

RECEIVED
Apr 12 2021
SC Court of Appeals

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

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 4

Daniel J. Westbrook
Travis Dayhuff
Nelson Mullins Riley & Scarborough LLP
1320 Main Street, 17th Floor (29201)
Post Office Box 11070 (29211-1070)
Columbia, SC 29211
(803) 799-2000

*Attorneys for Appellant Medical University
Hospital Authority d/b/a MUSC Health Emergency
Services*

David B. Summer
William R. Thomas
Amy S. Flanary-Smith
Parker Poe Adams & Bernstein LLP
1221 Main Street, Ste. 1100
Columbia, SC 29201

*Attorneys for Respondent Trident Medical Center,
LLC d/b/a Trident Medical Center and Summerville
Medical Center*

Ashley C. Biggers
Vito M. Wicevic
SC DHEC
2600 Bull Street
Columbia, SC 29201

*Attorneys for Respondent South Carolina
Department of Health and Environmental Control*

Jennifer J. Hollingsworth
Shannon Vogan Lipham
Nexsen Pruet, LLC
1230 Main Street, Ste. 700 (29201)
Post Office Box 2426
Columbia, SC 29202-2426

*Attorneys for Petitioner/Respondent 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*

**RECORD ON APPEAL
INDEX**

VOLUME 1

ORDERS

Order Denying MUHA’s Motion to Alter and Amend dated July 6, 2020	1
Order Denying MUHA’s CON for a Freestanding Emergency Department dated May 28, 2020.....	10
Amended Order Denying Summary Judgment (Standard 2 of South Carolina Health Plan) & Order Denying Motion for Reconsideration dated May 24, 2019	74
Order Denying MUHA’s Motion to Lift the Automatic Stay dated May 4, 2019.....	85
Order Denying Roper’s Motion for Summary Judgment (Standard 2 of South Carolina Health Plan) dated April 11, 2019	93
Order Denying Summary Judgment (Substantial Change) dated April 11, 2019.....	103

PLEADINGS

Roper’s Request for a Contested Case Hearing dated December 15, 2017, with exhibits:	110
Exhibit A – DHEC’s Decision Letter granting a Certificate Of Need to MUHA dated September 25, 2017;.....	114
Exhibit B – Roper’s Request for Final Review of DHEC Decision regarding MUHA’s application dated October 6, 2017;	122
Exhibit (A) – DHEC’s Decision Letter Granting a Certificate of Need to MUHA dated September 25, 2017;	125
Exhibit (B) – Roper’s Opposition letters to MUHA’s CON; Letter from Kathy Platt dated July 21, 2017 Letter from Ralph Barbier dated July 31, 2017;	133
Exhibit C – DHEC’s November 15, 2017 letter denying a final review of DHEC’s decision regarding MUHA’s application;	183
Exhibit D – Letter from Kathy Platt dated July 21, 2017 in opposition to MUHA’s CON	186
Exhibit E – Letter from Ralph Barbier dated July 31, 2017 in opposition to MUHA’s CON	199

Exhibit F – Roper’s August 24, 2017 PowerPoint presentation in opposition to MUHA’s CON	203

TRANSCRIPTS

Transcript of the 30(b)(6) Deposition of Thomas Matthew Hermann as Corporate Representative of Intuitive Health	238
Exhibits 1-71 to the Hermann Deposition Transcript <u>(FILED UNDER SEAL)</u>	397

VOLUME 2

Contested Case Hearing Transcript July 22, 2019 – August 2, 2019	747

Testimony:

Gregory Hall, MD

• Direct Examination	864
• Cross-Examination.....	953
• Re-Direct Examination	1040
• Re-Cross Examination	1079

Stephen D. Porter

• Direct Examination	1090
• Cross-Examination.....	1141

VOLUME 3

• Cross-Examination (CONT’D).....	1151
• Re-Direct Examination	1179
• Re-Cross Examination	1184

Joy Huntington

• Direct Examination	1186
• Cross-Examination.....	1264
• Re-Direct Examination	1299

Kathryn M.T. Platt

• Direct Examination	1316
• Cross-Examination.....	1513

VOLUME 4

• Cross-Examination (CONT’D).....	1551
• Re-Direct Examination	1582

Lisa Valentine

•	Direct Examination	1589
•	Cross-Examination.....	1636
•	Re-Direct Examination	1702
Joan Eccleston		
•	Direct Examination	1717
•	Cross-Examination.....	1748
•	Re-Direct Examination	1791
Richard Preston Wendell, MD		
•	Direct Examination	1792
•	Cross-Examination.....	1837
•	Re-Direct Examination	1855
Daniel Sullivan		
•	Direct Examination	1860

VOLUME 5

•	Direct Examination (CONT'D)	1951
•	Cross-Examination.....	1981
•	Re-Direct Examination	2053
Margaret Parham Murdock		
•	Direct Examination	2062
•	Cross-Examination (MUHA).....	2120
•	Cross- Examination (Roper)	2144
•	Cross-Examination (Trident)	2347

VOLUME 6

•	Cross-Examination (Trident) (CONT'D)	2351
Patrick Cawley, MD		
•	Direct Examination	2443
•	Cross-Examination (Trident)	2507
•	Cross-Examination (Roper)	2559
•	Re-Direct Examination	2610
David Louder, MD		
•	Direct Examination	2621
•	Cross-Examination.....	2663
•	Re-Direct Examination	2690
David Levitt		
•	Direct Examination	2692

VOLUME 7

- Direct Examination (CONT'D) 2751
- Cross-Examination (Roper) 2917
- Cross-Examination (Trident) 2952

Kathryn M.T. Platt

- Direct Examination 2973
- Cross-Examination.....3038

Daniel Sullivan

- Direct Examination 3060
- Cross-Examination.....3122
- Re-Direct Examination 3145

VOLUME 8

- Re-Direct Examination (CONT'D).....3151

TRIAL EXHIBITS

Joint Trial Exhibit 1 – MUSC’s CON Application for the Development of a Freestanding
Emergency Department 3155

VOLUME 9

Joint Trial Exhibit 1 – MUSC’s CON Application for the Development of a Freestanding
Emergency Department (CONT'D).....3551

MUSC Exhibit 02 – CV of Gregory Hall, MD 3718

MUSC Exhibit 03 – CV of David Levitt 3724

MUSC Exhibit 07 – April 9, 2018 Trident Medical Center, LLC CON for the
Construction of a Freestanding Emergency Department to be Located in James Island, SC
.....3728

VOLUME 10

MUSC Exhibit 07 – April 9, 2018 Trident Medical Center, LLC CON for the
Construction of a Freestanding Emergency Department to be Located in James Island, SC
(CONT'D).....3951

MUSC Exhibit 08 – April 12, 2017 Summerville Medical Center CON for the Construction of a Freestanding Emergency Department to be Located in Summerville, SC	4040

VOLUME 11

MUSC Exhibit 08 – April 12, 2017 Summerville Medical Center CON for the Construction of a Freestanding Emergency Department to be Located in Summerville, SC (CONT'D).....	4351

ROA 4531 through 5405 were removed from the Record by consent of all parties and a placeholder was inserted in their place

MUSC Exhibit 12 – November 7, 2017 Summerville Medical Center CON for Emergency Department and Ancillary Support Services Expansion	5406

VOLUME 12

MUSC Exhibit 12 – November 7, 2017 Summerville Medical Center CON for Emergency Department and Ancillary Support Services Expansion (CONT'D).....	5626

MUSC Exhibit 18 – LWOT Rate versus Patient Visits	5694A-B

MUSC Exhibit 30 – 2019-2024 MUSC Freestanding ED Service Area Population Growth	5694C

MUSC Exhibit 31 – 2019-2024 MUSC Freestanding ED Service Area Population Growth	5694D

MUSC Exhibit 32 – Map showing service area population growth	5694E

MUSC Exhibit 33 – Map showing the original and current proposed FED sites	5695

MUSC Exhibit 34 – FY 2015-2018 MUSC Downtown ED Patient Origin Growth.....	5695A

MUSC Exhibit 35 – Chart showing Tri-County Area and Berkeley County Resident ED Visit Growth 2015-2017	5696

MUSC Exhibit 36 – Chart showing Top 10 Fastest Growing Counties in SC 2019-2024.....	5697

MUSC Exhibit 37 – Chart showing Tri-County Area Hospitals Trend in ED Visits 2012-2017.....	5698

ROA 5699 and 5700 were removed from the Record by consent of all parties and a placeholder was inserted in their place

MUSC Exhibit 40 – Chart showing Proposed FS ED Service Area is Based on Shift of Existing MUSC Patients Resulting in More Convenient Access to Services they Already Seek at MUSC.....	5701

ROA 5702 was removed from the Record by consent of all parties and a placeholder was inserted in its place

MUSC Exhibit 42 – Map showing MUHA FSED Service Area Shift and Other Facility Locations.....	5703
MUSC Exhibit 44 – Chart showing MUSC Actual FY 2016 ED Visits and Projected Shift of Existing Patients	5704
MUSC Exhibit 49 – FY 16 MUSC ED Visits by Acuity Level, Berkeley FED Service Area compared to MUSC Total	5704A
MUSC Exhibit 50 – Chart showing MUSC FY 2016 MUSC ED Visits and Admissions by Level	5705
MUSC Exhibit 51 – Chart showing Comparison of FY 2016 Actual MUSC ED Patient Payor Mix.....	5706
MUSC Exhibit 60 -- Trial Exhibits of David S. Levitt (pp. 16-19; 30, 31).....	5707
Roper Exhibit 05 – February 24, 2017 Letter to Louis Eubank from Shannon Cantwell (Quarterly Progress Report regarding CON SC-16-01).....	5712
Roper Exhibit 06 – Page 8 of Data provided in native format	5719
Roper Exhibit 07 – Draft Deposition Exhibits of Kathryn M.T. Platt.....	5720
Roper Exhibit 19 – 08/30/2018 Email to Margaret P. Murdock from Louis Eubank attaching CON tracker	5743
Roper Exhibit 55 – 2015 South Carolina Health Plan	5809
Roper Exhibit 55 – 2015 South Carolina Health Plan	5951
Roper Exhibit 56 – 2017-2018 South Carolina Health Plan.....	5962

