a
21 textbook duplication of services, Your Honor.
22 A freestanding ED -- you're going to hear
23 evidence from their medical director, from our
24 medical director. They are duplicating what we
25 are building at exit 199 less than a mile away.



1 And it's unnecessary. They don't need to do
2 it.

3 And what's interesting about it is they
4 had to get all of these different consultants,
5 these third parties to help them. And I know
6 that what you've heard is they're not using any
7 of those people now. But the evidence is going
8 to show differently. The evidence is going to
9 show they chose the location of Intuitive --
10 that Intuitive proposed and they also took the
11 design that Intuitive recommended and they
12 reproduced it, you're going to see slides, for
13 their freestanding ED. They are using
14 Intuitive's documents. And as I mentioned at
15 the bottom, the person who we believe is going
16 to be the medical director of the facility and
17 oversee it has never worked a single day in a
18 freestanding ED.

19 So, we do believe from an adverse impact
20 perspective, the intent here is to capture
21 market share. And, you know, what's
22 interesting is that if their market share was
23 so robust in the north area, which I refer to
24 as North Charleston, Berkeley, and Dorchester
25 counties, why did they need three different



1 consultants to come and help them and tell them
2 what to do and where to build it and how to
3 build it?

4 So, again, I'm not -- we believe that MUSC
5 is somewhat in a state of disarray, just given
6 three different projects. And in fact that, as
7 of last -- July 2nd, the project changed again.
8 We don't really think they're really certain of
9 what they want to do there or how they want to
10 do it. But, you know, we are here today, so
11 we've got to deal with it.

12 So we believe that the Department's
13 original decision was arbitrary and capricious.
14 But the interesting thing about the original
15 decision is it's for Nexton. It wasn't for
16 this project. And based on what we know, the
17 CON director, while informed about certain new
18 details of the new location, the new project,
19 she's never blessed off on it. She's never
20 approved it. I think she's looking to this
21 Court, just saying you handle it. That's not
22 how it's supposed to work, Your Honor.

23 The bottom line is that there's only one
24 freestanding ED needed at exit 199. You know,
25 there are going to be 167 ED treatment rooms



1 available in the area.

2 And the other thing we'd like to do, since
3 The Court is going to take note of this change
4 that we found out about in 2019, The Court also
5 needs to take note about the 130 million
6 purchase for MUHA that the hospitals around the
7 state, they got -- The Court needs to take note
8 and notice of MUHA's horrible balance sheet.
9 They've got to take notice -- The Court's going
10 to have to confront the fact that an ultra
11 vires entity, MUSC SV, made key decisions in
12 this case as to location. And this board,
13 which is we believe an illegally-formed board,
14 actually made the decision to relocate from
15 Nexton to exit 199. And, you know, we
16 understand that you're not bound by Judge
17 Funderburk's decision, but we believe it's a
18 good decision, and one that you may want to
19 consult, because we will probably be filing a
20 very similar motion again, Your Honor.

21 So we request that you overturn DHEC's
22 decision to approve the CON application.
23 Again, it doesn't comply with the Health Plan,
24 the applicable one or the later ones, which you
25 can take notice of. There's no need for the



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1 project. There's no access issues. There's
2 really -- it doesn't really comply with any of
3 the purposes of the CON Act. And some of the
4 other things that we've already discussed is
5 that we didn't find out about this until 2019.
6 You know, a lot of these changes were literally
7 disclosed at the last minute. And we believe
8 that MUSC SV cannot have made the decisions
9 that it made.

10 So in the alternative, we ask that The
11 Court simply remand this application back to
12 DHEC and let them review it and then make their
13 decision, one that then The Court could
14 actually review and decide on. Thank you.

15 **THE COURT:** Thank you, Mr. Thomas. Ms. Biggers.

16 **OPENING STATEMENT - BY MS. BIGGERS:**

17 **MS. BIGGERS:** Thank you, Your Honor. The proposed
18 project at issue in this case is the
19 establishment by MUSC, a freestanding emergency
20 department in Berkeley County. A freestanding
21 emergency department is a defined term under
22 the CON Act. It is also referred to as an off-
23 campus emergency service. It means an
24 extension of an existing hospital emergency
25 department that is an off-campus emergency



1 service and that is intended to provide
2 comprehensive emergency services. Hospitals
3 shall have a valid license and be in operation
4 to support off-campus services. In this case,
5 MUSC is the hospital. A hospital, under the
6 definition of a healthcare facility in the CON
7 Act, MUSC as a hospital, is a healthcare
8 facility.

9 The reason that MUSC had to submit an
10 application for this, if you look at the
11 section in the CON Act that lists reasons why
12 someone would need to apply for and receive a
13 CON for a project, there's a requirement that
14 a healthcare facility -- or that a person or
15 healthcare facility apply for a CON if they are
16 going to make a capital expenditure that is
17 associated with the addition or substantial
18 expansion of a health service with specific
19 standards of criteria in the South Carolina
20 Health Plan. There are standards in the South
21 Carolina Health Plan for freestanding emergency
22 services. And for that reason, freestanding
23 emergency services itself meets the definition
24 of a health service, as that's defined in the
25 South Carolina -- in the CON Act.



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1 So here, this -- we are not talking about
2 the establishment of a new healthcare facility.
3 We're talking about an existing healthcare
4 facility adding or expanding a health service
5 for which there are standards in the Plan.
6 MUSC provides emergency services at its main
7 hospital campus. And here it needed review
8 under the Standards for an off-campus emergency
9 service. That's what the project is. That's
10 what the project was per the application that
11 came in the door to DHEC. And that's what the
12 project is that's before you for this de novo
13 contested case hearing and for your view. It
14 remains a project by MUSC, a hospital, to
15 provide a health service, freestanding
16 emergency services, for which there are
17 standards in the Plan, in Berkeley County.
18 That remains the same.

19 DHEC reviewed this application for
20 compliance with the Standards in the Plan for
21 freestanding emergency services, for compliance
22 with specific project review criteria as
23 outlined in the Department's decision letter.
24 The Department further found it complied
25 generally with the purposes of CON. And we



1 look forward to presenting the testimony of our
2 witness, who was the reviewer and decision
3 maker in this case, who can explain that
4 further.

5 Now, there's been a lot of talk by the
6 Petitioners about changes to information about
7 the project. And I think in some of the
8 pleadings that have been filed prior to this
9 hearing, there have been some comparisons of
10 information submitted in the CON application
11 form and information that may have been
12 presented or come up during discovery. The CON
13 application is set forth in the CON Regulation
14 at section 202. So section 202-1 says an
15 applicant has to submit two copies of their
16 application to the Department in the following
17 format and shall contain the following
18 information as applicable, as applicable to the
19 project. So this is a form. Then the form is
20 set forth at section 202-2, application form;
21 as a proposal page and a part A questionnaire,
22 that's a basic application form, places to
23 check boxes and enter certain information.
24 It's actually in the appendix of the CON
25 Regulation, that form and the boxes. And it



1 has a part B for additional information, a part
2 C for programmatic documents, part D for
3 assurances.

4 That proposal page, which is generally the
5 first page of the application that comes in the
6 door, has a signature line. And below it, it
7 says the applicant certifies this information
8 contained in this application is correct to the
9 best of his knowledge and belief. So they're
10 making that certification when it comes in the
11 door to DHEC. This is a form with information
12 -- this is a format that DHEC prescribes for
13 the applicant to submit the information to the
14 Department and we require that the applicant
15 certify at the time that they're submitting it,
16 that at that time it's true to the best of
17 their knowledge and belief. And the
18 information that is important is the
19 information applicable to the project.

20 We look forward to presenting testimony
21 from our reviewer that in this case the project
22 remains the same as it came in the door at DHEC
23 and as it was reviewed and approved by DHEC.
24 And to the extent that there are any changes
25 that may come out during the testimony in this



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1 case about answers to particular questions, our
2 witness would still focus on the things that
3 were important to her in her decision. And
4 those things still support the Department's
5 approval of this application. Thank you.

6 **THE COURT:** Thank you. Mr. Westbrook.

7 **OPENING STATEMENT - BY MR. WESTBROOK:**

8 **MR. WESTBROOK:** Thank you, Your Honor. May it
9 please The Court. I'm Dan Westbrook. I'm here
10 on behalf of MUSC. And I suppose it is not
11 uncommon for a judge or anybody to hear the
12 same story told two entirely different ways, so
13 you're probably used to what you're going to
14 hear for the next couple of weeks. But in this
15 case, MUSC sees the story of it's FED project
16 a lot differently than our opponents do.
17 MUSC's story is not very dramatic. It's not
18 very theatrical. It's pretty straightforward,
19 direct. It focuses on things like criteria.
20 Our opponent's story, by contrast, just the
21 tone of it is loud and abrasive and hurried and
22 filled with anxiety and innuendo and conspiracy
23 theories. The strategy behind the Trident-
24 Roper story is to distract The Court and drown
25 out the real story. So nothing wrong with



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1 that. It's a tried and true old legal
2 strategy, standard legal strategy. When you
3 don't have the facts, you argue the law. When
4 you don't have the law, you argue the facts.
5 And when you don't have the facts or the law,
6 you pound the table. And that's what they're
7 doing.

8 MUSC, they say, has abandoned its project.
9 There's so many changes we don't even know what
10 the project is anymore. MUSC is plotting to
11 form an illegal joint venture with illegal
12 companies with some wild west consulting firm
13 called Intuitive. Oh, my God, MUSC is moving
14 into an Applebee's. Well, none of that's true.
15 That's the problem with their story.

16 What MUSC has made perfectly clear to them
17 and what MUSC will make perfectly clear to this
18 Court over the next couple of weeks is the
19 following. First of all -- first of all, we're
20 going to demolish the Applebee's and build a
21 new building to put our freestanding ED in.
22 So, it won't be in an Applebee's.

23 Second, Intuitive, which is a reputable
24 consulting company in Texas, made a proposal to
25 MUSC, which MUSC rejected. Intuitive at this



1 point has nothing to do with this project, nor
2 do these other third-party consultants that
3 we've talked about today.

4 The MUSC SV decision, which Mr. Thomas
5 talked a good bit about, is on appeal. With
6 all due respect to Judge Funderburk, I think he
7 got it wrong and we're appealing that decision.
8 It's in the Court of Appeals now. So, you
9 know, if at some point in time it's determined
10 that MUSC SV is illegal, an illegal entity,
11 then at that point in time we'll determine what
12 we have to do, which I assume would be to
13 substitute MUHA or some other MUSC entity into
14 this role. But we're going to cross that
15 bridge when we come to it and we don't think
16 we're going to come to it, because we're
17 confident we're going to win the appeal.

18 Finally, there have been only a few
19 changes to this project. Dan, let's look at
20 demonstrative three, please. And here are the
21 changes. Relocation, we are relocating less
22 than a mile from the original site. Now,
23 because it's being located, there's going to be
24 a different developer, a different land owner
25 that we're going to lease the property from.



1 But it's only .7 miles from the original site.
2 Let's look at exhibit 33 kind of quickly there.
3 See the area in green up there, Your Honor.
4 That's the Nexton development area. This red
5 dot here, the one that's further to the north,
6 is where our original site was on the very edge
7 of the southern tip of the Nexton development.
8 Right across the interstate, this red dot is
9 our current site. That is closer to the
10 interstate exit. It's better access. And
11 that's why they moved.

12 Let's go back to demonstrative three, Dan.
13 Okay. The size, you're -- you know, they're
14 right, we've downsized. We've gone from 15,000
15 square feet to a little under 11,000 square
16 feet. And the cost of the project has gone
17 down from 13.6 million to projected estimated
18 11.3 million dollars. So, there's less cost.
19 And there's no CDU. We decided to go, to not
20 use the CDU or helipad. Those both were talked
21 about in our application.

22 Let's look at demonstrative four.
23 Interesting thing about the CDU and the helipad
24 is this is from Trident's petition that it
25 filed with this Court. I'm going to read this



1 into the record about the CDU Trident in its
2 petition said, quote, MUSC presented no
3 evidence of any clinical benefits that would be
4 derived from the establishment of a CDU because
5 there are none. Helipad, quote, the expense of
6 operating a helicopter does nothing to promote
7 cost containment, end quote. Well, it seems
8 like they ought to be flattered if we decided
9 to take out the CDU and the helipad, but I
10 guess they're taking a different position on
11 that. It's not that we agree with those
12 quotes, particularly the first one about the
13 CDU. It's that, as Dr. Cawley and others will
14 testify, after thinking this through more
15 carefully, they decided that the benefits of
16 having a CDU and a helipad, while there are
17 benefits, would probably be outweighed by the
18 cost. And to save on costs, they eliminated
19 those two features. It's as simple as that.

20 Now, let's go back to demonstrative three,
21 Dan. Thank you. So, here are the changes to
22 the project. The issue of course is whether
23 these changes are substantial. And we've --
24 both parties have briefed this. We've argued
25 this. You've issued an Order that discusses



1 some of this. But we don't believe these
2 changes are substantial. Our position, as you
3 know, is that the appropriate test The Court
4 should use -- should apply to determine whether
5 changes are substantial is the test found in
6 the Belfair case, which is demonstrative eight.
7 And that is -- and that case says that a
8 substantial change depends on whether the
9 amended project meets those same project review
10 criteria it originally met in substantially the
11 same way. That's, we think, how you evaluate
12 if something's substantial or not. And we'll
13 obviously present you with some testimony to
14 that effect.

15 Now, it is true that at one point there
16 was going to be another project change. Back
17 in February, as Mr. Thomas said, MUSC filed an
18 affidavit by Dr. Pat Cawley from MUSC that said
19 the only project changes were those four we
20 just talked about; the relocation, the
21 downsizing, less cost, and no CDU and no
22 helipad. But this affidavit also added another
23 change. He talked about urgent care. He said
24 that the decision was they were going to
25 provide urgent care services in the same



1 building where we would provide emergent
2 services. And he testified at his deposition
3 about that. But, as you will hear later this
4 week, about a month or so ago -- that's just
5 very roughly -- a few weeks ago we were
6 notified by DHEC that they had some concerns
7 about that. And not from a CON perspective,
8 but from a licensing and certification
9 perspective. And you will hear testimony about
10 this. And the concerns were that combining
11 emergent and urgent care under the same roof
12 would be inappropriate under licensing and
13 certification regs. So we were told that. So
14 what we said was, okay, then we won't do urgent
15 care. Now, we could have contested that. We
16 could have resisted and argued to this Court in
17 this de novo hearing, that DHEC certification
18 and licensing staff who raised those concerns,
19 those were unfounded. We could have made that
20 argument. But the issue is just not that
21 important to us. We're not looking for a fight
22 with DHEC. We're not looking for a fight with
23 anybody. We just want to open our FED.

24 Here's why we want to open our FED. Let's
25 look at example -- not example, excuse me,



1 exhibit -- I see EX and I can't remember what
2 it stands for -- Exhibit 36. Berkeley County
3 is the third fastest growing, by percentage of
4 growth, county in the state of South Carolina.
5 Let's go to Exhibit 32, please. This map,
6 which I think they like to call it heat map,
7 shows where the population in Berkeley county
8 and this -- and what my friend Mr. Thomas calls
9 the north area is really heating up. It's
10 really growing. And the red is the hottest
11 area. That's where it's really growing, right
12 around where MUSC wants to put its freestanding
13 ED. No coincidence there.

14 Let's look at demonstrative 28, Dan.
15 There's another little map that shows not only
16 is the population growing along I-26, around
17 this area we're talking about, industry is
18 moving in. The airport's there. There's a
19 Google and an Amazon facility is there. We've
20 got plants from Volvo, Mercedes, and Boeing
21 that are all relatively new. I don't know
22 whether the population is following the
23 industry or vice versa, but this is a blooming
24 area, which is why it's attractive to MUSC and
25 other providers.



1 Let's look at Exhibit 37, please, Dan.
2 Exhibit 37 focuses on the growth, not in
3 population, but in emergency department visits.
4 It shows the facilities in the area. And the
5 green line highlighted at the bottom, for all
6 Tri-County providers the percentage of growth
7 in ED visits over this 2012 to 2017, six-year
8 period, the growth is 23 percent -- over 23
9 percent. Let's look at Exhibit 35, Dan. 35
10 just focuses on the counties, the individual
11 counties, and shows that Berkeley county is the
12 one that's growing the most in ED visits, over
13 17 percent over the three years here that we
14 have data for. So, population is growing. ED
15 visits are growing.

16 Let's look at the Exhibit 42, Dan. Now,
17 as Mr. Thomas and Ms. Hollingsworth both said,
18 there are a lot of providers in this area now.
19 A lot of freestanding and hospital-based EDs
20 are in this area. But all of them belong to
21 either Roper or Trident. Now, for years these
22 two have fought each other over Berkeley County
23 CON projects. And even in this case, Roper
24 opposed Trident's project. Let's look at the
25 DHEC record, Bates page CON 490. Here's what



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1 Roper said about Trident's project. Did I say
2 that right a minute ago? I said even in this
3 case Roper has criticized Trident's project.
4 So, here's the criticism. Summerville
5 Freestanding ED will provide more costly urgent
6 and primary care for a freestanding ED without
7 any cost benefit to the patient. That's what
8 Roper thought of Trident's project. But now
9 Roper and Trident seem to be reconciled and
10 living with each other. They've got all these
11 EDs up in this area. And their primary focus
12 now appears to be on keeping other providers
13 out, particularly MUSC.

14 Let's go back to Exhibit 43 (sic), Dan,
15 all these area providers. You know, so there
16 are a lot of area providers here. But you
17 know, what the evidence is going to show, that
18 there are a lot of patients who live up in this
19 area, who right now and for the last several
20 years have been driving past these providers,
21 driving right past them and going all the way
22 down to the peninsula, through the traffic and
23 the flooding and everything else to go to
24 MUSC's hospital down on the peninsula to get ED
25 services down there. Let's look at Exhibit 38,



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1 Dan. As the green line at the bottom shows,
2 over 20,000 patients a year who live in these
3 ZIP codes -- and these are ZIP codes from what
4 I agree with Mr. Thomas' characterization of,
5 this as the north area -- over 20,000 patients
6 a year are driving down to the peninsula for ED
7 services. And the evidence in this case will
8 show that the vast majority of these patients
9 could be treated at MUSC's Berkeley County FED,
10 closer to where these folks live and much
11 easier to access than MUSC's downtown facility.

12 Let's go to Exhibit 44, Dan. So, MUSC's
13 health planner, Mr. Levitt, who is sitting
14 behind me over here, who will testify in this
15 case, Mr. Levitt's the fellow who drafted the
16 MUSC application. And he's going to testify
17 that in his opinion, based on his calculations
18 here and the data he's looked at, that 14 to
19 15,000 persons per year who are now choosing --
20 who live in this area, the north area, are
21 choosing to drive all the way past the Roper
22 and Trident facilities to go downtown to MUSC,
23 14 to 15,000 each year would go to an MUSC
24 owned FED in Summerville.

25 This project that MUSC is going to be



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1 talking about in this case to you this week is
2 the same project MUSC submitted to DHEC in
3 2017. None of the project changes that we've
4 talked about affect MUSC's compliance with the
5 relevant criteria under the Belfair test.

6 Dan, let's look at demonstrative two,
7 please. Here are the reasons for this project,
8 this is why MUSC wants to do this. I'm not
9 going to talk about them quite in the order
10 they're listed there, so just bear with me.
11 First, I'm going to start with the one on top.
12 This project improves access for residents of
13 the north area who currently drive to MUSC's
14 downtown hospital on the peninsula for ED
15 services.

16 The second one, I'm going to just skip
17 over to capacity constraints. This project
18 relieves overcrowding at the MUSC downtown
19 hospital.

20 Next to the last one that's listed on the
21 slide there, this project is needed because of
22 the very rapid population growth around I-26
23 corridor in Berkeley County.

24 And finally, the second one listed up
25 there, this project is also needed because of



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1 the rapid growth in ED visits in this area, as
2 we've showed by the slides a few minutes ago.

3 Your Honor, that's our case. It's a
4 simple case. There it is right there. Our
5 opponents do not have the facts on their side
6 in this case and they don't have the law.
7 Their only recourse therefore is to continue
8 pounding that table in an effort to distract
9 The Court and drown out the real story, which
10 is right there. I'm sure this is going to be
11 a loud and interesting trial. I look forward
12 to it. Thank you very much.

13 **THE COURT:** Thank you, Mr. Westbrook.

14 **MR. SUMMER:** Your Honor, may I note one thing for
15 the record, please, ma'am?

16 **THE COURT:** Yes.

17 **REPLY STATEMENT - BY MR. SUMMER:**

18 **MR. SUMMER:** Part of I think the frustration here on
19 this side of the courtroom is how things
20 constantly change. And to be here at near the
21 close of discovery on July the 2nd and to get
22 an email, which repudiate the affidavit that
23 they avoided summary judgement on was extremely
24 puzzling to us. We had a deal. We weren't
25 going to exchange emails between the parties,



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1 although we did have a deal that any emails
2 going back and forth to DHEC should be
3 produced. So, apparently there's been a
4 discourse between MUSC and DHEC. And that
5 discourse has been, gee, we've been looking at
6 your affidavit and we're concerned about doing
7 urgent care, which is basically a physician's
8 office, inside a licensed facility. Nobody on
9 this side of the table was able to listen to
10 that discourse. Nobody on this side of the
11 table was able to comment on that discourse.
12 And the CON law requires notice and an
13 opportunity to be heard. So, we spent all of
14 our discovery time from February until July the
15 2nd pursuing this notion of a hybrid -- you'll
16 hear Dr. Cawley talk about the hybrid project.
17 DHEC obviously had a problem with it. We
18 didn't know that. None of our clients were
19 aware of that. And the notion that on the eve
20 of trial they're going to abandon what we spent
21 tens of thousands of dollars in discovery
22 trying to learn about this hybrid model,
23 obviously is puzzling, but it's also wrong.
24 It's wrong to play discovery games. It's wrong
25 not to allow our clients to be able to



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1 participate and comment on these issues, which
2 I think, Your Honor, is why this case at a
3 minimum should have been remanded and say,
4 MUSC, please make up your mind. DHEC, give
5 everybody a chance to make a record below on
6 whatever this project's going to be.

7 So I suspect that there will be a great
8 deal of frustration if we go forward with this
9 case over the couple of weeks, because we're
10 learning about this as we go along. And it's
11 in derogation of our client's due process
12 rights to have notice and opportunity to be
13 heard. So, again, Your Honor, we promise that
14 we are going to handle this case with all due
15 decorum, but we are extremely frustrated by the
16 conduct on the other side of The Court. Thank
17 you.

18 **THE COURT:** I hear you, Mr. Summer. Mr. Westbrook.

19 **REPLY STATEMENT - BY MR. WESTBROOK:**

20 **MR. WESTBROOK:** Well, I've never heard of a rebuttal
21 to an opening before or a reply to the
22 rebuttal, but I guess I'll ---

23 **THE COURT:** Well, this has been an unusual case.

24 **MR. WESTBROOK:** And I think it will continue to be
25 unusual. Well, you know, Mr. Summer has -- can



1 take some solace, I suppose, of the fact that
2 it is highly unlikely that we will be making
3 any further revelations or changes during this
4 trial. I think he's heard them. And as soon
5 as DHEC expressed the concerns to us, we made
6 the change. Dr. Hall's deposition was given
7 after that change. And the position at MUSC,
8 as I said, based on the concerns raised by
9 DHEC, is simple; we're not going to do urgent
10 care services if DHEC thinks that violates that
11 regs, we won't do them.

12 Now, in terms of the emails, there were no
13 emails to that effect. There was -- these were
14 conversations. And the only email that related
15 to any of this was the email that we produced
16 to Trident and Roper from Dr. Cawley to Dr.
17 Hall, which is now -- I think it's on the
18 exhibit list of somebody. And all of this will
19 be explained to you fully during The Court and
20 we don't -- I mean, during the trial.

21 And projects do change. And the issue to
22 come back to is whether the change is
23 substantial or not. The changes of this
24 project are not unlimited as our opponents
25 would suggest. They are the ones that are on



1 that screen that we talked about. And I think
2 The Court's job here with respect to the
3 substantial change argument that's been raised,
4 is simply to say -- to determine whether these
5 changes do affect compliance with the criteria.
6 And if they do, it's a substantial change and
7 we have to start over. And if they don't, then
8 it's the same project. It's not two projects.
9 Thank you.

10 **THE COURT:** Okay. At this point we are going to
11 proceed with the case as scheduled. I am going
12 to adjourn the hearing for lunch. We should
13 reconvene here at -- we'll reconvene at 2:45.

14 **(Off the Record)**

15 **THE COURT:** I hope everyone had a decent lunch. And
16 we'll get ready to reconvene. And I think Dr.
17 Hall is going to be the first witness for
18 Trident.

19 **MR. DAYHUFF:** The first witness for MUSC, Your
20 Honor.

21 **THE COURT:** Oh, for MUSC. Sorry about that.

22 **MR. DAYHUFF:** That's all right. Thank you again for
23 allowing him to go out of order. And thank you
24 opposing counsel for that courtesy.

25 **THE COURT:** Okay. Mr. Dayhuff, you may proceed.



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1 **MR. DAYHUFF:** Thank you. I call Dr. Hall to the
2 stand.

3 **GREGORY HALL, M.D.,** having been duly sworn, testifies
4 as follows:

5 **COURT REPORTER:** Please state and spell your first
6 and last name.

7 **DR. HALL:** Gregory Hall, G-R-E-G-O-R-Y H-A-L-L.

8 **DR. HALL - DIRECT EXAMINATION BY MR. DAYHUFF:**

9 Q: Good afternoon.

10 A: Good afternoon.

11 Q: Where do you live, Dr. Hall?

12 A: I live in Mt. Pleasant, South Carolina.

13 Q: Now I understand you're an emergency medicine
14 physician at MUSC.

15 A: That is correct.

16 Q: All right, Dr. Hall. I've asked you to come to
17 court today to provide expert testimony related
18 to this case, including your opinions about
19 MUSC's proposed FED ---

20 A: Yes.

21 Q: --- in Berkeley County. Are you prepared to
22 offer those opinions today?

23 A: Yes.

24 Q: Have certain demonstrative exhibits been
25 prepared with your input that will help you



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1 present your testimony today?

2 A: Yes.

3 Q: Now, before I ask you to move into your
4 testimony --

5 **MR. DAYHUFF:** Are we good? Okay, good.

6 Q: Let's talk about your education and experience.
7 And we have the first demonstrative that we'd
8 like on the screen. What if anything does this
9 disturbing individual have to do with your
10 formal education?

11 A: That appears to be a cowboy. I went to
12 undergrad at the University of Wyoming.

13 Q: I see. And what degree did you obtain?

14 **MR. DAYHUFF:** Please take that down. It's
15 distracting.

16 A: I received a bachelor of science in zoology.

17 Q: And what year did you graduate?

18 A: In 1996.

19 Q: Where did you attend medical school?

20 A: The University of Cincinnati.

21 Q: And when did you graduate?

22 A: In 2000.

23 Q: All right. Did you participate in a residency
24 program after med school?

25 A: I did. University Hospital, Cincinnati, Ohio.



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1 Q: And what types of emergency departments did you
2 work in during your residency?

3 A: During residency, I worked -- our primary
4 emergency department was our large university
5 hospital emergency department. But we also
6 worked in two community hospitals and provided
7 the services as a flight physician for the
8 University's air care.

9 Q: What is a flight physician?

10 A: In Cincinnati our program was a flight
11 physician and a flight nurse. We were
12 scheduled shifts to respond both to other
13 facilities or to scene calls to pick up
14 patients that needed to be transferred either
15 to our hospital or other hospitals.

16 Q: When did you complete your residency in
17 emergency medicine?

18 A: In 2004.

19 Q: And after completing that program in 2004, I
20 understand you practiced emergency medicine in
21 Ohio.

22 A: Yes.

23 Q: And was that from 2004 to 2012?

24 A: Yes.

25 Q: All right. And what type of ED or EDs did you



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1 work in during that eight-year period?

2 A: During that period I primarily worked in a
3 moderate-sized community hospital, Mercy-
4 Fairfield in Fairfield, Ohio.

5 Q: And were you part of an emergency medicine
6 practice during those eight years of practicing
7 in Ohio?

8 A: Yes. I was working for a large physician
9 contract, emergency physician contract group.
10 Primarily my employer was Mercy Emergency
11 Physicians. But that was a subsidiary of
12 Premier Healthcare Services, which subsequently
13 was renamed Premier Physician Services.

14 Q: And I understand you held leadership positions,
15 directorships, both at the practice Premier and
16 through Mercy. Explain that leadership role.

17 A: Yes. While I was with that group, I worked for
18 the practice group as a associate director of
19 risk management. And under my job with Mercy
20 Emergency Physicians I worked as both an
21 assistant medical director and a medical
22 director there. Each hospital that we
23 contracted with required our physician practice
24 to provide a medical director to work, not only
25 with the physicians there in terms of hiring,



1 staffing, payroll, et cetera, but also with the
2 hospital working on performance improvement and
3 working with nursing leadership to provide
4 optimal care for patients.

5 Q: Give me an example of the performance
6 improvement initiative or process that you were
7 involved in.

8 A: The primary ones that we were involved in when
9 I was there was looking at throughput issues
10 with our emergency departments. We improved
11 throughput by initiating direct bedding
12 processes. We changed around our registration
13 processes. We changed around our fast-track
14 process and worked with leadership in radiology
15 and laboratory services to improve turnaround
16 times.

17 Q: Briefly, what is throughput?

18 A: Throughput, when you're seeing a patient in the
19 emergency department, the time the patient
20 arrives in your emergency department until they
21 go is what you consider your throughput.

22 Q: And fast track was another term you mentioned
23 in that answer.

24 A: Fast track, for minor complaints presented to
25 the emergency department you like to be able to



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1 take care of minor things expeditiously. And,
2 you know, major things or more significant,
3 higher acuity things like chest pain and
4 abdominal pain tend to take longer to work up.
5 But minor things like ankle sprains, back pain,
6 toothaches, those are a lot easier to take care
7 of. And so fast-track processes are made so
8 that you can see those patients and get them
9 through the system a lot quicker.

10 Q: And remind me, the hospital you were working at
11 at this time, Mercy?

12 A: Mercy-Fairfield Hospital.

13 Q: Did the Mercy-Fairfield Hospital develop an FED
14 during the time when you held the director
15 role?

16 A: Mercy Health -- the Catholic Health Partners
17 and the Mercy Health System in Cincinnati had
18 I believe at least one other freestanding ED.
19 And then they developed another freestanding ED
20 while I was working there.

21 Q: All right. What role, if any, did you have
22 with the development of FED services at Mercy?

23 A: During that time while I was the medical
24 director, our practice, Premier Physician
25 Services, provided most of the emergency



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1 physician contracts for Mercy. And when Mercy
2 decided to put in a freestanding ED, they
3 utilized us for essentially consultant services
4 in terms of working on processes, staffing,
5 resources that would be needed toward that
6 freestanding ED.

7 Q: All right. Did you practice emergency medicine
8 in the FED service that was developed at Mercy?

9 A: No, I did not pick up the shift there.

10 Q: Did you practice in any FED during your time
11 practicing in Ohio?

12 A: I did not work shifts there, although in my
13 time, specifically during residency, I did pick
14 up patients at freestanding EDs, I treated
15 patients from freestanding EDs onward to higher
16 levels of care.

17 Q: So that is in a transfer mode, is that what's
18 happening there?

19 A: Yes.

20 Q: Okay. 2012, you moved to Charleston; is that
21 right?

22 A: Yes.

23 Q: And became associated with MUSC?

24 A: That's correct.

25 Q: I understand you have three main positions at



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1 MUSC; assistant professor of medicine, in
2 emergency medicine, the medical director of the
3 adult ED, and trauma liaison. Is that correct?

4 A: That's correct.

5 Q: All right. Let's talk about your position as
6 assistant professor. Do you teach?

7 A: Yes.

8 Q: Who do you teach?

9 A: We teach residents and students in emergency
10 medicine.

11 Q: All right. And how do you teach?

12 A: Mostly it's clinical training. We do some
13 didactic lecture training. The residents and
14 students have lectures once a week on Thursday
15 mornings. But a lot of the training that they
16 get, both the residents as well as the
17 students, is sort of hands-on training during
18 shifts in the emergency department.

19 Q: Okay. And with respect to your professor role
20 at MUSC, do you do research and writing?

21 A: Yes.

22 Q: All right. Have you been the principal
23 investigator for emergency medicine research
24 and writing projects?

25 A: Yes.



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1 Q: And have they received grant funding?

2 A: Yes.

3 Q: Could you give me an example?

4 A: We currently have a HIV and Hepatitis C
5 screening process in our emergency department
6 that is externally funded. And I'm the
7 principal investigator, manager of that.

8 Q: What does it mean to be the principal
9 investigator of a project like that?

10 A: So, the principal investigator is the person
11 who is most responsible for whatever the
12 project is. There are certain projects that
13 may actually be developed at multiple different
14 sites. We currently have a couple of those
15 projects in sepsis. And I'm the co-
16 investigator for those, along with one of the
17 co-investigators from our pulmonary critical
18 care team. But we work with places like Johns
19 Hopkins, Vanderbilt, Emory University to run
20 some of those projects. Other local projects,
21 the principal investigator is the primary
22 person for the entire project.

23 Q: Have you published in the field of emergency
24 medicine?

25 A: Yes.



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1 Q: Could you give us an example or two?

2 A: We published an article on early recognition of
3 sepsis a couple of years back.

4 Q: So apparently sepsis is a big issue for
5 emergency medicine.

6 A: Yes.

7 Q: Just briefly, what's the issue there?

8 A: Sepsis is essentially your body's response to
9 a bad infection. And unfortunately the
10 mortality of sepsis is quite high, so there's
11 been a big push over the last probably 20 years
12 to improve our processes, to improve the
13 outcomes of patients with sepsis.

14 Q: Have you given presentations in the field of
15 emergency medicine?

16 A: Yes.

17 Q: All right. Let's talk about your second
18 position at MUSC, medical director. In your
19 role as medical director, have you worked on
20 measures, processes, initiatives to improve the
21 quality of emergency medical care?

22 A: Yes.

23 Q: Can you give me an example?

24 A: Our early recognition of sepsis project, some
25 of our throughput initiatives, trying to



1 improve flow in our emergency department, and
2 working with our mental health providers to
3 improve the care that we provide to our mental
4 health patients.

5 Q: In your role as medical director, do you
6 routinely review data and statistics regarding
7 the main adult ED at MUSC?

8 A: Yes.

9 Q: All right. What type of statistics or what are
10 some examples of the statistics and metrics you
11 review?

12 A: The volume of patients coming in; the length of
13 time it takes to treat patients, both those
14 that are admitted to the hospital, those that
15 are discharged; a metric called our left
16 without treatment rates, which is those
17 patients that arrive seeking emergency care
18 that leave without receiving treatment; we look
19 at patient satisfaction scores and boarding
20 times in our emergency department.

21 Q: All right.

22 A: Just to name a few.

23 Q: What is boarding?

24 A: Boarding, once it's been determined that a
25 patient requires inpatient evaluation and



1 treatment, they are, quote, admitted to the
2 hospital. In many places, once you're admitted
3 to the hospital, you immediately go upstairs to
4 an inpatient bed. We unfortunately have
5 capacity constraints. And one of those
6 constraints leads us to keep a lot of these
7 patients that are admitted to the hospital, but
8 don't have an inpatient bed available. Those
9 patients stay in our emergency department for
10 long periods of time.

11 Q: The third position that I mentioned was trauma
12 liaison. What are your main duties and
13 responsibilities as the trauma liaison?

14 A: Since coming to MUSC in 2012, I've been working
15 with the trauma service. I work directly with
16 the trauma medical director, working on, again,
17 processes and improvements and issues with our
18 trauma service. We also have monthly meetings
19 where we review our trauma program. We also
20 have meetings where we look at poor outcomes,
21 what we call morbidity and mortality. And we
22 review those cases to see if there was anything
23 we could do from a system standpoint to improve
24 the care of those patients.

25 Q: Do you also practice emergency medicine at



1 MUSC?

2 A: Yes.

3 Q: And where do you practice?

4 A: I practice at both the adult emergency
5 department, our Chest Pain Center at the Ashley
6 River Tower, and our pediatric emergency
7 department.

8 Q: All right. Have you practiced anywhere else
9 other than MUSC EDs during your time at MUSC,
10 2012 to now?

11 A: No.

12 Q: All right. So you've not practiced in an FED?

13 A: That's correct.

14 Q: Is the practice of emergency medicine in an FED
15 different than the practice of emergency
16 medicine in a hospital ED?

17 **MR. THOMAS:** Objection. Calls for speculation, Your
18 Honor. He just said that he's never practiced
19 in one, So how can he know if it's different?

20 **MR. DAYHUFF:** I can lay a foundation for that, Your
21 Honor.

22 **THE COURT:** Okay.

23 Q: Do you understand the nature of the practice of
24 emergency medicine in an FED?

25 A: Yes.



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1 Q: How do you know the nature of the practice of
2 emergency medicine in an FED without having
3 worked there?