VOLUME 13

Roper Exhibit 56 – 2017-2018 South Carolina Health Plan (CONT'D).....	6026
Roper Exhibit 57 – 2018-2019 South Carolina Health Plan.....	6108
Roper Exhibit 59 – Kathryn M.T. Platt Exhibit and Demonstrative Presentation.....	6258
Roper Exhibit 62 – January 22, 2015 Letter to Mark Sims from Vonja Szatkowski deeming CON application 2105 complete	6292
Roper Exhibit 63 – Kathryn M.T. Platt Reply Exhibits.....	6293

Trident Exhibit 03 – February 19, 2019 Affidavit of Patrick J. Cawley, MD	6323
Trident Exhibit 20 – Charleston County map and three pages of handwritten notes of DHEC staff.....	6326
Trident Exhibit 47 – MUSC Freestanding ED Analysis Tri-County March 2016	6330
Trident Exhibit 53 – Charts showing capacity and utilization for MUSC facilities	6341
Trident Exhibit 62 – August 31, 2018 Summerville FSED Alternative Site.....	6344
Trident Exhibit 65 – Slide regarding the new ground lease for 1310 North Main, Summerville for Approval	6350
Trident Exhibit 67 – December 20, 2018 Minutes of MUSC Strategic Ventures Board of Directors meeting.....	6351
Trident Exhibit 68 – Intuitive Health ER & UC Program Joint Venture Package Presented to MUSC <u>(FILED UNDER SEAL)</u>	6353
Trident Exhibit 76 – July 2, 2019 E-mail to Greg A. Hall from Patrick J. Cawley.....	6367
Trident Exhibit 101 – Exhibits of Daniel J. Sullivan.....	6369

VOLUME 14

Trident Exhibit 102 – July 1, 2019 MUSC CON for 29 Additional Beds.....	6416

MOTIONS

Roper’s Motion for Summary Judgment dated February 8, 2019	6468
Exh. A 2015 South Carolina Health Plan, Chapter XI	6483
Exh. B 2017-2018 South Carolins Health Plan, Chapter 10.....	6491
Exh. C Referenced Excerpts from DHEC CON Record.....	6497
Exh. D 2018-2019 South Carolina Health Plan, Chapter 10	6526
Exh. E Affidavit of Kathryn M.T. Platt, Expert in Health Planning.....	6532
Att. 1 Curriculum Vitae	6537
Exh. F Summary Judgment Order in Berkeley Medical Center CON Extension Dispute	6541

Exh. G MUSC’s Memorandum in Opposition to Trident/Berkeley Medical Center’s Motion for Summary Judgment in Berkeley Medical Center CON Extension Dispute	6574
Exh. H DHEC’s Memorandum in Opposition to MUSC’s Motion for Summary Judgment in Berkeley Medical Center CON Extension Dispute.....	6591
MUSC’s Memorandum in Opposition to Roper’s Motion for Summary Judgment dated February 19, 2019	6600
Exh. A 09/25/2017 Decision Letter from M. Murdock to P. Cawley.....	6606
Exh. B 02/18/2019 Affidavit of David S. Levitt	6614
Exh. 1 Curriculum Vitae	6622
Exh. C Licensed Hospital List	6627
Roper’s Reply in Further Support of Motion for Summary Judgment dated February 25, 2019.....	6640
Exh. A 2015 Health Plan Excerpts as to Hospital Inventory	6648
Exh. B 2017-2018 Health Plan Excerpts as to Hospital Inventory	6658
Exh. C 2018-2019 Health Plan Excerpts as to Hospital Inventory	6668
MUSC’s Motion for Protective Order and Motion to Seal dated June 3, 2019.....	6678
Exh. A Commission for the Issuance of a Subpoena in Texas Compelling Intuitive Health, LLC to Produce Documents and to Appear and Provide Testimony	6685
Exh. 1 Subpoena Duces Tecum to Intuitive Health, LLC	6687
Exh. 2 Petitioner Trident Medical Center, LLC’s Notice of 30(B)(6) Deposition of Intuitive Health, LLC	6691
Exh. B Consent Confidentiality Order.....	6696
Roper’s Memorandum as to the Joint Defense Agreement Between Respondents dated July 30, 2019.....	6706
Trident’s Brief on the Joint Defense Agreement dated July 30, 2019.....	6713
Exh. A 03/04/2018 Email from Ashley Biggers.....	6721
Exh. B Excerpt from the deposition of Margaret Murdock	6724

MUSC’s Proposed Final Order dated November 8, 2019	6731
MUSC’s Proposed Final Order dated November 8, 2019 (CONT’D).....	6751
MUSC’s Motion to Alter and Amend dated June 8, 2020.....	6778
Roper’s Response in Opposition to MUSC’s Motion to Alter or Amend dated June 19, 2020.....	6785
<u>OTHER</u>	
MUHA’s Notice of Appeal, dated July 31, 2020.....	6794
2020 South Carolina Health Plan, pages 85-88	6870
CERTIFICATE OF COUNSEL	

1 the application.

2 Q: Well, whether it was there or not, it's been
3 moved -- these things have been moved to that
4 ---

5 A: They have been.

6 Q: Do you consider any of these individually or
7 collectively a substantial change?

8 A: I don't. And I also believe they were
9 appropriately presented in total and detail to
10 DHEC, which is the appropriate procedure.

11 Q: That would be the appropriate procedure by
12 regulation.

13 A: Yes.

14 Q: Once the CON is issued, right?

15 A: Yes.

16 Q: Are you aware of any regulation that says that
17 DHEC has the authority or the jurisdiction or
18 anything similar to that while a case is at the
19 ALC on a contested case appeal to make those
20 kind of determinations?

21 A: I think that's the typical practice, that you
22 would seek that same type of determination, you
23 know, if you're going to make changes to a
24 project before it's finally decided as well,
25 because it would be the same as if it's during



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

806

1 the review of a project, that you need to
2 notify the Department if you are going to
3 change something. And if it's substantial,
4 you'd have to re-file.

5 **MR. WESTBROOK:** Dan, let's look at Regulation 61-15,
6 Section 310, I believe.

7 **Q:** All right. It says -- as a regulation here --
8 or a section of the Regulation 61-15, it says
9 Project Changes During Review Period. If an
10 applicant amends his application during the
11 review process, the Department will determine
12 whether or not the amendment is substantial and
13 constitutes a new application. If the change
14 results in an increase in cost, the fees will
15 be adjusted accordingly.

16 Is it your understanding that we are in
17 the review process now?

18 **A:** No. We are in the litigation process, but we
19 are before the final approval. So, again, it's
20 sort of -- typically if you're going to make a
21 change, you seek a determination from the
22 Department whether it's substantial.

23 **Q:** Let's see here, Ms. Platt. Let me ask you
24 about some criteria, some project review
25 criteria. I tell you what, let's start by



1 going to the decision letter.

2 **MR. WESTBROOK:** Dan, can you find that for us and
3 put it up there for a minute?

4 **Q:** This is the DHEC decision letter from -- to
5 MUSC that was -- I think you looked at during
6 your Direct for a few minutes. Well, I tell
7 you what. While Dan's looking for that, Ms.
8 Platt, do you have it in front of you?

9 **A:** I do.

10 **Q:** Good. Where it lists the criteria that they're
11 looking at, the first one listed is community
12 need documentation; is that right?

13 **A:** It's compliance with need outlined in the South
14 Carolina Health Plan.

15 **Q:** All right. Well, let me go down from that to
16 -- I guess the second one would be community
17 need documentation; is that correct?

18 **A:** Yes.

19 **Q:** All right. With community need documentation,
20 I believe it's your testimony, but please
21 straighten me out on this if I'm mistaking
22 anything, that at the application period, you
23 evaluated this -- or analyzed or looked at this
24 application, you felt they did not -- that MUSC
25 did not comply with community need



1 documentation or activity; is that correct?

2 A: Correct, because they did not acknowledge all
3 the existing providers in the area.

4 Q: All right. And you don't believe that the
5 project complies with that criteria now either,
6 do you?

7 A: Correct.

8 Q: All right. How has that compliance changed
9 between then and now? I know how the project
10 has changed, but how has the compliance changed
11 with that criteria?

12 A: I guess my initial criticisms of the
13 application with respect to the information
14 provided about existing providers, about
15 capacity of those existing providers has not
16 necessarily changed, but that, within the
17 context of the projections, the projections
18 have not been updated, nor have they been
19 changed to reflect the range of services now to
20 be offered without the CDU. So my criticisms
21 are sort of doubly compounded by the fact that
22 we don't have a current projection or one that
23 reflects the new size of the facility or
24 service offerings.

25 Q: Right. Now, you felt the service area was too



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

809

1 large from the beginning, right?

2 A: Yes.

3 Q: And you think the -- you still think the
4 service area is too large, correct?

5 A: Yes.

6 Q: All right. The projections that Mr. Levitt
7 made for the amount of people that would shift
8 from the MUSC ED to the FED, you disagree with
9 from the beginning; isn't that correct?

10 A: I did disagree with that, yes.

11 Q: And you still disagree with that, correct?

12 A: And I disagree with them even further now
13 because they have not been updated to reflect,
14 one, more current information, two, the smaller
15 size of the facility, and three, the change in
16 the scope of the services offered that has
17 eliminated certain services that might allow
18 them to have higher-acuity patients.

19 Q: And those services being what?

20 A: The CDU and the helipad.

21 Q: So it's your opinion that the CDU and the
22 helipad would have allowed them to provide
23 services to higher-acuity patients than they
24 can without the CDU and helipad; is that right?

25 A: It would have been more appropriate for them to



1 serve some higher-acuity patients with those
2 components.

3 Q: All right. Appropriateness aside -- let me try
4 to rephrase that question -- is it your opinion
5 that they will be able to serve more high-
6 acuity patients with the CDU and helipad than
7 without?

8 A: Well, they will be able to serve -- with the
9 CDU and helipad and the original size of the
10 project, they would be able to serve a larger
11 number of patients in total and they would have
12 better ability to serve higher-acuity patients
13 that might require less adjustment to the
14 original projections in the application.

15 Q: And the -- when you say the size of the project
16 affecting the volume of patients, you're
17 talking about having fast-track rooms instead
18 of the original five rooms that were -- that
19 the fast-track rooms have replaced. Is that
20 your point?

21 A: Well, so when you add the fast-track rooms,
22 you're sort of skewing the level of services to
23 a lower-acuity level of care and you're
24 eliminating the CDU that would support the
25 patients who are at a higher-acuity level and



1 might need, you know, continued observation for
2 a longer period of time. So it overall skews
3 the patient acuity lower.

4 Q: So it's your understanding that the fast-track
5 rooms are going to provide services to --
6 because of the fast -- let me rephrase, let me
7 start over again with this question. Do I
8 understand correctly that you believe, because
9 there are five fast-track rooms, they're going
10 to serve more low-acuity patients than they
11 would have if they didn't have those five fast-
12 track rooms?

13 A: Well, it's designed that way. It's designed
14 for more lower-acuity patients. But there's no
15 update to the projection that shows anything
16 about the acuity that they're going to serve at
17 all.

18 Q: And did you criticize the acuity back before
19 DHEC approved this project? Did you criticize
20 the acuity projections or the lack of an acuity
21 factor being built into Mr. Levitt's
22 projections?

23 A: I did criticize it and primarily that there's
24 just no information whatsoever provided.

25 Q: All right. Did you -- at the time of the



1 application, did you believe that this project
2 complied with the distribution, accessibility
3 criteria?

4 A: No.

5 Q: And do you believe that it applies with it now
6 -- complies with is now?

7 A: No.

8 Q: And how is the compliance different between
9 then and now?

10 A: Well, there's additional ED capacity that's
11 been approved since that time. The Roper St.
12 Francis Berkeley Hospital is that much closer
13 to being online. The -- anything that might
14 have made the project a little bit unique with
15 the CDU and the helipad has been taken out of
16 the project. It's unclear how the payor mix
17 might have changed as a result of the sort of
18 shifting of service offerings between the CDU
19 and then now the fast track. So there's a
20 variety of elements that kind of compound my
21 opinion with respect to distribution and
22 accessibility.

23 Q: Let me -- clarify something for me. The change
24 in the scope of services that you reference
25 from time to time, you're talking about the



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

813

1 CDU, the change in the CDU, the change in the
2 helipad; is that right?

3 A: Yes.

4 Q: And the change in the designation of these
5 rooms to fast-track rooms; is that another
6 service difference in your mind?

7 A: Yes.

8 Q: Any other?

9 A: And the overall size.

10 Q: And the over -- when you say overall size,
11 you're talking about the square footage?

12 A: And the number of overall treatment spaces.

13 Q: All right. So the number of overall treatment
14 spaces in your mind right now is how many?

15 A: It's seven freestanding ED, you know, fully-
16 equipped rooms, and five rooms that it's
17 unclear how they're going to be equipped, but
18 they're part of the freestanding ED.

19 Q: The fast-track rooms, right?

20 A: Yes.

21 Q: Okay. All right. How about medically-
22 underserved criterion? Did you believe that
23 this project complied with medically-
24 underserved criterion back at the time of the
25 application?



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

814

1 A: Well, there was no payor-mix information
2 provided in the application, but that was my
3 primary criticism.

4 Q: And so the lack of payor-mix information, did
5 that mean it did not comply with the medically
6 underserved or did you think it did comply with
7 the medically underserved?

8 A: Well, without that information, if I were the
9 Department, I wouldn't be able to make a
10 determination whether there was -- you know, to
11 what extent they were going to serve Medicare,
12 Medicaid, and indigent patients, because,
13 again, no payor-mix information was being
14 provided. And if the information's not
15 provided, I would have found that they were not
16 consistent.

17 Q: Well, but of course right now you're not with
18 DHEC, but you are a health planner.

19 A: Right.

20 Q: And so I'm asking you as a health planner --
21 not as maybe a hypothetical DHEC employee, but
22 as a health planner representing Roper, was it
23 your opinion that they complied with that
24 medically-underserved criterion? Yes or no?

25 A: No. Not based on the information, really the



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

815

1 lack of information in the application.

2 Q: I understand. That's fine. Now, is it your
3 opinion that they comply with that criteria
4 now?

5 A: No.

6 Q: For the same reasons?

7 A: We haven't been provided with any payor-mix
8 information based on the distribution of
9 services and types of services to be offered.

10 Q: All right. So for the same reason, right?

11 A: Well, I mean, it's compounded by the fact that
12 it's, you know, changed locations. Again, this
13 whole sort of -- maybe they're not doing
14 anything with Intuitive, but the model of care
15 certainly has been influenced by Intuitive.
16 And the whole focus of this Intuitive model is
17 about seeking, you know, the appropriate
18 location to attract the best payor mix,
19 focusing on, you know, areas with high
20 household incomes and high levels of commercial
21 insurance.

22 Q: Does MUSC have a history of providing care to
23 Medicaid and indigent patients?

24 A: Absolutely they do.

25 Q: And it's a good history, isn't it?



1 A: Yes.

2 Q: All right. And do you think, because they
3 engaged in talks that eventually did not pan
4 out with a consulting company from Texas, that
5 they're going to abandon their mission to
6 provide care to the indigent and the medically
7 underserved?

8 A: I don't think they're going to abandon their
9 mission, but you have to look at each project
10 based on the information relative to that
11 project and not just the system as a whole.
12 And there's not any information available to
13 know, again, what is their projected payor mix,
14 how much of their services is going to be
15 provided to low income, indigent, charity,
16 Medicaid patients, Medicare patients. We just
17 don't know that information. But we do know
18 they moved their location to the location that
19 Intuitive identified as sort of the most
20 financially beneficial.

21 Q: All right. The next criterion I want to ask
22 you about, you talked about some in Direct,
23 resource availability. And resource
24 availability criterion deals with staffing,
25 correct?



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

817

1 A: Yes.

2 Q: All right. And I believe you said at your
3 deposition that, with respect to the -- at the
4 time of the application -- maybe I'm dreaming
5 this. Let me start this question over again.
6 What was your opinion about resource
7 availability compliance at the time of the
8 application?

9 A: That they didn't address it and that that was
10 a significant concern to Roper in terms of
11 their ability to attract and retain sufficient
12 both physician and other clinical staff,
13 especially at a time when they're getting ready
14 to open or working towards opening the Roper
15 St. Francis Berkeley Hospital.

16 Q: All right. So, for that reason, you felt they
17 did not comply -- MUSC did not comply with that
18 criteria?

19 A: I definitely thought it was a concern that
20 should be recognized by DHEC.

21 Q: And you felt they didn't comply with it?

22 A: Yes.

23 Q: Okay. And right now, I believe you said you
24 don't know whether they comply with it or not
25 because you don't have enough information. Is



1 that what you told me at your deposition?

2 A: Well, I still think it is a major concern. And
3 therefore, they shouldn't comply. But we are
4 working in a bigger vacuum now to make that
5 determination, because we have no idea what the
6 revised staffing might be for this new model of
7 care and the new size and number of treatment
8 spaces.

9 Q: Right. And because of that, I think you told
10 me they might not comply with it. But I didn't
11 remember you telling me that they did not --
12 that in your opinion now they don't comply with
13 it. I thought you said you didn't have enough
14 information.

15 A: Well, I don't have enough information to access
16 what their resource needs are and compare that
17 to, again, the same time Roper is trying to
18 staff up its new hospital. But in terms of
19 consideration for the limitations of the staff,
20 I don't think they comply.

21 Q: All right. And I asked you earlier about Ms.
22 -- you heard Ms. Huntington's testimony
23 yesterday, right?

24 A: Yes.

25 Q: Was there anything she said in her testimony



1 that you took issue with?

2 A: Not that I can think of.

3 Q: Bear with me just a minute please. All right.
4 The only other criterion that I was going to
5 ask you about, unless you tell me there's some
6 others at issue, is the adverse impact
7 criterion, which is referred to as adverse
8 effects I think in the 61-15. I believe that's
9 one of -- always been one of your concerns
10 about this project, right?

11 A: It is. But you also skipped over financial
12 feasibility.

13 Q: I'm sorry. I'm sorry. Financial feasibility.
14 Well, let's go to financial feasibility. I
15 remember you saying on your Direct that you
16 could not offer an opinion on that. Is that
17 right?

18 A: Well, we don't have any new updated financial
19 statements that would reflect the wide variety
20 of assumptions that would have to be modified
21 to reflect the changes in the project,
22 including the size, the configuration, the
23 services, the charge structure, potential payor
24 mix, the staffing, the capital-related
25 expenses. We just don't have anything for the



1 updated project to be able to fully evaluate
2 financial feasibility.

3 Q: All right. Based on that -- on the pro forma
4 that's in the application doesn't give you the
5 information you feel you need to evaluate that
6 criterion; is that my understanding?

7 A: Correct. It doesn't reflect the new project.

8 Q: Okay. What about at the time of the
9 application. Did you feel that the project met
10 the financial feasibility criteria then?

11 A: I think the assumptions were -- there wasn't a
12 lot of assumption information provided, but my
13 main concern at the time of the application was
14 the utilization projections that fed into them
15 and that links back to my criticisms of the
16 utilization projections in the original
17 application.

18 Q: And you still have those same concerns about
19 utilization projections; do you not?

20 A: I do. But I also have a wide variety of other
21 financial concerns since nothing has been
22 updated for the new project.

23 Q: And in terms of updating that needs to be done,
24 you just went through a litany of things, those
25 are the kind of updates you're talking about



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

821

1 that need to be done, right?

2 A: Yes.

3 Q: Okay. All right. Well, let's now go to
4 adverse effects, okay?

5 A: Okay.

6 Q: Adverse impact has been a concern of your since
7 the beginning; is that correct?

8 A: Yes.

9 Q: All right. And I think you believed at project
10 review that this project did not comply with
11 the adverse effects criteria, correct?