4 A: Well, emergency medicine, when we train
5 residents, we have many residents that we train
6 to go on to work in FEDs. So, I'm training
7 residents that, you know, once they graduate,
8 that's where they practice. And they receive
9 their training from us in emergency medicine at
10 the medical university. And I know, from
11 talking to them afterwards, what their
12 experience is like. The practice of emergency
13 medicine -- and if you ask a cardiologist, you
14 know, if they worked in an office setting or in
15 a hospital, you know, the practice of
16 cardiology is the same regardless of where you
17 work. It's the same in emergency medicine.
18 Evaluating and treating patients with emergency
19 medical conditions, that's what we do and
20 that's what we train. The difference is the
21 level of resources if you have to take care of
22 that patient. And there are many times when
23 your patient may have a need for a higher level
24 of care. And you're trained in emergency
25 medicine to recognize that and then transfer



1 that patient to the most appropriate higher
2 level of care.

3 Q: And I think you hit on this, but just in case.
4 Is there different training provided in
5 residency or separate training for folks that
6 work in FEDs versus EDs?

7 A: No. The training in emergency medicine is the
8 same.

9 Q: Are there -- is there separate licensing or
10 certifications within emergency medicine or the
11 practice of FED emergency medicine versus
12 hospital?

13 A: No, there is not.

14 Q: All right. Do you serve on hospital committees
15 at MUSC?

16 A: Yes.

17 Q: I looked at your CV that we're going to look at
18 it in a minute. There were 11 that I saw, but
19 just give us a sampling of your work.

20 A: I am on the major trauma committee, trauma peer
21 review committee, the hospital credentialing
22 committee, I am on the sepsis steering
23 committee, just to name a few.

24 Q: All right. The three main roles that we went
25 through. It sounded like three main roles.



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1 Academic, administrative, and practicing.
2 Could you estimate in those roles the amount of
3 time you spend in each?

4 A: It's probably about a third each, depending on
5 the week. Some weeks I work a lot more
6 clinically. Some weeks I work a lot more
7 administratively. But overall, it probably
8 ends up being about a third each.

9 Q: Do you hold a license to practice medicine? I
10 hope so since you are currently practicing
11 medicine.

12 A: Yes, I do.

13 Q: All right. What state?

14 A: South Carolina.

15 Q: Are you Board Certified?

16 A: Yes.

17 Q: In what?

18 A: Emergency medicine.

19 Q: Have you been qualified by a court in the field
20 of emergency medicine to offer expert
21 testimony?

22 A: Yes.

23 Q: All right. Is that South Carolina court?

24 A: South Carolina, yes.

25 Q: All right. To sum up your qualifications,



1 including residency, you practiced emergency
2 medicine for how many years?

3 A: Including residency, 19 -- a little over 19
4 years.

5 Q: All right. And you've practiced, I think, but
6 correct me if I'm wrong, in a community
7 hospital setting, academic hospital, and a
8 children's hospital ED settings?

9 A: Yes.

10 Q: All right. You've had administrative roles in
11 community hospital EDs and academic center EDs?

12 A: Yes.

13 Q: Through your years of teaching, researching,
14 practicing emergency medicine, have you
15 developed an expertise in emergency medicine?

16 A: Yes.

17 Q: During your years of administering and managing
18 EDs, have you developed expertise in the
19 administration and management of emergency
20 departments?

21 A: Yes.

22 Q: Take a look at our screen.

23 **MR. DAYHUFF:** Dan, can you put up MUSC Exhibit 2?

24 Q: Take a moment to look at that, Dr. Hall. And
25 if you could, identify it for the record,



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1 please.

2 A: That is my CV.

3 Q: Does this CV provide detailed information about
4 your education, experience, and professional
5 qualifications?

6 A: Yes.

7 MR. DAYHUFF: Your Honor, I would ask that we enter
8 MUSC Exhibit 2, Dr. Hall's CV into evidence.

9 MR. THOMAS: No objection.

10 MS. HOLLINGSWORTH: No objection, Your Honor.

11 THE COURT: It's entered.

12 MR. DAYHUFF: Thank you, Your Honor.

13 (Respondent MUSC's Exhibit Number 2 was admitted into
14 evidence at this time.)

15 MOTION TO QUALIFY AS EXPERT:

16 MR. DAYHUFF: And, Your Honor, at this time I'd ask
17 The Court to qualify Dr. Hall as an expert in
18 emergency medicine and in the administration
19 and operation of emergency departments.

20 THE COURT: Okay.

21 MR. THOMAS: No objection.

22 THE COURT: I find that he is qualified.

23 MR. DAYHUFF: Thank you, Your Honor.

24 Q: All right. Dr. Hall, Let's start by talking
25 about MUSC's EDs. And let's start with MUSC



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1 Exhibit 5. Now, could you identify what
2 appears in MUSC Exhibit 5?

3 A: This is the entrance into our adult emergency
4 department.

5 Q: All right. And I think we established earlier
6 you're the medical director of this ED?

7 A: That's correct.

8 Q: And do you also practice in this ED?

9 A: Yes.

10 **MR. DAYHUFF:** All right. Let's go to the next
11 demonstrative or the first demonstrative, Mr.
12 Bupp.

13 Q: Tell us what appears on this demonstrative.

14 A: Our adult emergency department is -- has been
15 accredited by the Joint Commission as a
16 comprehensive stroke center. We are also a
17 Level II trauma center verified by the American
18 College of Surgeons Committee on Trauma.

19 Q: All right. What is a trauma center?

20 A: A trauma center is a specialized emergency
21 department and hospital that is specially
22 resourced to be able to provide care for acute
23 trauma patients.

24 Q: And are there levels of trauma centers?

25 A: There are.



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1 Q: And Level I, is that the highest level?

2 A: That's correct.

3 Q: All right. Are there other Level I trauma
4 centers in the Tri-County area; Charleston,
5 Berkeley, Dorchester?

6 A: No, there are not.

7 Q: All right. How many rooms do you have in the
8 adult main ED to care for patients?

9 A: In the adult main ED we have a total of 41
10 rooms.

11 Q: Are all of these 41 rooms available for
12 patients with physical emergency medical
13 conditions?

14 A: We have had two cohorts due to the volume of
15 mental health patients that we have. We've had
16 to utilize 12 of those beds to help care for
17 our mental health patients in the emergency
18 department in a safe manner.

19 Q: When you say cohort, what does that mean?

20 A: So we've taken 12 rooms in a specific area and
21 we've made those rooms much more psychiatric
22 safe, meaning we've tried to limit ligature
23 risks and limit the risks to mental health
24 patients that may be a harm to themselves or
25 others.



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1 Q: So that -- the 12 mental health rooms out of
2 the 41 that have been cohorted, are those
3 available for regular adult patients?

4 A: Theoretically they would be, but they are full
5 with mental health patients. And we try to
6 separate our mental health patients from our
7 medical patients. That's for obvious reasons.

8 Q: All right. And just to make sure we understand
9 the types of patient this ED treats, it's adult
10 only?

11 A: Yes.

12 Q: All right. And in this case there's been a
13 little discussion or mention of acuity level of
14 ED patients. Just explain the acuity level
15 concept for us.

16 A: Sure. So most emergency departments will see
17 patients coming in with all levels of acuity.
18 We have patients who come in that are, you
19 know, in cardiac arrest, undergoing CPR, all
20 the way down to a patient that may come in
21 with, you know, a toothache or just needing a
22 medication refill. So the acuity spans a
23 spectrum from the highest acuity. And when we
24 triage these patients, we give them a triage
25 level of one all the way down to the lowest



1 acuity, which is a triage level of five.

2 Q: So, one is the most serious emergency medical
3 condition, five is the least serious?

4 A: Correct.

5 Q: All right. And what acuity levels are the
6 adult patients that you see in the main
7 hospital ED MUSC?

8 A: We see all acuity levels.

9 Q: All right. Can you -- are you familiar with an
10 approximate breakdown of that acuity level
11 within your ED?

12 A: The bulk majority of the patients that we see
13 are at acuity level three. We see small
14 amounts of patients that are levels one and
15 two. And probably mild to moderate level of
16 patients that are four and five.

17 Q: All right. In that bulk, the three, what type
18 of patients are we talking about, what type of
19 conditions?

20 A: Patients that come in complaining of vomiting,
21 abdominal pain, chest pain, headache, that sort
22 of thing.

23 Q: All right. And four and five, I think you gave
24 me the example of five could be as simple as a
25 refill of medication.



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1 A: Exactly.

2 Q: What are the fours?

3 A: Fours usually are mild to moderate acuity. It
4 could be somebody with a mild asthma attack.
5 It could be somebody with an extremity injury
6 that's going to require, you know, x-raying,
7 but unlikely to require, you know, going to the
8 operating room or anything like that.

9 Q: What percent of the adult ED's patients are a
10 three, four, five acuity level?

11 A: Three, four, and five. I would say three,
12 four, and five is probably about 75, 80
13 percent.

14 Q: Okay. And is there a separate acuity scale
15 with respect to billing?

16 A: Billing is separate and it's almost a flip.
17 So, a level one bill is going to be your lowest
18 level bill. A level five bill is going to be
19 your higher level bill, based on the actual
20 treatment that was provided, the evaluation and
21 treatment.

22 Q: I was going to ask, why are there two levels of
23 acuity, billing and this apparently
24 presentation?

25 A: Yeah. So triage levels are based on what the



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1 patient's presenting like. That doesn't
2 necessarily always equate to the end diagnosis
3 and what was done to evaluate and treat that
4 condition. And so the billing level is after
5 the fact, after you've done everything, here's
6 what you did and here's what the evaluation of
7 treatment was and that's what you bill for.

8 Q: Are the billing acuity breakdowns, percentages
9 of acuity substantially similar to what you see
10 at your evaluation presentation?

11 A: Similar. Again the numbers are sort of flip-
12 flopped, but yes.

13 Q: Okay. All right. Patients get admitted
14 sometimes after being in the ED, right?

15 A: Yes.

16 Q: That's one thing that can happen. What is the
17 admit rate you are currently experiencing in
18 the adult main ED?

19 A: In our adult main emergency department our
20 current admit rate is right around 25, 26
21 percent.

22 Q: What does that admit rate tell you, if
23 anything, about the acuity level of our
24 patients at the main ED?

25 A: So national averages are closer to about 20



1 percent. So at MUSC our admission rate's a
2 little bit higher than average. So our
3 patients tend to be a little bit more
4 complicated and the admission rate shows that.
5 On the flip side of that, about 70 -- you know,
6 again, approximately 75 percent of our patients
7 that we see, we evaluate, treat, and discharge.
8 So they end up going home as opposed to needing
9 admission to the hospital.

10 Q: All right. Take a look at Exhibit 5 again.
11 This is a separate page in Exhibit 5. And
12 identify what you see here.

13 A: This is the entrance into our Chest Pain Center
14 at the Ashley River Tower.

15 **MR. DAYHUFF:** All right. And let's go to DX-21,
16 please.

17 Q: And tell us what appears on DX-21.

18 A: This is our Joint Commission accreditation as
19 a certified primary heart attack center.

20 Q: All right. And what type of patients are seen
21 at the Chest Pain Center ED?

22 A: Historically, we have seen a lot of patients
23 with cardiovascular complains, GI complaints,
24 and cancer-related complaints. More recently,
25 in the last few years, we have expanded that to



1 see just about every complaint like you would
2 in any other emergency department.

3 Q: Why do we expand to broader than just chest
4 pain, cardiac?

5 A: The -- over time we were seeing capacity issues
6 with our main adult emergency departments and
7 so we wanted to utilize the Ashley River Tower
8 to also try and take care of our emergency
9 medical patients.

10 Q: And how many rooms do we have in the chest pain
11 ED to care for patients?

12 A: The Ashley River Tower Chest Pain Center has
13 ten beds. That includes one triage bed.

14 Q: All right. And why do you segregate out the
15 triage bed for our consideration?

16 A: When patients come in, they go through a
17 process called triage. If we have beds
18 available, patients will go straight into a
19 bed. If not, the nursing staff evaluates the
20 patient and does what's called triage, where
21 they'll get vital signs, they'll take up chief
22 complaints, do an initial assessment, and
23 assess that acuity of the patient. And then
24 when the next bed's available, the higher level
25 acuties will go into that bed.



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1 Q: The Chest Pain Center, are these all adult
2 patients?

3 A: Yes.

4 Q: All right. And are all ten rooms in this ED
5 available for patients with physical emergency
6 medical conditions?

7 A: Yes.

8 **MR. DAYHUFF:** All right. Let's take a look at
9 Exhibit 5 again, Dan, please, on a separate
10 page.

11 Q: Identify what appears in this photo, please.

12 A: This is our entrance into our children's
13 hospital, children's emergency department.

14 **MR. DAYHUFF:** All right. Let's go to DX-22 please.

15 Q: Tell us what appears here.

16 A: Our pediatric emergency department is also a
17 Level I pediatric trauma center, as verified by
18 the American College of Surgeons.

19 Q: All right. How many rooms are in our pediatric
20 ED?

21 A: The main part of the pediatric emergency
22 department is 12 beds, but the pediatric ED
23 also utilizes an area called E pod, where there
24 are four rooms available for pediatric mental
25 health patients.



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1 Q: All right. And we talked about how the adult
2 ED had that cohort set aside for mental health
3 patients. Is that a similar situation with E
4 pod in these four rooms?

5 A: Yes.

6 Q: All right. Do we treat children with standard
7 physical emergency medical conditions in the
8 four room's E pod?

9 A: No.

10 Q: No?

11 A: No.

12 Q: And I presume the pediatric ED is only for peds
13 focus, right?

14 A: Correct.

15 Q: What does pediatric mean? What's the age
16 range?

17 A: Seventeen years of age and younger.

18 **MR. DAYHUFF:** All right. Let's take a look at
19 Exhibit 5 again, please, Dan.

20 Q: Another picture. What have we provided here?

21 A: This is the new Shawn Jenkins Women's and
22 Children's Hospital that's currently being
23 built.

24 Q: All right. And is there going to be an ED
25 resource in this facility?



1 A: There will be a new pediatric emergency
2 department here in this facility.

3 Q: Now, while this has not opened, does it have
4 final approval, CON approval to open?

5 A: That's my understanding, yes.

6 Q: All right. And how many rooms will this
7 pediatric ED have?

8 A: The pediatric ED here will have 20 rooms.

9 Q: All right. And will this facility treat only
10 pediatric patients?

11 A: Yes.

12 Q: All right. And if you've said this, I'm sorry.
13 When is it scheduled to open?

14 A: Later this year. I believe October is the goal
15 date.

16 **MR. DAYHUFF:** Your Honor, at this time I've gone
17 through several photos of MUSC. They're all
18 Exhibit 5, different pages. I would ask that
19 those be admitted into evidence.

20 **MS. HOLLINGSWORTH:** Your Honor, this starts to get
21 to part of the objection I had to a number of
22 exhibits produced for the first time, along
23 with the designations that we received on July
24 12th. While I don't have any specific problem
25 with photos that this witness has given us the



1 foundation for, I don't want that to be the
2 reason that there are a number of other
3 exhibits, particularly new slides, new
4 information, that I do want to preserve the
5 fact that we will need to address those, their
6 information. These documents were never
7 provided until July 12th, 2019, a month after
8 your discovery deadline in the Order. But the
9 photographs I don't feel the need to take up a
10 lot of time. I just don't want it to be
11 considered that somehow I've waived the other
12 issues with documents produced at the same
13 time.

14 **THE COURT:** Okay. That's understood.

15 **MR. THOMAS:** No objections to the photographs.

16 **THE COURT:** Okay. They're admitted.

17 **(Respondent MUSC's Exhibit Number 5 was admitted into**
18 **evidence at this time.)**

19 Q: All right. Question about the -- since we're
20 going to have a new children's hospital with a
21 new pediatric ED, what are we going to do --
22 what is MUSC going to do with the old peds ED
23 that's adjacent to the main hospital?

24 A: Senior leadership, we continue to have issues
25 with boarding of mental health patients at our



1 emergency departments, both on the adult and
2 pediatric side. And the current pediatric ED,
3 that current space they have designated -- at
4 least the latest that I have heard is that they
5 will use that space to help with the mental
6 health boarding issue. So it would be a mental
7 health space.

8 Q: All right. And there are two spaces, I guess,
9 right, that we're talking about. There's a
10 four-room E pod, that was the peds mental
11 health space and then the 12 regular peds
12 spaces.

13 A: Yes.

14 Q: Same answer for both?

15 A: The four E pod rooms, which are physically
16 quite separate from the rest of the emergency
17 department, that space has been -- it's been a
18 source of many complaints by patients and
19 families, as well as administrators who have
20 walked through that space. And they do not
21 believe that that is an appropriate area to
22 care for patients, specifically emergency
23 medicine patients, mental health patients. And
24 so they would like to take that space offline,
25 as it is quite separate from the rest of the



1 emergency department.

2 Q: By take offline, will that space be available
3 then for use for emergency care?

4 A: My understanding from senior leadership is they
5 do not want to use that space for patient care.

6 Q: And the 12 designated peds beds in the old
7 hospital will be available for what use?

8 A: Mental health patients.

9 Q: Peds or adults or both?

10 A: The latest I've heard is for pediatric. That's
11 the latest.

12 Q: All right. What effect would these changes
13 have on the number of rooms available for adult
14 ED, general medical condition?

15 A: It won't change.

16 Q: All right. Does MUSC have any other EDs
17 operating or EDs with final CON approval that
18 you're aware of?

19 A: None that I'm aware of.

20 Q: Okay. Let's look at DX-32. All right.
21 Doctor, DX-32 is what that we have shown here?

22 A: So, this is the total number of rooms, 41 adult
23 ED rooms, ten over at chest pain, and then the
24 pediatric ED, 12 primary spaces -- or rooms,
25 and four rooms from E pod.



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1 Q: And so a total of 67 ED rooms. And how many of
2 those 67 are segregated or cohorted for mental
3 health purposes?

4 A: Currently for mental health, 16 of those rooms.

5 Q: Which would leave how many for general medical
6 condition emergency medicine?

7 A: Fifty.

8 Q: Fifty. All right. Let's take a look at MUSC
9 Exhibit 14. Take a moment to look at this and
10 tell me if you can identify it.

11 A: This is a table from I believe the health
12 planners with Roper in terms of the capacity of
13 MUSC's downtown EDs.

14 Q: All right. I want to focus on the bay
15 analysis. Do you see that in the first column?

16 A: Yes.

17 Q: Have you reviewed that tally?

18 A: Yes.

19 Q: All right. Is that tally accurate?

20 A: The 79 that they have listed there is
21 inaccurate.

22 Q: All right. What is inaccurate about it? Can
23 you tell what is inaccurate about it?

24 A: If you look in the notes, they have six E pod
25 rooms. They include triage spaces, a



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1 behavioral room, a cast room, and a pelvic
2 room. As I said before, these are all spaces
3 that either are incorporated into the other --
4 the bulk of the other room number.

5 Q: All right. So what's the appropriate room
6 number again for our total?

7 A: So for our total with -- if we go back to the
8 last slide there -- our total is 67, 51 of
9 which we're currently using actively for
10 medical patients.

11 Q: All right.

12 **MR. DAYHUFF:** Your Honor, I'd like to move MUSC
13 Exhibit 14 into evidence.

14 **MS. HOLLINGSWORTH:** No objection, Your Honor.

15 **MR. THOMAS:** None here.

16 **THE COURT:** It's admitted.

17 **(Respondent MUSC's Exhibit Number 14 was admitted**
18 **into the record at this time.)**

19 Q: All right. Let's look at Exhibit 27, MUSC
20 Exhibit 27. Doctor, can you identify that one,
21 please?

22 A: This is a map of our downtown campus showing
23 the entrance to the main emergency department,
24 entrance to our children's pediatric ED and the
25 entrance to our Chest Pain Center.



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1 Q: Does this map accurately reflect the location,
2 the buildings on the campus, and more
3 particularly the EDs at MUSC that we've already
4 discussed?

5 A: Yes.

6 Q: Where are all these EDs located, generally?

7 A: So, the main ED and the pediatric ED are on the
8 first floor of the clinical science building
9 and the University Hospital. And then the
10 Chest Pain Center is at the Ashley River Tower.

11 Q: And are all of these located on the Charleston
12 peninsula?

13 A: Yes.

14 **MR. DAYHUFF:** Your Honor, we'd like to move 27 into
15 evidence, please.

16 **MS. HOLLINGSWORTH:** Your Honor, no objection. But,
17 again, I do reserve that this is a document
18 produced for the first time on July 12th, a
19 month after the discovery deadline.

20 **THE COURT:** Okay. Thank you.

21 **MR. DAYHUFF:** Your Honor, that document was produced
22 pursuant to this Court's order for the
23 production of exhibits. I appreciate the
24 reservation of rights, but we produced this
25 timely pursuant to your Court's Order for the



1 production of exhibits.

2 **MS. HOLLINGSWORTH:** Your Honor, I respectfully
3 disagree. It was a deadline to designate
4 documents for exhibit. It was not a deadline
5 by which you could come up with new
6 information. There's a discovery deadline when
7 you're supposed to provide information for
8 purposes of evidence. There was no -- the
9 deadline for designating documents and
10 exchanging our list is not a deadline to just
11 produce new material for the first time. That
12 is not what the scheduling Order provided for,
13 Your Honor. That's the discovery deadline.

14 **THE COURT:** I'm not going to get into a long debate
15 about this. You just generally don't have any
16 objection to this?

17 **MS. HOLLINGSWORTH:** Right. To the maps, Your Honor.
18 But we are going to get to substantive new
19 information and so I just want to make sure
20 that you're aware that -- I'm trying to be very
21 clear about your Court's -- your Order and the
22 compliance with it, but I'm not trying to
23 unnecessarily withhold information from the
24 record.

25 **THE COURT:** Okay. Very good. Thank you.



1 **MR. DAYHUFF:** I will not assert a waiver of your
2 right to object later, if you agree to the
3 particular exhibit that we're talking about.

4 **MS. HOLLINGSWORTH:** Right. That's what I -- that's
5 right.

6 **MR. DAYHUFF:** Great.

7 **THE COURT:** Yeah. It's admitted.

8 **MR. DAYHUFF:** Thank you.

9 **(Respondent MUSC's Exhibit Number 27 was admitted**
10 **into the record at this time.)**

11 Q: All right. Let's go to DHEC's 33. This is
12 just -- does this map accurately reflect the
13 location and we're kind of zoomed out from
14 downtown area?

15 A: Yes.

16 Q: And the blue H is reasonably placed to cover
17 those EDs we just talked about?

18 A: Yes.

19 Q: All right. Does MUSC have any EDs located
20 outside of downtown Charleston?

21 A: No. Well, MUSC did purchase four new hospitals
22 that are located well outside of the current
23 county area.

24 Q: Got you. How about any in the Tri-County area?

25 A: No.



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1 Q: All right. Fair enough. Generally, how would
2 you describe utilization of MUSC's EDs?

3 A: The utilization is high, specifically our adult
4 emergency department, which remains busy,
5 typically with patients waiting in our waiting
6 room just about 24 hours a day. Our pediatric
7 emergency department is very busy during a bulk
8 majority of the day, as is our Chest Pain
9 Center.

10 Q: All right. As the medical director of the MUSC
11 adult ED, do you have knowledge about where the
12 patients that we treat in our EDs on the
13 peninsula come from?

14 A: Yes.

15 Q: All right. What percent, if you know, of our
16 patients come from the Tri-County area;
17 Charleston, Berkeley, Dorchester county?

18 A: Approximately 80 percent of our patients.

19 Q: And then I want to know what patients come from
20 what we've heard described as the north area,
21 which I'll be more specific, Berkeley,
22 Dorchester county, and the North Charleston
23 area. What percentage of our patients come
24 from that area?

25 A: Approximately a quarter of our patients come



1 from that area.

2 Q: All right. Did you hear the opening statement
3 of Roper that MUSC does not serve the service
4 area in a meaningful way?

5 A: I did hear that.

6 Q: Is that accurate?

7 A: I don't agree with that statement, no.

8 Q: As the medical director of the adult ED, do you
9 have knowledge about the quality of the
10 clinical care that's provided in MUSC's EDs?

11 A: Yes.

12 Q: Generally, how does the quality of MUSC's care
13 in its EDs compare with other EDs you've
14 managed and worked at over the years?

15 A: It's excellent.

16 Q: What would you attribute the quality of care
17 that we provide to?

18 A: The faculty that we have in emergency medicine,
19 working in our emergency departments is
20 excellent. The faculty have to remain up to
21 date on cutting-edge technologies in emergency-
22 medicine care. We do -- we lecture across the
23 country. We're very involved in education
24 throughout the MUSC health system. And we have
25 experts in emergency medicine with specialties



1 in things like cardiovascular emergencies,
2 ultrasounds, even global health.

3 Q: As medical director of the adult ED, do you
4 have knowledge about how efficiently and
5 effectively MUSC's EDs operate?

6 A: Yes.

7 Q: All right. How are the EDs in the MUSC system
8 doing operationally? And let's start with
9 chest pain.

10 A: The Chest Pain Center does -- operationally
11 does a good job. Our left without treatment
12 rate there, patients leaving after waiting for
13 a period of time without getting treatment is
14 very low. Our overall throughput there is a
15 little higher than we would like, but the
16 acuity of the patients and the complicated
17 nature of many of the patients that are treated
18 there is high, which explains the length of
19 stay.

20 Q: How about the peds ED? How are we doing
21 operationally?

22 A: The peds ED does fairly well. Overall, it has
23 been over capacity. And one of the benefits of
24 building a new hospital is to be able to add
25 more beds for our pediatric patients.



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1 Q: How about the adult main ED?

2 A: Unfortunately our adult main ED has had some
3 capacity constraints. Our left without
4 treatment rate is higher than it should be.
5 Our overall throughputs, especially for
6 discharged patients, is higher than it should
7 be.

8 Q: Well, let's focus on the adult ED. You
9 mentioned some metrics. Let's look at DX-34.
10 I think some of these you may have mentioned,
11 but tell us what these are.

12 A: So three of the primary metrics that I look at
13 that give us an idea of how well we're doing
14 from an efficiency standpoint is door to
15 provider time or door to doctor time. Our door
16 to doctor time, at least over the last few
17 months, has been in the 45 to 47 minute range,
18 which is higher than it should be.

19 Q: And what would your goal be with that?

20 A: Optimally, our goal is around 27 minutes, so
21 about 20 minutes less than what it currently
22 is.

23 Q: All right. Over the past -- I'm sorry.

24 A: On average.

25 Q: On average. Over the past three years, what



1 trends, if any, have you observed for this
2 door-to-doctor metric for the adult ED?

3 A: Our door-to-doctor times have actually gotten
4 worse over the last -- at least the last
5 probably two to three years.

6 Q: Door to discharge, what is that?

7 A: So, when patients arrive in the emergency
8 departments, the door time is the time they
9 arrive. And for those patients that we're able
10 to discharge home, again, approximately 75
11 percent of our patients, we look at how long it
12 takes to see, evaluate, and treat those
13 patients that we're able to discharge back
14 home.

15 Q: How does door to discharge relate to
16 throughput?

17 A: So, that's -- that is the throughput for those
18 patients that are discharged, again, 75 percent
19 of our patients.

20 Q: All right. And there would also be throughput
21 for patients who are ---

22 A: Admitted to the hospital.

23 Q: I see. All right. What is the benchmark you'd
24 like to hit door to discharge?

25 A: Door to discharge our goal, based on some



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1 benchmarking data that we use, is 180 minutes.

2 Q: And how are we doing?

3 A: We are right now hanging out around 220
4 minutes.

5 Q: All right. Over the past three years, what
6 trend, if any, have you observed for the door-
7 to-discharge metric?

8 A: Over the last three years -- we were very close
9 three years ago. We were at 187 minutes. But
10 over the last three years that time has climbed
11 to well over 200 minutes.

12 Q: What is LWOT?

13 A: So that's the left without treatment rate. So
14 that's a percentage of patients that show up at
15 your emergency department seeking care and
16 evaluation that leave before they receive any
17 sort of treatment.

18 Q: Am I the person to use LWOT?

19 A: No.

20 Q: All right. What is the benchmark you'd like to
21 see for LWOT?

22 A: We'd like to see that less than three percent.

23 Q: And how are we doing on that?

24 A: We are -- over the last probably six months to
25 a year we've been closer to five percent,



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1 sometimes higher than five percent.

2 Q: All right. Just so we're clear, those are
3 people who are coming to our ED, but not
4 getting care?

5 A: That's correct.

6 Q: The past three years, have you observed trends
7 on that metric?

8 A: Yes, it's gotten worse.

9 Q: All right. Why is the adult ED having
10 operational issues?

11 A: It's multi-factorial.

12 Q: All right. Let's look at DX-35 that we put
13 together. What do we have on this
14 demonstrative?

15 A: So these are five bullet points explaining at
16 least big reasons -- big reasons why we have
17 capacity issues in our main adult emergency
18 department.

19 Q: All right. Let's talk about each one -- high
20 volumes.

21 A: So, during the course of the day, the bulk
22 majority of our patients arrive usually between
23 the hours of 11:00 a.m. and 11:00 p.m. During
24 those times our beds typically are full. We've
25 already used up all of the beds in the



1 emergency department. And so as sometimes ten
2 or more patients are arriving per hour, those
3 patients are going into our waiting room,
4 waiting to -- waiting for a bed to open up.
5 And it's during those high volume times where
6 we see a lot of patients that are leaving
7 without treatment.

8 Q: Has MUSC implemented any process measures to
9 address high volume?

10 A: Yes. We've worked on surg protocols. We've
11 even incorporated our telehealth system.

12 Q: First, tell me what are surg protocols.

13 A: So surg protocols, one of the issues -- and
14 we'll get to this -- is boarding. So patients
15 that are waiting for an inpatient bed. So when
16 we are over capacity, we have implemented
17 processes to move patients that are admitted to
18 the hospital that don't have an inpatient bed
19 to move those patients to a hallway upstairs in
20 the hospital to make room in our emergency
21 department for new patients coming in.

22 Q: All right. And I think you mentioned e-visits
23 when I interrupted you. What are those?

24 A: So e-visits, that is our tele sort of urgent
25 care platform. So MUSC has a large number of



1 telehealth initiatives. One of those is our e-
2 visits. And we're able to take care of a lot
3 of minor complaints. I believe, if I'm getting
4 my numbers right, they're between probably 70
5 to 80 complaints that we can take care of on
6 our telehealth platform that allows us to care
7 for some of these patients, that would
8 otherwise leave without treatment, virtually
9 without them actually having to wait in an
10 emergency department.

11 Q: Sampling of the type of complaints that can be
12 handled via e-visit.

13 A: So those complaints can be upper respiratory
14 infections, they can be medication refills,
15 potentially dental pain. There's a large
16 number of complaints.

17 Q: Have these changes, measures you've undertaken
18 eliminated the operational issues related to
19 high volume?

20 A: No, they have not.

21 Q: All right. Second bullet point -- tell us
22 about high volumes of psych patients. I think
23 we talked a little about this already.

24 A: So over the last probably -- at least the seven
25 years or nearly seven years that I've been at



1 MUSC, we have had every year increasing issues
2 with our mental health patients. These
3 culminated with a lot of concern for the safety
4 of our mental health patients a couple of years
5 ago. And we implemented processes -- in fact
6 we took 12 beds and made them psychiatrically
7 safe so that we could provide a much safer
8 therapeutic environment for our mental health
9 patients while they were waiting to be
10 evaluated by psychiatry or while they were
11 waiting for an inpatient bed at the Institute
12 of Psychiatry.

13 Q: Was this the cohorting of 12 beds we discussed
14 earlier?

15 A: Yes, it is.

16 Q: And did that dedication, the reservation of
17 beds improve conditions for the mental health
18 folks?

19 A: It made things much improved for our mental
20 health patients.

21 Q: What effect, if any, did it have o the overall
22 operation of your ED?

23 A: Unfortunately because of the -- although we did
24 have improvements in the care of our mental
25 health patients, our medical patients arriving



1 in the emergency department, unfortunately the
2 throughput for those patients lengthened, our
3 left-without-treatment rates lengthened. So
4 we've had improvements in the care that we're
5 able to provide for a subset of our patients,
6 but at the expense of some of our other
7 patients.

8 Q: So why did the throughput lengthen when you
9 took those steps to benefit the mental health
10 caseload?

11 A: So we've previously -- previously we utilized
12 one of our what we call B pod area to manage
13 our mental health patients. We would have
14 stretchers lining the hallways. We had
15 stretchers, you know, blocking routes of
16 egress. In a 12-bed section of our emergency
17 department we would sometimes have 20 patients.
18 And those patients weren't in a very sound,
19 therapeutic environment. We had a number of
20 staff that were getting injured by our mental
21 health patients. And because of all of these
22 issues and wanting to improve the care that we
23 provided for our mental health patients, we
24 made a much more safe environment for them.
25 The down side has been the 12 beds that we've



1 made safe for mental health patients tends to
2 remain full all of the time. And a lot of
3 mental health patients are still sort of
4 overflowing back into the remainder of our beds
5 in our adult emergency department.

6 Q: Let's be clear. Are the mental health patients
7 that come to the ED considered emergency
8 patients?

9 A: Yes, they are.

10 Q: All right. Just as a physical ailment can
11 create an emergency, a mental health issue can?

12 A: Yes.

13 Q: Now boarding is the next bullet point. And,
14 again, I think we've talking a little about it.
15 But tell us about boarding with respect to our
16 adult ED, what we're experiencing.

17 A: As I said, we have capacity constraints in
18 terms of the number of beds in our University
19 Hospital as well as our Ashley River Tower.
20 Because of this, a lot of times patients are
21 waiting for hours for an inpatient bed. We see
22 that a lot, especially on our neurologic side,
23 with stroke patients waiting sometimes, you
24 know, a full day before they can get a bed
25 upstairs. We also see boarding issues with our



1 mental health patients. And so that's one of
2 the reasons why our, what we call D pod area or
3 that section of 12 beds that we've made safe
4 for our mental health patients, why that
5 remains full, is because those patients are
6 many times waiting for a bed at the Institute
7 of Psychiatry.

8 Q: Have we taken steps to work on the boarding
9 issue that is causing us operational issues in
10 the ED?

11 A: Yes. We have a state-of-the-art bed boarder
12 admit transfer center that manages all of the
13 beds throughout the entire enterprise. We have
14 worked on our surg processes. Not that we like
15 sending patients to a hallway up on an
16 inpatient unit, but at times we have to do
17 that. I've also worked with Charleston Mental
18 Health. MUSC has provided funding, as has
19 Roper, for the Tri-County Crisis Stabilization
20 Center, so that we can get patients crisis
21 stabilization with Charleston Mental Health and
22 a separate units when they don't necessarily
23 need to be admitted to our Institute of
24 Psychiatry.

25 Q: I see. Now the bed board state of the art



1 system you mentioned, what is that?

2 A: So the -- all of our inpatient or admitted
3 patients, they are tracked by our ATC, our
4 Admit Transfer Center. They are the ones that
5 are managing the number of patients admitted to
6 the hospital that are coming out of the
7 operating room. They know exactly how many
8 beds are available, similar to a hotel, and
9 knowing how many rooms are available for new
10 clients. And so they're able to manage that
11 with a state-of-the-art system that tells them
12 exactly how many patients we have that need
13 beds and how many beds we have available and
14 when those beds are going to open up.

15 Q: Have those measures that you've described to me
16 related to boarding resolved the operational
17 issues we experienced?

18 A: They have not.

19 Q: All right. Next bullet point is complex cases.
20 What does that have to do with our operation
21 mission?

22 A: So as a tertiary care center and a
23 comprehensive stroke center and a Level I
24 trauma center, we see very complex cases every
25 day. We also see simple cases. But we see



1 transplant patients, we have heart transplant
2 patients, we have LVAD patients. Those are
3 patients that have a device that helps their
4 heart pump while they're waiting for
5 potentially a transplant. We see liver
6 transplant patients, kidney transplant
7 patients, oncology patients. We see complex
8 neurologic stroke patients. And all of those
9 patients tend to take longer times to evaluate
10 and treat and involve our specialists. And
11 because of that, that also delays the time that
12 they're in the emergency department.

13 Q: All right. Compartmentalized space, explain
14 that bullet point.

15 A: The Medical University of South Carolina
16 originally had a very small sort of evaluation
17 area. And over time we've added additional
18 areas to that. At one point in time it was
19 just the front sort of nine beds. And then we
20 added another 12 beds. And then we added
21 another eight beds. And unfortunately it
22 wasn't well designed, it was just adding beds
23 as space became available. And the challenge
24 to that is, if you're on one side of the
25 emergency department, if you're a provider on



1 one side of our emergency department, to
2 efficiently see a patient that may be all the
3 way on the other side of the emergency
4 department, that's difficult. And so the space
5 itself has some innate inefficiencies to it
6 that make it challenging.

7 Q: And that has what effect, if any, on our
8 operational efficiency?

9 A: It can make unfortunately the length of stay of
10 these patients longer and it makes our ability
11 to efficiently care for them sometimes not as
12 good as it should be.