12 A: Yes.

13 Q: And you still think that, right?

14 A: And I still think that.

15 Q: Are the reasons you think -- and the reasons
16 that you think that, I believe, are -- or at
17 least the ones that I've heard, are that Mr.
18 Levitt's projections about the shift of folks
19 who are going downtown who would shift to the
20 new FED are overstated and not being able to
21 meet those projections that they would
22 inevitably try to take patients away from
23 existing providers; is that right?

24 A: That's generally correct.

25 Q: Okay. And that was your belief back then and



1 that's your belief right now, isn't it?

2 A: That piece is still generally true, but I don't
3 have any updated projection in which to
4 evaluate if that has changed with the new
5 project and the new model.

6 Q: All right. Okay. What I would like to do now
7 is go through your new slides, probably not all
8 of them.

9 **MR. WESTWOOD:** And, Your Honor, I don't know how
10 long this is going to take. If you would like
11 to take a break, this might be another half
12 hour or so.

13 **THE COURT:** Okay. We'll take a ten.

14 **MR. WESTWOOD:** Thank you.

15 **(Off the Record)**

16 **THE COURT:** Okay. If everyone is ready, we can
17 resume.

18 **MR. WESTBROOK:** All right. Dan, let's put up the
19 new slides. I don't remember the exhibit
20 number. What -- Roper 59. Roper 59, let's
21 start with slide three, please.

22 Q: We're not going to go through all of these, Ms.
23 Platt. But there are a few that I want to ask
24 you questions about.

25 A: Okay.



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

823

1 Q: So this one I want to ask you about the box at
2 the bottom, the red box at the bottom. And
3 this is taken from both the 2017 -- I'm going
4 to call it the 2017 and the 2019 Health Plan.
5 But they are -- I think the language is
6 identical. That's your ---

7 A: I believe it is.

8 Q: Yeah. And it says, the applicant must
9 demonstrate need for the service by documenting
10 capacity constraints within existing emergency
11 departments in the service area and/or a travel
12 time of greater than 15 minutes to an existing
13 emergency department in the service area,
14 right?

15 A: Right.

16 Q: What do you -- how do you interpret the service
17 area in that? Which service area are we
18 talking about; of the applicant or is there
19 another service area?

20 A: The applicant.

21 Q: Yeah. Okay. And it says in -- so that's sort
22 of a two-part sentence, isn't it; the first
23 part being about documenting capacity
24 constraints and the second part about the
25 travel time, right?



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

824

1 A: Yes. But it's an and/or.

2 Q: It's an and/or, right. And so that first --
3 before the and/or it says existing emergency
4 departments in the service area, correct?

5 A: Yes.

6 Q: And then the second -- and the second part of
7 the sentence also, once again, says existing
8 emergency departments, correct?

9 A: Yes.

10 Q: Now, do you interpret existing to mean
11 operational or those that have been approved to
12 get a CON, but are not yet operational?

13 A: Both.

14 Q: Okay. Let's go to slide -- it's the one that
15 says on the bottom updated RSF 7-005. There
16 you go. That one.

17 A: Okay.

18 Q: So the facilities that are listed here, the
19 first one listed MUSC Berkeley Hospital is not
20 operational yet, is it?

21 A: It is not.

22 Q: In fact, there's a trial scheduled this fall
23 for that -- related to that case; isn't that
24 correct?

25 A: Yes. I don't know exactly. Some time coming



1 up.

2 Q: Some time coming up. And then the second one,
3 Roper St. Francis Berkeley, I think you told us
4 earlier it's scheduled to open in October of
5 this year, right?

6 A: Yes. My understanding is October 4th.

7 Q: So it's not operational until then, correct?

8 A: It's not operational.

9 Q: Right. And the source for this information,
10 you see down at the bottom, is -- bear with me
11 a second. The source down at the bottom of
12 this, it says you've got this -- I guess, the
13 mileage and the time in minutes from Google; is
14 that right?

15 A: Yes, Google Maps.

16 Q: Google Maps. Yeah, Google Maps. And when you
17 go on Google Maps or when you went on Google
18 Maps to get this time or get this mileage of
19 the time, did you specify a particular time of
20 day? Well, it wouldn't affect the mileage
21 obviously. But the time of day could affect
22 the time; wouldn't that be correct?

23 A: It could. And this is sort of the standard
24 time. You know, a lot of times it'll give you
25 kind of the regular time and then the time with



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

826

1 traffic if you're during a peak hour. This is
2 just the standard time.

3 Q: So this is not the time with traffic; is that
4 what you're telling me?

5 A: Correct.

6 Q: Okay. Did it give any other kind of ranges of
7 time on Google Maps?

8 A: If you pick different mileages, you could get
9 different times. But I picked -- we picked the
10 shortest amount of time.

11 Q: All right. So you picked -- okay. So for the
12 -- let's say for the first one, MUSC Berkeley
13 Hospital, 2.8 miles. Once you got that 2.8
14 miles, you just checked the time for that 2.8
15 miles, correct?

16 A: Yes.

17 Q: All right. And when you checked the time for
18 the 2.8 miles, it gave you a regular time and
19 a time with traffic; is that correct?

20 A: It would if you were doing a search during a
21 peak traffic time.

22 Q: Okay. But you didn't do it during a peak
23 traffic time?

24 A: I -- they were done over a period of time, so
25 I think they were all done one morning, so it



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

827

1 may have included some peak time. But we
2 didn't include the peak time. This is just the
3 standard time.

4 Q: Okay. All right. And did you do this or
5 somebody working with you ---

6 A: My research analyst did it.

7 Q: Okay. Is that Tori?

8 A: No, she's a consultant. Mary Catherine.

9 Q: Okay. Thank you. Let's see here. Did you
10 check any other sources for the mileage or the
11 time other than Google Maps?

12 A: No.

13 Q: The next page -- or the next slide, rather, I
14 guess, is labeled just number seven down at the
15 bottom. And it says Existing and Approved ED
16 Capacity Within 20 Miles of MUSC FSED. And,
17 again, the first one on there, Roper St.
18 Francis Hospital Berkeley, we know about that.
19 Berkeley Medical Center down there, that's the
20 Trident facility that's not open yet either;
21 isn't that right?

22 A: Correct.

23 Q: Okay. All right. Let me go over to slide 14,
24 please. All right. You remember this one.
25 This is where you looked -- the map on the left



1 is the proposed service area that Intuitive
2 sent. And then the one on the right focuses on
3 the service area that MUSC is using. Is that
4 our understanding?

5 A: The one on the right is MUSC's ZIP code service
6 area with my overlay of 15 minutes.

7 Q: Sure. And the thing I want to ask you about is
8 the quote from Intuitive here. It says,
9 usually 13 minutes is as far as we go. In our
10 experience, roughly 90 percent of our volume
11 comes from within 13 minutes of the location.
12 You read that, I think, earlier into the
13 record, correct?

14 A: Yes.

15 Q: Now, Intuitive Health, I don't know how much
16 you know about them, but do you know that in
17 their experience that they -- well, first of
18 all, let me ask you an easy questions.
19 Intuitive doesn't have any -- as far as you
20 know, any facilities or any operations going on
21 in South Carolina, do they?

22 A: That's my understanding from their
23 representative's deposition last week.

24 Q: And that was the CEO, right?

25 A: I believe it was.



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

829

1 Q: Mr. Herrmann?

2 A: Yes.

3 Q: Okay. And so they don't have anything going on
4 in South Carolina. Do you know if they have,
5 in their experience, anything where they would
6 be partnering with or providing any kind of
7 services to an academic medical center
8 comparable to MUSC?

9 A: I don't know one way or another. From what I
10 recall of the deposition, it was just talking
11 about health systems.

12 Q: Okay. Let's go to 16 for a minute, please,
13 slide 16, MUSC Market Share of Tri-County ED
14 Patients. The top chart up there, the last
15 column, it shows the percent change for those
16 three years. It looks like the total is minus
17 0.2 percent. Has that material changed in your
18 mind?

19 A: It is in terms of market share, because that's
20 not the percent change of the market share.
21 That's the raw change. So that can represent
22 a good number of patients, reflecting a decline
23 in MUSC's volume while the market is growing.

24 Q: All right. And Let's look at -- let's go over
25 to 21, please. Twenty-one. And 21 we talked



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

830

1 about this on your Direct a little bit. The
2 source was 39 -- MUSC 3919, which is the big
3 spreadsheet, correct?

4 A: Yes.

5 Q: And then the CON application, one page of that.
6 And then there's a note below it's source. It
7 says, note: Percent appropriate based
8 deposition of G. Hall at page 80. And you
9 testified about that on your Direct. Let's
10 look at -- I'm going to ask Dan to put up page
11 80 of Dr. Hall's deposition on the screen. Can
12 you see it from where you are?

13 A: Yes.

14 Q: All right. Take a minute and look over that
15 and tell me what it is on page 80 that you
16 relied on for this chart.

17 A: Do you have a version that I can see, so it's
18 ---

19 Q: Yes.

20 A: Because I can only see a piece of it here.

21 Q: Okay. Well, I'll tell you what.

22 A: Thank you. So I think you have to kind of
23 start at the bottom of 79.

24 Q: Okay.

25 A: And then it goes over on the top and it said,



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

831

1 I would say primarily most of your patients
2 showing up at the freestanding ED would be
3 levels three and four. Level five is more
4 appropriate for urgent care or even perhaps
5 their family practice.

6 Q: Okay. And that's what the reference is on the
7 bottom of slide 21?

8 A: Yes. And some of the discussion starts on 79.
9 Perhaps I should have put 79 on there as well.

10 Q: Okay. Where does it -- tell me what line the
11 discussion starts on on 79.

12 A: So I guess it's -- the question starts on page
13 20 (sic). And there's a clarification ---

14 Q: You mean -- I'm sorry. You mean line 20?

15 A: I'm sorry, line 20 of page 79. And there's a
16 clarification about the severe high-level
17 traumas, the strokes, and they're talking about
18 ones and twos there. So it starts with that
19 clarification. Then it says, I would say
20 primarily most of your patients showing up at
21 the freestanding ED would be level three and
22 four.