13 Q: Can we do fast track emergency medicine care in
14 the adult ED?

15 A: Unfortunately right now we don't have the space
16 to do so.

17 Q: Let's go back to demonstrative 34, the metrics
18 that we talked about a minute ago, bring this
19 kind of full circle. The operational issues
20 that we just went through, what effect on the
21 metrics?

22 A: So all of these operational inefficiencies have
23 led to poor door-to-doctor times, poor door-to-
24 discharge times, and high left-without-
25 treatment rates specifically for our adult



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1 emergency department.

2 Q: All right. Let's focus for a minute more on
3 left without treatment. Take a look at MUSC
4 Exhibit 18. Do you recognize this document?

5 A: Yes, I do.

6 Q: Did you create this document?

7 A: I did.

8 Q: What does this document demonstrate?

9 A: So this document was an overlay of our main
10 emergency departments, our visits, through I
11 think toward the end of September, 2018. So
12 from July, 2017 through, I think, toward the
13 end of September 2018. So it's the number of
14 visits we see per month, what our left-without-
15 treatment rate has been, and the trend line for
16 that left-without-treatment rate.

17 Q: All right. And why do we see the trend line
18 going up rather markedly towards the end of the
19 table?

20 A: Well, a lot of that was related in January 2018
21 to when we segregated 12 beds for a safe space
22 for our mental health patients. At that time
23 our efficiencies went down. And because of
24 that and ultimately our left-without-treatment
25 rate started to climb.



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1 Q: And it reached -- what is the peak that it
2 reached, it looks like in August '18?

3 A: Yeah. A year ago -- just about a year ago we
4 were at eight percent left-without-treatment
5 rate for our adult ED.

6 Q: All right. Let's talk about our proposed ED in
7 Berkeley County. If the FED CON application is
8 approved by The Court, where will our FED be
9 located?

10 A: It will be located Main Street in Summerville.

11 Q: When we started your Direct, we mentioned that
12 you have some expert opinions about the FED.
13 Do you have opinions about the effect that FED
14 would have on MUSC's patients?

15 A: Well, right now, again, approximately a quarter
16 of our patients are coming from that area. The
17 ability of our patients that seek MUSC for
18 their care to have a much more convenient
19 location to go that would be much more
20 efficient, would help the patient primarily.
21 But if we were able to just divert a few of our
22 patients from the downtown campus, I think that
23 would have exponential improvement in terms of
24 our ability to get rid of some of the log jams
25 we currently have.



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1 Q: Let's look at DX-37. You preempted me with
2 your testimony. What is -- what appears on 37?

3 A: So this is two primary bullet points in terms
4 of the effects we would expect from our
5 freestanding emergency department.

6 Q: All right. Well, talk to us about the first
7 main bullet point. And I think you started
8 into it. Improved access, distance and time to
9 care.

10 A: So, again, many of our patients are coming from
11 that northern area. The ability to put a
12 freestanding ED in Summerville would -- it
13 would significantly decrease the distance that
14 they would have to travel to seek MUSC
15 emergency care.

16 Q: Let's look at 36. What's represented there?

17 A: And then this is the location of our peninsula
18 campus along with the proposed Summerville
19 site.

20 Q: All right. And talk to me about time to care.
21 How is that different than distance?

22 A: So, time to care -- distance is one thing.
23 Distance, when you're a patient seeking care,
24 how long does it take me to get someplace to
25 get that care? That's one thing. Once you get



1 there, then how long does it take us to
2 actually see and evaluate you? Well, right
3 now, if patients are driving quite a distance
4 to get to our peninsula location, they're then
5 arriving many times during prime hours, at
6 which point they're waiting in our waiting room
7 sometimes for hours before we're able to get
8 them back into a room for the provider to see
9 them.

10 Q: So it takes the folks from Berkeley,
11 Dorchester, North Charleston area, the north
12 area, time to drive from the north area down
13 the peninsula.

14 A: Yes.

15 Q: And then they have to wait.

16 A: Yes.

17 Q: They likely do have to wait.

18 A: Yes.

19 Q: Is there a clinical issue? I understand the
20 distance and I understand the waiting once you
21 get there. Is there any clinical emergency
22 medicine issue?

23 A: Well, emergency medicine is all about quickly
24 seeing and evaluating patients, determining if
25 there is an emergency medical condition or not.



1 The faster we see patients, the faster we can
2 determine if there's an emergency medical
3 condition; and if there is, initiate treatment.
4 Sometimes those treatments require expertise.
5 Sometimes they require operating rooms,
6 sometimes the cath lab. Other times we're
7 evaluating patients and they don't have an
8 emergency medical condition or it's something
9 we can quickly treat. So being able to see
10 those patients efficiently improves the care
11 that those patients receive.

12 Q: All right. Let's look at MUSC Exhibit 28. Can
13 you identify that?

14 A: That is ---

15 **MS. HOLLINGSWORTH:** Your Honor -- and I apologize
16 for interrupting -- I do have an objection to
17 this document. This document is actually used
18 as a source of the document. The diagram has
19 been changed. And so, I do object to even
20 really any testimony about this document,
21 because this document is not reflective of MUSC
22 4481. It has been changed. And this was one
23 of the things that was just produced to us on
24 the 12th. I object to this document even being
25 testified about because it is different.



1 **MR. DAYHUFF:** So, this is the schematic for the FED
2 we proposed to build in Berkeley County. It is
3 a schematic that is based on that source
4 document, but it has been changed. This
5 document was provided at the exhibit
6 designation deadline. So it was timely. It
7 was a timely exhibit. So we need to be able to
8 provide this Court information about what we
9 plan to do at the location. This is an effort
10 to block all information that they view as new
11 that we have been talking about since January
12 of 2018, at the motions hearing in February --
13 of 2019, I'm sorry, 2019. So, this is a
14 schematic of what we propose to do. On one
15 hand they argue everything's been substantially
16 changed. On the other now they're arguing that
17 we can't enter a schematic that reflects what
18 we're going to do at the location.

19 **MR. THOMAS:** Your Honor, I have a separate objection
20 than Ms. Hollingsworth. Mine is based on -- I
21 actually submitted a motion in limine. This
22 captured one of the -- this exhibit is captured
23 in the motion in limine Your Honor, as the --
24 this is the new footprint of the new location,
25 which was entered -- which was I guess



1 procured, released by MUSC's Strategic
2 Ventures, which has been adjudicated as illegal
3 and ultra vires and therefore should not be
4 considered by this Court. Moreover, the
5 location change that resulted in this
6 footprint, this new location, was also done by
7 MUSC Strategic Ventures' board, which is
8 actually an illegal board and has been found by
9 this Court to be ultra vires.

10 **MS. HOLLINGSWORTH:** So, Your Honor, I want to be
11 really clear, because I think that this could
12 get very confusing. The Scheduling Order that
13 this Court entered, it says, number one, all
14 discovery and depositions in this matter shall
15 be concluded no later than June 14, 2019,
16 subject to each parties rights subsequently to
17 move The Court for an extension if
18 circumstances warrant. And in fact point two
19 of this Scheduling Order, Your Honor, filing
20 dispositive motions no later than June 21 is a
21 deadline that just came up recently in your
22 Order and that the parties were held to. It,
23 of course, stands to reason that the
24 dispositive motion deadline came after when we
25 should have received all the documents. The



1 deadline of July 12th, Your Honor, was the
2 party shall exchange final witness lists and
3 exhibits lists, all but demonstrative. There's
4 nothing about that deadline, Your Honor, that
5 says you can create new documents and produce
6 them for the first time a month after the
7 discovery deadline and weeks after the
8 dispositive motion deadline. This document,
9 Your Honor, is one of the documents that for
10 the first time -- it's actually another
11 schematic because they have changed information
12 on the slide. We've deposed a number of
13 witnesses about this floor plan. People have
14 testified under oath regarding it. This is a
15 different document. And I do object to this
16 being provided in evidence for The Court when
17 it wasn't produced to anyone until July 12th,
18 a month after that deadline. And we've been
19 held to those deadlines. And nobody approached
20 The Court, there's no consent to doing
21 additional exhibits. I mean, our experts would
22 have loved to do opinion slides and new
23 exhibits through July 12th. We did not do
24 that, Your Honor. And I submit that it would
25 be fundamentally unfair to allow MUSC to come



1 up with new and different exhibits and now
2 offer them to The Court as evidence when we've
3 had no ability to conduct any discovery or
4 evaluate. And this will be first-time
5 testimony about this document, when I've
6 already examined Dr. Hall about 4481, which is
7 different.

8 **MR. DAYHUFF:** Your Honor, the parties routinely
9 exchange exhibits at the exhibit designation
10 timeline in CON cases. My friends at Trident
11 I bet provided slides and exhibits at that
12 time. My friends at Roper submitted documents
13 after your deadline, days after your deadline,
14 that they're attempting to get into evidence.
15 That's one. Two, there were depositions taken
16 after the exhibit deadline. This document,
17 they know full well its origin. It comes
18 originally based on an intuitive document that
19 has been modified to change only the label that
20 used to say urgent care and now it says fast
21 track. That's the only change here. There is
22 no prejudice. There is no problem with
23 exchanging an exhibit like this, that had been
24 testified to before that deadline. This
25 witness testified about the nature of the



1 facility we were going to have. And he talked
2 about it having 12 treatment rooms, which is
3 reflected there, in that design with fast-track
4 rooms. His testimony was the urgent care
5 description was not accurate. It's fast track.
6 So this exhibit should be entered. This an
7 attempt to artificially limit this Court's
8 consideration of what's actually going to be at
9 the location.

10 I don't know how in a de novo setting we
11 could not have a schematic of what we propose
12 to establish. They have talked all morning
13 about we don't know what's going on. That's
14 not accurate. But it's really unusual, then,
15 to try to keep the information from The Court
16 that you need to analyze to decide the health
17 planning issues in this case. We ask that you
18 admit this exhibit.

19 **MS. HOLLINGSWORTH:** Your Honor, there's a difference
20 between demonstrative -- there have been a
21 number of demonstrative exhibits that you've
22 seen up on the screen. We have not said one
23 word about that. My position, Your Honor, this
24 is a document, a source document -- that
25 document 4481, it has been re-labeled. And to



1 sort of say, oh, no big deal, it went from
2 urgent care to fast track. That's a
3 significant change, Your Honor. It was part of
4 what you heard this morning. This was provided
5 to us on July 12th. So, for the -- July 12th
6 for the first time and we're given notice, hey,
7 by the way, our people are now going to testify
8 about something that looks different yet again.
9 If it's a demonstrative exhibit and they
10 explain how they've changed and all that good
11 stuff, Your Honor, my position is -- and there
12 will be even more of these style documents that
13 we just got on July 12th. And my position,
14 it's the Scheduling Order, Your Honor. I'm not
15 -- there's all sorts of stuff that came after
16 the Scheduling Order. There's nothing that
17 I've identified as a deposition -- or as a
18 designation that was not produced before the
19 discovery deadline, nothing. My objection is
20 that this information came for the first time
21 on July 12th.

22 If it's demonstrative and it doesn't come
23 into evidence, I think that's a different
24 issue, and I would respect The Court saying I'm
25 happy to have it up here, I'm happy to hear



1 about it. We can object perhaps to foundation
2 or relevance. But in terms of it being offered
3 into evidence, Your Honor, I would submit it is
4 prejudicial, it's outside of the Scheduling
5 Order, it was not with the agreement of the
6 parties. We had no knowledge that MUSC was
7 going to come up with new slides, new opinions,
8 new information, on July 12th. We would have
9 taken advantage of that additional time as
10 well. We weren't told about it.

11 **MR. DAYHUFF:** Your Honor, there's one more thing and
12 I'll move on. It's not new. You heard this
13 morning we got this email, this mysterious
14 email that said they weren't going to do urgent
15 care. I believe this witness testified about
16 that. He received the email. This schematic
17 is all about that issue.

18 And what you also just heard is, oh, it's
19 okay if it's just a demonstrative. Well,
20 that's true. We can use any kind of
21 demonstrative. And then you know what that
22 means; you're the only person who doesn't get
23 to keep that. The Court doesn't get to keep
24 that to use it later to help you decide the
25 issues of the case. Sure, we can make it a



1 demonstrative, but then it goes away. It
2 doesn't come into evidence and you don't have
3 it. That disadvantages The Court in this case.

4 So I'd ask you to -- even though I haven't
5 moved to admit it, I guess I move to admit it
6 -- would ask you to admit 28, please.

7 **MS. HOLLINGSWORTH:** And I guess I would just submit,
8 Your Honor, if that's the case, then I
9 certainly -- when my experts are on the stand
10 and I have slides representing opinions that
11 we've developed in part in response to this new
12 information, that The Court similarly consider
13 that those become evidentiary slides. I mean,
14 it has to be ---

15 **THE COURT:** And when we get to that point, I will
16 consider that, Ms. Hollingsworth. But one of
17 the things that I'm being asked to decide is
18 the changes; do they constitute substantial --
19 a substantial change such that this needs to go
20 back or -- and I think that that goes -- that
21 actually is relevant when it comes to my
22 deciding that issue. So I'm going to allow it.

23 **MS. HOLLINGSWORTH:** I understand, Your Honor.
24 Again, my point is it violates your Scheduling
25 Order. I certainly understand that you



1 overrule it, but I want to just make it clear
2 that this -- and I guess I will absolutely
3 reserve my right that there will be other ones
4 that I think we'll address separately, because
5 the schematic might be different than some
6 other slides. But I certainly appreciate your
7 ruling on it.

8 **THE COURT:** Okay. Thank you, Ms. Hollingsworth.

9 **MR. DAYHUFF:** Thank you, Your Honor.

10 **(Respondent MUSC's Exhibit Number 28 was admitted**
11 **into the record at this time.)**

12 Q: Doctor, we're back to you. I think -- I don't
13 know if I got to this question. What does this
14 represent on MUSC Exhibit 28? What is this?

15 A: This is a floor plan or layout for the proposed
16 freestanding ED in Summerville.

17 Q: All right. And how many treatment spaces or
18 treatment beds, stretchers appear here?

19 A: In terms of rooms, there are 12 rooms. There's
20 also an additional triage room.

21 Q: All right. And can you see -- I described in
22 the argument that there are fast track. I'm
23 not close enough to see. Is there a fast track
24 designation on these that you can see? And
25 perhaps Dan can help us out.



1 A: Yeah. So those five rooms closest to the
2 triage room, those on this demonstrative are
3 labeled fast track. What we try and do, at
4 least from a flow standpoint, we try and keep
5 the patients with more minor complaints closer
6 to triage. What we call vertical patients, we
7 like to keep patients vertical. Those patients
8 that need a stretcher, or horizontal patients,
9 we take further into the back of the emergency
10 department where they're going to get lengthier
11 evaluations and treatments versus patients with
12 minor complaints, we try and keep them closer
13 to the front door so we can turn them around
14 and discharge them faster. It's more efficient
15 that way.

16 Q: All right. More efficient. And do we do this
17 fast tracking in the adult ED now?

18 A: We don't.

19 Q: All right. Now, acuity. I've got an acuity
20 question while we're here. Patients with more
21 serious problems generally go to hospital EDs;
22 is that right?

23 A: That's correct.

24 Q: All right. So, is there any clinical benefit
25 of an FED for a higher acuity patient?



1 A: Sure. The problem with many conditions,
2 patients have symptoms and patients present to
3 emergency departments with symptoms. Those
4 symptoms, like chest pain, may be a serious
5 medical problem or it may not. The faster you
6 see an emergency medical provider or physician,
7 the faster you can determine whether or not
8 somebody has a life-threatening emergency
9 medical complaint, like a heart attack, or
10 something more minor, like, you know, a bruise
11 to their rib. So when we provide access to
12 patients that seek specifically MUSC for
13 emergency care, when we provide access for
14 those patients to see a provider faster, we're
15 able to make that determination, whether or not
16 this is truly a high-risk, high-level, high-
17 acuity issue or whether it's not.

18 Q: And if it is a high-risk, high-acuity issue,
19 what do you do at the FED with that patient?

20 A: As you would do in a small community hospital,
21 a critical access hospital, when you determine
22 that a patient requires a certain level of
23 care, then you need to get that patient to that
24 level of care if you can't provide that level
25 of service.



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1 Q: All right. And so that would be to a higher
2 level of care?

3 A: Yes.

4 Q: All right. So thinking about our FED,
5 Summerville, if we get to establish it and you
6 have a higher acuity patient that you decide is
7 indeed higher acuity, you stabilize and
8 transfer. The transfer options -- MUSC would
9 be an option?

10 A: Sure.

11 Q: All right. How about the Trident hospitals in
12 the area?

13 A: Sure.

14 Q: All right. Would that include the trauma
15 center at Trident?

16 A: Sure.

17 Q: How about their cardiac programs?

18 A: It could.

19 Q: How would you determine, as an ED provider or
20 an emergency medicine provider, if you were in
21 that ED with a higher acuity patient, where you
22 would send that person?

23 A: Every patient's a little bit different. So
24 patients that want to -- that are MUSC patients
25 that want to stay within the MUSC system, if



1 the risks of transferring down to MUSC aren't
2 outweighed by the -- if the risks don't
3 outweigh the benefits and they want to stay
4 within the MUSC system, then that's -- you
5 know, that's what you would do. As emergency
6 medicine physicians, we're trained in sort of
7 determining those risks and benefits. If
8 there's a benefit of transferring closer, say
9 to Trident, you know, that you're going to
10 discuss with the patient. Ultimately it's up
11 to the patient to make a decision once they're
12 informed.

13 Q: All right. Now, if the FED gets approved by
14 The Court, what, if any, review of the
15 healthcare resources in the immediate vicinity
16 of the FED will MUSC undertake, if any?

17 A: Part of coming up with processes and policies
18 for the FED would be working with, not only
19 MUSC, but the local healthcare providers,
20 including folks like SCIPES (phonetic) with
21 Trident, to determine, you know, transfer
22 processes and policies.

23 Q: All right. Let's go back to DX-37. And DX-37,
24 just to refresh, is benefits for patients
25 related to establishment an FED. And I think



1 we've talked about distance and time to care.
2 High quality FED, talk to us about that bullet
3 point and the sub-point.

4 A: Well, our emergency medical physicians, our
5 faculty at MUSC spends their time working
6 clinically and training residents and keeping
7 up to date with the most comprehensive
8 emergency medical care. So, providing those
9 physicians to an FED I think would be a benefit
10 to the quality of care that patients would get
11 in an FED.

12 Q: Are you saying that emergency medicine staff at
13 non-MUSC EDs are substandard providers?

14 A: Absolutely not. Absolutely not.

15 Q: All right. What is your opinion of the
16 healthcare provided by emergency medicine folks
17 at Summerville and Roper?

18 A: I think all of those physicians are excellent.

19 Q: All right.

20 A: At least the ones I know.

21 Q: Very good. The benefit of having MUSC
22 physicians, I understand you've got physicians
23 and residents. Talk to me about that.

24 A: So the physicians, the faculty at MUSC are,
25 again, training the next, you know, level, the



1 next generation of emergency physicians. And
2 so the ability of them to remain up to date on
3 all the cutting edge technology in emergency
4 medicine is there. We train residents. Those
5 residents also go out to work at Roper and
6 Trident. So many of the staff at those
7 hospitals we train. But having the quality of
8 our faculty at an FED I think is a benefit,
9 along with our access to our specialists.

10 Q: Tell me about that. How will folks that come
11 to our FED in Berkeley County get access to
12 specialists?

13 A: So, the -- it's sort of two-fold. We work with
14 our specialists. We work with our transplant
15 folks. We work with our oncologists on a daily
16 basis. And so we know them very well. We know
17 what processes they take. If their patient
18 calls them and says, I'm having X going on, we
19 know what our specialists want to do in terms
20 of an initial evaluation and we can communicate
21 with them. The benefit of MUSC is also we have
22 our telehealth platform. We already provide
23 tele-psychiatric services. We provide tele-
24 stroke services. We provide tele-ICU services.
25 And all of these services would be available to



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1 our patients, along with a lot of other
2 services that are being developed.

3 Q: What kind of services are being developed
4 specialist-wise that could conceivably come
5 into play?

6 A: Over the last two years all of our faculty at
7 MUSC, again, from just about every service that
8 we provide at MUSC, have all been credentialed
9 to provide telemedicine services.

10 Q: What effect, if any, will specialist
11 participation in the FED have on the level of
12 acuity this FED can handle?

13 A: There's many times when you take care of a
14 complicated patient. If you're in a
15 freestanding ED, you might not be comfortable
16 taking care of that patient. Because of our
17 access to our specialists, because of working
18 with them on a daily basis, we understand the
19 type of patients that they see and we
20 understand the work-ups that they do. And we
21 can assist with that and we can potentially
22 determine that patients don't necessarily need
23 to be transferred to a higher level of care.
24 We may be able to take care of them without
25 having to transfer them or admit them to the



1 hospital.

2 Q: So does that mean conceivably or in your
3 opinion higher acuity patients than a standard
4 FED could be treated at our FED?

5 A: I think that's a possibility, yes.

6 Q: All right. Protocols and processes, what does
7 that refer to?

8 A: So, we're always working on quality improvement
9 processes. We work throughout the MUSC
10 enterprise on improving care for -- like I
11 said, for sepsis patients. We have quality
12 improvement metrics for trauma patients. We
13 have work flows for chest pain evaluation, for
14 treatments of venous thromboembolism, we have a
15 large number of different processes that we
16 have adopted through some of the experts that
17 work on our faculty. And we -- obviously,
18 having the faculty work at a freestanding ED
19 would allow us to utilize a lot of the
20 processes and protocols for the benefit of our
21 patients.

22 Q: All right. And part two I believe of your
23 expert opinion is that an FED in Berkeley
24 County would be good for the MUSC ED system; is
25 that right?



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1 A: Yes.

2 Q: All right. What effect, if any, would the FED
3 have on the main hospital, the adult main
4 hospital, where you're the director?

5 A: As mentioned before, I believe with an
6 estimated quarter of our patients coming from
7 that area, if we're able to even divert some of
8 those patients up to our freestanding ED, that
9 is going to, again, help to relieve some of
10 that log jam that we have in our adult
11 emergency department right now.

12 Q: Take a look at DX-34. What effect, if any, on
13 the door-to-doctor, door-to-discharge LWOT that
14 we talked about earlier?

15 A: I think if we are able to, again, manage some
16 of these patient at a separate location, those
17 patients are going to see an improvement in
18 door-to-provider times and door-to-discharge
19 times, throughput times. But also, the rest of
20 our patients that we're taking care of on the
21 main campus, I think will also see significant
22 improvements.

23 Q: All right. Just a few, I suppose, odds and
24 ends now. Why not improve the capacity at main
25 to resolve the issues?



1 A: Well, we've worked -- as I mentioned before,
2 we've worked on a lot of different processes.
3 Over the last three years we have had numerous
4 quality improvement processes. We worked with
5 our mental health. We've had a mental health
6 task force with Dr. Cawley being our executive
7 sponsor. We've worked on improving the care
8 that we provide. Some of that has been
9 successful in terms of the care that we provide
10 to our mental health patients. But some of
11 those efforts have not been as successful, as
12 we're still having issues with our throughput
13 and capacity.

14 Q: All right. What about adding space downtown?

15 A: The challenge with adding space, again, what
16 historically we've done is we've added
17 compartmentalized space, which doesn't improve
18 your efficiency. In fact, if we added the 12
19 beds -- the 12 pediatric beds, well that's
20 currently a separate space, you know, distinct
21 from where our main emergency department is.
22 And so getting patients to that area, staffing
23 that area, there would be a lot of
24 inefficiencies with doing that. That would be
25 a challenge. But more than anything, we've



1 looked at revamping the entire emergency
2 department downtown. And the cost of that is,
3 you know, ten years ago -- actually, I take
4 that back -- five years ago the last that I saw
5 the cost was in the 35 million range. And that
6 was five years ago.

7 Q: How does that compare to the FED in Berkeley
8 County?

9 A: The FED is substantially cheaper.

10 Q: Now, I've heard the notion, perhaps in
11 discovery and maybe in the openings,
12 questioning whether MUSC has the experience to
13 operate an FED. Did you hear that?

14 A: Yes.

15 Q: All right. What opinions do you have about
16 that notion, that MUSC doesn't have the
17 experience to operate an FED?

18 A: Well, I can't speak to the nursing component of
19 an FED. But on the physician side, we do have
20 physicians that have worked in FEDs. We do
21 have -- overall, probably the best answer to
22 that question is, you know, emergency medicine
23 -- like I said before, emergency medicine is
24 emergency medicine. We're all trained in
25 emergency medicine and we provide excellent



1 care in emergency medicine. And the processes
2 and things that we do to care for those
3 patients doesn't change if you're in an FED as
4 opposed to a tertiary care center. Most of my
5 providers have worked at small hospitals where
6 they've had to transfer patients. I, in fact,
7 have worked at a hospital where we didn't have
8 trauma service. We didn't have neurology. We
9 didn't have neurosurgery. We didn't have hand
10 surgery. And we didn't have trauma surgery.
11 And working at those places, you quickly would
12 -- you quickly work on processes whereby you
13 can evaluate what a patient needs. And if you
14 don't have that service available for the
15 patient, then you work on getting that patient
16 transferred to a place where they do have that
17 service.

18 Q: In your expert opinion, do you have any
19 concerns about the quality of the clinical care
20 that MUSC would be able to provide in a
21 freestanding ED center?

22 A: No.

23 Q: All right. Has the FED we propose to establish
24 in Berkeley County changed in any way from the
25 FED we originally submitted in June of 2017?



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1 A: Yes.

2 Q: All right. Did the location change?

3 A: Yes.

4 Q: What's your understanding of the nature of that
5 change?

6 A: The original location was going to be on one
7 side of the highway in a new development, the
8 Nexton development. The proposed new location
9 will be just on the other side of the highway,
10 less than a mile away.

11 Q: Let's look at Exhibit 33. Can you just
12 describe the original site and the current
13 site? Does this map accurately reflect the
14 area in which our original and current site for
15 the FED?

16 A: Yes.

17 Q: All right. And does it accurately reflect the
18 locations of the original and current site?

19 A: Yes.

20 **MR. DAYHUFF:** All right. We'd ask that this be
21 entered into evidence. This is Exhibit 33.

22 **MR. THOMAS:** Your Honor, I just put my objection on
23 the record regarding the illegal procurement of
24 this site by MUSC Strategic Ventures.

25 **THE COURT:** Okay.



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1 **MS. HOLLINGSWORTH:** Your Honor, I just reserve my
2 objection for document production.

3 **THE COURT:** Okay. Thank you. It's admitted.

4 **(Respondent MUSC's Exhibit Number 33 was admitted**
5 **into the record at this time.)**

6 **MR. DAYHUFF:** Thank you.

7 **Q:** Did the size of the proposed FED change from
8 the original to now?

9 **A:** When we originally looked at some of the
10 blueprints for the original site, we had
11 included five observation CDU, clinical
12 decision unit beds. Senior leadership, after,
13 again, probably crunching the numbers, decided
14 that the cost benefit was not there for that
15 and so the CDU beds were scratched from the
16 project.

17 **Q:** And taking the CDU beds out enabled us to have
18 a smaller FED?

19 **A:** Yes.

20 **Q:** All right. How about cost? Are you familiar
21 with changes in the cost?

22 **A:** Yes. I believe they were able to save by doing
23 that at least a couple of million dollars.

24 **Q:** All right. And with respect to the CDU, by not
25 having a CDU, in your expert opinion, does that



1 compromise the quality of the emergency
2 medicine care we would provide?

3 A: No.

4 Q: Why not?

5 A: Well, CDU, the thought of a CDU is to keep a
6 patient in an emergency department for a longer
7 period of time to do a longer assessment or
8 observation of that patient, and determine
9 whether or not that patient would need to be
10 admitted to a hospital or not. Right now we do
11 not currently have an active CDU. We have had
12 observation medicine at MUSC previously and so
13 we have expertise in that. However, we haven't
14 found it to be necessarily a huge benefit to a
15 freestanding ED.

16 Q: All right. Did the original plan call for a
17 helipad?

18 A: Yes, it did.

19 Q: Does the current plan call for a helipad?

20 A: No. The current location is in a sort of a
21 shopping center area with a large parking lot.
22 The previous location was going to be, again,
23 a new sort of development where everything was
24 going to be built from the ground up. With a
25 large parking lot right next to your



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1 freestanding ED, you don't need necessarily to
2 build a dedicated helipad. Most ---

3 Q: How would that work?

4 A: Well, most places, most fire departments have
5 dedicated landing zones for landing helicopters
6 when necessary. And in this particular case,
7 that would be something that we would work with
8 the local department to cordon off an area
9 close to the freestanding ED to utilize as an
10 LZ.

11 Q: All right. If MUSC gets this Court's approval
12 to establish the FED and if at sometime in the
13 future MUSC gets approval for the community
14 hospital, will the FED at its new site continue
15 to exist or not after the establishment of the
16 community hospital?

17 A: Yes.

18 Q: All right. We've heard a lot already about
19 Intuitive Health. What is Intuitive Health?

20 A: Intuitive Health is a consulting ED group that
21 manages and consults with health systems
22 regarding freestanding ED. And they have a
23 freestanding ED urgent care model that they
24 use.

25 Q: Did you have any communications with Intuitive?



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1 A: I've had some, yes.

2 Q: Describe the nature of those. Are they
3 meetings, phone calls?

4 A: There was a combination. There were -- and I
5 don't recall exactly how many. But there were
6 a couple of phone calls with Intuitive where
7 they sort of described what they did to some
8 extent. And then they came to Charleston. And
9 I was invited to one meeting, about an hour-
10 long meeting with Intuitive. I don't recall
11 exactly who was there. It was some of the
12 leadership from Intuitive. And they talked
13 about what -- you know, what their service was
14 and some of the ideas that they would have if
15 MUSC was interested in working with them.

16 Q: So you mentioned an urgent care FED model.
17 What is the model?

18 A: So, the model, as I understand it, that
19 Intuitive uses, is they place a freestanding
20 ED. And patients who seek care at that
21 freestanding ED get seen and treated
22 effectively like an emergency medicine patient.
23 On the back end, however, when they bill for
24 the service, they only bill for the service
25 that was provided. So if a patient came in



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1 with let's say an ankle sprain and only
2 required a urgent care level of service, that's
3 what they would bill the patient for, as
4 opposed to billing them the full charge of a
5 freestanding emergency department.

6 Q: Does Intuitive have an ownership interest in
7 the proposed FED?

8 A: No.

9 Q: Does Intuitive have a management contract to
10 manage the proposed FED?

11 A: No.

12 Q: Was there consideration by folks at MUSC
13 regarding the Intuitive model that you're aware
14 of?

15 A: Yes.

16 Q: All right. But ultimately will MUSC be
17 utilizing the Intuitive model?

18 A: No.

19 Q: Why not?

20 A: There was -- I was told that there was some
21 concerns from DHEC about having an urgent care
22 and a freestanding ED in the same location.
23 And although that -- my understanding of the
24 project, at no point in time were we going to
25 cohort both in the same location. It was a



1 billing issue on the back-ends. The confusion
2 there made senior leadership decide that we're
3 just -- we're going to stick with what our
4 original plan was.

5 Q: All right. So no ownership interest, no
6 management contract, no use of the model. Did
7 MUSC's communications and interaction with
8 Intuitive have any effect on the proposed FED
9 project?

10 A: I have to assume this. I was not involved in
11 these discussions. But ---

12 **MR. THOMAS:** Well, we'll just object on that basis
13 then, Your Honor. If he's just going to assume
14 and he wasn't involved in the discussion, let's
15 get the ---

16 **MR. DAYHUFF:** Let me ---

17 **MR. THOMAS:** --- up here who knows.

18 **MR. DAYHUFF:** --- lay some foundation, perhaps.

19 Q: Did we -- did MUSC, to your knowledge, consider
20 any of the opinions or ideas of Intuitive with
21 respect to changes that ultimately got made to
22 the FED?

23 A: Yes.

24 Q: All right. And what ideas, thoughts that
25 Intuitive had had some effect on our project



1 that you're aware of?

2 A: The primary one was the condensed footprint.
3 Leadership likes the smaller size. I'm
4 assuming the -- sorry for using assuming, but
5 ---

6 Q: You're going to get stomped if you use assuming
7 again. You realize that, right? Just stick to
8 what you are aware of.

9 A: So it's cheaper.

10 Q: Okay. Cheaper, smaller. To your knowledge,
11 did Intuitive have anything to do with the
12 suggestion of the new site?

13 A: I am not aware of that.

14 Q: Fair enough. Ultimately, what entity made the
15 decision about whether to make the changes that
16 we've made to our project?

17 A: Dr. Cawley is the ultimate decision maker.

18 Q: At MUSC?

19 A: At MUSC. All right. You got an email that was
20 mentioned I think in opening the day before
21 your deposition. I don't have that email. But
22 do you recall that email?

23 A: Yes.

24 Q: All right. What did that email -- what was the
25 purpose of that email?



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1 A: Dr. Cawley just emailed me to make it clear
2 that we were doing a freestanding ED, the
3 project hadn't changed. That, you know,
4 essentially the whole confusion over urgent
5 care, that we weren't going to do that.

6 Q: So, if there had been consideration of the
7 urgent care hybrid model, when you received
8 that email, did you understand it to be the
9 traditional FED model that we were moving
10 forward with?

11 A: Yes.

12 Q: And is that traditional FED model the model we
13 had in our CON application?

14 A: Yes.

15 Q: All right. And do you recall how many
16 treatment areas we had or treatment rooms we
17 had in the original CON application versus the
18 current?

19 A: The treatment areas, there were 12, and then
20 five CDU beds.

21 Q: And in our current proposal we have how many
22 treatment rooms?

23 A: Twelve.

24 Q: Of which how many are five -- or fast track?

25 A: Five.



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1 Q: Okay. So 12 and 12. In your role as medical
2 director of the adult ED, are you familiar with
3 how hard or easy it is for MUSC to recruit
4 emergency physicians and staff?

5 A: In my experience it hasn't been difficult. We
6 usually have a large number of physicians
7 specifically that are sending us CVs all the
8 time.

9 Q: All right. Do you believe it will difficult to
10 recruit physicians or staff for the FED, if we
11 are approved to open it?

12 A: I don't believe so, no.

13 Q: All right. You might have heard today in
14 opening there was a suggestion that by
15 establishing the FED we could somehow
16 compromise quality in surrounding EDs. Do you
17 have an opinion about that?

18 A: I don't believe that's -- I don't believe
19 that's the case.

20 Q: Why not?

21 A: Well, the care that we're all providing, we're
22 all, you know, for the most part, emergency
23 medicine trained and we're caring for patients
24 regardless if it's in an emergency department
25 at Trident or in a freestanding ED. We're all



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1 trained to take care of patients, to evaluate
2 and treat those patients. . And we have some
3 very good physicians in the Tri-County area.
4 And I don't believe adding another facility is
5 going to compromise their ability to evaluate
6 and treat patients.

7 **MR. DAYHUFF:** All right. Beg The Court's
8 indulgence. Please answer any questions
9 opposing counsel has for you.

10 **THE COURT:** Before we get to testimony from opposing
11 counsel, I am going to call a ten-minute
12 recess.

13 (Off the Record)

14 **THE COURT:** Okay. If everyone is ready, you can
15 begin your cross.

16 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

17 **DR. HALL - CROSS-EXAMINATION BY MS. HOLLINGSWORTH:**

18 **Q:** Dr. Hall, it's nice to see you again.

19 **A:** Nice to see you.

20 **Q:** We met just a couple of weeks ago at your
21 deposition. Do you recall that?

22 **A:** Yes.

23 **Q:** And so, of course, at the deposition we went
24 through a number of topics and issues and
25 documents. And so, having heard your Direct



1 Examination, I will both kind of talk to you
2 about some of the things we talked about in
3 your deposition, but then also perhaps some of
4 what I heard today. And going to sort of the
5 basis on which you've supported some of these
6 expert opinions you've offered us, but I did
7 understand you've not worked in a freestanding
8 ED before, correct?

9 A: That's correct. I haven't worked that yet.

10 Q: Okay. And you had worked with the planning
11 related to an FED with Mercy; is that right?

12 A: That's correct.

13 Q: In Ohio?

14 A: Yes.

15 Q: And I think actually what you told me at your
16 deposition is that FED was within a few miles
17 of the main hospital, right?

18 A: That -- the hospital that I worked at was
19 farther away. There was a Mercy Hospital that
20 was within a few miles of that FED, yes.

21 Q: Right. I think you described that the FED was
22 like a couple exits ...

23 A: Yes.

24 Q: Maybe three exits away and you said within a
25 few miles of that supporting hospital, right?



1 A: Yes.

2 Q: And so in terms of the geography that we have
3 here. you don't have experience with planning
4 related to an FED as geographically distant as
5 this one is; is that fair?

6 A: That's fair.

7 Q: Okay. With regard to your opinions, you
8 haven't done any review of freestanding EDs for
9 -- freestanding EDs associated with academic
10 medical institutions, right?

11 A: Correct.

12 Q: And you haven't done that since your
13 deposition?

14 A: No.

15 Q: And saying -- as I understood your deposition,
16 you don't have any knowledge or expertise in
17 evaluating the efficiencies and outcomes for
18 freestanding emergency departments; is that
19 right?

20 A: Well, the metrics by which we evaluate all
21 emergency departments are the same. We look at
22 the same type of thing. So whether or not it's
23 a freestanding emergency department or a
24 hospital-based emergency department, your
25 patient satisfaction and your left-without-



1 treatment rates, your throughput rates, those
2 are all the same.

3 Q: So some of those performance metrics with
4 regard to maybe the patient experience?

5 A: Yes.

6 Q: Is that fair? But what about in terms of
7 efficiencies or outcomes from a financial
8 perspective? You don't have any knowledge or
9 expertise with regard to the financial aspects
10 of an FED, do you?

11 A: No. That wasn't asked of me.

12 Q: Okay. And so not generally nor about this
13 project; is that fair?

14 A: That's correct.

15 Q: Okay. Now, we talked about your role as the
16 medical director of the adult ED. And when we
17 say that, that's meaning one of sort of three
18 emergency spaces that MUSC has downtown; is
19 that right?

20 A: That's correct.

21 Q: So sort of the main ED or the adult ED I think
22 I've seen it referred to?

23 A: Yes.

24 Q: And that's the largest one; is that right?

25 A: That's correct.



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1 Q: The most volume is associated with that
2 department, so to speak?

3 A: Yes.

4 Q: Okay. And then the CPC or the chest pain
5 clinic, that's the Ashley River Tower; is that
6 right?

7 A: That's correct.

8 Q: And then separate and distinct is the pediatric
9 emergency department, right?

10 A: Yes.

11 Q: Or the children's ED I think on the map?

12 A: Uh-huh (affirmative response).

13 Q: Okay. And you don't have any clinical
14 oversight with regard to the pediatric ED; is
15 that right?

16 A: No. The pediatric emergency department has its
17 own medical director and it's run through the
18 Department of Pediatrics.

19 Q: Okay. And so you might work and practice in
20 that department and pull shifts in that
21 department, but you don't have any supervision
22 or responsibilities for the performance of the
23 pediatric ED; is that right?

24 A: That's correct.

25 Q: Same with the Chest Pain Center?



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1 A: As part of the senior leadership for the
2 Department of Emergency Medicine, most of the
3 decisions that we make regarding the Chest Pain
4 Center and the adult emergency department we
5 make in conjunction. My partner, Dr.
6 Matuskowitz, is the Chest Pain Center medical
7 director.

8 Q: Okay. If you can, why don't you spell his name
9 since I know that would be helpful for the
10 court reporter.

11 A: I'll try. M-A-T-U-S-K-O-W-I-T-Z, Matuskowitz.

12 Q: Okay. It's like a spelling bee.

13 A: It is.

14 Q: Okay. So you talked, though, about in terms of
15 addressing the throughput issues, processing
16 procedures, those things that you do for the
17 adult ED. You actually have a counterpart that
18 does those same things in the Chest Pain
19 Center; is that right?

20 A: Correct.

21 Q: You don't have the responsibility for that --
22 performing that supervision for the Chest Pain
23 Center?

24 A: Not directly.

25 Q: Okay. And the children's ED is sort of down



1 the hallway, but in the same building as the
2 main ED; is that right?

3 A: It is.

4 Q: They're in the same physical structure,
5 although I understand you described the space
6 as compartmentalized, right?

7 A: Yes.

8 Q: And in fact the children's ED has its own
9 separate entrance for emergency transport,
10 right?

11 A: Correct.

12 Q: Okay. And that's moving to Shawn Jenkins
13 Women's and Children's Hospital, right?

14 A: Yes.

15 Q: And as I understood it, it's going to add a
16 good bit of emergency services space to the
17 pediatric ED, right?

18 A: They're going from 12 beds to 20 beds.

19 Q: And is there even some additional space as well
20 that'll be in there?

21 A: Additional ...

22 Q: In the new Shawn Jenkins?

23 A: Additional space in regards to ...

24 Q: And we'll get to a document where we can do it.
25 Let me see. I thought that there was going to



1 be some other spaces, like after-hours space or
2 something in addition to the 20. But we'll
3 have a document that we'll look at about that.

4 Okay. And we talked about the metrics
5 that you monitor, right? And you talked to us
6 about your length of stay goal for discharges,
7 leave-without-treatment goal, door-to-provider
8 goal. As I understand it, you don't have a
9 goal, so to speak, for admissions, right,
10 inpatient admissions?

11 A: Correct. There's not like a quota for how many
12 patients we admit to the hospital.

13 Q: But you monitor that in terms of evaluating how
14 many of your visits are translating into
15 admission -- inpatient admissions?

16 A: Yeah. Part of the dashboard that we see is
17 that. And that gets reported out to
18 benchmarking. We report our metrics out to
19 some national benchmarking places, so we can
20 see where we compare to other facilities.

21 Q: Okay. And actually I think you talked about
22 that on your direct, that your -- the kind of
23 ED visits that convert over to inpatient
24 admissions, that you have an average, I think
25 you said this afternoon 25 to 26 percent?



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1 A: Bout that, yes.

2 Q: Okay. And you said that's a little actually
3 higher than the national average of 20 percent?

4 A: Yes.

5 Q: Is that right? And the Chest Pain Center
6 actually has a much higher admission rate,
7 doesn't it?

8 A: That's correct.

9 Q: I think what we talked about is 40 percent.

10 A: Close to 40, yes.

11 Q: So, the population that's coming to the Chest
12 Pain Center has a much higher rate of
13 converting to an inpatient admission; is that
14 fair?

15 A: That's fair, yes.

16 Q: And I guess that rate's double the national
17 average for emergency department; is that
18 right?

19 A: Approximately.

20 Q: Okay. So, when we were looking at some of
21 those metrics -- and you mentioned the
22 dashboard. I think it would be -- let's take
23 a look at Roper St. Francis 44. And you do
24 have a notebook in front of you. And if
25 technology goes well, it'll be on the screen,



1 but you're welcome to also flip there. Do you
2 recognize the document that is marked Roper's
3 Exhibit 44?

4 A: Yes. This is ED scorecard dated 2016.

5 Q: And this first page, MUSC 4122, is that -- tell
6 us, what is that? Is that for all of the EDs
7 combined or what is that evaluating?

8 A: This looks like it is just the main adult
9 emergency department.

10 Q: And is that calendar year 2016?

11 A: Yes.

12 Q: Let's just turn so that we get the full
13 exhibit. If you could turn over to page two of
14 that exhibit. What is this document?

15 A: This is the same rolling scorecard for the
16 Chest Pain Center.

17 Q: All right. And then the third page of that
18 document?

19 A: This is the Pediatric Emergency Department.

20 Q: And is this the type of information that you
21 regularly monitor as medical director of the
22 adult ED?

23 A: It's similar information, yes.

24 **MS. HOLLINGSWORTH:** Your Honor, we would move to
25 have Roper St. Francis Exhibit 44 in evidence.



1 **MR. DAYHUFF:** No objection.

2 Q: Okay. If you could take a look ---

3 **THE COURT:** It's admitted.

4 **(Petitioner Roper's Exhibit Number 44 was admitted**
5 **into the record at this time.)**

6 Q: --- at the first page of the exhibit for the
7 rolling 12 months adult ED 2016 metrics. And
8 so that we can orient ourselves, kind of
9 starting at that top line what does that grand
10 total number 49,825 represent?

11 A: That's the number of visits during that
12 particular calendar year.

13 Q: Okay. And if we look, this scorecard gives us
14 those metrics that you're kind of -- that you
15 described as being the most important; is that
16 right?

17 A: Yes.

18 Q: Length of stay goal for discharge is 180
19 minutes. That was your testimony earlier; is
20 that right?

21 A: That is correct.

22 Q: And so if we look on this document, Exhibit 44,
23 first page, that would be average length of
24 stay for all discharges in hours? It's
25 actually the second ---



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1 A: Yes.

2 Q: --- pink or red line; is that right?

3 A: That's correct.

4 Q: And that number is 3.87; is that right?

5 A: Yes.

6 Q: And so, I guess -- math, as you recall from
7 your deposition, is not my strong suit. But
8 180 minutes is three hours, right?

9 A: That's correct.

10 Q: So, we're slightly above. We're at 3.87?

11 A: Yes.

12 Q: Okay. So, that is an important metric that
13 you've described, right?

14 A: Yes.

15 Q: If you could -- let's talk about the other
16 ones. You have a leave-without-treatment goal
17 of less than three percent, right?

18 A: Yes.

19 Q: So what was that -- what was that -- how did
20 you perform in your ED for the 12 months ending
21 December 2016?

22 A: That was actually a very good year. It started
23 off a little rough, but by the end of the year
24 we had done a much better job and we were at
25 right about our goal, three percent.



1 Q: Nearly spot on, right?

2 A: Nearly spot on.

3 Q: And some really good months it looks like, in
4 the 2.15, 1.94. Those are well below your goal
5 number, right?

6 A: Yes.

7 Q: And I think you told me in your deposition that
8 if only you could go back to 2016, I think you
9 said?

10 A: A lot of stuff, it would be -- we had some
11 better numbers back then for many things.

12 Q: And, now, I don't know that Mr. Dayhuff asked
13 you this in your Direct, but these documents,
14 these metrics refer to IOP admissions. What
15 are those?

16 A: So the Institute of Psychiatry, those are our
17 mental health admissions.

18 Q: Okay. So we did hear a lot of testimony about
19 the mental health patient population and how
20 they are contributing to some of the capacity
21 issues in the ED; is that right?

22 A: Yes.

23 Q: So that patient population is captured, though,
24 within these metrics; is it not?

25 A: Those coming through the adult ED, yes.



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1 Q: Okay. So when you're describing capacity
2 issues, capacity constraints, and talking about
3 the mental health population, that population
4 is captured within these totals and these
5 metrics, right?

6 A: Yes.

7 Q: And so in terms of the boarding hours -- or
8 let's do it this way. The average length of
9 stay, that's sort of how the data transfers, is
10 it not, to how long the patients are waiting
11 once it's been determined they need an
12 inpatient bed, until they get into the bed?

13 A: Correct.

14 Q: Is that a fair ...

15 A: Fair, yes.

16 Q: Okay. And so it's actually broken out and you
17 all track that data, that average length of
18 stay for admissions and separate out the mental
19 health patients waiting for psychiatric
20 admissions versus the non-IOP; is that right?

21 A: Yes.

22 Q: So would it be fair to say that, when your --
23 two numbers that might be interesting or
24 important to compare is the difference between
25 your average length of stay for discharges and



1 your average length of stay for the non-
2 psychiatric or non-IOP admits?

3 A: Can you rephrase?

4 Q: Well, let me ask you -- the difference between
5 a patient who is sitting and just waiting to
6 discharge home versus the patients who's
7 sitting, it's time to go inpatient, and then
8 were waiting to get a bed, would you agree with
9 me that that difference is sort of attributed
10 to really an inpatient capacity issue and not
11 an ED issue?

12 A: Yes.

13 Q: Okay.

14 A: Yes.

15 Q: So that metric -- so that didn't garble it too
16 much. But the difference between the amount of
17 time -- the length of stay for someone waiting
18 to go home and the additional amount of time
19 that someone is waiting to get to an inpatient
20 bed, that is a function of inpatient capacity
21 constraints, not ED capacity constraints; is
22 that fair?

23 A: To some extent. Patients that are admitted to
24 the hospital, their work-ups tend to be a
25 little bit longer, so they tend to be in the



1 emergency department as an active patient a
2 little bit longer than those patients that are
3 discharged. But otherwise that difference, the
4 delta between their length of stay in the
5 emergency department for admission versus
6 length of stay for discharge, a lot of that is
7 related directly to inpatient capacity.

8 Q: Okay. And I think we talked in your deposition
9 about how a lot of the metrics that you're
10 looking at have an issue that's tied to the
11 inpatient capacity and throughput issues with
12 inpatient discharge as opposed to your
13 department or the emergency departments; is
14 that right?

15 A: Yes.

16 Q: Okay. That was a yes?

17 A: Yes.

18 Q: Okay. And you -- the emergency department
19 doesn't have control over discharge issues or
20 capacity issues with the inpatient beds, do
21 you?

22 A: We work with the inpatient teams. We work with
23 the bed management. But we don't have direct
24 control.

25 Q: Okay. And I think you told me that MUSC needs



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1 to improve the efficiency of the discharge
2 process from sort of the inpatient to discharge
3 status. Is that fair?

4 A: That's one of the things that MUSC's been
5 working on for a number of years. Yes.

6 Q: And some of those protocols and processes you
7 talked about, there are those as well related
8 to improving inpatient discharge ---

9 A: Yes.

10 Q: --- metrics; is that fair?

11 A: Yes.

12 Q: Okay. All right. So we've looked at this
13 scorecard. So 49,825, that was the number of
14 visits in 2016 for this is the adult main ED,
15 right?

16 A: Yes.

17 Q: So, this means that that number does not
18 include your Chest Pain Center visits?

19 A: That's correct.

20 Q: And it does not include your pediatric patients
21 that were treated through the pediatric
22 emergency department; is that right?

23 A: That is correct.

24 Q: So, in looking then at sort of the metrics for
25 your, the main ED, the adult main ED, that



1 you've kind of testified as having these
2 capacity constraints, there is actually a
3 volume number, is there not, here at the bottom
4 for total number of pediatric patients seen in
5 your ED; is that right?

6 A: There is a volume that tends to be adolescent
7 trauma patients.

8 Q: Okay.

9 A: The trauma system recognizes that 16 and 17
10 year olds are adult trauma patients and so
11 those come in through the adult ED. We also --
12 up until recently when our pediatric emergency
13 department got its Level I trauma designation,
14 we utilized our adult ED for our Level A
15 pediatric traumas, meaning the sickest of the
16 sick pediatric trauma patients would come
17 initially through our adult ED for
18 resuscitation.

19 Q: Okay. And so would that -- in that event, if
20 you have sort of the sickest of the sick
21 pediatric patient that comes first to your ED
22 and then perhaps goes over to the pediatric
23 children's ED, is it captured twice or just the
24 first time in your visit counts?

25 A: I don't know the specific answer to that. Our



1 current dashboard, our electronic dashboard,
2 which is very similar to this, allows us to
3 pull up by first ED, meaning it would pull
4 those patients up based on where they arrived
5 first.

6 Q: Got you.

7 A: How they -- back then this was all done -- this
8 was a report that was sent to us and so I don't
9 know that I ever actually asked whether or not
10 those patients are getting counted twice.

11 Q: And do you recall why you got this report?

12 A: This was a report that was sent out from our
13 analytics folks on a monthly basis.

14 Q: Got you. Okay. But in looking again though at
15 that pediatric volume, there's only 84
16 pediatric patients within the adult ED visit
17 volumes in 2016; is that right?

18 A: That's correct.

19 Q: So that's -- I did the math earlier. It's
20 roughly .17 percent?

21 A: A small number.

22 Q: So when we're looking at sort of the pediatric
23 experience at MUSC, nearly all of that
24 pediatric experience is actually within the
25 children's emergency department; is that right?



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1 A: Yes.

2 Q: The pediatric experience at the adult ED is .17
3 percent in 2016; is that right?

4 A: Yes.

5 Q: Okay. The Chest Pain Center -- if you'll go to
6 page two of that document that you have in
7 front of you, Roper 44, this looks like there
8 were 11,000 visits in the Chest Pain Center in
9 2016. Is that right?

10 A: Yes.

11 Q: And some of this -- some of this data that you
12 have here, you've got .43 percent left without
13 treatment.

14 A: Yes.

15 Q: That's a very small number; is that right?

16 A: Yes, very small.

17 Q: Is it fair to say that the people that are
18 showing up at the Chest Pain Center are getting
19 treated?

20 A: They are staying, yes.

21 Q: And -- because I think you told The Court
22 earlier your Chest Pain Center has some very
23 specialized designations. Is that right?

24 A: It is a Joint Commission Accredited acute Chest
25 Pain Center.



1 Q: Well, I guess just going back to that adult
2 main, page one of 44. We looked at the average
3 length of stay for all discharges was 3.87
4 hours. And we looked at the non-IOP
5 admissions, 7.76 hours. It looks like the
6 average length of stay for the Institute of
7 Psychiatry admissions was 31 -- almost 31 and
8 a half hours.

9 A: Yes.

10 Q: And, now, is this the patient population that
11 you're using some of these spaces that you
12 talked about that sort of are dedicated to the
13 mental health population?

14 A: Yes.

15 Q: So those spaces then -- those spaces are being
16 used for patients that are being captured in
17 this report; is that right?

18 A: Yes.

19 Q: And then let's look at Roper Exhibit 45. I
20 think this might be the version of the
21 scorecard that you were just talking about.

22 A: Yes. This is the updated version.

23 Q: Okay. And right along the top -- and I
24 apologize for the small print. That's your
25 attorney's fault.



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1 **MR. DAYHUFF:** Objection. Withdrawn.

2 **MS. HOLLINGSWORTH:** That was not speculation.

3 Q: If you look at the very top, it does say First
4 ED Department. Was that -- so this tells you
5 for certain then that the visits being captured
6 here, this is the first -- wherever they came
7 to into the MUSC ED system, it's that first
8 capture that this report ---

9 A: Yes.

10 Q: --- is measuring; is that right?

11 A: Yes.

12 Q: Okay. And this document at Roper 45, it's two
13 pages. And it looks like we have the CPC
14 center is Roper 45-1. And if you'll look at
15 the second page of that document, MUSCED 1 West
16 Adult. Is that your ED?

17 A: That's the main adult emergency department.

18 Q: Okay. And what time period is this scorecard?

19 A: So this is 2017 calendar year.

20 **MS. HOLLINGSWORTH:** Your Honor, I would move to
21 admit Exhibit 45 into evidence.

22 **MR. DAYHUFF:** No objection.

23 **THE COURT:** It's admitted.

24 **(Petitioner Roper's Exhibit Number 45 was admitted**
25 **into the record at this time.)**



1 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

2 **Q:** Just looking at your ED's metrics just to give
3 us sort of the measuring stick, we have the
4 leave without treatment -- and it is small
5 print, I'm so sorry -- it looks like 3.94
6 percent; is that right? Do you see that?

7 **A:** Yes, 3.94.

8 **Q:** And what we just looked at for last year is
9 3.87. Is that relatively consistent? Is that
10 markedly higher in your view?

11 **A:** The 2016 it was 3.04 I believe.

12 **Q:** You're right, 3.04 to 3.94.

13 **A:** 94.

14 **Q:** Right?

15 **A:** So up by almost a percentage.

16 **Q:** Okay. And then looking at the average length
17 of stay for discharges. So the period of time
18 that your patient, from the time they come into
19 your ED and the time they discharge to the
20 street -- so they're not waiting for a bed,
21 they've come in, treated, they go home -- that
22 is actually steady, would you agree with me, in
23 2017? It's at 3.91 hours.

24 **A:** Yes, for the average.

25 **Q:** For the average, as compared to 3.87 in 2016?



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1 A: Yes.

2 Q: And the volume difference is, just so we can
3 have it in the record, 49,825 in 2016, 50,292
4 in 2017; is that right?

5 A: Yes.

6 Q: What was your volume at your ED in 2018?

7 A: 2018, the total volume was very similar. Off
8 the top of my head we were right under 50,000
9 in the main adult ED. We were just under
10 12,000 at the Chest Pain Center.

11 Q: So, you had an increase then in the Chest Pain
12 Center population '17 to '18 it sounds like?

13 A: Yes. The Chest Pain Center volume over the
14 last probably 10 years or so tends to go up on
15 a yearly basis. Sometimes it's relatively
16 flat, but usually goes up. The volume at the
17 main adult ED has remained relatively flat.

18 Q: Okay. Has it been flat to declining?

19 A: This past year it was down a little bit from
20 the year prior.

21 Q: Now, you talked this morning -- or this
22 afternoon about -- I think you alluded to an
23 evaluation that had been done about using space
24 sort of refurbishing and redoing the emergency
25 department I think five years ago was your



1 testimony.

2 A: Yes. At one point in time I was shown
3 blueprints for revamping the adult emergency
4 department. And those blueprints, I believe it
5 was 2014.

6 Q: And I think you testified that it was more
7 expensive than constructing the FED?

8 A: That's correct.

9 Q: Take a look at -- take a look, if you would, at
10 Roper Exhibit 36. Are you there?

11 A: Yes.

12 Q: Even just judging by the time period that you
13 mentioned, this sounds like you might have been
14 looking at something related to this June 25,
15 2014 MUSC Adult Emergency Department Proposed
16 Plan Phasing and Budget Meeting. Is this
17 perhaps where the floor plans you saw came
18 from? Flip through the document. There's
19 floor plans at the back of it.

20 A: This looks familiar.

21 Q: Okay. And there's a few -- it appears there's
22 a couple of options that were being evaluated
23 with various phases and I think a few ways in
24 which those phases could be implemented. Do
25 you have any specific recollection of which



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1 ones were being considered or which ones
2 weren't?

3 A: I don't.

4 Q: Okay. Were you at this meeting?

5 A: No.

6 Q: What role would you have had, if any, in 2014
7 related to proposed updates or renovations to
8 the adult main ED?

9 A: None.

10 Q: None? And you came to the facility in 2012?

11 A: Yes.

12 Q: But these schematics are familiar to you?

13 A: Specifically the blueprints were, yes.

14 Q: Okay. But in terms of the budgets that are
15 four million dollars or five million dollars,
16 do you recall where you would have seen a
17 budget that was in excess of 11 to 13 million
18 dollars?

19 A: Specifically I had had conversations with Tom
20 Crawford who was the administrator for our
21 service line. This would have been probably
22 maybe three years ago. And he specifically
23 stated at the time that freestanding emergency
24 departments would be a lot cheaper. And that's
25 probably where that -- those figures may have



1 come from.

2 Q: Okay. Have you had any conversations with
3 senior leadership about pursuing any of those
4 floor plans that you were shown a few years
5 ago?

6 A: I have not had any specific conversations with
7 any of the senior leaders in regards to rolling
8 out any of these specific floor plans. I've
9 just been told previously that it's a budgetary
10 issue and too expensive.

11 Q: Okay. Take a look, if you would, at Roper's
12 Exhibit 46.

13 A: Okay.

14 Q: And let me ask you one other question on that
15 to follow up, when you were told it was too
16 expensive. Who is the decision maker that's
17 going to determine whether or not you would
18 pursue renovation of the main ED?

19 A: The person, the chief executive officer, Dr.
20 Cawley, would ultimately make that
21 recommendation.

22 Q: Okay. All right. Now, and I don't know that
23 you got into this on your Direct, but the -- we
24 talked at your deposition about the reporting
25 structure, so to speak, or how the hierarchy,



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1 sort of academic side as opposed to medical
2 side for your emergency department; is that
3 right?

4 A: Yes.

5 Q: And your emergency department falls within the
6 acute critical and trauma care. I thought it
7 was ICE, but this says ICCE.

8 A: We say ice, we just don't spell it right.

9 Q: I got you. Okay. So this document at Exhibit
10 46, Roper Exhibit 46, have you seen this
11 document before?

12 A: I believe -- vaguely recall this from my
13 deposition I believe.

14 Q: Okay.

15 A: I believe this was shown to me.

16 Q: In August of 2017 you were the medical director
17 for the adult main ED, right?

18 A: Yes.

19 Q: Would it be fair to say that you would have had
20 some involvement in an annual plan summary for
21 the service line that your department falls
22 under or ...

23 A: I -- that would have been -- the annual plan
24 summary would have been done by the chief of
25 the service line, or the ICCE chief, along with



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1 the administrator at the time. That was Tom
2 Crawford.

3 Q: Okay. And so when the sort of strategic plans
4 or initiatives are being evaluated for your
5 department, do you have input into those?

6 A: In terms of our department, yes. We do have
7 quarterly leadership meetings between the
8 emergency department and the ICCE.

9 Q: Okay. Take a look at the second page of
10 Exhibit 46.

11 A: Okay.

12 Q: The strategic priorities. Would you have any
13 input or participation in determining the
14 strategic initiatives for the emergency
15 department?

16 A: So in terms of the strategic initiatives, these
17 were service lines, so all of the acute
18 critical and trauma care ICCE strategies. The
19 only one related -- well, the two related to
20 emergency medicine were improve the operations
21 of the emergency department and improve patient
22 satisfaction.

23 Q: Okay. Would it be fair to say as the director
24 of the adult main ED you would have some role
25 in determining the strategic initiative for the



1 emergency department?

2 A: I'm not sure that they -- I know that that was
3 the hospital's goals, which they would have
4 given to me to work on.

5 Q: Okay.

6 A: I don't believe it was -- I don't believe I was
7 asked about the specific strategic initiatives.

8 Q: So, as the medical director for the adult main
9 ED, you wouldn't -- you weren't involved in
10 planning the strategic initiative, but you
11 would have been told what it was in order to
12 further it or help implement the initiative?

13 A: Yes.

14 Q: Is that fair?

15 A: That's fair.

16 Q: Okay. Take a look at the next page of the
17 document, then. Because the emergency
18 department specifically, again, identified FY18
19 Initiatives and Measures for Success.

20 A: Okay.

21 Q: In looking at this document, the emergency
22 department, that's listed as its own sort of
23 separate identifier; is that right?

24 A: Yes.

25 Q: And in August of 2017, the CON application that



1 we're here about today, that had been filed; is
2 that right or do you recall?

3 A: I don't recall exactly the date that it was
4 filed.

5 Q: Okay. And so the -- as I understood your
6 testimony, the purpose for the freestanding ED
7 was to alleviate capacity constraints in your
8 emergency department. Is that right?

9 A: Yes.

10 Q: Now that initiative, that plan, that's not
11 identified here in this FY18 Initiatives and
12 Measures for Success, is it?

13 A: It is not.

14 Q: It does discuss enhancing ED to IOP throughput;
15 is that right?

16 A: Yes.

17 Q: And to use non-medical terms, that's enhancing
18 the emergency department to Institute of
19 Psychiatry throughput; is that right?

20 A: Correct.

21 Q: So it's those patients we were talking about
22 that had the 30 plus hours of waiting or
23 boarding time trying to get an inpatient bed?

24 A: Yes.

25 Q: And so that was an important initiative that is



1 being evaluated as of this time period; is that
2 right?

3 A: Yes.

4 Q: And it also talks about increasing the CPC
5 volume; is that right?

6 A: That is listed there, yes.

7 Q: And actually I guess the first column addresses
8 what you do in the adult main because it -- one
9 of the initiatives is to increase MUSC capture
10 of trauma volume, right?

11 A: Yeah. That's listed in the first column.

12 Q: And trauma volume is what you would kind of --
13 that's what your department among the three,
14 you would have the most trauma volume?

15 A: We are where the trauma patients arrive. That
16 particular goal would have been for the trauma
17 medical director. The trauma team and the
18 trauma service does a lot of sort of PR. They
19 go to a lot of the smaller hospitals throughout
20 South Carolina to discuss our trauma system and
21 our trauma program to try and improve, you
22 know, transfer of trauma patients into our
23 system.

24 Q: But as a Level I trauma center, that is sort of
25 an area in which MUSC has a designation that no



1 one else in the area has; is that right?

2 A: Correct.

3 Q: So, the highest, most complicated, complex
4 trauma cases are going to come to your downtown
5 emergency department?

6 A: Yes.

7 **MS. HOLLINGSWORTH:** Your Honor, I would move to
8 admit Roper's 46.

9 **MR. DAYHUFF:** So, I object. I don't think a
10 foundation has been laid that this witness can
11 authenticate this or -- certainly he was asked
12 a lot of questions about it, but we never heard
13 that he was part of this meeting. He told
14 counsel that he didn't create these
15 initiatives. He may have been told to do
16 different things, but this isn't a document
17 that he can get into evidence.

18 **MS. HOLLINGSWORTH:** Your Honor, he's the medical
19 director for one of the service lines. He
20 established the foundation of what this would
21 be for. He testified that he would be
22 responsible for implementing the initiatives
23 for his department. I think it's completely
24 appropriate to come in through this witness.

25 **MR. DAYHUFF:** Has he seen this before the deposition



1 that she handed it to him? Is this something
2 he saw in his everyday work? I mean, those are
3 foundational questions. Were you at the
4 meeting? Did you get the initiative? Have you
5 seen this outside of this being handed to you
6 at your deposition? If that kind of foundation
7 is laid and he says yes to that, then I think
8 it's a different story. I don't think that can
9 come into evidence through this witness.

10 **THE COURT:** Do you want to ask further questions on
11 this if you can?

12 **MS. HOLLINGSWORTH:** I mean, I'm happy to, Your
13 Honor. I think this is -- reminding myself
14 here of who's keeping out what. This is a
15 document clearly relates to the subject matter.
16 This is an expert witness that has been
17 provided. I mean, that alone, I think, Your
18 Honor, would be a reason that this document
19 could come in. This document is addressing
20 quality improvement initiatives. It goes to
21 the merits of the justification for the
22 project. If this expert witness on emergency
23 service and the director of the adult main ED
24 can't be a foundation for the acute critical
25 and trauma care ICCE annual plan summary ---



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1 **THE COURT:** The problem that I see here is he has
2 limited actual knowledge about the document.

3 **MS. HOLLINGSWORTH:** But he -- yes, Your Honor. But
4 as to the emergency department, he testified to
5 all of those initiatives, that they would be
6 what he was required to do as part of his job.
7 He implemented these initiatives. I asked him
8 about every one and he explained every one of
9 them to me.

10 **THE COURT:** Yeah, but now you're wanting to admit
11 the document. He can't really authenticate the
12 document, is I think what the problem is.

13 **MS. HOLLINGSWORTH:** Okay, Your Honor. That's fine.
14 We've got other witnesses. I guess Mr. Cawley
15 will be a very long witness.

16 **THE COURT:** Okay.

17 **MS. HOLLINGSWORTH:** I can appreciate that.

18 **THE COURT:** The objection is sustained.

19 Q: Have you prepared, Dr. Hall, any sort of
20 problem statement or summary to your
21 supervisors that addresses these capacity
22 constraints that are the foundation of your
23 opinions on this FED project?

24 A: Summary statement for my superiors, no.

25 Q: So, have you prepared any sort of presentation



1 or analysis or report that describes the
2 capacity constraints and documents how the
3 freestanding emergency department will improve
4 those issues and that you've provided that to
5 your superiors to implement, have you done
6 anything like that?

7 A: No. That wasn't asked of me.

8 Q: Well, as the -- I understand it wasn't asked of
9 you for purposes of trial. I'm asking have you
10 done that in your role as medical director for
11 the adult ED for these past two plus years?

12 A: No. We've had multiple discussions about our
13 capacity constraints, our needing more space.
14 That was the discussions that I had with Tom
15 Crawford, our ICCE administrator at the time.
16 I made him aware of this on numerous occasions,
17 that, you know, our biggest constraint is we
18 need more space. And so -- but utilizing the
19 freestanding ED, that was developed as a plan
20 by, you know, senior leadership.

21 Q: Okay. You need more space. So how is it that
22 more space will help you deal with patients
23 waiting for an inpatient bed?

24 A: Well, right now patients waiting for an
25 inpatient bed take up the rooms that we



1 currently have. And so right now those
2 patients that need emergency care or arriving
3 wanting emergency care, those patients are
4 waiting in our waiting room and we don't have
5 the space to bring those patients back so we
6 can appropriately assess them. Previously we
7 have done things like putting patients in the
8 hallways. At times the emergency department
9 looks like a sardine can. That's not the type
10 of care that we want to provide at MUSC. And
11 so the overall issue is that we don't have
12 enough beds to get patients back, regardless of
13 whether or not that's patients boarding for a
14 medical bed, patients boarding for a
15 psychiatric bed, or patients getting extensive
16 work-ups for things like stroke. Our ability
17 to get patients back and put them in an
18 appropriate evaluation area is primarily our
19 issue.

20 Q: So if you add more patients coming downtown for
21 direct admission to inpatient bed from the FED,
22 you're actually bringing even more bodies in to
23 try to get to the inpatient beds; is that
24 right?

25 A: Well, I think the opposite actually. If those



1 patients that are currently coming down and
2 waiting to be seen in our emergency department
3 are seen in our FED and we are able to quickly
4 evaluate them, determine whether or not they
5 need to go downtown or not, we'll be able to
6 actually see more patients and not have to have
7 those patients wait.

8 Q: But you'd agree with me that to the extent that
9 there are more patients coming down, being fed
10 to the main ED from the freestanding ED, that
11 that can actually exacerbate the waiting time
12 for inpatient beds?

13 A: It's a possibility, yes.

14 Q: Let's take a look at Trident's Exhibit 53. Dr.
15 Hall, do you recall us talking about this
16 document at your deposition?

17 A: Yes.

18 Q: This document was produced to us in discovery
19 by MUSC, Bates number 4177. There's a formula
20 error in the document, but it has I think a
21 couple of pages. That's a summary page and
22 then maybe there's a couple of pages behind it
23 that explain it further. So this is what I was
24 trying to recall when we were talking earlier
25 about the Shawn Jenkins, that this has a



1 reference to 20 beds and then there's clinic
2 rooms, eight clinic rooms. What are those
3 clinic rooms for?

4 A: I don't know. I've been told that the new
5 pediatric ED will be 20 beds. I haven't been
6 told of clinic rooms, so I'm not sure what that
7 refers to.

8 Q: So you're not able to tell us with regard to
9 sort of the capacity for emergency services
10 that's going to be coming online at Shawn
11 Jenkins, what the clinic rooms are going to be
12 used for?

13 A: No. I'm not aware of that.

14 Q: And going back to the -- so these are the three
15 EDs, thought, that we've been talking about,
16 right?

17 A: Yes.

18 Q: And this document shows a change in the bed
19 capacity for the main ED over a period of time
20 going from 31 to 39 to 51; is that right?

21 A: Yes.

22 Q: And the Chest Pain Center, though, has always
23 had the ten treatment areas?

24 A: Yes.

25 Q: And the 12 has been the number at the peds ED



1 consistently; is that right?

2 A: Yes.

3 Q: And so the peds ED, that's actually going to
4 get a significant jump in capacity with the
5 opening of Shawn Jenkins, right?

6 A: Yes. Currently the pediatric ED, there are 12
7 rooms. There are four hallway spaces that we
8 routinely use on the pediatric side to take
9 care of patients. At times we'll also use --
10 we'll put a nurse practitioner down the hallway
11 in endoscopy to also see patients. So the new
12 pediatric ED will hopefully be large enough to
13 manage the current volume of patients coming
14 in.

15 Q: And in thinking through kind of what's going to
16 happen with these spaces, that is later this
17 year, I think you said October 2019?

18 A: Yeah. I don't recall the exact date, but I
19 believe the goal is to open it sometime in
20 October.

21 Q: And your testimony here this afternoon, which
22 I think might have been a little updated from
23 your deposition, but that the last you've
24 heard, that that space is going to be used to
25 address some of the mental health population;



1 is that right?

2 A: That's the last that I was told by senior
3 leadership.

4 Q: And that mental health population right now is
5 in the main ED currently, right?

6 A: Currently some of that population is in the
7 main ED. The goal of senior leadership was to
8 get rid of the E pod rooms of where we're
9 currently sort of boarding our pediatric mental
10 health patients. They did not build a
11 pediatric mental health space at the new Shawn
12 Jenkins and therefore they were looking at
13 using the current peds ED as that pediatric
14 mental health space.

15 Q: Taking all of the space for pediatric mental
16 health?

17 A: I don't specifically how many rooms.

18 Q: So to the best of your knowledge it's in some
19 manner to address the mental health population;
20 is that right?

21 A: That's correct.

22 Q: And it's the mental health population that's
23 coming into one of your EDs downtown; is that
24 fair?

25 A: Yes.



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1 **MS. HOLLINGSWORTH:** Your Honor, we would offer
2 Trident 53.

3 **MR. DAYHUFF:** No objection.

4 **THE COURT:** It's admitted.

5 **(Petitioner TMC's Exhibit Number 53 was admitted into**
6 **the record at this time.)**

7 Q: Let's talk a little bit about sort of the
8 utilization and capacity that was some of what
9 we talked about at your deposition. And
10 thinking through, I mean, in terms of the
11 volume of visits -- and we looked at some of
12 the scorecards -- approximately how many visits
13 per year do you see of the adult population at
14 adult main and CPC?

15 A: Between adult main and CPC we see approximately
16 60 to 62 thousand patients.

17 Q: Okay. And when you add the children's ED
18 volume, where do you end up?

19 A: Right around 85,000 patients.

20 Q: But that volume, do you agree with me, is sort
21 of segregated in terms of how your campus is
22 set up and how your departments are set up?

23 A: Yes.

24 Q: And with the opening of Shawn Jenkins, that
25 will even be more physically segregated?



1 A: Yes.

2 Q: And we talked a little bit about benchmarks
3 when we were exploring your thoughts on
4 emergency services. If you recall, we were
5 talking about patient acuity. Do you remember
6 that?

7 A: Yes.

8 Q: And in terms of the number, sort of this
9 utilization or benchmark that we've been
10 hearing of how many patients per treatment
11 space per year, sort of as a basis to do a
12 utilization calculation, you would agree with
13 me that your opinion that it was between 1,000
14 and 2,000 per year for a hospital-based ED?