23 Q: Okay. And based on that, you made the decision
24 to assign these percentages on 21?

25 A: Yes.



1 Q: All right. And did you consider -- let's take
2 a look at page 79 up where Dr. Hall's talking,
3 starting on line nine. Let me just read it in
4 and I'll ask you if you consider this is --
5 where it says, I would say, with the exception
6 of your acute stroke, your high-level trauma
7 patients, and your acute MI, all of which you
8 can expect to see at some point in time in a
9 freestanding ED, because they may come in
10 through those doors, but I would expect that
11 EMS would take those all to an accredited
12 center, which is what EMS is trained to do.
13 Other than that, freestanding ED should be
14 equipped with both the providers and services
15 and resources to be able to initially care for
16 any of those levels. Is that something you
17 considered?

18 A: Yes.

19 Q: And how is that reflected on this spreadsheet?

20 A: So they're -- I mean, a freestanding ED,
21 because they are a licensed part of the
22 hospital, has to be equipped and capable of
23 providing any level of care. But following on
24 down when there's a discussion of what really
25 comprises the ones and twos, the high-level



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

833

1 traumas, you know, the cardiac events and
2 stuff, basically they do have to be equipped to
3 care for those, but very few of those patients
4 would typically be transported there. Those
5 are the types of patients where you're going to
6 -- they are going to be transported by EMS and
7 EMS is not trained to do that. So I discounted
8 the ones and the twos based on that discussion
9 and then reflected, you know, the vast majority
10 of threes and the fours and the fives.

11 Q: All right. Okay. And let's go to slide 25.
12 Twenty-five has this from the 2015 State Health
13 Plan. And I think you read into the record the
14 sentence down at the bottom of the box, the
15 sentence that begins the benefits. Do you see
16 that?

17 A: Yes.

18 Q: And it says, the benefits of improved
19 accessibility will be equally weighed with the
20 adverse effects of duplication in evaluating
21 CON applications for this service, right?

22 A: Yes.

23 Q: Now, we also looked at on your Direct the two
24 health plans that followed this one.

25 A: Yes.



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

834

1 Q: Correct? And there's different language in
2 those plans for that sentence; is that not the
3 case?

4 A: There's a sentence I think before this one and
5 then, I think, a slight rewording of this
6 sentence.

7 Q: All right. Now, this one says improved
8 accessibility and adverse impact are equally
9 weighed, correct?

10 A: Yes.

11 Q: Let's look --

12 **MR. WESTBROOK:** Dan, why don't you pull up the
13 Health Plan. Is this the 2017 Health Plan?
14 The one that followed this one by three days,
15 I believe, past our application being filed, if
16 I heard that correctly. Yeah, not that
17 sentence, Dan. Let's take that off, that
18 highlight off. Go to the next page, Dan. No,
19 that's not it. No. No. Oh, yeah, there it
20 is. I'm sorry. I was looking at the -- I was
21 distracted by the first sentence. It's the
22 second sentence that's the corollary sentence.
23 Here it says, the benefits of improved
24 accessibility will outweigh the adverse effects
25 of duplication, correct?



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

835

1 A: It does.

2 Q: So this is the one that was not in place when
3 this application was filed, but it's the one
4 that followed that application, correct? I
5 mean -- let me start over there, that sentence.
6 So just to get this right. I know you've been
7 over this before. Just to make sure. When
8 this application was filed, it was the 2015
9 Plan, which says that improved accessibility
10 will be equally weighed with adverse effects,
11 correct?

12 A: Yes.

13 Q: And the State Health Plan it followed says
14 improved accessibility will outweigh the
15 adverse effects, correct?

16 A: It does. And it also qualifies that by now
17 putting a definition to what access means in
18 the first sentence, that access should be
19 available within 15 minutes. And that's why I
20 evaluated the services -- the existing service
21 availability within 15 minutes.

22 **MR. WESTBROOK:** Thank you. Speaking of 15 minutes,
23 I think that's what it's going to take for me
24 to get to my car, because that's all the
25 questions I have.



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

836

1 MS. HOLLINGSWORTH: It's a really hard act to follow,
2 literally, Mr. Westbrook.

3 THE COURT: Let's -- Ms. Biggers, do you have any
4 questions?

5 MS. BIGGERS: No. No questions, Your Honor. Thank
6 you, Your Honor.

7 MS. HOLLINGSWORTH: And I promise you, Your Honor,
8 it's not even more than a page. Just a couple
9 of questions.

10 MS. PLATT - RE-DIRECT EXAMINATION BY MS.
11 HOLLINGSWORTH:

12 Q: Maybe, too, it would just make sense to just go
13 backwards. Ms. Platt, if you would open the
14 CON application, Joint 1, and look at --
15 starting at -- let's just look at the decision
16 letter, quickly It's at 551.

17 A: Okay. I'm there.

18 Q: Okay. And then if you would just, you know,
19 quickly look over the decision letter, three or
20 four pages. And my question is simply -- you
21 were asked about this language in the 2015
22 Plan, that the benefits of improved
23 accessibility will be equally weighted with the
24 adverse effects of duplication in evaluating
25 Certificate of Need applications for this



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

837

1 service. And my question is, do you see
2 anywhere in the decision letter where that
3 requirement is addressed by the Department in
4 the decision letter?

5 A: No. I don't see any place where they address
6 that language.

7 Q: You were asked about the Roper -- you were
8 asked several questions about a project update
9 that Roper St. Francis provided to DHEC on the
10 Roper Berkeley construction update? You ---

11 A: Yes.

12 Q: --- remember that document?

13 **MS. HOLLINGSWORTH:** It's Roper 242 at the bottom.
14 There it is. It's been marked Roper 5. I would
15 move to have Roper's Exhibit 5 into evidence.

16 **MR. WESTBROOK:** No objection.

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

18 **(Petitioner Roper's Exhibit Number 5 was admitted**
19 **into the record at this time.)**

20 Q: And I just want to ask you, both of the Roper
21 witnesses were asked about this document
22 yesterday; do you recall that?

23 A: Yes.

24 Q: And I wanted to ask you -- my recollection, Ms.
25 Huntington, she testified about this document



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

838

1 as well; is that right?

2 A: Yes.

3 Q: And she was asked the same thing about the
4 bays. And do you recall her mentioning or
5 discussing that one of the rooms would have
6 two beds in it?

7 A: Yes.

8 Q: Okay. And so would you -- whatever her
9 testimony was as the director of emergency
10 services for Roper St. Francis in terms of any
11 bed count or space count in the Roper Berkeley
12 project, would you defer to her testimony about
13 that?

14 A: Absolutely.

15 Q: Okay. And then let me just ask you -- if we
16 could go up to the top of the second page of
17 the exhibit, perhaps. You were asked about
18 this letter to Mr. Eubank. Is your
19 understanding of the letter, especially having
20 gone through it in Cross, is Roper St. Francis
21 asking the Department to make a determination
22 about whether the Department believes the
23 changes are substantial?

24 A: Yes. That's my understanding of why the letter
25 was submitted.



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

839

1 Q: And I don't know that we were really clear
2 about it, but what was the project -- what was
3 the CON application for that Roper Berkeley
4 submitted back in, I guess, 2008?

5 A: I guess big picture, a 50-bed hospital in
6 Berkeley County.

7 Q: Okay. It wasn't an application for a
8 freestanding emergency service, was it?

9 A: No.

10 Q: All right. And it wasn't an application for
11 just an emergency department, was it?

12 A: No.

13 Q: And then I think the only other thing I just
14 wanted to ask you about your slides, Roper's
15 Exhibit 59. I just want to make sure I
16 understood. On Direct you were asked about the
17 -- you discussed this briefly with Mr.
18 Westbrook. We had originally looked at a
19 different slide and it had a different, maybe,
20 time period or source period. But he asked you
21 about this slide. Do you recall that?

22 A: Yes.

23 Q: And I just want to make sure I understood.
24 Your -- you agreed that -- and you had data
25 that supported that second column, that the



1 second column reflects -- as you found in the
2 MUSC data, this second column, that those were
3 the visits at the MUSC ED downtown? Total
4 visits. The second column on each of those --
5 it says visits at the top.

6 A: Yes.

7 Q: Okay. And so -- and that's what you were able
8 to document in the discover data?

9 A: Yes.

10 Q: Okay. But with regard to any assumptions
11 otherwise contained in the analysis in the
12 application, do you agree with those, the ZIP
13 code percentages or the totals of those, do you
14 agree with those?

15 A: No. I do not agree with the number of ZIP
16 codes included and how broad the area is. And
17 I don't agree with the appropriateness of the
18 shift for the vast majority of those ZIP codes.

19 **MS. HOLLINGSWORTH:** I don't have any other
20 questions. And Your Honor ...

21 **THE COURT:** Ms. Platt, let me ask you -- my attorney
22 here -- no, you can stay where you are.

23 **MS. HOLLINGSWORTH:** Okay.

24 **THE COURT:** My attorney here. Did you reference CMS
25 as being a source of data that you use?



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

841

1 **MS. PLATT:** There was an exhibit in my -- in the
2 RSF-7 packet that relied on information ---

3 **THE COURT:** Now, what is CMS?

4 **MS. PLATT:** It's the Center for Medicare and
5 Medicaid Services, the federal ---

6 **THE COURT:** Okay. Thank you. I just wanted
7 clarification on that. Thank you.

8 **MS. HOLLINGSWORTH:** And, Your Honor, although Ms.
9 Platt will be back next week, she does have
10 some travel commitments, so we would ask, if
11 everyone's okay with it, that she would be
12 released this afternoon. She will be back to
13 join us next week, if that's okay with The
14 Court.

15 **THE COURT:** We can't keep her away. Any problems
16 with that from ---

17 **MR. SUMMER:** No objection.

18 **MR. WESTBROOK:** (Shakes head negatively).

19 **THE COURT:** Thank you, Ms. Platt. And we'll see you
20 next week.

21 **MS. PLATT:** Thank you.

22 **MS. HOLLINGSWORTH:** And, Your Honor, those are the
23 witnesses that Roper St. Francis would offer in
24 our case. And we would be prepared to respond
25 next week to MUSC's witnesses and offer



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

842

1 rebuttal.