15 A: Yes. That's -- depending on the type of ED,
16 that's usually the going numbers.

17 Q: Okay. And I think actually what you told me,
18 that 2,000 patients kind of per space per year
19 is what you would see in a community hospital
20 setting, right?

21 A: Usually. I believe the benchmark data for this
22 past year was -- their top-end number was
23 around 1,750. But, you know, round up to
24 2,000.

25 Q: You would agree with me, when we talked at your



1 deposition, that that was your impression or
2 your opinion, that it was about 2,000 patients
3 per space in a community hospital setting?

4 A: I believe that might have been related to the
5 community hospital I used to work at. We were
6 close to, I think, that, yes.

7 Q: Okay. And to that point, I think, if I looked
8 at those numbers correctly, you had told me
9 that that's Mercy Fairfield, right?

10 A: Uh-huh (affirmative response).

11 Q: And they were doing about 65,000 patients a
12 year?

13 A: Yes.

14 Q: And I believe you told me that they had 30
15 treatment spaces.

16 A: I believe it was 30.

17 Q: Okay. So that's ---

18 A: Thirty, 31.

19 Q: That's at 2200 patients per space in that
20 hospital, right?

21 A: Yes.

22 Q: And I think you described that hospital earlier
23 in your testimony as a moderately-sized
24 community hospital.

25 A: Yes.



1 Q: Does that sound right?

2 A: Uh-huh (affirmative response).

3 Q: Sixty-five thousand patients per year, I mean,
4 that's actually more than you see in your ED,
5 right?

6 A: The emergency department's fairly busy. The
7 number of actual inpatient beds in the
8 hospital, the ED was actually a lot busier than
9 you would usually see for a hospital with that
10 many inpatient beds.

11 Q: And sort of looking at the volume with which
12 they got folks in and out, I mean, did they
13 have good throughput with the visits that they
14 did have?

15 A: Yes, we did.

16 Q: Now, you talked a little bit about staffing and
17 your role with staffing of the emergency
18 department downtown. But you don't have a role
19 with nursing staffing, do you?

20 A: I do not.

21 Q: And so same with regard to sort of the
22 technicians that you use in the emergency
23 department, you have no role in staffing for
24 those positions, do you?

25 A: I do not.



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1 Q: And so you don't have an opinion -- or you're
2 not going to offer opinion about nursing
3 staffing and whether or not there are shortages
4 in the service area for nurses?

5 A: I'm not in charge of that, so I -- I have an
6 opinion, but I haven't offered it.

7 Q: And you're not involved with that at MUSC at
8 all, are you?

9 A: No. I see the ramifications of it and it's
10 discussed with me, but ...

11 Q: Okay. All right. So -- because I certainly --
12 in terms of the -- you have a counterpart that
13 handles the nursing side of your nursing
14 department, right?

15 A: Yes.

16 Q: Let's talk a little bit about the freestanding
17 ED and some of the assumptions about the
18 patient population. You agree with me that the
19 freestanding ED will have a fairly low volume
20 of pediatric patients, right?

21 A: I would assume so, yes.

22 Q: You would agree with me that, when we were
23 looking at the scorecard, the pediatric volume
24 at your ED was less than .2 percent, right?

25 A: I think the reasoning for that is on campus



1 there's a pediatric emergency department, so
2 there are a large number of pediatric patients
3 showing up to MUSC, but they are directed to
4 the pediatric emergency department when they
5 come downtown.

6 Q: And that large pediatric volume is because of
7 the specialized type of care that you have
8 available at MUSC, right?

9 A: Yes.

10 Q: Is there any other Level I pediatric emergency
11 department in the area?

12 A: No.

13 Q: That's not going to be a designation that the
14 Summerville FSED has, will it?

15 A: No.

16 Q: And I think you've told me it's not going to be
17 advertised as a pediatric emergency department
18 at all. Correct?

19 A: No. It will be advertised as a -- my
20 understanding it will be advertised as a MUSC
21 emergency department, I would assume at
22 Summerville, something along those lines.

23 Q: They haven't put you in charge of the naming
24 and the signage?

25 A: No. They told me specifically I wasn't allowed



1 to name anything.

2 Q: Well, now that we saw that opening slide, that
3 might make some sense.

4 A: That makes lots of sense.

5 Q: So looking at the patient mix for your -- the
6 MUSC's emergency departments, do you actually
7 have -- there's a high pediatric mix if you
8 combine all three of the emergency departments
9 downtown; is that right?

10 A: Yes.

11 Q: Much higher than probably any other hospital in
12 the area. Is that fair?

13 A: No. Many community hospitals will see about 20
14 percent pediatrics.

15 Q: And I'm not sure what year we were looking at,
16 but we were somewhere in the neighborhood of 28
17 percent or more that MUSC's experience was.

18 A: Yes.

19 Q: In looking at the -- let's look -- in terms of
20 the application that was provided to the
21 Department, you had a role in kind of the
22 development of that project; is that right?

23 A: I was asked at times for different documents
24 and some of the metrics and that type of thing.

25 Q: Okay. And as I understood your testimony, you



1 actually had some -- you were consulted with
2 regard to the floor plan or what you wanted to
3 see in it kind of before it went to the
4 Department in terms of what the facility would
5 look like, how it would be laid out. Is that
6 right?

7 A: Yes. The -- there was a architectural firm
8 that had come up with some floor plans and they
9 asked for some input. And we had given them
10 some -- you know, our opinion as to how things
11 looked and what things we'd need to change.

12 Q: And that was before it was submitted to the
13 Department, right, the consulting?

14 A: Yes.

15 Q: Okay. Let's look at Roper Exhibit 32. Is this
16 floor plan familiar to you, Dr. Hall?

17 A: Yeah. I believe this is one of the floor plans
18 proposed for the Nexton site.

19 Q: And the date of this is May 25th, 2017. It has
20 Equity, Davis Wince, and Health Facilities
21 Planning Partners in the legend. Looking at
22 the floor plan, as I understood the testimony
23 at your deposition, that you did assist with --
24 you were consulted on sort of the design and
25 architecture of the building, right?



1 A: Yes. The Strategic folks at MUSC would send us
2 the floor plans and ask for our input in terms
3 of how things were laid out and that type of
4 thing.

5 Q: Did you think that this proposal was a good
6 proposal to make for the freestanding emergency
7 department?

8 A: I think at the time I did not have any -- to my
9 recollection I didn't have any significant
10 changes. It's fairly standard layouts, nursing
11 and providers in the middle with rooms around
12 the outside.

13 **MS. HOLLINGSWORTH:** Your Honor, we would offer Roper
14 32 into evidence.

15 **MR. DAYHUFF:** That single page?

16 **MS. HOLLINGSWORTH:** Yes.

17 **MR. DAYHUFF:** No objection.

18 **THE COURT:** Okay. It's admitted.

19 **(Petitioner Roper's Exhibit Number 32 was admitted**
20 **into the record at this time.)**

21 Q: If we could look at Trident's 51. Dr. Hall,
22 you were actually a member of the Nexton FSED
23 workgroup, weren't you?

24 A: I was -- I don't know if I was officially part
25 of the workgroup. I was involved in some of



1 the conference calls related to the
2 freestanding ED when it related to things like
3 the floor plan and that type of thing.

4 Q: Okay. Take a look at the last page of this
5 document, it's the seventh page. You are
6 listed there, aren't you ---

7 A: Yes.

8 Q: --- on the MUSC Nexton FSED workgroup?

9 A: Yes.

10 Q: Do you recall participating in this
11 freestanding emergency department proposal in
12 May of 2017?

13 A: I believe I was able to tour the site. They
14 asked both Ms. Dawson, who is also part of this
15 workgroup, and I about what type of supplies
16 and equipment and that sort of thing that we
17 would need.

18 Q: And you participated in those things, right?

19 A: Yes.

20 Q: Did you continue to participate in that as sort
21 of the process went on, through the point of
22 filing the application and as the kind of
23 discussions continued in furtherance of the
24 project or did you just stop working on it?

25 A: The Strategic folks did the actual filing of



1 the CON. I didn't really have any input once
2 they had gotten the information that they
3 needed from us in terms of what our thoughts
4 were. And after they had submitted, you know,
5 there wasn't a whole lot of involvement as we
6 were waiting for the process to move forward.

7 **MS. HOLLINGSWORTH:** Your Honor, we'd offer Exhibit
8 51.

9 **MR. DAYHUFF:** Your Honor, I'm not sure that he
10 authenticated that documented or laid a
11 foundation for that document from the first
12 page and the last page. It's a draft. It's
13 from the Office of Strategic Planning. I think
14 she can use that to ask him questions about his
15 role and that's fine. Again, I don't think he
16 can submit it into evidence.

17 **MS. HOLLINGSWORTH:** Your Honor, he's identified in
18 the document. He described his role with the
19 proposal. He's an expert witness, offered by
20 MUSC to talk about emergency service and the
21 freestanding -- he's identified by name, Your
22 Honor. Absolutely, the document comes in.

23 **MR. DAYHUFF:** Did he receive the document? Has he
24 ever seen this document before? Does he know
25 if this is a draft or not? Was this circulated



1 to him? Not to mention the fact that it's a
2 draft. So that's -- the broad discovery
3 requests gets draft. So there may be a final
4 version of this. There may not be. But this
5 is -- she's asking for this to become evidence
6 in the case without laying the foundation here
7 with this witness.

8 **MS. HOLLINGSWORTH:** I have laid the foundation. The
9 witness has confirmed that he was on the
10 workgroup. He's identified here in the
11 document. This is addressing the exact --
12 everything about the project. All I'm trying
13 to do is move us along. The fact that it says
14 draft, I don't know why. I didn't get a
15 document that said final, so all I have is
16 what's provided in discovery. I think it comes
17 into evidence. It's relevant. The witness is
18 identified by name in the document. He's
19 described his role with the project. Don't
20 know why we wouldn't admit it and move on to
21 talk about the next topic.

22 **MR. THOMAS:** Your Honor, I'd also like to add
23 something if I could, representing Trident, is
24 that ---

25 **MR. DAYHUFF:** I don't think Trident can offer,



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1 during this examination, arguments in support
2 of admitting this into evidence. If Trident
3 wants to admit it into evidence later, I
4 suppose they could. But it's not proper to
5 have a second attorney arguing for the
6 admission of something during Roper's case.

7 **THE COURT:** I am going to go ahead -- I am going to
8 allow you to admit it.

9 **(Petitioner TMC's Exhibit Number 51 was admitted into**
10 **the record at this time.)**

11 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

12 **Q:** If we could take a look at Roper's 31. Dr.
13 Hall, this document produced by MUSC at Bates
14 label 2230, we've identified it as Roper
15 Exhibit 31, this length-of-stay analysis, is
16 this the type of information that you would be
17 reviewing regularly in your role as clinical
18 director of the ED downtown at MUSC?

19 **A:** Information like this, yes.

20 **Q:** Well, in fact, this is -- these are the exact
21 metrics that you spoke about at length in your
22 Direct; is it not?

23 **A:** Yeah. The metrics that I look at are on our ED
24 dashboard, which was the other documents that
25 you've previously showed. This particular



1 length-of-stay analysis, there were some parts
2 of our Tableau dashboard, that's our analytic
3 stuff, that never really worked right, so this
4 is not something that I necessarily gave a
5 whole lot of attention to.

6 Q: So is it your testimony that this document
7 produced by MUSC is inaccurate?

8 A: I don't know of the accuracy of it.

9 Q: We talked at length in your Direct and we've
10 talked about these metrics, door to ED bed,
11 right?

12 A: Yes.

13 Q: We talked about that. We talked about door-to-
14 provider time, right?

15 A: Yes.

16 Q: We talked about the boarding time?

17 A: Yes.

18 Q: And the total length of stay, right?

19 A: Yes.

20 Q: Aren't those actually four metrics that you've
21 talked about as being sort of important metrics
22 that you regularly monitor?

23 A: Yes.

24 Q: And so as I understood the document that was
25 produced by MUSC, this is just a graphical



1 charting of the metric that's just being
2 captured in numbers on your scorecard, right?

3 A: The -- it is a graphical analysis of this. I'm
4 not sure which emergency department this is
5 related to. The fact that the door to ED bed
6 time appears to be very short makes me believe
7 that this is not the adult emergency
8 department, but I don't know that for sure.

9 Q: Okay. So it sounds like we can't be certain
10 what data we received from MUSC in discovery
11 then?

12 MR. DAYHUFF: Object to the form. It's an improper
13 question. It's pounding the table.

14 MS. HOLLINGSWORTH: I really have the softest voice
15 in the room I think, Mr. Dayhuff. I'm trying
16 to understand the testimony. It's a document
17 produced by MUSC.

18 Q: So, as I understand then, Dr. Hall, you think
19 that this can't be your emergency department
20 because the metrics ---

21 A: Those metrics don't look -- the door-to-
22 provider time there in terms of median minutes
23 is probably reasonably accurate. I'm just --
24 the door-to-ED bed time throws me off because
25 that tends to be what takes the longest when



1 our patients get there. In terms of boarding
2 time, I'm not sure what that relates to. That
3 -- the boarding time for -- is that our regular
4 admitted to medicine patients excluding our IOP
5 patients? I'm not sure. That would be a
6 really low number if they included our
7 Institute of Psychiatry patients. So it's hard
8 to say for sure.

9 Q: Okay. So, we don't know who performed this
10 analysis at MUSC?

11 A: I believe it comes off of some of our Tableau
12 reports. But where the actual data files for
13 that that lead into this, I don't know.

14 Q: You don't know. I don't know. So we'll have
15 to move on from that one. All right. Let's
16 talk about the -- again, the application. And
17 I'll ask you specifically about the documents
18 in the DHEC record. So there's --

19 **MS. HOLLINGSWORTH:** Your Honor, I'd hazard to guess,
20 since this is the only joint exhibit we have,
21 that we could agree to admit the CON record
22 into evidence without an argument. But I'm
23 just not certain at this point.

24 **MR. THOMAS:** Trident consents to that exhibit, Your
25 Honor.



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1 **MR. DAYHUFF:** We do too. Ms. Biggers remains
2 silent, though.

3 **MS. HOLLINGSWORTH:** It's not that join.

4 **MS. BIGGERS:** We consent as well.

5 **(Joint Exhibit Number 1 was admitted into the record**
6 **at this time.)**

7 **Q:** So this is the DHEC record. We talked about
8 this document at your deposition.

9 **A:** Yes.

10 **Q:** And I think it's Joint Exhibit 1. Is that
11 right? So, Dr. Hall, take a look at page 87 of
12 the document of the DHEC record. This
13 document, again, from the record presented to
14 the Department, this is the pro forma for the
15 FSED project. And I think you told me actually
16 just a moment ago that you did have some input
17 or were consulted on things like supplies and
18 equipment. Is that right?

19 **A:** That's correct.

20 **Q:** Were you consulted in any other way with regard
21 to any of the assumptions that are in this
22 financial pro forma?

23 **A:** To my recollection, no. I do believe that they
24 asked how many physicians we would staff there.
25 And I'm sure that I gave them a number. It



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1 would be single coverage. You know, in terms
2 of coming up with staffing costs and personnel
3 and that sort of thing, though, I wasn't
4 consulting in terms of specific numbers.

5 Q: Okay. So in terms of the projections or the
6 assumptions used for the revenue volume and the
7 projection of 15,129 cases, did you have any
8 role or were you consulted in the development
9 of that number?

10 A: No.

11 Q: Are you offering any opinions about the
12 financial pro forma that was provided to the
13 Department with this application?

14 A: No.

15 Q: Do you know who prepared it?

16 A: I do not specifically.

17 Q: In looking at the -- page 89 of the DHEC
18 record, the Top CPT Codes by Volume and
19 Charges, fiscal year '16. Did you provide this
20 information to anyone for the application?

21 A: I do not believe so, no.

22 Q: Okay. And you were discussing with Mr. Dayhuff
23 sort of the difference between the acuity index
24 or the triage levels one through five, as
25 opposed to some of these billing levels. Do



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1 you recall that testimony?

2 A: Yes.

3 Q: And I think you actually testified that there
4 were five levels in each, but aren't there six
5 billing levels, one through six?

6 A: There are five specific E and M codes. And
7 then there are also procedural codes and
8 critical care codes.

9 Q: Okay.

10 A: So it's probably more than five.

11 Q: Okay. So in terms of -- and I think you said
12 this is -- so the trauma acuity index, that's
13 one through five with one being the most
14 severe, right?

15 A: Yeah. Yes. For any emergency patient.

16 Q: So, a level one visit from the triage, sort of
17 analysis, one is the most severe, most complex?

18 A: Yes.

19 Q: From the billing codes that we're talking
20 about, it's reversed; is that right?

21 A: Correct. Yes.

22 Q: So, if you will, explain to me these top 10 CPT
23 codes. How does that compare? So if we're
24 looking at level five, level four, level three,
25 level two emergency traits, how do those fall



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1 within what you were discussing with Mr.
2 Dayhuff and sort of the more complex to the
3 least complex?

4 A: So, the level fours and fives are your higher
5 level CPT codes. For our emergency department,
6 which is fairly consistent with most -- well,
7 many emergency departments, I won't say most,
8 but many emergency departments, our levels in
9 four and five are about probably 75 to 80
10 percent. And I think that's pretty consistent
11 with a lot of the emergency departments out
12 there. Level one tends to be -- you don't see
13 a whole lot of billing level ones. Even a
14 medication refill is usually billed out as a
15 level two.

16 Q: Okay. The triage levels -- and I think they're
17 called ESI ---

18 A: ESI level, yes.

19 Q: Those are the levels that you would be looking
20 at when you're evaluating sort of the acuity of
21 a patient population; is that fair?

22 A: Yes.

23 Q: You would not be looking at description by
24 billing codes, would you?

25 A: Billing codes don't necessarily accurately



1 reflect the patient that's coming in through
2 the door. How sick patients are when they show
3 up and how quickly you need to see them is
4 usually more reflected by your ESI level.

5 Q: Okay. So as I understood your deposition, you
6 weren't consulted at all when kind of building
7 the pro forma, the projections in terms of what
8 patient acuity you all expect at the
9 Summerville ED, were you?

10 A: I was not, no.

11 Q: Okay. And same with regard to -- we kind of
12 looked at -- there's various redirection
13 percentages. As I understood in your
14 deposition, you weren't consulted with regard
15 to -- I'm sorry, redirection percentages or
16 patient redirection for purposes of this
17 application, were you?

18 A: No.

19 Q: Do you think as the director of emergency
20 services at the main ED that you had useful
21 insight into the patient acuity that you think
22 would be out there in the Summerville FSED?

23 A: Unfortunately, you know, my experience
24 downtown, I would be -- I'd have obviously
25 experience with what we see downtown. To sort



1 of estimate what that's going to be in another
2 location was not necessarily my expertise.
3 That's why they utilized health planners that
4 would have a lot better information than I
5 would.

6 Q: Okay. Have you done any sort of analysis of
7 the utilization or capacity of the freestanding
8 EDs that are already up there in the northern
9 area, as you described it?

10 A: I have not.

11 Q: What about the freestanding EDs that are in
12 northern Berkeley County over in Moncks Corner,
13 have you done any analysis or evaluation of
14 their volume or capacity?

15 A: I have not.

16 Q: And you would agree with me though that sort of
17 the volume capacity for a freestanding ED like
18 the one MUSC's proposing in Summerville could
19 probably do greater than 2,000 patients per
20 treatment space per year?

21 A: That's possible, yes.

22 Q: And similarly would you expect that the
23 freestanding emergency departments in North
24 Charleston could do better than 2,000 patients
25 per space per year?



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1 A: I don't know what their volumes are like right
2 now, but I'm sure it's possible.

3 Q: And you in fact get transfers from some of
4 those freestanding EDs, don't you?

5 A: Yes.

6 Q: And in terms of those ESI codes that we were
7 talking about, as I understood your opinion
8 when we talked at your deposition, that most of
9 the patients that are going to show up at the
10 freestanding ED are the level threes and fours.
11 Is that right?

12 A: Yeah, three, four and fives.

13 Q: Okay. And let's talk a little bit about the
14 changes to the project. We talked a little bit
15 about it with Mr. Dayhuff. But we saw from
16 that document as of August 2017 that you were
17 on a workgroup, a planning workgroup, for the
18 Nexton FSED, right?

19 A: Yes.

20 Q: But you weren't consulted before the decision
21 was made to move the freestanding ED, were you?

22 A: I was not, no.

23 Q: And you weren't consulted about the changes to
24 the size of the freestanding ED, were you?

25 A: I was not.



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1 Q: So, your input into the Nexton freestanding ED
2 was solicited though, right?

3 A: In terms of the size and the location, that was
4 also - - I wasn't involved in those initial
5 decisions. It was after they had been made
6 that they asked me what I thought about the
7 location and the floor plan.

8 Q: Yes. The space planning for the Nexton
9 freestanding emergency department, right?

10 A: Yes.

11 Q: That's what you had him put into?

12 A: Yes.

13 Q: But you did not -- you were not consulted about
14 the changes to that plan that are represented
15 in what we talked about today, right?

16 A: No.

17 Q: And, in fact, as I understood your deposition,
18 you didn't even find out about any of the
19 changes until approximately April of this year,
20 2019?

21 A: Sounds about right.

22 Q: And it was because you were going to be getting
23 ready for a deposition in the case, right?

24 A: Yes.

25 Q: And at the time that you were, I think you told



1 me, brought up to speed on the project,
2 everything that we have talked about this
3 morning, the change in the size was already
4 done; is that right?

5 A: Yes.

6 Q: The decision had already been made where it was
7 going to go, right?

8 A: Yes.

9 Q: The decision had already been made about what
10 floor plan they were going to select or model,
11 for lack of a better word?

12 A: The decrease in size had been made. Yes.

13 Q: Okay. You were shown a document, weren't you,
14 that was a floor plan schematic for the 10,000
15 square foot space that was now being planned,
16 right?

17 A: Yes.

18 Q: And that all happened and you found out in
19 April of this year. Did you have any other
20 discussions about the changes after that time?

21 A: There were some discussions after the changes
22 had been made. There were some phone
23 conversations about why and that type of thing.

24 Q: Okay. And I think you described to me that the
25 project was going to be a little bit more lean



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1 and cost effective, right?

2 A: Yes.

3 Q: And we talked about -- and actually I think you
4 described it was going to be going to a site
5 location that had infrastructure?

6 A: Yes.

7 Q: Now, I heard this morning that they are going
8 to demolish the Applebee's. Is that your
9 understanding?

10 A: That's my understanding.

11 Q: So, what infrastructure are you referring to
12 that would have been kind of distinct about the
13 new location?

14 A: The location at Nexton is a complete build. It
15 was essentially a field with nothing there.
16 So, the current location that is planned is
17 basically removing a building that's already
18 there and replacing it with a new building, a
19 freestanding ED. There's, you know, parking
20 already there. There's parking lots. There's
21 roads already leading to and from it. There's
22 already that type of infrastructure that's
23 built for ease of access of patients getting to
24 that location.

25 Q: But the Nexton location was being developed as



1 part of a medical campus with Palmetto Primary
2 Care, right?

3 A: Yes.

4 Q: So it was actually designed to be kind of
5 located or co-located with a number of other
6 medical services in that kind of parcel, right?

7 A: That's my understanding.

8 Q: Is there still going to be a partnership with
9 Palmetto Primary Care for the North Main Street
10 location?

11 A: Not to my knowledge, no.

12 Q: You haven't been involved in any of those
13 discussions?

14 A: No.

15 Q: And so when you describe how the infrastructure
16 is there, but you'd agree with me that both of
17 them are going to require building a building,
18 right?

19 A: Correct.

20 Q: But for the current location, you're actually
21 going to have to demolish one first?

22 A: That's correct.

23 Q: And it's a much smaller space to set it down
24 on; isn't that right?

25 A: Yes. The floor plan or the footprint of the



1 building would be smaller.

2 Q: Okay. And so in terms of the -- even just the
3 supplies that you were asked about and the
4 equipment, in a freestanding ED that is now a
5 third of the size smaller, won't that impact
6 the supplies or the equipment that are going to
7 go into the space?

8 A: No. The supplies needed to care for the
9 essentially 12 beds that we had estimated
10 originally, it will be the same. But the
11 supplies needed in terms of monitors, IV poles,
12 you know, EKG machine, that type of thing, that
13 doesn't necessarily change much.

14 Q: But before, you had 12 full treatment rooms and
15 five CDU spaces, right?

16 A: That was the original foot plan, yes.

17 Q: And that entire CDU unit's gone, right?

18 A: Yes. The five beds for the CDU was removed
19 from the project.

20 Q: So, certainly all the equipment and supplies
21 related to the clinical decision unit is not
22 part of the project as it stands today, right?

23 A: Five stretchers and five rooms wouldn't be
24 needed, yes.

25 Q: And won't that impact staffing as well?



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1 A: The original staffing plan -- when we
2 originally talked about the plan, we were not
3 going to staff those initial five beds
4 immediately. Those are going to be utilized as
5 needed, depending on volume at the site. So I
6 don't believe the staffing is necessarily built
7 for all 17 beds. I believe it was built more
8 for 12 beds.

9 Q: Do you know that for sure?

10 A: That was the discussion that we've ha
11 previously, yes.

12 Q: And where is it addressed in the CON
13 application that you weren't going to staff the
14 CDU for a while?

15 A: I don't know.

16 Q: Okay. So in terms of the changes to the scope
17 of the project, you had no input into that and
18 you found out about it, what, several months
19 after the fact; is that right?

20 A: I don't know when the changes were necessarily
21 made. I was informed about it in the April
22 time frame.

23 Q: Okay. And so as far as bringing you up to
24 speed, they didn't kind of walk you back
25 through how that all came to be; they just said



1 here's what it looks like today?

2 A: It was a little more lengthy than that, yes.
3 But I was advised that they were making some
4 changes, what those changes were, what the
5 thought process was behind that. They didn't
6 take me through a full timeline of when those
7 changes had been made.

8 Q: Do you know if your counterparts in the CPC or
9 the children's ED were involved in the
10 decisions that changed the project?

11 A: I don't believe my counterpart at the CPC was
12 involved. In terms of the planning and when
13 they asked for specific opinions, usually they
14 originally went to Dr. Jauch. And then when
15 Dr. Jauch left, they asked me about those
16 things.

17 Q: Because you took Dr. Jauch's role, right?

18 A: Briefly, yes.

19 Q: Let's look at the document that's at Trident
20 56. It's the third page. Do you have it in
21 front of you on paper?

22 A: Which -- is that volume ...

23 Q: It's the Trident volume.

24 A: I've got it.

25 Q: You have it? Okay. It was 56, the third page.



1 And, Dr. Hall, we -- this is the -- sort of the
2 footprint of the schematic that we were talking
3 about, right?

4 A: Yes.

5 Q: This is the proposal that you were informed of
6 around April of 2019?

7 A: Yes.

8 Q: Okay. And is this the footprint that you
9 recall seeing?

10 A: Yes.

11 Q: And you saw this before your deposition, right?

12 A: Yes.

13 Q: Okay. And looking at this document, was it
14 your understanding that this is the layout and
15 the footprint that MUSC has decided to pursue
16 as of the updates that you're aware of?

17 A: Yes.

18 Q: If you -- I'm sorry for the terrible quality.
19 This is MUSC 4184. And it's a layout
20 footprint. If you look starting on the left
21 side of the page, there are five exam rooms
22 sort of on the -- looking on the document on
23 the left side. Do you see that?

24 A: Yes.

25 Q: And then there's two kind of larger treatment



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1 rooms there at the bottom. Do you see those?

2 A: Yes.

3 Q: And that's -- those seven spaces, those have
4 the outline of beds in them, right?

5 A: Yes.

6 Q: And I think sort of the schematic shows
7 probably a sink and some such?

8 A: Uh-huh, yes.

9 Q: And then we have over to the right side of the
10 page, five spaces that say urgent care. Do you
11 see those?

12 A: Yes.

13 Q: And at your deposition what you described to me
14 is that there were still going to be 12
15 treatment spaces, right?

16 A: Yes.

17 Q: But you described that seven of them were going
18 to be fully stocked.

19 A: Yes.

20 Q: But the other five spaces were something other
21 than fully stocked. And I think, as you
22 described it, they are fast-track-type rooms,
23 closer to triage.

24 A: Yes.

25 Q: Is that right?



1 A: Yes.

2 Q: So in terms of the 15,000 square foot plan that
3 you participated in the development of that had
4 12 treatment spaces and five CDU spaces, is it
5 your testimony that these two footprints and
6 layouts are functionally equivalent?

7 A: Functionally they would be equivalent. The 12
8 bays, I don't -- it's hard to tell from the
9 exact floor plan here. But the, you know, fast
10 track urgent care designated rooms that are
11 close to triage are not -- at least from
12 looking at this schematic, they're not
13 substantially smaller than the other five beds.
14 The primary use of, you know, fast-track beds
15 closer to triage would be to do those quick
16 procedural type things or the minor care type
17 things that you could turn patients around.
18 And that was the discussion that we had with
19 the original layout, which was creating a space
20 where we could see minor care patients quicker
21 up front and see, you know, the sicker patients
22 with higher acuity toward the back.

23 Q: Okay. And so you would agree with me that this
24 model, this footprint that is proposed
25 certainly anticipates that a fair, almost



1 nearly half of the treatment spaces are
2 intended for the lower, lowest acuity patients,
3 right?

4 A: Yeah. So five of the 12 beds would be, you
5 know, geared toward probably more for level
6 four and five patients.

7 Q: Uh-huh.

8 A: ESI level four and five, whereas the other
9 seven would be geared toward your level, you
10 know, three or higher acuity.

11 Q: Okay. So you would agree with me though that
12 the much larger 12 treatment space with five
13 CDU layout, the entirety of that footprint
14 would have been geared towards really any of
15 these acuities and not focus necessarily on
16 setting aside space for the lowest acuity
17 levels, right?

18 A: The discussions -- we hadn't gotten into how we
19 were going to operationalize all of the beds,
20 but the discussion was to have space closer to
21 triage to take care of those minor complaints.
22 And ultimately, when they cut the -- when they
23 cut the footprint down to this, that's
24 essentially what they had done, is place those
25 lower -- the beds that we can utilize for lower



1 acuity patients toward the front of the
2 facility toward triage.

3 Q: Okay. And have you done any evaluation of how
4 this impacts sort of your -- the assumptions
5 and the utilization projections and the change
6 from the much larger space with all fully
7 stocked rooms versus this lean footprint?

8 A: I have not.

9 Q: And just so I understand, because certainly you
10 heard us having a little bit of back and forth
11 about how this document may have changed, in
12 April of 2019 when you were advised of the
13 changes that had been made to the Nexton
14 freestanding ED, at that time what you were
15 told it was the hybrid combined urgent care
16 FSED model, right?

17 A: At the time I was told that they were still
18 looking at that model, yes.

19 Q: And certainly this footprint that you saw back
20 then is the model that has the urgent care
21 services within the freestanding space,
22 correct?

23 A: The way it's described in this particular
24 layout would suggest that, yes.

25 Q: What I'm asking is when you were advised in



1 April of 2019, brought up to speed I think you
2 said, were you not told in April of 2019 that
3 it was going to be urgent care and freestanding
4 emergency services in the space?

5 A: My understanding all along, even when that
6 model was discussed, was that patients coming
7 in would be coming into a freestanding ED.
8 There wouldn't be a separation of -- even with
9 the floor plan the way it looks, we wouldn't
10 separate out urgent care patients as different
11 from a freestanding ED patients.

12 Q: Okay. So, I'm just -- but I'm trying to
13 understand, because urgent care has a specific
14 meaning in your field.

15 A: Yes.

16 Q: Does it not?

17 A: It does.

18 Q: And this document has urgent care on these room
19 designations, correct?

20 A: It does.

21 Q: In April of 2019 when you were advised of the
22 changes to the project, it was with this
23 document and five spaces being dedicated to
24 urgent care, right?

25 A: Yes.



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1 Q: And as of your deposition, that had changed,
2 correct?

3 A: That's correct.

4 Q: And so at the time of your deposition as we've
5 talked about -- where is that? Sorry. Because
6 I don't want to -- I'd rather you have the
7 document in front of you instead of ...

8 A: Sure.

9 Q: Okay. It's Trident 76. We all got it at the
10 same time. It should be in the Trident
11 notebook at 76. Do you have that in front of
12 you?

13 A: Yes, I do.

14 Q: Okay. This actual document was discussed
15 earlier today. Is -- are you a recipient of
16 the email that's at the bottom of TMC Exhibit
17 76?

18 A: Yes.

19 Q: And is this an email to you from Patrick
20 Cawley?

21 A: Yes.

22 Q: And who is Patrick Cawley?

23 A: Dr. Cawley is the CEO for MUSC Health.

24 Q: Okay. And what is the subject of this email?

25 A: Freestanding ED - Summerville.



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1 Q: And what is the date of it?

2 A: The date was July 2nd.

3 **MS. HOLLINGSWORTH:** Okay. Your Honor, I would move
4 to admit this document into evidence.

5 **MR. DAYHUFF:** No objection.

6 **THE COURT:** It's admitted.

7 **(Petitioner TMC's Exhibit Number 76 was admitted into**
8 **the record at this time.)**

9 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

10 Q: Dr. Hall, timing-wise, when did you receive
11 this document?

12 A: Before my deposition.

13 Q: Okay. Was it maybe the day before your
14 deposition or two days before?

15 A: That sounds right. I think my deposition was
16 on the 3rd.

17 Q: July 3rd. And so this document, I think you
18 were describing it to us earlier, but in your
19 words what was the -- what did you take from
20 this document or why did you receive it?

21 A: I think I had had conversations as you
22 described. They brought me up to speed a few
23 months before. I had had some conversations
24 with Dr. Cawley since then. And at one point
25 there was confusion. My understanding all



1 along was that this proposed hybrid
2 freestanding ED/urgent care was really a
3 billing issue. Patients would arrive, we would
4 see and evaluate patients as we would any
5 emergency department patient. And on the back
6 end, to make it more patient-centric, we would
7 bill patients based on the level of service
8 that they received, not necessarily the
9 initially evaluation. And Dr. Cawley had
10 alluded to that previously in our
11 conversations, but had decided against trying
12 to do that because of some confusion that it
13 had over the thought of billing patients who
14 showed up at an ED for urgent care services as
15 opposed to ED services. And so, to clarify, he
16 sent me this email just making sure that we
17 were all on the same page, that we were moving
18 forward with a freestanding ED and we weren't
19 looking at this hybrid model at this time.

20 Q: Okay. I'm going to try to unpack that a little
21 bit, because I think what you testified is that
22 all along the plan was that the patients that
23 would come in, you would bill for urgent care
24 services if urgent care services were provided?

25 A: When we originally looked at the Nexton



1 freestanding ED, we were looking at a
2 freestanding ED. That project, at some point
3 in time Dr. Cawley liked the idea of this
4 hybrid model where you billed out services
5 based on what was provided. And when there
6 were changes made and I was brought up to speed
7 in April, that was one of the potential
8 changes, to do that billing aspect. And
9 subsequently because of the confusion over how
10 that would be done, regulatory issues, that
11 type of thing, that was taken off the table.

12 Q: Doesn't MUSC always bill for the services that
13 it provides?

14 A: Emergency department services are one billing
15 code. Urgent care services are a separate.
16 And urgent care services are a lot more
17 economical. The thought process that Dr.
18 Cawley had was we would bill based on the
19 service and this would be more patient centric
20 for our patients.

21 Q: Okay. And the model and the floor plan that
22 was then adopted was based on this idea that
23 there was going to be this urgent care
24 population that would be a focus of this
25 Summerville ED, right?



1 A: My understanding all along has been that, you
2 know, patients would come in -- from an
3 operational standpoint I wouldn't separate out
4 urgent care patients and freestanding ED
5 patients. We wouldn't register them
6 differently. We wouldn't necessarily put them
7 in a separate room or treat them any
8 differently. They would all be treated the
9 same. It was just a billing issue on the back
10 end as to how the patient would be billed. So
11 whether or not they were treated in one of
12 those rooms labeled urgent care or if they were
13 treated in one of the other rooms, it wouldn't
14 make a difference.

15 Q: So his email to you the night before your
16 deposition -- I mean, why did he send you this
17 email the night before your deposition?

18 A: Again, he was sending this to make sure we were
19 all on the same page. It was the day before.
20 To make sure that he had clarified his position
21 that we weren't moving forward or trying that
22 hybrid billing model.

23 Q: Did you have discussions with him at all about
24 what information he got provided in discovery
25 or to The Court about the changed model?



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1 A: In terms of what he provided, no.

2 Q: Were you involved in any of these discussions
3 that stemmed from the Department's confusion
4 over the urgent care model?

5 A: I was involved in a discussion and I don't
6 recall the date. But when it was a call
7 related to, you know, this whole billing
8 practice, urgent care versus freestanding ED, I
9 was involved in a call with the strategy folks
10 when I tried to clarify that this was a billing
11 issue, it had nothing to do with how we would
12 see and evaluate patients when they showed up
13 at our freestanding ED.

14 Q: Okay. So you were on a call. So were you on
15 a call with DHEC representatives?

16 A: I don't recall who was actually on the call.
17 I just remember it was a call with Sarah Bacik
18 who was with Strategy.

19 Q: Who else was on the phone that you do recall?

20 A: Dr. Cawley could not make it. Sarah was on the
21 call. I don't recall if Travis -- Travis might
22 have been on the call. I can't remember who
23 else.

24 Q: Was your health planner, Mr. Levitt, on the
25 call? Do you know?



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1 A: I don't recall.

2 Q: And you don't recall if there was anyone from
3 the Department on the phone?

4 A: I don't recall.

5 Q: So how is it that you came to be aware that the
6 confusion you were addressing was confusion on
7 the part of the Department?

8 A: When they set up the call, that's when -- I
9 called in. That's why they said we want to
10 address this issue. And that's at that point
11 when they said it's a billing issue, it's not
12 an operational issue for the ED.

13 Q: Okay. So you're saying billing issue, so is
14 that an issue that impacts the financial
15 projections and assumptions, but in your mind
16 not the triage or the treatment provided?

17 A: Yeah. From an operational standpoint I'm more
18 invested and interested in the operations of
19 evaluating and treating a patient. On the back
20 end how the patient gets billed out is not
21 something that I get involved with.

22 Q: So when you were first approached with the
23 model as it was presented to you in April 2019,
24 did you have any concerns that it expressly
25 provided for dedicated urgent care space? Is



1 that a concern that you raised with anyone?

2 A: No. Because from an operational standpoint, I
3 know how our emergency department works. From
4 a freestanding ED standpoint, patients could be
5 placed into beds as the beds were available.
6 We wouldn't have open beds and not place
7 patients there because we wanted to put them in
8 an urgent care bed. That wasn't something that
9 we were planning on operationalizing.

10 Q: And I guess the same goes for any of your
11 emergency departments, right? When you have a
12 treatment space and you have someone that needs
13 to be treated, you use the space, right?

14 A: You use the space. Yes.

15 Q: Okay. So to your knowledge, though, did you
16 participate in any discussions with DHEC over
17 the most recent change to the project to
18 eliminate the urgent care component?

19 A: I don't recall any discussions directly with
20 DHEC.

21 **MS. HOLLINGSWORTH:** Your Honor, if I can have just
22 one minute, I think I am just about done.

23 **THE COURT:** Okay.

24 **MS. HOLLINGSWORTH:** In -- one additional question.
25 I'm not going to try to traipse back out of



1 this thing. I'll just stand here if it's all
2 right with you.

3 Q: Comparing -- so a CDU, a clinical decision
4 unit, would it be fair to say that that sort of
5 an evaluation or a place where you have the
6 patient go sort of at the end of the
7 freestanding encounter and maybe that's where
8 they're waiting to determine, well, can you go
9 home or do you have to be admitted somewhere?

10 A: Yes.

11 Q: Would that be fair?

12 A: Observation space. Yes.

13 Q: Okay. And so that was the five spaces that
14 were in the original proposal, right?

15 A: Yes.

16 Q: But those spaces have been eliminated in the
17 current proposal, right?

18 A: Yes.

19 Q: Now, kind of the fast track, as it's now being
20 called, when is that evaluation done? Is that
21 on the front end that your saying, okay, you're
22 good. You go into the rooms without the sink
23 in the chair. No, you need to go over to the
24 rooms with the bed and fully stocked.

25 A: So, as patients are triaged they're -- for the



1 minor care complaints, for those complaints
2 that don't require the patient to lay on a
3 stretcher, to get IVs and that sort of thing,
4 those patients preferentially get kept toward
5 the front. And so that would be part of the
6 triage process. So, if a patient shows up and
7 says I'm here because I have a toothache, okay,
8 we'll get you right into this room here.
9 Versus if somebody came in complaining of chest
10 pain, we'd want to get them more toward the
11 back to one of the stretcher beds.

12 Q: Okay. And in this instance it's the left
13 versus the right, right?

14 A: Yeah.

15 Q: Kind of front of the house, back of the house,
16 but the same concept?

17 A: Front and back, yep.

18 Q: Okay. But certainly in the current model
19 there's a differentiation of space in that way.
20 There's five spaces that are sort of designed
21 and intended to be for that lower acuity I
22 guess toothache, it would be an expensive
23 toothache visit, and then the -- that space
24 with the beds and the treatments that needs to
25 be the potential chest pain ...



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1 A: In that particular -- I mean the floor plan
2 only -- I mean it only really shows the room
3 and the -- sort of the size of the space. How
4 we staff or how we equip that room, I don't
5 know that that's necessarily been determined,
6 whether or not we put recliners in those spaces
7 or chairs or stretchers or what we do.

8 Q: So you don't have an equipment list or anything
9 like that for the floor plan that we've just
10 looked at?

11 A: The equipment list I don't believe has changed
12 from what it was originally.

13 Q: The equipment for the 15,000 square foot space,
14 it's the same as for the ---

15 A: The majority of that equipment is going to be
16 the same.

17 Q: Thank you so much for your time. I appreciate
18 it.

19 A: Thank you.

20 **DR. HALL - CROSS-EXAMINATION BY MR. THOMAS:**

21 Q: Dr. Hall, my name's Will Thomas. We haven't
22 met. How are you?

23 A: I'm good, sir.

24 Q: I'm going to try not to plow over ground you've
25 already gone through, okay? And some of the



1 questions I ask are a little bit different,
2 but, again, not trying to plow that new ground.
3 But you haven't done any review or any study of
4 freestanding EDs from an academic perspective,
5 have you?

6 A: No.

7 Q: Okay. And in terms of specific numbers, you
8 weren't consulted in any way in this case -- or
9 this project in developing the utilization
10 projections for MUHA freestanding ED, were you?

11 A: No.

12 Q: And based on your recall I believe at your
13 deposition, you didn't review any parts of the
14 Certificate of Need application for the MUHA
15 freestanding ED before it was filed, right?

16 A: I didn't. I provided, I believe, the
17 information that was utilized to build it, but
18 I didn't review it before it was submitted.

19 Q: Okay. Good. And as far as peer review
20 journals and Mr. Dayhuff asked you about some
21 of your publications, you haven't published
22 anything related to a freestanding ED, have
23 you?

24 A: No.

25 Q: Okay. And no presentations or posters or



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1 anything like that about freestanding EDs
2 either?

3 A: No.

4 Q: Okay. And I know -- you've admitted that
5 you've never pulled a single shift in a
6 freestanding ED, but have you ever actually
7 been inside a freestanding ED?

8 A: Many times.

9 Q: Okay. Just not occasion to work there, right?

10 A: Technically I was working. I was transporting
11 patients.

12 Q: Transport. Got you. Now, you were the medical
13 director of, I guess, Mercy Fairfield, right?

14 A: Yes.

15 Q: Prior to coming to MUSC, correct?

16 A: Yes.

17 Q: Okay. And just so that Judge Robinson
18 understands this. Mercy Fairfield is located
19 in the suburb of Cincinnati, right?

20 A: That's correct.

21 Q: Okay. So in kind of a fairly large MSA, also
22 known as metropolitan statistical area,
23 correct?

24 A: Yeah.

25 Q: And in terms of establishing -- or planning to



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1 establish a freestanding ED at Mercy Fairfield,
2 I believe you testified previously in your
3 deposition that that was in 2012 maybe?

4 A: Yes.

5 Q: And that's the year you actually left and came
6 to MUSC, right?

7 A: The planning for that probably stem from 2011
8 into 2012 as we were building.

9 Q: Okay. But your planning for that was limited
10 to kind of developing a staffing and clinical
11 protocol plan; is that correct?

12 A: And how we -- equipment and that type of thing.

13 Q: Got you. Equipment. And I believe you
14 testified that Mercy Fairfield had about 150 to
15 200 beds. Is that right?

16 A: I believe that's about right.

17 Q: It saw about 65,000 patients per year, right?

18 A: Yeah.

19 Q: Okay. And 30 ED bays, right?

20 A: Thirty or 32, but I want to say it was 30.

21 Q: Okay. That's fine. If my math's correct,
22 that's about 2,166 visits per ED bay. Is that
23 right?

24 A: Yes.

25 Q: Would you agree with me that a freestanding ED



1 that treats some level threes and a lot of
2 fours and fives would at least be able to
3 handle as many visits as a community hospital
4 like Fairfield, given the efficiencies of a
5 freestanding ED?

6 A: I imagine they would probably be close, yes.

7 Q: Okay. Now, I believe that in your deposition
8 you testified that one purpose of a
9 freestanding ED is to improve access for heart
10 patients, right?

11 A: Any of our complicated patients, yes.

12 Q: Okay. But do you recall that you specifically
13 referenced heart patients?

14 A: I could have, yes.

15 Q: Okay. And I guess the raison d'etre of why
16 we're all here is that MUHA has capacity
17 constraints downtown, correct?

18 A: Yes.

19 Q: And you've testified redesigning and renovating
20 space would be very expensive, right?

21 A: Yeah.

22 Q: Now, as far as you know, you didn't participate
23 in some of the earlier potential like, you
24 know, planning sessions for redesign and
25 renovation of that area?



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1 A: No, I did not.

2 Q: Okay. Now, in terms of MUHA's freestanding ED,
3 I think you said it's going to help take
4 pressure off of downtown campus in terms of
5 utilization, right?

6 A: Yes.

7 Q: That you're going to build 12 spaces and those
8 12 spaces will then hopefully capture some of
9 those people that would have gone downtown and
10 now you're going to have 12 spaces worth to
11 work with downtown at the campus, right, give
12 or take?

13 A: That's one way to look at it, yes.

14 Q: Now, would you agree with me that would
15 probably be the case wherever MUHA placed a
16 freestanding ED as long as it had a fairly
17 robust historical utilization in that area?
18 Does that make sense to you?

19 A: It makes sense.

20 Q: Okay. Now, can you tell The Court the last
21 time that MUHA spent any money to redesign or
22 do any kind of renovations, significant
23 renovations in the MUSC ED downtown?

24 A: The main emergency departments, the 12 beds
25 that we talked about previously for mental



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1 health, I believe that was somewhere in the
2 range of 1.2 to 1.5 million dollars. And that
3 was done in and around 2016.

4 Q: Okay. But actually when you did that, you
5 actually had the effect of, I believe, and your
6 testimony is, increasing your LWOT, correct?

7 A: Originally when the space was opened up, it did
8 improve our throughputs, but we still had
9 issues with our mental patients. Again, we
10 were stacking them in like sardines, which was
11 not appropriate. And that's when we -- the
12 hospital actually put in another probably half
13 a million dollars to upgrade those 12 beds to
14 make them psychiatric safe. And that's where
15 we -- when we started moving those patients
16 over.

17 Q: And we're talking about a half a million here
18 and 1.2 million there, but you would agree with
19 me that in terms of the overall operation of
20 the ED operation downtown, that's somewhat of
21 a band-aid with respect to the amount of money
22 you think would really need to be put into the
23 renovations and redesign to make it a patient-
24 friendly experience; is that a fair statement?

25 A: To renovate the whole space would be a lot more



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1 money.

2 Q: Okay. And besides those two kind of minor
3 renovations, there really hasn't been a
4 significant redesign or renovation in the MUHA
5 ED as long as you've been there, correct?

6 A: Since I've been there, no.

7 Q: So that would be about seven years?

8 A: Yes.

9 Q: All right. Now, this morning there was
10 reference -- I'm just going to ask you, because
11 I don't want to go through this whole kind of
12 authentication thing. But I referenced
13 something called the ED scorecard. And it was
14 looking at different locations in the Tri-
15 County area where MUSC might place a
16 freestanding ED. Were you involved in that at
17 all?

18 A: I recall one, I believe it might have been a
19 phone conference, where other locations were
20 discussed.

21 Q: Okay. And two of the three locations kind of
22 on the scorecard that the primary ones that
23 MUSC was looking at were Mt. Pleasant, correct?

24 A: Yes.

25 Q: All right. And then one of them was Goose



1 Creek, correct?

2 A: I believe so.

3 Q: Okay. Now, but MUSC decided not to go with Mt.
4 Pleasant, right?

5 A: I believe ---

6 **MR. DAYHUFF:** Your Honor, let me offer an objection.
7 So we certainly did produce some documents that
8 talked about other locations. We had a hearing
9 where we talked about other locations and not
10 using this case to inquire about decisions that
11 have been made about other locations. So I
12 think that was your ruling -- your discovery
13 ruling and I would ask that that continue here.

14 **MR. THOMAS:** Your Honor, I mean, I'm asking because
15 he's saying -- they're saying that the best
16 location for this freestanding ED is up in
17 Berkeley County. So they also looked at
18 various other locations. And one of the things
19 we're saying is the best location is not in a
20 county, in an area, that is littered with ED
21 bays; but one that may not have a lot of ED
22 bays, but a significant population. So, I
23 think this is very relevant. And as the person
24 who was involved to some degree, said he was on
25 the phone calls, he would have reason to know



1 this information.

2 **MR. DAYHUFF:** So I believe Dr. Hall knows something
3 about confidential proprietary decisions that
4 have been made about other locations. Now, to
5 the extent Mr. Thomas wants to inquire into Mt.
6 Pleasant is a good place to put an ED, he's got
7 a healthcare planner that can talk about that,
8 population, and everything else. All I'm
9 worried about is protecting decisions that
10 aren't public about whether or not we're going
11 in different places. That could have effect on
12 MUSC's ability to purchase land, that -- we're
13 in a public forum. Whether we've made
14 decisions to go to Mt. Pleasant or elsewhere,
15 that was what we talked about in you discovery
16 ruling with respect to Intuitive and we, in
17 fact, showed you redacted documentation about
18 other places that we've considered. So that
19 shouldn't be the scope of this examination.

20 **MR. THOMAS:** What I'm trying to get at, Your Honor,
21 is they have a document that says that -- in
22 fact, the location they picked isn't even on
23 the analysis. It's not even located on the
24 analysis. So I'm asking him about that. Why
25 is he putting it here and not in the six other



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1 places they think are much better? I think if
2 I can't answer that question, I can't put on a
3 solid case. And I'm sorry, MUSC -- they're the
4 ones who applied. And unfortunately, stuff
5 like this may come out in a forum like this.

6 **THE COURT:** Okay. But correct me if I'm wrong. Are
7 you -- you're directing that question to Dr.
8 Hall. Did Dr. Hall have any input into
9 deciding ---

10 **MR. THOMAS:** He just said he did.

11 **THE COURT:** --- where they ---

12 **MR. THOMAS:** Yeah. He said he was on phone
13 conversations about it.

14 **THE COURT:** About the location?

15 **MR. THOMAS:** Yes. I asked him about it
16 specifically.

17 **MR. DAYHUFF:** His testimony was the planning people
18 do location of these things. He was consulted
19 about operational issues, and equipment, and
20 supplies, and emergency medicine. He's not a
21 healthcare planner.

22 **MR. THOMAS:** Well, he certainly thinks that -- he
23 certainly offered an opinion about Summerville
24 being a great place to put one. He said that.
25 And why, because so many patients they treat in



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1 that area. Well, they treat a lot of patients
2 in Mt. Pleasant. They treat a lot of patients
3 in West Ashley.

4 **THE COURT:** Okay. I'm sustaining the objection.

5 **MR. THOMAS:** Now I'm going to ask for a proffer,
6 Your Honor. And we can do it under seal. And
7 I'd ask that the court be -- I guess folks that
8 would know that would be, I guess, Mr. Porter
9 and others that could use the information. But
10 I need to proffer this. We need to get this on
11 the record. And this part of the transcript
12 can go under seal.

13 **THE COURT:** I really wanted to get out of here this
14 afternoon, Mr. Thomas.

15 **MR. THOMAS:** I did too, Your Honor.

16 **THE COURT:** Okay. I'm going to allow him to
17 proffer.

18 **MR. THOMAS:** Who do you want out?

19 **MR. DAYHUFF:** Everybody. I guess the -- no, not
20 even the healthcare planner. I mean, this is
21 confidential. I don't know what he's going to
22 do. But he was asking about MUSC plans for
23 additional EDs in different places.

24 **MR. THOMAS:** I'm not -- I'm not asking ---

25 **MR. DAYHUFF:** I don't think a proffer should even be



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1 allowed, Your Honor. I feel comfortable that
2 that would hold up, if he wants to appeal that
3 issue.

4 **THE COURT:** I'm going to allow him to proffer.

5 **MR. DAYHUFF:** All right. Fair enough.

6 **MR. THOMAS:** And, Your Honor, just for your record,
7 so that, you know, you'll have something at
8 least for approving the proffer, one of the
9 applications, provisions of the applications,
10 B12, says discuss alternative facilities and/or
11 services considered, including the advantages
12 and disadvantages of each alternative. Include
13 a statement as to why this project alternative
14 was adopted. Well, we've got a scorecard,
15 which I'm about to put into evidence, that
16 discusses these alternatives. And what we
17 don't understand by looking at that is why was
18 something chosen that wasn't even on their list
19 two years ago. That is very relevant to us.
20 Why are they choosing this location -- as Ms.
21 Hollingsworth and I've talked about adverse
22 impact and market capture and that's what
23 they're going after, is that this isn't about
24 just treating the patients that they want to
25 treat, because their own analysis doesn't even



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1 reference the location. It's Mt. Pleasant,
2 Goose Creek, and Mt. Pleasant. That's what's
3 referenced. So all of a sudden, they apply for
4 a place that we never heard about before -- or,
5 excuse me, that is not on their own analysis.

6 **MR. DAYHUFF:** So, the question that drew all this
7 out was, has MUSC decided to go to Mt.
8 Pleasant. That reveals confidential
9 information. To the extent he wants to ask
10 this witness about, were you part of any
11 planning of alternatives. I suppose that's
12 okay. I mean, that wasn't his role, but we
13 could ask that. What I'm concerned about is
14 where is MUSC going to put the next FEDs.

15 **MR. THOMAS:** That's not the question.

16 **MR. DAYHUFF:** That was the question that brought us
17 here. Are you putting one in Mt. Pleasant?
18 That's my concern.

19 **THE COURT:** Okay. Proceed with the proffer.

20 **MR. THOMAS:** Okay. Here's the proffer.

21 Q: Were you involved in discussions about
22 alternative locations for freestanding EDs?

23 A: Yes.

24 Q: Okay. Now, Mt. Pleasant was listed on the
25 scorecard twice, correct?



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1 A: Yes.

2 Q: Okay. One in 29464 and a location in 29466,
3 correct?

4 A: Yes.

5 Q: Okay. And Goose Creek was also listed on
6 there; do you recall that?

7 A: I recall that earlier, yes.

8 Q: But the location in Summerville, where it's
9 going now, that was not listed on the
10 scorecard, was it?

11 A: The discussions I've had about locations for
12 freestanding EDs with MUSC Health, the first
13 discussion I've ever had was the Summerville
14 Nexton location. At that time there was no
15 other discussion about other locations.

16 Q: So were you involved in the scorecard analysis
17 or not?

18 A: I don't recall when that scorecard was done.

19 Q: Okay. Let me ask you this. When was the first
20 discussion you had, if you recall, Dr. Hall,
21 about the location for the freestanding ED
22 being at Nexton?

23 A: The first discussion that I had was probably
24 early 2016.

25 Q: Okay. So, you had a discussion in early 2016



1 about the Nexton location?

2 A: Yes.

3 Q: Okay. Look at your notebooks back here, sir.
4 Yeah. You've got Trident 51 through 100, but
5 look at that one. It's going to be 47. Have
6 you ever seen the Freestanding ED Analysis Tri-
7 County dated March 2016?

8 A: Prior to -- I don't know if this was brought
9 out during deposition, but prior to that I
10 don't recall seeing this.

11 Q: Okay. But you think you had a discussion about
12 the Nexton site in early 2016, correct?

13 A: Early 2016 was the first discussion that I had
14 had. The other discussions about alternative
15 sites were probably last summer.

16 Q: Okay. If you would turn over to page seven in
17 that document, 47-007. And this document is
18 dated March 2016. Is the Nexton site listed
19 among the market scorecard leaders?

20 A: It is not.

21 **MR. THOMAS:** And, Your Honor, that's the entirety
22 that I want to ask this particular witness
23 about this document. I don't know that I've
24 revealed anything proprietary.

25 **MR. DAYHUFF:** I don't think you have.



1 **MR. THOMAS:** Okay.

2 **MR. DAYHUFF:** So this is fine. It doesn't have to
3 be in proffer.

4 **MR. THOMAS:** It sounds like he's withdrawing his
5 objection.

6 **MR. DAYHUFF:** No, my objection to the prior question
7 about Mt. Pleasant stands. But that testimony
8 was not eliciting anything that was
9 confidential or proprietary, so it's fine.

10 Q: Okay. Are you aware of a freestanding ED in
11 the Mt. Pleasant market?

12 A: In the Mt. Pleasant market, no.

13 Q: And you seem to know -- you referenced earlier
14 in your testimony that about 25 percent of the
15 patients MUSC treats in its ED downtown come
16 from what we've kind of colloquially called the
17 north area, correct?

18 A: Yes.

19 Q: Do you know what that percentage is for West of
20 the Ashley?

21 A: I do not.

22 Q: Do you know what it is for James Island?

23 A: I do not.

24 Q: Do you know what it is for Mt. Pleasant?

25 A: I do not.



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1 Q: How is it that you just know what it is for the
2 north area? Is it because of this case?

3 A: Because of this case.

4 Q: Okay. Are you aware of any freestanding EDs in
5 the West Ashley area?

6 A: No, I'm not.

7 Q: And in fact, the only ED in the West Ashley
8 area is St. Francis.

9 A: St. Francis.

10 Q: Yeah, St. Francis Bon Secours, correct?

11 A: Yes.

12 Q: Okay.

13 **MR. THOMAS:** Several of these questions I'm going
14 through, Your Honor, because I've already asked
15 -- they've already been asked. I'm trying to
16 run through them quickly. Can you put up
17 Respondent's 46.

18 Q: And, Dr. Hall, can you go into -- I guess it's
19 going to be MUSC trial exhibits. Yeah, MUSC's
20 46. Are you there? If you go to the MUSC
21 documents, their exhibits go to 46.

22 A: You said 46?

23 Q: Yes. Let me see if I can help you out. Okay.
24 This is an exhibit that was prepared, we
25 believe, by MUSC, because it has a MUSC



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1 document number 6506 (sic). And the ED based
2 mentioned there is 67 and that comports with
3 your earlier testimony today, correct?

4 A: Yes.

5 Q: Okay. Capacity per bay, the capacity source is
6 17-ALJ-07-441-CC, Hall Deposition Transcript,
7 pages 111 to 112. We've got there 1250. Do
8 you agree or disagree with That capacity
9 number?

10 A: I believe that's probably appropriate. Our
11 capacity, specifically downtown on the
12 peninsula is on the lower end compared to
13 emergency departments across the country.
14 Emergency departments across the country
15 usually range between 1200 and 1700, something
16 along those lines.

17 Q: But are we good with 1250 in the MUSC slide
18 that was produced to us? Are you good with
19 that?

20 A: Yes.

21 Q: Okay. Now, if I multiply 1250 by 67 bays, I
22 get 83,750 ED visits. Do you have any reason
23 to doubt my math?

24 A: No.

25 Q: Okay. And I believe in fiscal year 2018 MUSC



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1 saw approximately 78,213 ED visits. Does that
2 sound about right to you?

3 A: When was that?

4 Q: In fiscal year 2018 we -- 78,213. That's per
5 R-46, so that's -- that's Respondent's 46.
6 That's right there, the number that we were
7 provided from MUSC. Does that look right to
8 you?

9 A: That appears to be a bit on the low side. We
10 -- between the Chest Pain Center and the main
11 emergency department we are at 60,000
12 patients. And with the pediatric ED, which the
13 number of bays here includes the pediatric ED,
14 that's another 23 to 25 thousand patients. So,
15 around 85,000.

16 Q: So do you dispute this document produced by
17 MUSC as being too low?

18 A: The numbers there for total ED visits appears
19 low.

20 Q: Okay. Have you checked this? I mean, have you
21 gone back and looked at fiscal year 2018
22 numbers and you tell us definitively today that
23 it's at 85,000?

24 A: The last time I looked and ran the numbers we
25 were at 24,000 on the pediatric side and 60,000



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1 on the adult side. So that would be around
2 84,000.

3 Q: Were those calendar year or fiscal year
4 numbers?

5 A: That would have been fiscal year.

6 Q: Okay. We will go with your numbers. So, MUHA
7 treats about 24,000 peds ED visits annually.
8 That's your testimony, right?

9 A: Yes.

10 Q: And you've got -- now, does that include the
11 mental health patients as well? You would
12 include those numbers?

13 A: Pediatric mental health patients, yes.

14 Q: Do you know what percentage that 24,000 peds
15 patients would be that are mental health?

16 A: Not off the top of my head.

17 Q: They could be less than 500?

18 A: The total number -- it would be more than 500
19 I believe.

20 Q: Less than 1,000?

21 A: On a monthly basis, probably about 100 a month
22 maybe. So ---

23 Q: So about 1200 ---

24 A: --- I would say maybe 1200.

25 Q: Fair enough. We'll use that. But those are ED



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1 visits, and those are patients that are in
2 those 16 rooms, right? Those 24,000 peds
3 patients are treated within the 12 rooms plus
4 the four kind of peds mental health rooms?

5 A: Yes.

6 Q: Is that fair? Okay. And if you take the 1200
7 out, because I think you said you were going to
8 segregate the peds mental health patients from
9 the new Shawn Jenkins Hospital, right? You
10 said you were going to keep maybe treating
11 those somewhere?

12 A: They would initially be evaluated in the
13 pediatric ED. But then they would be moved to
14 a different spot, specifically the old
15 pediatric ED for their mental health
16 evaluation.

17 Q: Okay. That's just 1200, right? You're going
18 to have 12 pods there -- or 12 ED bays, right?
19 So that's 24,000 patients that will not be
20 treated in that area anymore, correct?

21 A: Yes.

22 Q: Okay. And if you take 1200 from 24,000, I
23 guess that gives you 22,800. That's what's
24 being treated in those 12 rooms for peds, give
25 or take?



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1 A: Yes.

2 Q: And MUHA is getting the 20 new peds hospital ED
3 bays, correct?

4 A: Yes.

5 Q: All right. So, that's going to give you some
6 additional capacity for peds patients, right?

7 A: Yes.

8 Q: And it's your expectation that a significant
9 portion of the peds patients who travel
10 downtown today will continue to do that from
11 the north area, correct?

12 A: I imagine that they would.

13 Q: So, if you've got the 20 -- and I'm just trying
14 to sort of work this out in my head. That's
15 freeing up 12 bays in the main hospital.
16 You're adding 20 at a new location. And you've
17 got -- you're treating about 54,000 adults or
18 maybe 60,000 adults that are treated in the
19 main hospital and at the Ashley River Tower,
20 correct?

21 A: Correct.

22 Q: Okay. So those 60,000 or so adults will now
23 have -- they will have 67 rooms to be treated
24 within, correct? Have I got my math right
25 there?



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1 A: Well, that -- the 12 -- 12 of those rooms --
2 actually 16 of those rooms, again, currently
3 are being utilized for the pediatric ED and
4 mental health. Four of those rooms are being
5 taken offline because they're not felt to be
6 appropriate for emergency department patients.
7 The -- they're also quite separate from the
8 rest of the emergency department. And then the
9 12 beds that are currently there are planned
10 for mental health patients.

11 Q: Okay. But those mental patients are emergent
12 mental health patients, correct?

13 A: Correct.

14 Q: And those emergency mental health patients are
15 within that 54,000 or 60,000 adults who would
16 be treated, I guess not in 67 rooms, but in 63
17 rooms. Is that your testimony?

18 A: Yes.

19 Q: Okay.

20 A: Along with the pediatric patients.

21 Q: So you're going -- you're going to be mixing in
22 peds patients, peds mental health patients with
23 adult mental health patients in those 12 rooms?

24 A: Currently the plan that I heard was utilizing
25 the 12 beds for pediatric mental health



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1 patients. Exactly how they're going to
2 differentiate and separate out pediatric mental
3 health patients and the adult, how many of
4 those rooms we're going to use, I don't know
5 that that's been determined.

6 Q: So I want to get this straight. MUSC that's
7 here today telling this Court that it's had all
8 kinds of capacity constraints, LWOTs that are
9 off the charts, having trouble with boarding
10 hours, getting throughput through, that you're
11 going to use those 12 rooms for 1200 peds
12 mental health patients when you're building a
13 350 million dollar peds hospital right across
14 the street and you really need the ED space for
15 adults, you're going to use those for 1200 peds
16 patients. Is that what I'm hearing?

17 A: That's the latest option that I've heard, yes.

18 Q: Okay. Now, just so we've got the record
19 straight, there was something called a project
20 review meeting at DHEC. Are you familiar with
21 what that is, for a Certificate of Need
22 application?

23 A: I've been told in the deposition essentially
24 what that was.

25 Q: Okay. You didn't attend the one for the Nexton



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1 site, did you?

2 A: I did not.

3 Q: Okay. Were you aware that MUHA at the project
4 review meeting presented the Nexton as the
5 ideal site location for a freestanding ED?

6 A: That was the original site location.

7 Q: But were you aware of kind of how it was touted
8 and with the ancillary services and that type
9 of thing?

10 A: No, I was not.

11 Q: Okay. And I believe you testified that that
12 15,000 square foot freestanding ED at Nexton,
13 that size was something that the architects
14 told you was an optimal size for a freestanding
15 ED. Do you remember testifying to that?

16 A: Yes.

17 Q: But it's going to be 10,000 square feet now,
18 right?

19 A: Yes.

20 Q: Okay. And you don't expect to have a trauma
21 team at the MUHA freestanding ED, do you?

22 A: No.

23 Q: Okay.

24 A: Part of a trauma team, the emergency physician
25 components of it, but not trauma surgery.



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1 Q: Right. There won't be a trauma team, there
2 won't be trauma activation at that location,
3 will there?

4 A: No.

5 Q: Okay. And you would expect, Doctor, based on
6 your experience, that EMS is going to take
7 patients whom they believe experienced a trauma
8 event, let's say a vehicle extrusion of greater
9 than 20 inches, which normally would call for
10 trauma activation, right?

11 A: I don't know it that's one of our trauma
12 criteria.

13 Q: Are you a trauma physician?

14 A: I am.

15 Q: And you do not know that 20 inches is a
16 criteria to call for trauma activation?

17 A: It has been in the past. I'm not sure that
18 that's actually one of our criteria.

19 Q: What is?

20 A: Each trauma center actually comes up with their
21 own criteria.

22 Q: Let's scratch that. Gunshot wound. EMS, their
23 protocols are going to take a gunshot victim to
24 the closest trauma center that can help that
25 patient, correct?



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1 A: Correct.

2 Q: Okay. Same with an adult myocardial
3 infarction, correct?

4 A: Yes.

5 Q: Now, in terms of metrics, MUHA does not compare
6 well to national averages in terms of length of
7 stay and sepsis, correct?

8 A: Length of stay and sepsis?

9 Q: Yeah.

10 A: I am not aware of a length of stay metric with
11 sepsis.

12 Q: No, no. The length of stay metric and the
13 sepsis metric.

14 A: Oh. Separate, yes.

15 Q: Yeah. So, MUHA does not compare well with the
16 national average in terms of those two separate
17 metrics, correct?

18 A: Correct.

19 Q: Okay. And in terms of length of stay of an ED
20 patient who presents to and then are discharged
21 home the same day, would you agree with me that
22 that's a metric that can be improved over time?

23 A: Yes.

24 Q: And I know you've testified MUHA downtown ED,
25 it's very compartmentalized, correct?



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1 A: Yes.

2 Q: And it's fair to say you're frustrated with the
3 current ED physical plan downtown, aren't you?

4 A: I don't know if frustrated is the right word.
5 But it is challenging at times, yes.

6 Q: So you've never had frustration about the
7 physical plan downtown?

8 A: I've had a lot of frustrations at work, as most
9 people have.

10 Q: How about with physical plan?

11 A: I believe the physical plan could be improved,
12 yes.

13 Q: Dr. Hall, I'm going to open -- opening up your
14 sealed deposition. Got some exhibits in here.
15 Hand that to you. I'd like you to turn to page
16 161 of your deposition. Tell me when you get
17 there.

18 A: One sixty one?

19 Q: Yes.

20 A: I've got a 151 and a 165.

21 Q: Okay. There may be another section in here.
22 Let's hope there is. Yeah, it's not in here.
23 Let me see this. Give me a second. It felt a
24 little slim.

25 A: Yes, a little light.



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1 Q: How about that. Let me make sure it's not
2 otherwise in there.

3 **MR. THOMAS:** Sorry, Your Honor. For some reason in
4 our sealed deposition packet -- this one feels
5 heavier. Let me try this one. Let see if this
6 will work. Success.

7 Q: There you go, sir.

8 A: Thank you.

9 Q: All right. Mr. Summer, I believe, maybe was
10 taking your deposition at this time frame, but
11 he asked you some questions about why Dr. Jauch
12 left; do you recall that?

13 A: Yes.

14 Q: Now, he asked you, I believe -- if you look
15 down at line 13, I'll do the question and then
16 -- the question is, did he indicate to you any
17 dissatisfaction that he had with the
18 administration here before he left? What did
19 you say?

20 A: I said we all have. We all -- we all have some
21 dissatisfaction. There were times when he was
22 frustrated with administration here, as I have
23 been. But, you know, we didn't talk at length
24 about specifics.

25 Q: And then the question was asked, what were



1 those primary frustrations? What was your
2 answer?

3 A: Most of our primary frustrations are our
4 current physical plants in terms of the
5 emergency department.

6 Q: Go on, just finish out that.

7 A: Sure. And the, you know, pressure is to
8 provide better care for our patients. We sort
9 of have a physical plant that makes it very
10 challenging to meet all the expectations of our
11 patients.

12 Q: Okay. So you've had some -- you yourself have
13 had frustrations with the physical plant,
14 correct?

15 A: Yes.

16 Q: And you would agree with me that in your
17 opinion, the MUHA emergency department was
18 never really thought through in terms of a
19 dedicated ED; it doesn't flow well, which makes
20 it difficult for you and your staff to take
21 care of patients, right?

22 A: Yes.

23 Q: And it makes it difficult for you to meet your
24 patients expectations and deliver a good
25 experience for them, correct?



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1 A: Yes.

2 Q: And you would agree with me that the ED is the
3 front door of a hospital, isn't it?

4 A: Yes.

5 Q: And I can say this because I have a red-headed
6 child, but you would agree with me that there
7 are times when the MUHA ED feels kind of like
8 the red-headed step-child of the University
9 Medical Complex, doesn't it?

10 A: I'm not sure that we've described it exactly
11 like that, but it would be nice to have a
12 brand-spanking new emergency department. That
13 just hasn't been fiscally possible at this
14 point.

15 Q: It hasn't been fiscally possible, right?

16 A: (Nods head affirmatively).

17 Q: Are you aware that MUHA has recently spent 137
18 million dollars on rural hospitals throughout
19 the state of South Carolina?

20 A: Yes.

21 Q: Are you aware that they are proposing to spend
22 20 million dollars in Beaufort County on a
23 micro hospital?

24 A: Yes.

25 Q: Are you aware that they have proposed to spend



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1 350 million dollars on a hospital in Berkeley
2 County?

3 A: Yes.

4 Q: But the ED downtown, they spent about a million
5 seven in the last five, six years?

6 A: Something along those lines, yeah.

7 Q: You would agree that the downtown ED needs to
8 be redesigned and renovated to improve the
9 patient experience and their expectations,
10 wouldn't you?

11 A: I believe that's one option, yes.

12 Q: Is it fair to say that at the time of your
13 deposition you weren't very familiar with kind
14 of the services offered at Trident Medical
15 Center?

16 A: I have not been to Trident Medical Center, so
17 that's a fair statement.

18 Q: Okay. Was it fair to say that you didn't
19 realize that Trident has a comprehensive cath
20 lab, fully staffed to handle STEMI patients at
21 any time of day?

22 A: I am aware of that, yes.

23 Q: You're aware of that now?

24 A: I was then as well.

25 Q: You were then?



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1 A: Uh-huh (affirmative response).

2 Q: Then why, when you were asked about a patient
3 who's having an acute, you know, myocardial
4 infarction, about getting them to the closest
5 cath location, did you say, well, it depends on
6 if that's a fully-staffed cath lab?

7 A: I'm aware that they provide cath services. In
8 terms of my response to that question during my
9 deposition, I'm aware that they provide that
10 service. Ultimately, it's a discussion that
11 you have with a patient in terms of where they
12 want to go.

13 Q: But sometimes you can't have that discussion
14 with the patient, correct, because they're
15 literally dying on the table?

16 A: Well, regardless if the patient's awake, you
17 have to have that discussion. I can't send a
18 patient for a cardiac cath who's awake and
19 talking to me without their consent. And they
20 have to consent to where they go.

21 Q: And do you explain that the longer they wait to
22 have their cardiac event handled, they could be
23 losing tissue?

24 A: You have the discussion that you need to get
25 them taken care of as soon as possible. You



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1 have that discussion with the patient, yes.

2 Q: And you would agree with me time -- there's a
3 saying in terms of cardiology, time is tissue
4 when it comes to a heart attack, isn't it?