2 **THE COURT:** Okay. And, Mr. Summer, your witness
3 will be ---

4 **MR. SUMMER:** We're ready to start first thing in the
5 morning, bright and early, 9:00 o'clock, Your
6 Honor.

7 **THE COURT:** Okay. We'll be here at 9:00. Okay.

8 **MR. SUMMER:** Thank you.

9 **THE COURT:** We'll adjourn until 9:00.

10 **MS. HOLLINGSWORTH:** Thank you, Your Honor.

11 **(Wednesday, July 24, 2019 administrative hearing**
12 **ended at 4:57 p.m. and reconvened on Thursday, July**
13 **25, 2019 at 9:17 a.m.)**

14 **DAY FOUR - JULY 25, 2019**

15 **MR. SUMMER:** Good morning, Your Honor.

16 **THE COURT:** Good morning. And we're ready?

17 **MR. SUMMER:** We are ready.

18 **THE COURT:** Okay. Mr. and Mrs. Summer (sic), you're
19 going to begin?

20 **MR. SUMMER:** We'll kick it off this morning. Thank
21 you, Your Honor. Trident would like to call
22 its first witness. That would be Mrs. Lisa
23 Valentine.

24 **THE COURT:** Ms. Valentine, if you -- before you take
25 your seat, if you'll face the court reporter,



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

843

1 raise your right hand, she will swear you.

2 **LISA VALENTINE**, having been duly sworn, testifies as
3 follows:

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

6 **MS. VALENTINE:** Lisa Valentine, L-I-S-A V-A-L-E-N-T-
7 I-N-E.

8 **MS. VALENTINE - DIRECT EXAMINATION BY MR. SUMMER:**

9 Q: Good morning, Ms. Valentine. How are you
10 today?

11 A: I'm good, thank you.

12 Q: Would you do me a favor and tell The Court a
13 little bit about your background? Where were
14 you originally from?

15 A: Sure. Born and raised in north Florida in a
16 little town called Live Oak, the rural part of
17 north Florida on a farm.

18 Q: And where did you go to college?

19 A: I went to college at the University of Florida
20 for my bachelor's degree in physical therapy.
21 And then after that, master's in health
22 administration at Virginia Commonwealth
23 University.

24 Q: Tell The Court a little bit, if you don't mind,
25 about your work experience. What have you done



1 during the course of your career?

2 A: So just about 33 years in healthcare
3 experience. I started my career as a physical
4 therapist. Actually my first job was in an
5 inpatient rehabilitation hospital working with
6 spinal cord injured patients, head injured
7 patients, those with traumatic injuries.
8 Worked as an outpatient physical therapist, in
9 orthopaedic practice, also worked at a hospital
10 in occupational medicine practice as well. I
11 did that for -- in clinical practice about
12 eight or ten years. Went on to be the director
13 of a rehabilitation services department in a
14 hospital for several years. Then a service
15 line administrator for rehabilitation services
16 for five hospitals there in Richmond, Virginia,
17 which is where I was, doing both strategy and
18 operational planning for those hospitals for
19 rehabilitation services.

20 Q: Where -- what does the name of those hospitals
21 in that system that you were in?

22 A: It's the HCA system there. It's Henrico
23 Doctor's Hospital, Chippenham Medical Center,
24 Johnston Willis Medical Center, John Randolph
25 Medical Center, Henrico Parham, and we have a



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

845

1 Henrico Retreat now is the name of the
2 hospitals.

3 Q: So that was a multi-hospital system?

4 A: That's correct.

5 Q: How many beds were in that system?

6 A: You know, well over 1,000 plus in that role for
7 those hospitals. I then went on to be the
8 chief operating officer for Henrico Doctor's
9 Hospital, which is a three-campus, 700 plus bed
10 hospital. My role there as COO was to manage
11 operations for the hospital, work on strategic
12 planning, just a variety of things.

13 Q: Okay. And when did you come to South Carolina?

14 A: I came here in 2014 as the chief executive
15 officer of Summerville Medical Center. So I've
16 been in that role a little over five years.

17 Q: Okay. Let's talk a little bit about the
18 Trident system. And tell me first of all what
19 is your role at a Summerville Medical Center.

20 A: So I'm the chief executive officer there. My
21 job is to manage all of the operational,
22 strategic priorities for the facility, really
23 to just make sure that we're meeting our
24 mission and serving the community. And that's
25 everything from quality to operations and then,



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

846

1 again, the community engagement piece as well.

2 Q: Okay. And I see that you're a fellow with
3 FACHE. Can -- I think The Court's getting to
4 learn a lot of acronyms this week. But would
5 you explain to The Court what that organization
6 is?

7 A: Sure. So the American College of Healthcare
8 Executives is the national professional
9 association for healthcare executives. The
10 fellow, which is the F in this acronym, is the
11 certification that you receive for achievement
12 and certifying your capabilities and experience
13 as a healthcare executive. And so you have to
14 have a certain number of years of experience.
15 You have to have references from other
16 individuals who achieve that certification.
17 And you have to take an exam, a national exam,
18 and pass that, in order to obtain the
19 certification. And then you re-certify every
20 six or eight years or so.

21 Q: What I'd like to do next is let you explain to
22 The Court two things really. And that would be
23 the history of Trident Medical Center, and now
24 Trident Health System, and then the evolution
25 of those facilities, okay?



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

847

1 A: Sure. So HCA and Trident Health System really
2 started back in the early '70s and really
3 before we were working in the market and
4 serving the community here. There were only
5 ten hospitals in the area, both in Charleston,
6 Berkeley, and Dorchester. Eight of those were
7 for non-military residents. And so of those
8 eight -- or eight of those ten, rather, were
9 actually in the Charleston County area. So --
10 and when you looked further into that, six of
11 those ten hospitals were really down by the
12 peninsula.

13 Q: Okay. Is this how they break down?

14 A: Sure. So, again, this is before Trident
15 Medical Center came to the market. And so on
16 the peninsula itself of course you had MUSC,
17 Roper Hospital, St. Francis, McClennan Banks,
18 Charleston County, and, again, a VA hospital.
19 Additionally in the county, more in that
20 northern part, a little bit away from the
21 peninsula you had Roper Hospital, a Navel
22 hospital.

23 Q: Okay.

24 A: And then really the -- our deficits were in
25 Dorchester and Berkeley County. And you can



1 see in Dorchester County, which is, you know,
2 obviously where Summerville is, in downtown
3 Summerville you had a 78-bed hospital. It was
4 in very poor condition in the early 70s. In
5 fact, it either needed major renovation or
6 replacement. And you can see a little bit of
7 that evidence, because in 1972 they requested
8 a waiver for sprinkler code requirements.
9 That's a pretty dire request in my view for a
10 hospital to ask for. So definitely a facility
11 that needed a lot of infrastructure work.

12 In Berkeley County, you had a 60-bed
13 hospital. But really they only had 37 beds in
14 use. It was out in Moncks Corner. And, again,
15 either needed a major renovation or replacement
16 in order to be functioning effectively.

17 Q: My understanding is that there was a community
18 committee that was called the Charleston Area
19 Comprehensive Health Planning Counsel. And
20 they apparently made some kind of a
21 recommendation. What was that?

22 A: So, as I understand it, there was this
23 community counsel that came together with
24 representatives from both of the counties and
25 the healthcare providers in the area. And



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

849

1 really, to determine how do we address this
2 issue of gap in this northern Dorchester,
3 Berkeley County market. And so what you see
4 there is a portion of that report. And from
5 there the board of directors of that planning
6 committee are really recommending a regional
7 hospital to serve that broader area.

8 Q: Okay. And so who stepped up to the plate to
9 provide that facility?

10 A: So Hospital Corporation of America, also known
11 as HCA now, is my parent company of Summerville
12 Medical Center and Trident Medical Center. And
13 they came forward -- and they were asked to
14 build and they came forward and did, in fact,
15 meet that request.

16 Q: Okay. And what was your -- what's your
17 understanding about what the community
18 understanding was, the commitment was, what was
19 going to happen to those hospitals, the one in
20 Summerville and the one in Moncks Corner, if
21 HCA were to make this investment?

22 A: So -- and this is an excerpt from, I believe,
23 the Board of Trustees of the Berkeley County
24 Hospital. Those other facilities were going to
25 go on to be other types of healthcare



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

850

1 facilities, depending upon the needs of the
2 community, but no longer functioning as a
3 hospital, again, for many reasons. But
4 certainly it sounds like the condition of those
5 facilities was really significantly and for
6 repair. And so creating one hospital to serve
7 this regional -- this north regional area was
8 the request or recommendation.

9 Q: So those two county hospitals agreed to close
10 if HCA built a hospital?

11 A: That's correct.

12 Q: When was the CON issued?

13 A: So 1972. And what you see there is a portion
14 of that CON document. So Tommy Frist actually
15 is a physician and he's a founder of our
16 company. And so that's a letter to him with
17 the CON approval.

18 Q: And it says construction of a 200-bed full-
19 service hospital. Is that what it was?

20 A: That's correct. So it originally was called
21 North Trident Regional Medical Center. And
22 that is what is today known as Trident Medical
23 Center.

24 Q: Okay. So if you don't mind, explain to The
25 Court what's depicted on this map.



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

851

1 A: I'm going to look a little closer to this one
2 where I can see it here. So what you see there
3 in the green is what was originally known as
4 North Trident Regional Hospital, now known as
5 Trident Medical Center. That's that 200-bed
6 hospital that was requested by this planning
7 counsel and our company, you know, stepped
8 forward to provide and the CON was issued. So
9 that is that 200-bed hospital. And then what
10 you see those boxes on the right and the left,
11 on the right is the Berkeley County Hospital
12 that closed and then on the left is the
13 Dorchester County Hospital that closed. Those,
14 again, were those hospitals referenced earlier
15 as being in disrepair.