5 A: Yes.

6 Q: And you would agree with me that, if you're
7 going to run -- if MUSC's going to have a
8 freestanding ED, it's important to really know
9 what the closest resources are for the patients
10 in the area?

11 A: Sure.

12 Q: Now, have you or anybody else from MUHA
13 approached Trident or Summerville about
14 transfer agreement for patients who arrive at
15 the MUHA freestanding ED and need transport to
16 either Summerville or Trident, which is a Joint
17 Commission Certified Stroke Center?

18 A: No, we have not.

19 Q: Okay. Now, do you have any idea about how many
20 ED bays are going to be opening up at Roper
21 Berkeley just a few miles away from MUSC's
22 freestanding ED?

23 A: It was, I believe, in our -- in y'all's opening
24 statement earlier today you mentioned, what, 10
25 beds.



1 Q: Fifteen, maybe?

2 A: Fifteen.

3 Q: But at the time of your deposition did you know
4 that?

5 A: No, I didn't.

6 Q: Did you know that Trident has 46 ED treatment
7 areas?

8 A: I wasn't sure of the ---

9 **MR. DAYHUFF:** Your Honor, I'm going to offer an
10 objection. This witness hasn't been offered on
11 anything with respect to capacity of Roper or
12 these other places. That's a health planning
13 question. We offered him on emergency medicine
14 opinions, on how this facility would be better
15 for patients, and how it would be better for
16 the ED system particularly as adult ED.

17 **MR. THOMAS:** That's fair, Your Honor. I'll move on.

18 **THE COURT:** Okay.

19 Q: Do you recall who told you the ED would cost 30
20 million dollars to renovate downtown?

21 A: The discussions I've had about cost were, I
22 believe, with Tom Crawford, who was the
23 administrator for the ACTIs at the time.

24 Q: And have you reviewed Summerville Medical
25 Center's CON application for a freestanding ED



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1 in this case?

2 A: No.

3 Q: You haven't? So is it fair to say that at this
4 point you can't compare the two in terms of
5 what MUSC is doing and what Trident's going to
6 be doing with the freestanding ED -- at their
7 freestanding ED off of exit 199?

8 A: I cannot make any judgements.

9 Q: Now, I believe you said in your Direct Exam
10 that the practice of ED medicine is the same no
11 matter which type of ED you practice in. Is
12 that fair? Do you still believe that?

13 A: Your evaluation and treatment of the patient in
14 front of you is the same, yes.

15 Q: Okay. Based on this 25 percent, I know that
16 Mr. Dayhuff said you weren't a health planner,
17 but you have testified that it's within your
18 knowledge the 25 percent -- that MUSC treats 25
19 percent of their ED patients from the north
20 area, correct?

21 A: Yes.

22 Q: How many of those are mental health patients?

23 A: The specific number I don't know.

24 Q: Okay. How many of those come to MUSC by EMS?

25 A: Off the top of my head I don't know.



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1 Q: How many of those come to MUSC in a police car?

2 A: Again, I don't know. I don't have that data.

3 Q: A lot of psych patients arrive by the police,
4 don't they?

5 A: Most of the psychiatric patients that arrive
6 come by EMS.

7 Q: Okay. Do you know how many of those 25 percent
8 are referred down to MUSC's ED by their primary
9 care physician or another physician?

10 A: Off the top of my head I don't know.

11 Q: And do you know how many of those people arrive
12 in a vehicle that is driven by either
13 themselves or their family members?

14 A: Off the top of my head I don't know.

15 Q: Okay.

16 **MR. THOMAS:** I'm finishing up, Your Honor. I
17 promise. On the home stretch.

18 Q: You mentioned something on your direct with Mr.
19 Dayhuff. You stated that the ED physicians at
20 MUSC are very -- they're up to date on the
21 latest treatments for emergency medicine,
22 correct?

23 A: Yes.

24 Q: And they teach these methods to residents and
25 medical students, correct?



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1 A: Yes.

2 Q: Do you have any evidence at all that says that
3 the ED physicians at Trident, Summerville,
4 Center Pointe, Moncks Corner Medical Center,
5 the ones that are at Roper's Moncks Corner
6 facility or their northwest facility aren't on
7 the top of their game with respect to emergency
8 medicine treatment?

9 A: I don't.

10 Q: Okay. You haven't worked with the local fire
11 department to develop a landing zone area
12 around the freestanding ED location in
13 Summerville, have you?

14 A: Personally I have not, no.

15 Q: Do you know anybody who has for MUHA?

16 A: I believe somebody from senior leadership, that
17 might have been Tom Crawford as well, said that
18 that was something that they would -- you know,
19 once we were able to move forward with the
20 project, that would be on the list of things to
21 discuss. But I don't believe that's been a
22 discussion as of yet.

23 Q: As of today there's been no approval or no
24 plans for where a landing zone for a helicopter
25 could be around that freestanding ED; is that



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1 a fair statement?

2 A: As of right now, no.

3 Q: Okay. And did you review the CON application
4 for MUHA's project for your testimony today or
5 for your deposition?

6 A: No. It was shown to me during deposition.

7 Q: Okay. So, prior to that you hadn't reviewed it
8 and you still haven't reviewed it, right?

9 A: Correct.

10 MR. THOMAS: That's all I've got, Your Honor.

11 THE COURT: Okay.

12 MR. DAYHUFF: Your Honor, briefly, if I may. I'm
13 sure briefly is key at this point.

14 THE COURT: It is.

15 MR. DAYHUFF: Well, I will be brief.

16 DR. HALL - RE-DIRECT EXAMINATION BY MR. DAYHUFF:

17 Q: So with Ms. Hollingsworth you went through data
18 regarding the year 2016. Do you recall that?

19 A: Yes.

20 Q: You went through data on door-to-discharge
21 times and left-without-treatment times. Do you
22 recall that?

23 A: Yes.

24 Q: Since 2016, in the adult ED, what has happened
25 to that metric, those two metrics?



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1 A: They've gotten worse.

2 Q: Gotten worse. All right. Is the adult ED
3 capacity constrained in your opinion?

4 A: Yes.

5 Q: Would additional capacity in a freestanding ED
6 assist with those capacity constraints that
7 you're experiencing in the adult ED?

8 A: Yes.

9 Q: All right. You have discussed, I think -- but
10 let me make this clear. You haven't issued
11 formal reports to someone about the capacity
12 constraints and about the FED alleviating those
13 constraints. Had you had meetings about that
14 issue?

15 A: We've had meetings about our throughput issues,
16 our length-of-stay issues. We have meetings
17 with leadership all the time.

18 Q: All right. And I think you might have even
19 mentioned Tom Crawford with respect to those
20 meetings?

21 A: Yes.

22 Q: All right. No memos but lots of discussion,
23 lots of interaction about those issues?

24 A: Yes.

25 Q: And that's kind of how MUSC operates, lots of



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1 meetings, based on my experience; is that
2 true?

3 A: That is correct.

4 Q: All right. The -- I saw a document -- well,
5 there was a document -- I think it's Trident
6 53, we don't need to pull it up -- that had a
7 number for peds treatment rooms ED and that
8 clinical room thing. Here's my question. Do
9 you believe there are going to be any more than
10 20 ED rooms in the new children's hospital for
11 peds?

12 A: Not that I'm aware of. What I've been told is
13 the new ED has 20 rooms.

14 Q: While you're not sure what those clinic rooms
15 are, that doesn't cause you to believe they're
16 going to be added into the peds number?

17 A: Not that anyone from pediatric leadership has
18 told me.

19 Q: All right. You looked at, with Ms.
20 Hollingsworth, the pediatric treatment rate
21 that you experienced in the adult ED. Do you
22 recall that?

23 A: Yes.

24 Q: That was really low, right?

25 A: Yeah.



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1 Q: Was it below one percent?

2 A: Yes.

3 Q: And why is that peds treatment rate really low
4 for the adult ED?

5 A: Because on the other side of the floor there's
6 pediatric emergency.

7 Q: Right. Is the adult ED peds treatment rate a
8 fair comparator to what you would expect to
9 have happen at the FED in Summerville if we get
10 to establish that?

11 A: No.

12 Q: No. Will we treat pediatric patients in
13 Summerville?

14 A: Yes.

15 Q: There was another exhibit, and I think it's
16 Trident 31, that had 51 treatment rooms for
17 your adult ED. Is that number correct?

18 A: Fifty-one treatment rooms ---

19 Q: For the adult ED.

20 A: --- for the adult ED. If you include -- there
21 are 41 current treatment rooms in the adult ED,
22 12 pediatrics, four more pediatric mental
23 health rooms on the other side, and then ten at
24 Ashley River.

25 Q: And I may be confused. But just for clarity,



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1 the adult ED has how many rooms for treatment
2 right now?

3 A: Right now 41.

4 Q: Okay. The changes in our project, did those
5 changes that you were made aware of in April
6 2019 ---

7 A: Yes.

8 Q: --- did they have, in your expert opinion, any
9 effect upon the nature of the emergency medical
10 care we would provide at that FED?

11 A: No.

12 Q: Did it have any effect upon the benefits that
13 patients will receive if we are able to open
14 that FED?

15 A: No.

16 Q: Did they have any benefit -- did they have any
17 material effect upon the capacity constraint
18 relief we would achieve if we were to gain
19 additional capacity?

20 A: No.

21 Q: Were you upset that you weren't consulted about
22 the change from the original location, .74
23 miles to the new location?

24 A: No.

25 Q: Why not?



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1 A: It didn't seem to be a big deal to me.

2 Q: Why wasn't it a big deal, the changes that we
3 made in this project?

4 A: It's the same location. It's just a slightly
5 different spot.

6 Q: All right. We'll use some French, *raison*
7 *d'etre*. The *raison d'etre* is to fix your
8 capacity constraints. Is that accurate? Isn't
9 there more than one reason we're doing this?

10 A: Yes.

11 Q: In fact, what's the primary reason we offered
12 in your testimony?

13 A: (No response).

14 Q: It's getting late, isn't it?

15 A: It is getting late.

16 Q: Right. You had opinions with respect to two
17 elements. One was capacity constraints.

18 **MR. THOMAS:** Your Honor ---

19 Q: What's number one?

20 **THE COURT:** Mr. Dayhuff. Mr. Thomas.

21 **MR. THOMAS:** I was just objecting to what I thought
22 was about to be a leading question.

23 **THE COURT:** Okay.

24 A: The primary reason is to provide MUSC emergency
25 services to our patients from that area that's



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1 a lot more convenient and a lot more efficient.

2 Q: Those are the two main reasons, right?

3 A: (Nods head affirmatively).

4 Q: Okay. Do you believe that, if we get approval
5 to establish this FED, that we will, if we
6 haven't already, determine the landing zone
7 issue for the helicopter?

8 A: Yes.

9 Q: All right. How about a transfer agreement?

10 A: Yes.

11 Q: Will we inquire into the resources in the
12 vicinity of the ED to help us better decide how
13 to transfer patients effectively and
14 efficiently?

15 A: Yes.

16 **MR. DAYHUFF:** No further questions, Your Honor.

17 **THE COURT:** Ms. Biggers, did the Department have any
18 questions that they needed to ---

19 **MS. BIGGERS:** No, Your Honor.

20 **THE COURT:** Okay.

21 **MS. BIGGERS:** Thank you.

22 **THE COURT:** Thank you.

23 **MR. DAYHUFF:** Your Honor, may this witness be
24 excused?

25 **THE COURT:** Mr. Thomas, Ms. Hollingsworth?



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1 **MR. THOMAS:** No objection.

2 **MS. HOLLINGSWORTH:** No, Your Honor. We appreciate
3 Dr. Hall's patience.

4 **THE COURT:** Okay. Thank you, Dr. Hall. You're
5 excused.

6 **MR. DAYHUFF:** And we appreciate you going late in
7 light of his schedule tomorrow.

8 **THE COURT:** Okay. That is fine. And I think that
9 the hearing is adjourned for today and we'll
10 resume tomorrow at 9:00 a.m.

11 **(Monday, July 22, 2019 the administrative hearing**
12 **ended at 7:31 p.m. and reconvened on Tuesday, July**
13 **23, 2019 at 9:08 a.m.)**

14 **DAY TWO - JULY 23, 2019**

15 **THE COURT:** Are we ready to begin?

16 **MR. DAYHUFF:** Your Honor, one preliminary item, if I
17 could.

18 **THE COURT:** Yes.

19 **MR. DAYHUFF:** I neglected yesterday during my
20 examination of Dr. Hall to ask The Court to
21 move into evidence Exhibit 18, MUSC Exhibit 18.
22 That was the leaving without treatment table or
23 graph that Dr. Hall discussed. I have
24 consulted with my colleagues and I believe they
25 are okay with me admitting that or asking you



1 to admit that at this time.

2 **MS. HOLLINGSWORTH:** No objection, Your Honor.

3 **MR. THOMAS:** No objection, Your Honor.

4 **THE COURT:** Okay. Thank you. It's admitted, Mr.
5 Dayhuff.

6 **(Respondent MUSC's Exhibit Number 18 was admitted**
7 **into the record at this time.)**

8 **MR. DAYHUFF:** Thank you.

9 **THE COURT:** Okay.

10 **MS. HOLLINGSWORTH:** The lawyers are dropping like
11 flies, Your Honor. I don't know what that
12 means, if day two we've got several people that
13 didn't come back for us. They're getting a
14 head start on us. And, Your Honor, may it
15 please The Court. Jennifer Hollingsworth here
16 on behalf of Roper St. Francis and ready to
17 present our case in chief. We had to take one
18 witness out of order, so getting started with
19 our folks. And I neglected -- I should have
20 introduced to you when we got started
21 yesterday. But in addition to Mr. Porter, who
22 we'll call up here in a moment, we have here
23 with us Joy Huntington, who is our director of
24 emergency services for Roper St. Francis, and
25 Ms. Platt is our health planning expert.



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1 **THE COURT:** Okay.

2 **MS. HOLLINGSWORTH:** So, if it suits the -- well, one
3 -- actually, I do have a preliminary matter.
4 Yesterday we filed deposition designations of
5 Intuitive's 30(b)(6) deposition. At the time
6 we filed, we only had a rough transcript from
7 the court reporter. We did last night get a
8 link with the final transcript and the
9 exhibits. So at the office right now we're
10 working to pull together those materials. And
11 if it suits The Court, because it's voluminous
12 pages, we would supplement the hard file with
13 the certified version of the transcript. But
14 we could provide The Court a thumb drive for
15 the documents and the exhibits ---

16 **THE COURT:** Okay.

17 **MS. HOLLINGSWORTH:** --- if that would suit you. And
18 of course the same for all of the attorneys.

19 **MR. DAYHUFF:** And, Your Honor, just for my
20 information, we would have an opportunity I
21 suppose to object to designations and submit
22 counter designations ---

23 **THE COURT:** Yes.

24 **MR. DAYHUFF:** --- and would that be done at the
25 conclusion of the case?



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1 **THE COURT:** Let me give it some thought as to how
2 we're going to do it logistically. But, yes,
3 you will have the opportunity.

4 **MR. DAYHUFF:** Thank you.

5 **MS. HOLLINGSWORTH:** And I think the rule speaks to
6 the timing, but I also would be happy to see if
7 we can consult together and reach any joint
8 designations on how we do that as well.

9 **MR. DAYHUFF:** I think that would be -- agree.

10 **THE COURT:** That would be great.

11 **MS. HOLLINGSWORTH:** And if that suits everyone, then
12 we'll actually hold off on all of the documents
13 and exhibits and see if we can confer to reduce
14 the amount of paper.

15 **THE COURT:** Okay.

16 **MS. HOLLINGSWORTH:** Wonderful. Your Honor, if we
17 may, we would call Stephen Porter to the stand.

18 **THE COURT:** Good morning. Mr. Porter, before you
19 take your seat, if you'll face the court
20 reporter, raise your right hand, she will swear
21 you in.

22 **STEPHEN D. PORTER,** having been duly sworn, testifies
23 as follows:

24 **COURT REPORTER:** Please state and spell your first
25 and last name.



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1 MR. PORTER: Stephen D. Porter, S-T-E-P-H-E-N, P-O-R-
2 T-E-R.

3 COURT REPORTER: You said P-H? I'm sorry.

4 MR. PORTER: Yes.

5 COURT REPORTER: Thank you.

6 MR. PORTER - DIRECT EXAMINATION BY MS. HOLLINGSWORTH:

7 Q: Good morning, Mr. Porter.

8 A: Good morning.

9 Q: It's good to see you. You stated your name for
10 the record. Can you tell us where you live?

11 A: Well, I'm splitting locations now. During the
12 work week I am in Peachtree City, Georgia. But
13 my residence is in Charleston, South Carolina.

14 Q: Okay. And you were here yesterday for the
15 first day of testimony; is that right?

16 A: Yes, I was.

17 Q: And so the CON application that we're talking
18 about for a freestanding emergency department
19 in Berkeley County proposed by the Medical
20 University that was filed in July of 2017, I
21 believe. What were you doing in July of 2017?

22 A: In July of 2017 I was transitioning from
23 Virginia to Roper St. Francis, when I became
24 the CEO of Bon Secours St. Francis Hospital.

25 Q: Okay. And so you were the CEO of Bon Secours



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1 St. Francis. What did you do -- how long did
2 you serve in that role?

3 A: I served in the role maybe four -- three to
4 four months. There was a leadership change
5 with Roper. The COO Matt Severance left. And
6 soon after that I was asked to take the
7 position of CEO of Roper Hospital.

8 Q: Okay. And that's the downtown Roper Hospital?

9 A: That is the downtown Roper Hospital.

10 Q: And as part of your role as the CEO of Roper
11 Hospital, did you have any other
12 responsibilities within the system?

13 A: I had a number of responsibilities. I had
14 responsibilities for key service lines,
15 emergency services, cardiovascular, oncology,
16 orthopaedics, and I also -- about a month or so
17 after taking on the CEO role at Roper, I was
18 asked to take on the Roper Berkeley Hospital
19 project.

20 Q: Okay. All right. And let's back up for a
21 minute -- well, before we go, since you're not
22 living in Charleston anymore, did you leave
23 that role? Did you change roles from CEO of
24 Roper Hospital?

25 A: I did. I -- we went through a reorganization.



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1 Before I went to my current employer with
2 Piedmont Healthcare, I also served as the vice
3 president of business development and strategy
4 for Roper St. Francis Healthcare.

5 Q: Okay. And when was the timing that you moved
6 to Georgia and you're working with Piedmont
7 now?

8 A: I started June 24th of this year.

9 Q: So, last month?

10 A: Last month.

11 Q: Okay. All right. To step back a little bit,
12 can you give us your educational background?

13 A: Yes. I have a bachelor's of business
14 administration degree from James Madison
15 University, which I received in 1989. And a
16 master's in healthcare administration from the
17 Medical College of Virginia, which I received
18 in 1997.

19 Q: Okay. And what experience -- are you involved
20 in any organizations related to your healthcare
21 degree?

22 A: I'm involved with the American College of
23 Healthcare Executives. It's the professional
24 organization for healthcare administrators and
25 business persons.



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1 Q: Okay. So you said 1997 is when you got your
2 master's in healthcare administration?

3 A: Master's in healthcare administration in 1997
4 and then I had a fellowship program or
5 fellowship responsibility. And I did that at
6 Sentara Healthcare in Virginia.

7 Q: Okay. So what did you do once you graduated or
8 completed your master's degree?

9 A: As I mentioned, I had a fellowship with Sentara
10 Healthcare for a year. From there I joined
11 Sentara Healthcare as a director of contracting
12 with Optima Health Plan, which is owned by
13 Sentara Healthcare. I did that for about three
14 or four years. From there I moved to
15 ambulatory development, developing freestanding
16 emergency departments, ambulatory campuses,
17 surgery centers. And from there into hospital
18 operations, developed de novo hospital
19 campuses. Was vice president for Princess Anne
20 Development and then president of Sentara
21 Bayside Hospital. And then moved from Sentara
22 Bayside to president of Sentara Princess Anne
23 Hospital. And then I had a corporate role, I
24 was corporate vice president for Sentara
25 Healthcare for our new market in northern



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1 Virginia. So, I was corporate vice president
2 in northern Virginia and president of Northern
3 -- Sentara Northern Virginia Medical Center.

4 Q: Okay. So, going back a little bit, tell us
5 about -- what is Sentara?

6 A: Sentara is a large integrated healthcare system
7 located primarily in the state of Virginia.
8 But we do now have -- or they do now have a
9 North Carolina presence and an Ohio presence
10 and I also believe Alabama. Twelve hospitals,
11 about 2,000 physicians, a large health plan of
12 about 350,000 members, 11 nursing homes,
13 statewide ambulance service. So a true
14 integrated healthcare system.

15 Q: Okay. And is it a -- is it a not for profit,
16 a for profit?

17 A: It's a not for profit healthcare system.

18 Q: It's a not for profit system?

19 A: It is.

20 Q: Okay. And when you say integrated healthcare
21 system and you mentioned the health plan, tell
22 me a little bit more about that.

23 A: Integrated just means a healthcare entity that
24 owns or controls across the continuum. So we
25 finance healthcare, we have the hospitals with



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1 the delivery of healthcare in the physician
2 practices and we integrate them into a
3 comprehensive care model.

4 Q: Okay.

5 A: So we're able to manage the population across
6 the continuum.

7 Q: Okay. Can you -- tell me about the -- what was
8 it? I think -- your first, again, describe
9 that for me with a insurance plan or health
10 plan.

11 A: With the health plan I was director of
12 contracting; primarily specialty contracting
13 and head key service lines, orthopaedics,
14 radiology, emergency services, that I was
15 responsible for contracting with the providers
16 who provided those services to the health
17 planning.

18 Q: Okay. And the health plan was a plan
19 associated with Sentara somehow?

20 A: Yes, it was. Optimum Health Plan, owned and
21 controlled by Sentara Healthcare.

22 Q: Okay. And at the time that you were working
23 with them, approximately how many members of
24 participants were there in the health plan?

25 A: About 350,000.



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1 Q: All right. And so you quickly went over a
2 number of roles. So it was 1997 when you
3 started with Sentara; is that right?

4 A: 1997 as a fellow with Sentara Healthcare. And
5 then from -- in 1998 I moved into Optima, my
6 first full-time role with Sentara.

7 Q: Okay. And so from 1998 did you stay within
8 Sentara's system until you came to Roper St.
9 Francis in 2017?

10 A: Yes. I was with Sentara for approximately 20
11 years.

12 Q: Okay. All right. And then, before we talk
13 about your transition to Roper St. Francis,
14 you've mentioned several roles. We talked
15 about the one with the Optima Plan. Tell me
16 about -- I think you said Bayside Hospital.

17 A: Yes. Bayside Hospital was a hospital that we
18 acquired from Humana a number of years ago. It
19 was the retirement of the CEO or the president
20 of that hospital and I was asked to take on
21 that role.

22 Q: Okay. And approximately how large was that
23 hospital?

24 A: Sentara Bayside Hospital was licensed I believe
25 for about 130 beds. We operated 90. It was a



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1 small community hospital between two of our
2 larger community hospitals, Sentara Leigh
3 Hospital, and Sentara Virginia Beach Hospital.

4 Q: Okay. And where was that located, the Bayside
5 Hospital?

6 A: It was in Virginia Beach, Virginia.

7 Q: Okay. And then from there did you go to
8 Princess Anne Hospital?

9 A: While I was president of Sentara Bayside
10 Hospital, I was also developing a de novo
11 healthcare campus, a 72-acre healthcare campus,
12 initially developed as a comprehensive
13 ambulatory campus, a freestanding emergency
14 department, about 55,000 ED visits, a joint
15 venture ambulatory surgery center, a
16 comprehensive cancer center, and a
17 comprehensive imaging service, what we call an
18 advanced imaging center, and about a 180,000
19 square feet of additional medical office space.
20 I operated that for about four to five years
21 until we were approved for a hospital. Then we
22 built a 160 bed hospital on the campus as well.

23 Q: On that campus that you described those various
24 types of services that were developed?

25 A: Yes.



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1 Q: Okay. All right. And then I think you
2 mentioned you had a corporate vice president
3 role with the northern Virginia market. Tell
4 us about that.

5 A: Sentara started growing outside of the Hampton
6 Roads market, and northern Virginia was our
7 first move outside of Hampton Road. So we
8 acquired a hospital, Potomac Hospital. So,
9 with that, Sentara moved into the northern
10 Virginia market. I was asked to go up into
11 that market, become the CEO of that hospital,
12 but also I was responsible for Sentara's global
13 presence in northern Virginia. So, essentially
14 from Fredericksburg to D.C. to Winchester.
15 Worked on bringing Sentara's health plan
16 products into the market, growing our medical
17 group from about four physicians to 70
18 physicians. So, really bringing Sentara's
19 presence into that market, putting together a
20 comprehensive market strategic plan and looking
21 at partner opportunities or partnership
22 opportunities with our other healthcare
23 providers in the market.

24 Q: Okay. And then -- so what was the last role
25 you had with Sentara before you came to Roper



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1 St. Francis?

2 A: It was that role.

3 Q: That role.

4 A: The corporate vice president, yes.

5 Q: Okay. And so what brought you to Roper St.
6 Francis?

7 A: A number of things. I had gotten to learn
8 about Roper St. Francis several years ago when
9 I was putting together a joint venture between
10 Sentara and Bon Secours Health System. We
11 joint ventured the Princess Anne Hospital with
12 Bon Secours. So I met with the Roper folks as
13 a joint venture model. And when the
14 opportunity for St. Francis came -- was open,
15 they contacted me. It was something my wife
16 and I were interested in. And we came down to
17 Charleston.

18 Q: So was the Charleston draw that brought you?

19 A: Primarily the Charleston draw.

20 Q: Okay. All right. And so you came -- when did
21 -- you say it was it July of 2017 that you
22 started?

23 A: July 10th of 2017.

24 Q: All right. And so July 10th of 2017 you came
25 to fill the position of CEO of Bon Secours St.



1 Francis, right?

2 A: Yes.

3 Q: And what was the time period before there was
4 some movement and you moved over to the Roper
5 Hospital downtown CEO position?

6 A: About three to four months.

7 Q: Okay. All right. And as I understood you said
8 -- what was the period of time when you then
9 picked up the development of the Roper Berkeley
10 Hospital?

11 A: Maybe about 30 to 45 days after taking on
12 Roper.

13 Q: Okay. All right. Now, when you came to the
14 area in July of 2017 and within a few months
15 took on these roles for Roper Hospital and
16 Roper Berkeley Hospital, what was the status?
17 What was going on with Roper Berkeley Hospital?

18 A: When I was interviewing in May, they had just
19 broken ground on the Berkeley Hospital campus,
20 so it was fairly fresh in terms of its
21 construction development. We were starting to
22 really look at how we were going to approach
23 our medical staff development. So that's one
24 of the first things I've started working with,
25 is our physician leadership, to identify



1 physicians, physician growth strategies,
2 recruiting strategies and such. And then
3 making sure we had the project plan in place,
4 everything dotted and crossed to ensure that we
5 were going to be able to meet our target
6 opening this year.

7 Q: Okay. All right. And what kind of background
8 were you given about Roper Berkeley Hospital
9 when you took over the continued developed?

10 A: It was very clear that this was the number one
11 strategic priority for this system, significant
12 investments in terms of time, energy, and
13 resources, approximately 153 million dollar
14 project. So it was -- it is viewed as a
15 critical project for Roper St. Francis
16 Healthcare and it was very clear that this is
17 our strategic priority from the board all the
18 way down to front-line leadership and staff.

19 Q: Okay. What were -- I think you talked through
20 your responsibilities as part of the
21 development for the Roper Berkeley Hospital.
22 At the time that you transitioned to the
23 Piedmont, what kind of -- where were you in
24 those responsibilities?

25 A: Essentially the hospital was complete from a



1 construction perspective. It was turned over
2 from a certificate of occupancy perspective
3 this past June. Medical staff structure was in
4 place. And by structure I mean governance and
5 bylaws and such. We were finalizing the board
6 structure, the government structure of the
7 hospital. We were making final purchases of
8 equipment and finalizing some service-line
9 planning, specifically around how we would
10 manage populations that do present to the
11 hospital that we may not have a service for,
12 i.e. the cath labs, or how would we manage
13 cardiac patients who present, working with the
14 community partners in the market already, and
15 ensuring that we had seamless transitions. So
16 really -- and then hiring and staffing of the
17 hospital. We started our staffing in the
18 February or March time frame and really ramped
19 up our clinical front-line staffing initiatives
20 in the April time frame. So really focused on
21 getting the hospital ready for October 4th,
22 which is our planned opening date.

23 Q: And I should have done this earlier. You
24 simply have a photograph, nothing untoward I
25 promise. Okay. So, as of late June 2019,



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1 those -- all of those things that you've
2 described have been done?

3 A: Essentially. We are still, as I understand it
4 -- and I know, you know, finalizing staffing,
5 so we're still completing the staffing of
6 certain areas. Most areas have a good
7 complement of staff. I've identified that we
8 still have some areas that still need to be
9 ramped up from the staffing perspective.

10 Q: Okay. All right. And so -- okay. Well, I
11 will -- I'll keep going. We'll be able to get
12 that. All right. Even when -- when you had
13 the role for the development of Roper Berkeley
14 Hospital, what was the plan in terms of sort of
15 how the administrative or executive leadership
16 plan for the Roper Berkeley Hospital?

17 A: We have changed recently. Initially it was
18 going to fall under my direct leadership. I
19 was going to be CEO of Roper Hospital and CEO
20 of Berkeley Hospital. I would have a chief
21 administrative officer at Berkeley who would
22 report to me. When I picked up the system role
23 for strategy and business development, we had
24 reorganized and put all acute care operations
25 under a single operating leadership umbrella.



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1 So, once the hospital opened, it would still
2 have a chief administrative officer, a chief
3 nursing officer, a chief medical officer. But
4 that would then report up to our acute care
5 leader, Anthony Jackson. And I would assist in
6 program development strategy and such, but
7 operationally it would report up to the acute
8 care division.

9 Q: Okay. And in terms of the hospital itself,
10 what services will Roper Berkeley Hospital
11 provide?

12 A: It's a 50-bed hospital, so it's going to be a
13 very streamlined, general, acute-care hospital.
14 Labor and delivery services, emergency
15 services, imaging services, surgery, and
16 general medical surgical, a small ICU. So that
17 was really the focus -- that is the focus of
18 the hospital. We were recently approved for a
19 ---

20 **THE COURT:** Ms. Hollingsworth and Dr. Porter, I hate
21 to interrupt you, but let's let the IT guy see
22 if he can get something going.

23 **(Off the Record)**

24 **MS. HOLLINGSWORTH:** Your Honor, while they work on
25 that, we'll continue if that's okay.



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1 **THE COURT:** That's fine. Thank you.

2 Q: We were discussing the service that Roper
3 Berkeley would have. And I know you rolled
4 through a number of them. I think you said
5 would OB services.

6 **THE COURT:** We're having some talking over here
7 that's disruptive. Sorry, Ms. Hollingsworth.

8 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

9 **THE COURT:** Proceed.

10 Q: OB services, was that one?

11 A: Correct, yes.

12 Q: And tell me again what some of the other ones
13 were?

14 A: General medicine, emergency services, imaging,
15 surgical services. We have a small ICU. So
16 supporting the general medical services. And
17 then maybe a quarter or two after the hospital
18 opens, the cancer services will -- with the
19 linear accelerator.

20 Q: Okay. So you did say it'll have ER services?

21 A: Yes.

22 Q: So that's the Roper Berkeley will have an
23 emergency department?

24 A: Yes, it will.

25 Q: Okay. Where is Roper Berkeley located?



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1 A: It's in the Commerce Crossroads area of
2 Berkeley. It's interesting. There are about
3 three. It's -- depending on who you talk to,
4 it's either in Summerville, Goose Creek, or
5 Moncks Corner.

6 Q: Okay.

7 A: But it's right at the intersection of 176 and
8 17A.

9 Q: 176 and 17A, okay. Approximately how far is
10 the Roper Berkeley Hospital from Roper Hospital
11 downtown?

12 A: Approximately 20, maybe 27 miles I would say.

13 Q: All right. And in the emergency department, do
14 you know how many treatment spaces the
15 department will have?

16 A: There are 15.

17 Q: 15?

18 A: Yes.

19 Q: Okay. And when -- at the time you turned over,
20 is that -- I think how you described it, sort
21 of turned over the development, your role was
22 done?

23 A: Turned over -- you know, with the start of the
24 hospital it would fall under acute care
25 operations, yes.



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1 Q: Okay. So when -- at the time you turned it
2 over, what was the scheduled date for opening?

3 A: October 4th is our planned first patient seen
4 date.

5 Q: Let's talk a little bit more generally about
6 emergency services at Roper St. Francis. From
7 a larger perspective, tell us about what
8 comprises the Roper St. Francis system from
9 sort of the hospital services?

10 A: Roper St. Francis from the emergency services
11 within Roper?

12 Q: Well, starting more broadly. Like tell The
13 Court about what hospitals ---

14 A: Roper St. Francis is currently a three-hospital
15 system -- Mt. Pleasant Hospital, Roper
16 Hospital, and Bon Secours St. Francis Hospital.
17 We will have the Roper Berkeley Hospital
18 opening in October of this year. We have about
19 a 225-manned physician group, Roper Physician
20 Partners. So that is the basic organization of
21 the system. Roper is more the tertiary
22 hospital within Roper, does the cardiac work,
23 and the interventional work, and the more
24 complex surgeries, robotic surgeries. Mt.
25 Pleasant, a small community hospital, about an



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1 85-bed hospital with the associated emergency
2 department. And then St. Francis is our West
3 Ashley campus. It's about 198 to 200-bed
4 hospital and has a -- our more robust emergency
5 services, about 52,000 or so ED visits a year.
6 And then we have two freestanding emergency
7 departments, Northwoods location and our Moncks
8 Corner location, both off of the license of
9 Roper Hospital downtown.

10 Q: Okay. All right. So, focusing on the
11 emergency department at Roper St. Francis, you
12 mentioned that St. Francis has 50 -- sees about
13 52,000 patients per year ---

14 A: Plus or minus.

15 Q: --- visits per year? Okay. What about Mt.
16 Pleasant?

17 A: Mt. Pleasant's around 16,000, 16 five. And
18 Roper Hospital proper is about 32 to 33. And
19 Northwoods is approximately 32. And Moncks
20 Corner is in that 15 to 16,000-visit range.

21 Q: Okay. What is the significance of an emergency
22 department to a hospital?

23 A: Well, I think for -- unless you're a niche
24 specialty hospital, the emergency departments
25 act as the front door to most hospitals. Most



1 of your admissions come through the emergency
2 department, most general medical and surgical.
3 So it is really the 24-hour base of the -- to
4 the community. And so it is, you know, what we
5 use -- always say is it's the front door of the
6 system to the community.

7 Q: Okay. And you've spent roughly 22 years in
8 various development, strategic, executive
9 positions for hospital systems; is that right?

10 A: Yes.

11 Q: As a hospital executive, how important is the
12 emergency services line to you in that role?

13 A: Well, it's extremely important. As I mentioned
14 before, it's the front line. It's the front
15 door. Some of the hospitals -- and then some
16 of the hospitals I've worked in accounted for
17 about 60 percent of our hospital's financial
18 performance, but also patient volumes. It is
19 a significant investment in terms of resources,
20 both in terms of manning the hospital from a
21 staffing perspective, from a physician resource
22 perspective, a relationship perspective with
23 our subspecialists and specialists that support
24 the department and the investments that we need
25 to ensure that we have comprehensive healthcare



1 services within the community. So, emergency
2 departments are really core to any hospital's
3 operations.

4 Q: Okay. And you talked to us about the emergency
5 departments that the Roper St. Francis system
6 has. You were -- for the majority of your
7 tenure, you were the CEO for Roper Hospital,
8 right?

9 A: I was CEO of Roper Hospital, but I had the
10 emergency services line reporting to me, so I
11 was responsible for emergency services for
12 Roper St. Francis Healthcare as well.

13 Q: So what were your responsibilities with regard
14 to then that service line?

15 A: Well, providing administrative support and
16 oversight with -- for Joy and her team, really
17 looking at how the support from a resource
18 perspective, a capital perspective, clearing
19 roadblocks. Under our emergency services
20 umbrella is our ambulance service, and working
21 with Joy and her team to secure a new ambulance
22 fleet. Physician contracting, so I was
23 responsible for negotiating all of our ED
24 physician contracts for each of the locations.
25 We currently have three emergency provider



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1 groups within the system, so maintaining those
2 relationships. Daily operational oversight and
3 metrics and such, so.

4 Q: Okay. And you were here for Dr. Hall's
5 testimony yesterday?

6 A: Yes, I was.

7 Q: You heard the discussion about metrics
8 associated with emergency departments?

9 A: Yes.

10 Q: The metrics that we discussed with Dr. Hall,
11 are those the types of metrics that are
12 important to you?

13 A: Yes. I would say they were fairly similar and
14 important to any hospital executive or system.
15 Yes.

16 Q: Okay. We heard about and we've seen I think
17 even some demonstratives about MUSC's trauma
18 designation. Do any of the Roper St. Francis
19 Hospitals have a trauma designation?