16 Q: Okay. Now, what was your commitment, if you
17 will, in terms of future growth to the
18 community?

19 A: Yeah. So the commitment was that we would
20 begin with this regional medical center, but as
21 the community grew, would continue to add
22 services, add locations, add, you know,
23 resources to serve the community as it grew.
24 And so 1972 is when the Certificate of Need
25 approval was received. And three years later,



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

852

1 about the building time, design and building
2 time of a new facility, is when Trident
3 Regional Medical Center was opened, in 1975.
4 They're, again, known as Trident Medical
5 Center.

6 Q: Okay. Tell me a little bit about that first
7 hospital.

8 A: Sure. So it had full range of services. Of
9 course emergency services, medical-surgical
10 care, women's care, maternity care, pediatrics,
11 intensive care services, cardiac services. So
12 really kind of that full array of services you
13 would want in an acute care hospital.

14 Q: It had 200 beds?

15 A: Two hundred beds.

16 Q: Which is substantially more than the two
17 counties combined had before?

18 A: Yeah. Interestingly enough, you know, I'm
19 pleased to say someone had a lot of foresight
20 in looking at what the needs of the community
21 would be going down the road. So you had a 78-
22 bed hospital I believe in Summerville. You had
23 this 60-some-odd-bed hospital in Moncks Corner
24 that only operated 37. And so to really build
25 ahead of the need, frankly, you know, I'm



1 grateful that somebody really looked ahead and
2 did that and made that sizeable investment in
3 this replacement facility.

4 Q: Okay. Talk to me a little bit about how your
5 commitment to these two counties has evolved
6 through the years. Let's start first with
7 Berkeley.

8 A: So Berkeley County, we have their Moncks Corner
9 Medical Center. In 1983 it actually started.
10 So this was -- if you think about it, it was
11 1972 the CON was approved, 1975 Trident
12 Regional Center was opened. And as the
13 community began to grow, we added new services.
14 So in 1983 in Moncks Corner there was an
15 outpatient facility. So diagnostic service,
16 things like x-ray, ultrasound, lab services,
17 and some part-time physician services as well.
18 And then later in 1999, a full-service, 24-hour
19 freestanding emergency room was built there as
20 well.

21 Q: Okay. And then how has your commitment evolved
22 in Dorchester County?

23 A: So in Dorchester County, Summerville Medical
24 Center, which is the hospital, of course, that
25 I oversee, in 1989 we built a 24/7 freestanding



1 emergency room. So full-service emergency room
2 services for that community, as well as
3 outpatient services. So, again, x-ray, lab,
4 ultrasound, those kinds of things that the
5 community needs for outpatient care. And then
6 in 1993 the hospital was built. So full
7 service, again, acute-care hospital, emergency
8 room, medical-surgical services, women's
9 services, intensive care services. So our
10 Hospital has been there now, you know, well
11 over 25 years serving the community.

12 Q: And how about in North Charleston?

13 A: So as, again, the community continued to grow,
14 we continued to grow with it. And so in the
15 North Charleston area, Centre Pointe Emergency,
16 which, again, is a full-service, 24/7
17 freestanding emergency department, was opened
18 in 2014.

19 Q: Okay. So talk to me a little bit about what it
20 looks like today in toto.

21 A: Sure. So if you see on the left, obviously,
22 that's the early '70s, right. That's the
23 result of the counsel's or the advisory group's
24 recommendation, which is let's place a hospital
25 in this northern market, North Trident Regional



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

855

1 Hospital, and let's close these other two
2 hospitals, with the agreement of the counties,
3 and let's make sure we've got something that
4 will actually serve the community going into
5 the future and continue to make investments as
6 the community grows in order to serve this
7 market. So on the right side, what you see is
8 a current state of both hospitals and
9 freestanding emergency rooms. On the far left,
10 of course, on the bottom there is Summerville
11 Medical Center. And we are in Summerville,
12 South Carolina. Down on the right, adjacent to
13 that is Trident Regional -- excuse me, Trident
14 Medical Center. And that's currently in North
15 Charleston. Full-service hospital. And I
16 think we're going to talk about that in just a
17 moment. Down below on the right is that Centre
18 Pointe freestanding emergency room that we just
19 discussed. And in the top right is Moncks
20 Corner Medical Center, that freestanding
21 emergency room with outpatient services as
22 well.

23 Q: So over the last 44 years I'm assuming that
24 each time you needed one of these services, you
25 went and relied upon the CON program to get it.



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

856

1 A: Absolutely. You know, that's the purpose of
2 CON, is appropriate healthcare planning for the
3 community and making sure that, as
4 organizations and hospitals are working to
5 better serve the community, that the CON
6 process is there to help us do that, guide that
7 process, ensure that we're, you know, meeting
8 the needs of the community.

9 Q: And so over the last 44 years, your company has
10 expended hundreds of millions of dollars in
11 reliance on that program?

12 A: We have. So, again, came to the community and
13 started spending resources in 1972. Trident
14 Regional Medical Center was opened in '75. We
15 have spent hundreds and hundreds of millions of
16 dollars investing in facilities, equipment,
17 resources, recruiting specialists, recruiting
18 staff, building programs. So, as the community
19 grew, we really looked at, you know, what kind
20 of needs are there in community; who's coming
21 to our emergency room; what kind of services
22 are physicians saying that we don't have that
23 our community needs and methodically building
24 those. It has been a sizeable investment.
25 It's one that we're committed to. It's our



1 mission. It is our commitment to the
2 community. It was made in the '70s, but we're
3 still living it out today. It's incredibly
4 important to me as an executive to make sure
5 that we continue to do that. And I think our
6 company's done a very good job. And it's
7 personal for me. You know, I started as a
8 clinician. I'm a physical therapist by trade.
9 I've been at the bedside. So what happens in
10 our community makes a difference to me. And
11 I've really been focused on, as an executive,
12 how do we continue to grow the services our
13 neighbors need, our employers need, our
14 community needs, as we go forward. So I'm
15 proud of the work that we've done. And it has
16 been a big investment on the part of our
17 company.

18 Q: Okay. Let's just take a snapshot and look at
19 2018, just to give The Court an example of how
20 broad this healthcare system is and all these
21 facilities, what they do.

22 A: Sure. So this is 2018, just so one year's
23 data. You can see across our health system all
24 of these entities, 376,000 patients treated.
25 And we do a lot of ER care. So ER visits,



1 174,000 in our four ERs. That's significant.
2 We have over 3,000 employees. We call them
3 colleagues. So we are, you know, invested in
4 the community. We're a part of the community.
5 We're ingrained in the community. We have over
6 231 million dollars in salary wages and
7 benefits each year. So we do support that
8 growth. And just in 2018 alone, we spent 71
9 million dollars in capital investments. That's
10 just one year. Across our ERs, you know, we're
11 probably talking 50 to 60 million dollars in ER
12 expansion over the last several years. So,
13 again, we've worked very hard to invest in this
14 community to make sure we're serving them well.

15 We also, in that one year alone, provided
16 more than 51 million dollars in charity care.
17 We are a tax-paying entity and I'm proud of
18 that. I'm proud that we're investing in the
19 infrastructure of our community. And so we
20 paid 34 million dollars in taxes as well in
21 2018.

22 Q: What I'd like to do now is pivot and look at
23 each of the major facilities and just talk
24 about what they do. Let's start first with the
25 original flagship, which is Trident Medical



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

859

1 Center. First I would ask you, who is the CEO
2 over that center?

3 A: So Todd Gallati is the chief executive officer
4 for Trident Medical Center.

5 Q: And explain to The Court the breadth of the
6 services that are available there.

7 A: Sure. From a 200-bed hospital now to a 321-bed
8 acute-care hospital, Trident Medical Center
9 really is a tertiary specialty hospital for our
10 health system. They certainly have a very busy
11 24-hour emergency room. They do have a Level
12 II trauma program. Again, incredibly important
13 as this northern part of the Tri-County
14 continues to grow. Neuroscience services,
15 stroke care, cardiovascular services,
16 orthopaedic, spinal care, cancer care is an
17 important part of the program, services that
18 they offer there as well. Behavioral health.
19 You know, our community, like many communities,
20 has a real need for those services and we've
21 certainly made investments there as well. A
22 wide array of surgery offerings, robotic
23 surgery, a burn clinic as well, inpatient,
24 outpatient rehab services, wound care.

25 This is not an all-inclusive list, but



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

860

1 really what I think the folks that have been
2 leading that hospital have done really well
3 over the last 40 years, it's been over 40 years
4 since this hospital opened, is methodically
5 added services that the community needed,
6 understanding what is happening in the
7 community, what are the gaps, what are the
8 needs, how do we ensure residents have access
9 to that service there in their home community.

10 Q: Okay. Now, does Trident have a full-service
11 cardiac program?

12 A: They do.

13 Q: Okay. So they have open-heart surgeries?

14 A: They do.

15 Q: Do they do emergency catheterization?

16 A: They do.

17 Q: 24/7?

18 A: Yes.

19 Q: Okay. Talk to me a little bit about -- I think
20 you know more about this hospital.

21 A: Sure.

22 Q: Talk to me about this one.

23 A: This is my hospital. So we're now a 124-bed
24 hospital. Again, full service. We do have a
25 very busy 24-hour emergency room. And most



1 recently -- again, this is not an all-inclusive
2 list, but most recently we've made some
3 significant investments in women's neonatal and
4 pediatric services. In fact, we've just, in
5 the last couple of months, finished up a 53
6 million dollar expansion of our women's and
7 neonatal services. And really, that was driven
8 by our community need. So we have a brand new
9 labor and delivery, Level II NICU. We've, as
10 well, added dedicated pediatric ER care. We
11 have a pediatric intensive care unit, with
12 critical care physicians that oversee those
13 patients. Maternal-fetal medicine is -- are
14 the specialists, the physicians who care for
15 moms with high-risk pregnancies. And so we've
16 added services for that as well. Genetic
17 counselor for those moms as well.
18 Urogynecology. We have a full array of
19 surgical services also, bariatric,
20 neuroscience, stroke care, and outpatient
21 services.

22 Again, not an all-inclusive list. But as
23 we look at where we began and where we are now,
24 it really has been a targeted process of
25 understanding what does the community need,



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

862

1 where are the gaps, what do we need to be doing
2 at this hospital to better serve our community.