20 A: Today they do not. In the past they did, but
21 no longer.

22 Q: And do you know why they no longer have a
23 trauma designation?

24 A: Costly to duplicate services that are, you
25 know, within -- that require -- that have



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1 limited resources to support in a community.
2 MUSC has a very comprehensive trauma program
3 and service. Trident has their trauma program
4 and service. So the market just could not
5 support three trauma-designated facilities.

6 Q: Okay. So as we walked through -- let me do
7 that summary of the emergency departments you
8 talked about. There are -- there's the
9 hospital-based department at Roper Berkeley
10 Hospital; is that right?

11 A: Yes.

12 Q: Okay. And how many sort of -- I don't know
13 that we discussed. How many treatment rooms or
14 spaces does the Roper Hospital emergency
15 department have?

16 A: Downtown Roper?

17 Q: Yes, sir.

18 A: I believe it's 32 or 33.

19 Q: Okay. And we talked about Bon Secours St.
20 Francis and West Ashley. Do you know
21 approximately how many treatment rooms or
22 spaces they have?

23 A: Honestly, off my head -- top of my head, no.
24 I'm thinking 25 or so, but I could be wrong.

25 Q: Okay. And what about -- do you know for Roper



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1 Mt. Pleasant?

2 A: Roper Mt. Pleasant I believe is in that 15 to
3 16 range.

4 Q: Okay. And then you mentioned freestanding
5 emergency departments. So Roper St. Francis
6 has some freestanding emergency departments?

7 A: Yes. It has our Northwoods location and the
8 Moncks Corner location.

9 Q: And where is the Northwoods location?

10 A: Northwoods has recently relocation to Rivers
11 Avenue in North Charleston. That opened in its
12 new location about three months or so ago.

13 Q: And so during your tenure as CEO of Roper
14 Hospital and sort of the executive responsible
15 for the emergency services service line, were
16 you serving in that role as Northwoods'
17 relocation replacement took place?

18 A: Yes. I picked up the relocation project when
19 I assumed the CEO of Roper. The decision to
20 relocate it, it was made prior after it flooded
21 in one of the hurricanes. But I did pick up
22 that project and oversaw that project with Joy
23 and others.

24 Q: All right. And then you've mentioned Moncks
25 Corner. What's in Moncks Corner?



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1 A: Moncks Corner is a campus that was developed
2 about 27 or so years ago. It is a freestanding
3 emergency department and imaging center, a
4 surgical center, ASC, and physician practices.

5 Q: Okay. And Moncks Corner, that's in Berkeley
6 County, right?

7 A: It's in Berkeley County in Moncks Corner. Yes.

8 Q: The Northwoods location, what county is that
9 in?

10 A: I believe that's Charleston county, North
11 Charleston.

12 Q: Do you know -- you mentioned Roper Berkeley
13 Moncks Corner opened about 27 years ago?

14 A: Northwoods -- yeah. Moncks Corner was 27 years
15 ago and the original Northwoods I believe was
16 about 25 years ago.

17 Q: Okay. All right. You mentioned -- so, we've
18 got the two freestanding emergency departments
19 that you worked with in the Roper St. Francis
20 system. I think you also described
21 freestanding emergency departments were part of
22 what you did with the Sentara system?

23 A: Correct. I was involved in the development
24 and/or operations of about five freestanding
25 emergency departments with Sentara healthcare.



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1 Q: Okay. All right. And then -- so what was the
2 reason -- or was there a reason that you're
3 aware of that Sentara sort of employed a
4 freestanding emergency department model?

5 A: There were several reasons that Sentara
6 evaluated when we were looking at it. One is
7 our ambulatory campus development plan.
8 Depending on the market and the population
9 densities, we would do what we call big box
10 ambulatory campuses, which would usually
11 include freestanding emergency departments.
12 Sometimes it would be a access strategy for our
13 health plan. We had a health plan with a large
14 population base, but we had hospital systems in
15 some of our markets that did not contract with
16 our health plan, so we brought ambulatory
17 campuses including freestanding emergency
18 departments there to provide access to our
19 health plan members. A lot of times it would
20 be a hospital -- future hospital strategy where
21 we would lead with a comprehensive emergency
22 service location, surgery and such, with the
23 understanding or hope that we would be building
24 -- or expectation that we would build a
25 hospital at that site at some point in the



1 future.

2 Q: Okay. And as sort of as an executive, what are
3 you looking at or evaluating when you're
4 considering a freestanding ED model?

5 A: Historically what I would look at is the
6 ability to get to a minimum patient seeing
7 point of about 20 to 25,000 visits. When we
8 did the business modeling with Sentara
9 Healthcare, at 20 to 25 thousand visits you
10 were able to cover really your cost. Not just
11 your direct cost for the emergency department
12 itself, but people forget you have to have
13 security, you have to have imaging staff, you
14 have to have lab staff. So looking at the
15 total cost -- and then the physician subsidy
16 support and the ability to make sure the
17 physicians were and to cover, we targeted about
18 20, 25,000 ED visits.

19 Q: Okay. And that was -- throughout your time
20 with Sentara that was typically what you were
21 looking at?

22 A: Yes. Typically. Again, we were very selective
23 in terms of the geographic markets to make sure
24 we had the population density that would be
25 able to support that level of an investment.



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1 Again, we called these big box ambulatory
2 campuses, so they had to have enough population
3 density support. So that was a consistent
4 model. Yes.

5 Q: Okay. And were all of the freestanding EDs
6 that you worked with in Virginia associated
7 with the hospital?

8 A: Yes. All freestanding EDs that I worked with
9 were associated with the hospital. Personally
10 I believe -- I really believe in the
11 freestanding ED model. But I do have an
12 opposition to freestanding EDs like in Texas
13 and other states that are not part of hospital
14 systems. They don't have the medical staff
15 support. They don't have, you know, the
16 ability to transition patients easily when they
17 need to have the care provided in a hospital.
18 So I believe freestanding EDs are best served
19 when they are part of a hospital's governance
20 structure and licensure.

21 Q: Okay. And so thinking about the manner in
22 which South Carolina does it, what are your
23 thoughts on CON, you know, Certificate of Need
24 applying to freestanding emergency departments?

25 A: I'm very supportive of it, to insure that we --



1 that appropriate resources are being utilized
2 and if there is control in terms of ensuring
3 that we have that relationship with the
4 hospital system.

5 Q: Okay. What type of services do you expect are
6 provided in a freestanding emergency
7 department?

8 A: Freestanding emergency departments, since they
9 are not -- since they're independent, have to
10 be selective and really work in educating the
11 community and the EMS providers in terms of
12 what's appropriate for a freestanding
13 department versus what is not. It's usually
14 lower acuity visits, things that can be
15 stabilized and treated appropriately there with
16 a transition plan to a higher level care if
17 needed. You know, we -- this basic rule that
18 we've always followed is, you know, no
19 penetrating traumas, no active labor, no active
20 -- from an EMS perspective, no active chest
21 pain and such. Things that you would want to
22 divert to a hospital setting that would not be
23 appropriate in the freestanding basis. But
24 the freestanding site has to be able to
25 stabilize and manage anything that walks



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1 through its door.

2 Q: Okay. Tell me -- what do you mean by
3 transition plan, having to have a transition
4 plan in place?

5 A: A transition plan is just that. You know, when
6 someone comes in, they receive treatment,
7 they're either discharged home or they had to
8 be transitioned to the next appropriate level
9 of care. So that's usually through a
10 transition program, a transfer agreement
11 process, or, you know, a -- or connected to
12 your home hospital, a seamless transition from
13 that emergency department to it's -- for that
14 patient to the next appropriate level of care.

15 Q: Okay.

16 A: Be it the emergency department at that host
17 hospital or the surgical services or the
18 inpatient unit.

19 Q: Okay. Are transfer agreements something that
20 you've dealt with in your roles with Roper St.
21 Francis?

22 A: Yes. Transfer agreements between local
23 facilities are something I've worked with, yes.

24 Q: Okay. All right. And then I think you also
25 mentioned it's important to educate the



1 community. Tell me about that. You said -- I
2 think you said community and EMS.

3 A: Well, community is important. One of the
4 things that we learned early on when we were
5 setting freestanding emergency departments is
6 educating the community in terms of what is a
7 freestanding emergency department. What is its
8 capability. When is it appropriate to come
9 directly to the freestanding emergency
10 department. Again, take the active labor. If,
11 you know -- we did deliver babies in our
12 freestanding emergency departments, but that
13 was not the best location, but trying to
14 educate the community that if you're in active
15 labor, go directly to your hospital, not your
16 freestanding emergency department.

17 Q: Okay. So, what are the types of acutities that
18 you expect and would educate the community are
19 appropriate for a freestanding emergency
20 department?

21 A: You know, stroke interventions in some cases.
22 Some of our freestanding emergency departments
23 were stroke-certified centers. We --
24 orthopaedic cases, fractures, and such, general
25 medical. Yu know, things that were not



1 appropriate maybe for an urgent care center.
2 So, higher acuity patients than urgent care,
3 but something that could be managed
4 appropriately in a freestanding environment.

5 Q: And when you're using acuity, we've heard that
6 word a good bit yesterday, are you using that
7 word in the same context we heard yesterday in
8 terms of the acuity in levels; one, two, three,
9 four and five?

10 A: Yeah. You heard there was a little confusion
11 yesterday as well. There is the -- what I call
12 the triage acuity and then there's the
13 discharge. And they're kind of the opposite.
14 So, triage -- you know, level one triage is a
15 sick patient. Level five is a fairly -- is a
16 less acute patient. Discharge level five is a
17 higher acuity patient and so.

18 Q: Okay. So when you're discussing acuity levels
19 and the education of the community in EMS, and
20 you described lower acuity, you're referring to
21 the one through five, with the level one being
22 the highest acuity?

23 A: Yes.

24 Q: And the level five being the lowest acuity?

25 A: Yes.



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1 Q: Okay. All right. When you have -- you've
2 talked about the transition plan. But what is
3 the plan? What does happen if you have a
4 patient that's come in with a high acuity
5 that's not best served in a freestanding
6 department?

7 A: Well, of course the care team is going to
8 stabilize that patient and make sure the
9 patient is able to be cared for, stabilized,
10 and then an appropriate coordination with the
11 receiving specialist and receiving hospital is
12 done. Appropriate location, again, is it an ED
13 transfer; is it a ED to cath lab transfer; is
14 it a ED to surgical transfer; or is a direct
15 admit to the hospital? But in training this
16 you have the transfer relationships in place to
17 ensure a seamless transition of that patient.

18 Q: Okay.

19 A: And working with your EMS or your ambulance
20 service to coordinate the patient transfer
21 itself.

22 Q: And when you're talking about those transfer
23 relationships, are those hospitals that are
24 nearest to you that you're talking about?

25 A: Traditionally, I mean, you know, if you have a



1 patient that is unstable, you want to go to the
2 next closest level of care. So take Berkeley
3 Hospital, we don't have a cath lab, so we are
4 currently working and talking to Trident about
5 where should the patient go if we have an
6 unstable patient from a cardiac perspective.
7 We could take them to Roper, but Roper's 27
8 miles away. It'd probably in the best interest
9 of that patient to go to Trident.

10 Q: So that's what you're talking to, is sort of
11 who are the people around you that can provide
12 care?

13 A: Correct.

14 Q: Okay. And in terms of capacity in your work
15 and evaluating both the development of
16 freestanding EDs and of course having
17 responsibility for an ED service line, do you
18 have any impression or belief about the
19 capacity of a freestanding emergency department
20 versus a hospital-based emergency department?

21 A: I do. You know, there were a number of things
22 discussed yesterday as well. You know, lower
23 acuity locations can have more patients through
24 the beds. So when we -- in my past, Sentara,
25 we were 24 to 26, maybe 2800 visits per year



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1 per bed. But as your acuity goes up, your
2 throughput in terms of number of patients per
3 bed may go down. A very active trauma program
4 may be 12 to 1800 per bed. So, acuity and
5 volume -- but also the number of beds you have
6 available can play a big part of that as well.

7 Q: Okay. And when you -- when you said an active
8 trauma program, 1200, 18, is that -- that means
9 a hospital base?

10 A: That's a hospital base, yes.

11 Q: Okay.

12 A: But from a freestanding perspective, you know,
13 I would target, you know, 22 -- between 22 and
14 28. Twenty-eight was a very -- Princess Anne
15 as an example, we did 55 to 58,000 visits. We
16 had 22 treatment bays. So that was about 2700
17 patients per day.

18 Q: Okay. And where was Princess Anne again?

19 A: That was in Virginia Beach, southern Virginia
20 Beach.

21 Q: Okay. All right. And when you're considering,
22 sort of bays or spaces, how does that -- are
23 you considering just whatever treatment space
24 you have or do you limit what you consider a
25 treatment space?



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1 A: I mean, most EDs are set up that they have
2 psych rooms, may have GYN rooms, and maybe a
3 pediatric room. But if the rooms weren't being
4 utilized, our philosophy was pull -- you know,
5 forward and, you know, see patients in any
6 location, sometimes even hallways. We had
7 designated hallway spaces as well where we see
8 patients.

9 Q: Okay. And what sort of is the -- kind of the
10 geographic radius from which you would see
11 patients at your freestanding emergency
12 departments?

13 A: My experience has been about 70 to 75 percent
14 of the patients would come within five to seven
15 miles, maybe ten miles of the campus, but
16 primarily concentrated within five to seven
17 miles. Again, that could be based by density
18 as well. Moncks Corner has a much broader
19 geographic base because its population is
20 fairly sparse and not dense like some other
21 areas.

22 Q: Okay. But in the areas that have a more dense
23 population base, what was your ---

24 A: Primarily it's, you know, local, so five to
25 seven miles was where we probably received



1 about 70 percent of our patients from.

2 Q: Okay. And in the work you did both with
3 Sentara and Roper St. Francis, did you kind of
4 in those positions become familiar with the
5 financial aspects of emergency services in
6 freestanding emergency departments?

7 A: Yes.

8 Q: And so tell us a little bit about that.

9 A: Well, in general, you know, freestanding
10 emergency departments, if you -- again, to my
11 point earlier, if you have enough critical mass
12 of patients coming through -- I hate to view
13 healthcare from a financial bottom-line
14 perspective -- but can be profitable entities
15 for healthcare systems. But I have had
16 experience where some have been very good from
17 a profit perspective. Again, when I'm 55 to
18 58,000 ED visits, the acuity is lower, your
19 overhead's a little bit lower because you don't
20 have 400,000 square feet of overhead to cover.
21 You may have 15,000 square feet. But our
22 Moncks Corner location is not profitable. That
23 15,000 visits, it's -- when you look at it from
24 a staffing perspective, a physician overhead
25 perspective, 24/7 imaging services, that one



1 struggles to even break even.

2 Q: Okay.

3 A: So ...

4 Q: And so of course when you are talking about
5 profitable, I mean, that means your revenues
6 are covering your expenses, right?

7 A: Yes.

8 Q: Okay. So, tell me a little bit more then about
9 the distinction between a freestanding
10 emergency department versus a hospital-based ED
11 and what expenses or overhead differentiates
12 them.

13 A: Well, first of all, freestanding EDs and
14 hospital-based EDs are paid the same. They're
15 under the hospital's licensure. They are under
16 the hospital's provider number. The
17 freestanding EDs, since they are lower acuity,
18 may have lower reimbursement associated with
19 them, but they should also have lower overhead
20 in terms of the brick and mortar and everything
21 else. The other expenses are fairly
22 comparable, because you still have to have
23 support services, security services,
24 registration services, 24-hour staff, 24-hour
25 physicians. So, from that perspective, they're



1 fairly comparable. The real difference is the
2 brick and mortar space required and then the
3 changes in reimbursement associated with the
4 acuity. Some will say that freestanding EDs
5 may have a better payor mix and that can have
6 an impact. But, again, some of our centers
7 show that we had a payor mix in our
8 freestanding EDs that is comparable to our
9 hospital-based EDs.

10 Q: All right. And so when you're planning,
11 particularly planning for a freestanding
12 emergency department, in terms of the patient
13 acuity, are you evaluating or anticipating a
14 different type of acuity versus when you're
15 looking at your hospital-based emergency
16 department?

17 A: Yeah. You're looking at a lower-acuity patient
18 population in general. You know, from a bell-
19 curve perspective, skewing more to the lower
20 acuities, probably level two to level threes on
21 a -- what I say on a discharge side. So maybe
22 level four -- level threes and fours on the
23 triage side.

24 Q: And, you know, we've talked a good bit about
25 this area where Roper Berkeley Hospital will



1 sit, right?

2 A: Uh-huh.

3 Q: Carnes Crossroads, the Nexton development,
4 you're familiar with that, right?

5 A: I am, yes.

6 Q: Okay. Are you familiar with the Summerville
7 Dorchester area?

8 A: Yes, I am.

9 Q: Okay. And so tell us a little bit about sort
10 of those areas and the population in those
11 areas.

12 A: Well, they're fast-growing areas, as was
13 mentioned yesterday. And, you know, as you can
14 read about, they are, you know, developing from
15 both a population perspective, but they're also
16 from a industry perspective, are growth areas.
17 And we're seeing that around the Berkeley
18 Hospital campus with the Carnes Crossroads
19 Development. And so, from a growth
20 perspective, a very -- you know, a very
21 favorable market in terms of growth and from a
22 population and economic perspective.

23 Q: Okay. And so, is the -- I think it was
24 referred to as -- now I can't remember what we
25 called it yesterday. But that North



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1 Charleston, Summerville, southern Berkeley
2 County area, are those in close proximity to
3 each other?

4 A: As I understand the geography, yes.
5 Summerville, Carnes Crossroads, maybe five or
6 so miles separate, maybe five to six miles.
7 North Charleston, I'm not exactly sure. You
8 know, our Northwoods location is maybe ten
9 miles from the Berkeley Hospital campus.

10 Q: Okay. So, we've got the Northwoods
11 freestanding emergency department. Are there
12 any other emergency departments in that north
13 Charleston area?

14 A: Yes. There is Trident's location in the North
15 Charleston area. And then our St. Francis
16 Hospital is not too far from that north
17 Charleston area. I'd say maybe seven miles or
18 so.

19 Q: Okay. And the -- sort of going to the other
20 side of where Roper Berkeley Hospital is going
21 to sit, are there other emergency departments
22 over in that southern Berkeley Summerville ---

23 A: Yes. There is the Trident Summerville
24 location, the Trident Medical Center location,
25 and there's the approved Trident freestanding



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1 ED, when that will be built and open. And then
2 there's the Trident freestanding up in the
3 Moncks Corner location.

4 Q: Okay. And what about the Summerville Medical
5 Center? Where is that in relation to this area
6 of North Charleston, southern Berkeley County?

7 A: As I -- the way I do it from a geographic
8 perspective, I believe it's within about six,
9 seven miles.

10 Q: Okay. All right. And the Trident Hospital and
11 the Summerville Medical Center, do they have
12 emergency departments?

13 A: Yes, they do.

14 Q: Do you think that the Berkeley County area or
15 this southern Berkeley County area where Roper
16 Berkeley Hospital is opening in October has a
17 need for emergency services?

18 A: It has a need for emergency services. I do not
19 feel it has a need for emergency services
20 beyond what has currently been approved or
21 currently existing in the market.

22 Q: Okay. Even with the population growth that
23 you've talked about?

24 A: Even with the population growth. I mean, right
25 now, the Berkeley Hospital is not open, so



1 that's going to add the 15 additional beds from
2 a capacity perspective. The Trident
3 freestanding emergency department will have
4 capacity. When I have looked at it -- there's
5 a rule of thumb, you know, if you look at
6 Robert Wood Johnson and others, ED visits per
7 thousand population is about 600 or so visits
8 per thousand. If you look at that, that market
9 probably has about 100 and -- maybe 135, 140
10 some thousand visits. And I would say between
11 the Trident services, the Roper services,
12 there's enough capacity to support that today
13 and for several years in the future.

14 Q: Okay. And when we're talking about the
15 capacity today, and as of the time you left
16 late last month, what was your impression in
17 terms of how busy was the Roper Northwoods
18 freestanding ED in North Charleston?

19 A: Well, in our old location, it was very busy
20 given the space constraints. And today it's
21 still 32 to 33,000. It looks like the new
22 location, you know, is still attractive to the
23 community, so it's maintaining that volume
24 level, about 75, 80, maybe 90 patients a day.
25 So it's still a very -- if that's your



1 question.

2 Q: In terms of even with the relocation, does it
3 have the capacity to serve more patients?

4 A: It does have the capacity. We were -- you
5 know, we built for 15. We're operating ten.
6 And I think at some point we will need that 15,
7 but that will be a -- that additional five, but
8 we will look at staffing that based on how the
9 services are developing and does the volume
10 support the opening of those five.

11 Q: And then what about the Moncks Corner
12 freestanding ED that Roper Berkeley -- I'm
13 sorry, Roper Hospital has? Does that have the
14 ability to see more patients?

15 A: It does have the ability to see more patients,
16 yes.

17 Q: And actually I think you used that as an
18 example, that that facility maybe isn't
19 generating more revenue than its overhead; is
20 that right?

21 A: Yeah. And that's a function of both volume and
22 the payor mix within that market. And then,
23 again, to fixed cost in the overhead associated
24 with operating a 24/7 freestanding emergency
25 department.



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1 Q: Okay. Do you believe that the freestanding
2 emergency department proposed by the Medical
3 University will impact Roper St. Francis?

4 A: I think it has the ability to impact Roper St.
5 Francis. Again, you know, when we're looking
6 -- right now, Roper St. Francis Berkeley is
7 projecting and we're targeting maybe about
8 22,000 or so ED visits. So any service in the
9 market has the ability to move volume from one
10 location to another. When you look at what it
11 takes to support an emergency department, we're
12 making investments in physicians in that market
13 who will be in that market to see patients in
14 that market. So that's of a concern that, even
15 though we're not talking about huge numbers,
16 any shift can have a major impact on your
17 expectations and your forecast for, not just
18 the hospital operations, but the cost to
19 support those operations.

20 Q: And tell us a little bit more about the
21 investment that Roper St. Francis has made in
22 the Roper Berkeley Hospital.

23 A: Well, there is everything that you need from a
24 hospital perspective, the brick and mortar, the
25 equipment and everything else. But it doesn't



1 just stop there. We are investing in virtual
2 technologies to allow specialists to be more
3 present in that market. We are bringing
4 specialists to the market. We have recruited
5 several orthopaedic surgeons, some general
6 surgeons. Assisted with the -- we've hired
7 several OB/GYNs. We've assisted in recruitment
8 based on community need for other OB/GYNs. So
9 we are making a -- it's not just a brick and
10 mortar hospital investment, but it is also the
11 investment in the physician resources to
12 support that hospital in that community.

13 Q: And as an executive and the -- sort of the
14 analysis that you've done, both, again, in
15 developing these type of facilities and having
16 responsibility for them, do you think it makes
17 sense to add a freestanding emergency
18 department before Roper Berkeley opens?

19 A: No. I do not think it makes sense to add
20 another before the Roper Berkeley opens.

21 Q: Okay. I believe you've talked about physician
22 staffing. How much involvement did you have in
23 nurse staffing for the Roper Berkeley Hospital?

24 A: I had involvement from, you know, an overall
25 perspective, having to improve the staffing



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1 plan for the hospital, working with HR and our
2 nurse executive at Berkeley in terms of a
3 recruitment plan, a strategy. So very involved
4 in terms of the global perspective. The daily
5 recruitment and staffing falls upon our chief
6 nursing officer and Joy and others, the
7 department leadership for the services.

8 A: Okay. Let me ask you, we've talked a good bit
9 yesterday about CDUs, clinical decision units,
10 and fast track rooms.

11 Q: Uh-huh.

12 A: Can you just talk to those? Tell us a little
13 bit -- what's the difference between a clinical
14 decision unit and a fast-track room?

15 A: Well, I'd say fast track is on the front end.
16 So fast track is once someone has come in and
17 had medical screening exam, they'd been
18 screened, they'd be appropriate for a fast
19 track. They -- I think the reference yesterday
20 was the vertical patients, the patients that
21 are very low acuity, will require very little
22 resource, may not require any advanced imaging
23 studies, this, that or the other. They may be,
24 you know, your cold patient, more of an urgent
25 care level type visit, is what I would say.



1 Very low acuity traditionally can quickly get
2 them in and out of the emergency department.
3 They're on the front end.

4 Q: Are these the level fours and fives in the
5 acuity triage index?

6 A: On the triage side they would be your fours and
7 fives, yes.

8 Q: Okay.

9 A: Probably even maybe pushed more towards a five,
10 but.

11 Q: Okay.

12 A: CDU is after the patient has been treated and
13 they're looking at where is the appropriate
14 place for this patient. So you heard maybe a
15 comment observation; they're not quite well
16 enough to be discharged and they're not quite
17 sick enough to be determined -- to make the
18 determination that they need to be an
19 inpatient. So there are a place that patients
20 can be used -- where a decision can be made.
21 Sometimes there's, you know, re-hydration,
22 maybe asthma treatments or some other things.
23 So, that's kind of the post-placement, once the
24 ED physician has stabilized and made his
25 assessment.



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1 Q: Okay. And so thinking in terms of mostly level
2 fives on that acuity triage index in the fast-
3 track room, is that the same acuity level that
4 if you have a CDU you're expecting to see?

5 A: Well, a CDU, you -- traditionally because
6 they've taken more resources, they can't be
7 discharged home, they're going to be a higher-
8 acuity patient, probably more on the level twos
9 and threes. On the triage side, levels may be
10 a high level three. Level four on the
11 discharge side.

12 Q: Okay. On those billing codes we talked about?

13 A: Yeah.

14 Q: Okay.

15 A: Looking at it on the CDU, you know, one of the
16 things, depending on what your business model
17 is, they almost have to be operated as a
18 separate department from a billing -- if you're
19 going to bill and charge for the services, a
20 separate physician, and sometimes separate
21 staff, because they're not ED visits. They are
22 separate -- if they're operating as an
23 observation unit of department as well.

24 Q: Okay. What do you know about the changes or
25 any changes that MUSC has made to the CON



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1 application that was filed when you came over
2 to the system?

3 A: Really, the only thing is what was discussed
4 yesterday; the relocation from Nexton to
5 Summerville, the elimination of the CDU, and
6 the elimination of the helipad.

7 Q: Okay. And in -- as we kind of looked at the
8 different floor plans and talked about the
9 different ways they're set up, as -- again, as
10 sort of an executive, do those financial
11 metrics for those two proposals look different
12 to you?

13 A: I just want to make -- can you ---

14 Q: So the first proposal that had the 12 rooms
15 plus five CDU, 15,000 square feet and then the
16 proposal with the seven treatment rooms, five
17 fast track, in the 10,000 square foot, when
18 you're looking at how you're planning the
19 financial metrics -- or planning for that, does
20 that look different between the two?

21 A: Well, it does look different, yes. I mean, a
22 very different level of investment, very
23 different level of resource required to
24 operate. This is Steve Porter speaking. You
25 know, based on what I know in terms of their



1 anticipated visits, the CDU model really didn't
2 make a lot of sense to me. Fifteen, 16,000
3 visits can be tough to justify a CDU population
4 base. I was, again, 55, 58,000 and had a very
5 difficult time maintaining a ten-bed CDU, so.

6 Q: Okay. And in thinking about the resources that
7 are in that area already, has there been a
8 significant investment of resources in that
9 southern Berkeley county area for emergency
10 services?

11 A: Yeah, there's been a significant investment of
12 resources in that southern area. Again, not
13 only the Roper Berkeley Hospital location, the
14 planned Trident facility, the investments in
15 the trauma designations at Trident and their
16 other facilities. There's significant
17 investment already within that community.

18 Q: Okay.

19 **MS. HOLLINGSWORTH:** Your Honor, if I can just have
20 one moment, I will -- I think I might be done.

21 Q: It's a demonstrative up on the screen, but can
22 you tell The Court, what is that up there?

23 A: That is the Berkeley Hospital. That would be
24 the emergency department facing us. The taller
25 portion of that building is the inpatient unit.



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1 And to the right-hand side is the surgical and
2 imaging services for the hospital. The back
3 right-hand side is the central utility plant,
4 so the power plant supporting the hospital and
5 the campus.

6 Q: Thank you so much. Answer any questions the
7 other counsel has.

8 A: Thank you.

9 THE COURT: Mr. Thomas.

10 MR. THOMAS: Sorry. I have no questions, Your
11 Honor.

12 MR. DAYHUFF: You ready for me, Your Honor?

13 THE COURT: Yes.

14 MR. DAYHUFF: All right.

15 THE COURT: Mr. Dayhuff, I'm not sure how long your
16 Cross is going to take, so that -- let's let
17 the witness take a ten-minute break ---

18 MR. DAYHUFF: Sounds good.

19 THE COURT: --- before we start with the Cross.

20 (Off the Record)

21 THE COURT: Okay. Mr. Dayhuff, you may proceed.

22 MR. DAYHUFF: Thank you. And before we begin, just
23 in case -- I don't expect to use a lot of TV,
24 but can we switch to Mr. Bupp

25 MR. PORTER - CROSS-EXAMINATION BY MR. DAYHUFF:



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1 Q: Mr. Porter, how are you?

2 A: Doing well.

3 Q: Nice to see you again. When did you come to
4 Roper? What date?

5 A: July 10 was my hire date.

6 Q: July 10. What year?

7 A: Of 2017.

8 Q: All right. And I understood from your Direct
9 Examination that maybe your main priority as an
10 administrator at Roper was that Roper -- is,
11 was that Roper Berkeley County Hospital.

12 A: Yes. I was CEO of Roper Hospital downtown and
13 Roper Berkeley.

14 Q: Yeah. And I guess one of the main project that
15 you were there for ---

16 A: Yes.

17 Q: --- was to make sure that hospital gets off the
18 ground, ready to go, and open this year?

19 A: Correct, yes.

20 Q: Okay. Good. Now, let's step back. I want to
21 talk a little about Sentara, that health system
22 that you worked in before you came to Roper.

23 A: Uh-huh.

24 Q: I understood that's a -- when you were there,
25 primarily Virginia, a little North Carolina



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1 based?

2 A: Correct.

3 Q: And you established FEDs when you were with
4 Sentara?

5 A: Yes.

6 Q: And we talked about this at your deposition,
7 that you had certain things you wanted to see
8 in a location before you established the FED.
9 And I want to talk about a few of those.

10 A: Yes.

11 Q: And I guess first I'll just tick them off and
12 then we'll kind of go deeper on a few. You
13 wanted to put an FED in a place that had
14 significant population and population growth,
15 correct?

16 A: Population that could support the services,
17 yes.

18 Q: Right. Well, and it'd be nice if you found a
19 place with population growth, right?

20 A: Correct.

21 Q: Population growth translates into potentially
22 more ED utilization; is that right?

23 A: Yes.

24 Q: Particularly if that population growth is in
25 the over 65 age cohort, agree?



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1 A: Yes.

2 Q: Because over 65 age cohort are high users of
3 all medical services, including ED; is that
4 right?

5 A: They are high utilizers, yes.

6 Q: More so than the general population, true?

7 A: In general, yes.

8 Q: Okay. Now, back to that list. So population
9 access. One of the things you looked at for a
10 location is, is it going to improve access to
11 your patients -- improved access for your
12 patients to ED services? That was the factor.

13 A: Correct.

14 Q: And when we're talking about access, we're
15 talking about geographic access, the time it
16 takes them to get to the ED. If you could
17 shorten that, that's one of the factors you
18 looked at when you were establishing an FED.

19 A: We looked at that. And part of it was the
20 payor access was a big primary driver for us.

21 Q: Right. And we can talk about that just
22 briefly. There was a health plan you all had.

23 A: Yes.

24 Q: And if folks didn't have ED services, they were
25 a part of that health plan, right, that would



1 be another reason you might establish an FED?

2 A: If the health plan population can support that,
3 then that's -- yes.

4 Q: Right. Another one that I think you mentioned
5 to me was sometimes communities would ask you,
6 hey, we'd like to have some services and that
7 would be a factor you would consider.

8 A: Yes.

9 Q: And then maybe last, and I think we discussed
10 this a little bit, you'd want to be sure that
11 you could hit a certain utilization at that ED?

12 A: Correct.

13 Q: And that was the 20 to 25,000 visits that you
14 talked about at your deposition and here today?

15 A: Correct, yes.

16 Q: All right. And I want to drill down, I
17 suppose, a little bit more on a couple of
18 those, maybe. On access, just maybe a little
19 bit on access. We talked about, you know,
20 decreasing the distances people have to go to
21 get care. That's one part of it, right?

22 A: Yes.

23 Q: And the health plan access is another part.
24 And there's a third part, which is the time to
25 care concept that we talked about with Dr. Hall



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1 yesterday, true?

2 A: True. Yes.

3 Q: And I guess the idea being that, if you could
4 put an FED in a location, folks can get care
5 quicker than perhaps maybe going to a downtown
6 hospital-based main ED.

7 A: Yes.

8 Q: Yeah.

9 A: If the services are provided there.

10 Q: Right. So that's one of the benefits. Now, we
11 talked a little yesterday, and I think you were
12 here for that, the capacity constraints MUSC's
13 experiencing in its adult ED. You heard that
14 testimony, right ---

15 A: I did.

16 Q: --- from Dr. Hall. Now, I believe when we
17 talked at our deposition, you told me you had
18 never developed an FED at Sentara specifically
19 to alleviate capacity issues in a ED, hospital
20 ED; is that true?

21 A: Not to alleviate, but we may have had some
22 shifting of business to those freestanding EDs.

23 Q: All right. So -- and I wanted to make sure I
24 understood that. Even though you didn't
25 establish an FED specifically to address



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1 capacity constraints somewhere else, when you
2 established an FED in the vicinity of a
3 hospital ED, you experienced a shift in
4 volumes.

5 A: Yes. I would say most of our freestanding EDs
6 though were within 10 miles of any of our
7 hospital campuses.

8 Q: Okay. So there was a shift in volume reducing
9 the volume at your hospital ED, particularly,
10 as we talked about in your deposition, during
11 high demand and peak times.

12 A: Uh-huh (affirmative response).

13 Q: Now, you're familiar with MUSC's proposed FED
14 and you were familiar at your deposition and
15 you heard more about it yesterday I suppose.

16 A: Yes.

17 Q: Let me ask a few questions about that proposed
18 FED. Let's look at MUSC Exhibit 33. All
19 right. So, this was entered into evidence
20 yesterday and it shows the original and current
21 FED site. And I want to focus on the current
22 FED site. Is the current FED site in an area
23 that is experiencing rapid population growth?

24 A: As I understand the geography, yes.

25 Q: And it's in an area that's experiencing rapid



1 population growth of the 65 plus cohort as
2 well?

3 A: Yes.

4 Q: And in fact, as you told me at your deposition,
5 the area that we're establishing this FED is
6 one of the fastest growing areas in the state;
7 isn't that right?

8 A: Yes.

9 Q: Now, as a former Roper administrator, you are
10 aware, are you not, that MUSC has ED market
11 share in the north area, as we called it
12 yesterday -- Berkeley County, Dorchester
13 County, North Charleston area.

14 A: Yes.

15 Q: Roper has market share in that same area.

16 A: Yes.

17 Q: Trident has market share in that same area.

18 A: Yes.

19 Q: So if we have market share in that area now,
20 those folks who are using us for ED services
21 are having to go where to get those services?

22 A: They are having to go to your MUSC location.
23 But I don't know -- are they working downtown
24 when they receive those and that's more
25 convenient or are they going from their home



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1 and that's more convenient?

2 Q: Yeah. I suppose we'd have to ask them that.
3 But sufficed to say, there are people who
4 reside in the north area who are going to MUSC
5 for ED services. And to get those right now
6 they go downtown.

7 A: Yes.

8 Q: Would it surprise you that MUSC's ED volumes
9 from the north area account for 25 percent, a
10 quarter, approximately of the total ED volume
11 that we do?

12 A: I can't say that I'm either surprised or not
13 surprised.

14 Q: Fair enough. Don't know. Fair enough. For
15 those patients, however many there are, and we
16 know there are some, who come from the north
17 area, now having to go all the way downtown to
18 get their ED care, because they choose to,
19 establishing an FED in that location would
20 improve geographic access for those patients.

21 A: For those patients that want specifically to go
22 to MUSC, yes.

23 Q: Right. It's just they'd have to drive less.
24 It's geography. You don't have any concerns
25 about MUSC providing high-quality ED care, do



1 you?

2 A: No.

3 Q: No concerns about MUSC emergency physicians
4 providing high-quality care?

5 A: No.

6 Q: In fact, as we heard yesterday, some of our
7 folks trained emergency physicians that work at
8 Roper, right?

9 A: Right.

10 Q: Psych holds. We heard some discussion about
11 that yesterday. Psych boarding. You're
12 familiar with both of those ---

13 A: Oh, yes.

14 Q: --- ideas, right? There were times when Roper
15 -- and there are times, I suppose -- when Roper
16 has psych patients boarding in the ED.

17 A: Yes.

18 Q: And that can be four, five, six, seven days,
19 trying to place those folks.

20 A: It can vary, depending on how difficult the
21 placement is.

22 Q: And why is it difficult? Where are we trying
23 to place?

24 A: Usually in an appropriate psych facility and
25 the psych hospital or other within the local