3 Q: Talk to me a little bit about Centre Pointe.

4 A: So Centre Pointe Medical Center is a 24/7
5 freestanding emergency room. So Board
6 certified emergency medicine physicians and
7 ancillary staff, nurses and others, who provide
8 emergency care. You'll see, again, medical
9 imaging, laboratory services, those kinds of
10 things that support that emergency --
11 freestanding emergency care. That's in the
12 North Charleston area. And that's the one, I
13 believe, that opened in 2014.

14 Q: Okay. Explain to The Court what HCA has up in
15 Moncks Corner.

16 A: So Moncks Corner Medical Center, again, is a
17 freestanding, full-service, 24/7 emergency room
18 with all of the Board certified emergency
19 medicine physicians and clinicians needed to
20 care for those patients. We also have some
21 physician practices that rotate through there.
22 We have imaging, ultrasound, laboratory
23 services, and other outpatient services to
24 serve that community in that upper part of
25 Berkeley County.



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

863

1 Q: Let's talk a little bit about the services that
2 you provide. And let's start with what we're
3 here for today, and that's emergency services.

4 A: So across our health system, I think we talked
5 earlier, 174,000 emergency visits in 2018
6 alone. And really what we've seen and what
7 we've been planning for, is, you know, keeping
8 up with that growth in the community. And we
9 certainly have been doing that with investments
10 at all of our hospitals.

11 At the Trident Medical Center campus,
12 about a year ago they finished up a 14 million
13 dollar expansion and renovation there, really,
14 again, designed to keep up with the needs of
15 community. At our Summerville campus we just
16 kicked off a 24 million dollar ER expansion,
17 which started in April and will finish up this
18 summer, to expand both adult and pediatric
19 emergency services for our community.
20 Additionally, we had a CON approved and funding
21 approved and will break ground probably next
22 month on a freestanding emergency room there in
23 the Summerville area. I believe it's less than
24 a mile away from the MUSC's proposed
25 freestanding ER. We also, in addition to



1 emergency care, we have urgent care centers as
2 well. And we've got two of those that we
3 opened up in the last year, one in Goose Creek
4 and one in that North Charleston area.

5 Q: You mentioned there were two separate projects,
6 one at Trident and one at Summerville, that
7 include renovation and expansions. What kind
8 of efficiencies and improvements do you get
9 when you modernize an ED and do those
10 renovations?

11 A: Well, if you do it well and you look through
12 the analysis and you understand your workflow,
13 you are looking at everything from how does the
14 patient enter the facility, to what size is the
15 waiting room, to what does the triage area look
16 like, and what's the workflow patterns of the
17 patients that are in there. And so when we
18 work through those design processes, we're
19 looking specifically at where are we having our
20 biggest opportunities; what might the existing
21 facility not have anticipated that we need to
22 go and correct at this point, based on what
23 kinds of patients we're seeing, what time of
24 day we're seeing them. So it absolutely makes
25 a big impact.



1 Not only on capacity, so just the ability
2 to see more patients, but you can improve
3 throughput through better design. And what you
4 design in 19 -- for us in 1993 or 1989 is going
5 to look different than what we see today.
6 Medicine has changed. Our community has
7 changed. So you do try to take some time in
8 that design process to really understand what's
9 working well, what's not. Involve your
10 clinicians, you know, hearing from ER
11 physicians, hearing from ER staff,
12 incorporating those things in the design make
13 a difference. Because healthcare is changing,
14 medicine is changing, and we want to make sure,
15 as we're bringing in new services on line and
16 renovating them and expanding, that we're
17 bringing those current practices into the
18 equation.

19 Q: When you speak of throughput, can you explain
20 to The Court what throughput is and what your
21 goal is in terms of trying to shorten that time
22 period?

23 A: That's a really good question. So, you know,
24 whenever you come to the ER for care, no matter
25 what you're there for, you want it fast, right?



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

866

1 And it doesn't matter if it's for yourself or
2 for your family. And so we do measure every
3 component of the process. For example, a
4 patient who comes into the facility, walks in
5 the facility, our goal is to in no less than
6 ten minutes have that patient seen by a
7 provider, either a physician or a physician
8 assistant; someone in the clinical realm is
9 looking at them and beginning that process.
10 That happens -- triage happens within minutes.
11 But that is one of the goals, that arrive-to-
12 greet, as we call it, in a ten-minute or less
13 time frame. So that's one of them. You know,
14 Joan Eccleston is an expert in ER care. I'm
15 sure she can dig into the details a little bit
16 better than I. But that's just one example.
17 We want ER care to be fast. We want it to be
18 effective. We want it to be caring and kind.
19 And so we look at all of those things as we're
20 designing and renovating ERs.

21 Q: Okay. Talk to me a little bit about trauma.

22 A: Yes. So trauma, this is a program at Trident
23 Medical Center. They are a Level II trauma
24 program. This program started several years
25 ago and really has been, in my view, a great



1 benefit to the community and frankly getting
2 those patients faster care. Just like with a
3 lot of very, very serious conditions, trauma,
4 minutes matter. And so being able to have this
5 trauma program in that north part of
6 Charleston's critical. They do have Board
7 certified trauma surgeons and a variety of
8 resources obviously to care for those patients
9 that come in.

10 Q: Okay. Talk to us a little bit about CV care.

11 A: So cardiothoracic and vascular care, again, at
12 Trident Medical Center, they have the full
13 array of open heart surgical care,
14 interventional cardiac care, stroke care as
15 well, and have recruited surgeons and added
16 resources, invested in new cath labs and other
17 things over the course of the years. Again, as
18 medicine has changed and as the community has
19 grown, really making sure that that service is
20 keeping up with the needs of the community.

21 We do have telehealth robots in the ER --
22 in all of our four ERs. And what that is and
23 why that's important is because, when you come
24 in with a symptom of stroke or have a family
25 member that comes in with a symptom of stroke,



1 they need -- minutes matter, again. You know,
2 you want to get that care immediately. You
3 want to assess quickly, determine if this is a
4 stroke, what kind of stroke, and what type of
5 intervention do they need quickly. And so not
6 only do we have a neurologist on staff, we have
7 ER physicians, obviously, on staff, but we can
8 quickly have a neurologist link in via
9 telemedicine and also provide expertise in that
10 care.

11 Q: Again, this week we've been throwing a lot of
12 phrases around like AMI and STEMIs and things
13 of that nature. When a patient is having a
14 heart attack, what is the standard cardiac
15 treatment usually going to be?

16 A: It's going to be a cardiac cath or an
17 intervention as we call it, a cardiovascular
18 intervention.

19 Q: Can you explain to The Court what cardiac
20 catheterization is?

21 A: Well, David ...

22 Q: Generally. As an administrator -- as an
23 administrator.

24 A: All right. You're going to get the CEO
25 version. Is that okay?



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

869

1 Q: That's fine.

2 A: All right. So there's a blockage somewhere in
3 that vessel, in that heart vessel. And so the
4 goal is to go in there and take the blockage
5 away, put a stint in or something to preserve
6 the vessel. And quickly. Because, while that
7 vessel is occluded, or blocked, you are losing
8 heart muscle. And when you lose heart muscle,
9 you lose function over time. You diminish the
10 ability for the heart to work effectively. And
11 so minutes do matter, just like in stroke or
12 just like in trauma. So, yes, the team at
13 Trident Medical Center does a great job,
14 really, in making sure that that process goes
15 as quickly as possible.

16 Q: As an administrator, is door-to-balloon time
17 important?

18 A: It is. And so door to balloon is from the
19 moment the patient enters your facility to
20 balloon, meaning when that vessel is unclogged.
21 And door-to-balloon time is very, very
22 important. We have metrics around it. We
23 review every single case. It's the same --
24 these are national benchmarks that all
25 hospitals work on. You know, at Trident



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

870

1 Medical Center today I believe their median
2 door-to-balloon time is 50 minutes. That puts
3 them just under the 90th percentile in
4 performance. So they do a very good job in
5 meeting those standards.

6 Q: Okay. Talk to me about behavioral health in
7 your system.

8 A: So Trident Medical Center has an inpatient
9 behavioral health program. I believe they
10 opened up probably three or four years ago.
11 Just like every other community, you know, we
12 are seeing a growing number of patients with
13 behavioral health needs. It is a critical need
14 for our community. So we saw that and the
15 Hospital added those beds. A requested CON
16 went through the process, built them, had it
17 funded. And so those beds were opened up a
18 couple of years ago. They've also added what's
19 called a partial hospitalization program, which
20 is really, you know, kind of a step down
21 between inpatient and outpatient, as well as an
22 intensive outpatient program. So they have a
23 full array of psychiatrists and nurses and
24 ancillary staff and those that care for those
25 patients in the community.



1 Additionally, there is a CON approved for
2 our hospital -- or our health system, rather,
3 to build a freestanding behavioral health
4 hospital. The need is great and our community
5 needs more capacity. And so there's a 60-bed
6 behavioral health hospital that is planned. I
7 think it's all total maybe around 34 million
8 dollars in cost. But, again, I'm really proud
9 of the fact that we're stepping up and taking
10 care of the community.

11 Q: And does that take pressure off your emergency
12 rooms to create those beds, to make that spin
13 and create those beds?

14 A: It does. It does. You know, I've been -- so
15 I've been CEO five years. And I think, you
16 know, for anyone who works in healthcare, we
17 know that behavioral health patients come to
18 the ER. They do. I mean, that's very often
19 the first point of entry into the system, when
20 they're having a crisis of some kind. And as
21 we've added inpatient beds, as we've added the
22 outpatient service, we've also added -- we have
23 telehealth behavioral health. So we can get a
24 -- I can have a patient at the Summerville ER
25 who has a psychiatrist at the Trident Medical



1 Center facility and I can get a quick
2 assessment in the ER of that patient and make
3 a disposition of what kind of service they
4 need; inpatient, outpatient, so forth. So all
5 of those things have made a real difference in
6 making sure those patients are triaged and
7 assessed appropriately and get to the
8 appropriate place they need for care.

9 Q: What oncology services are provided in your
10 system?

11 A: Primarily, again, in our Trident Medical Center
12 campus really a full array of oncology
13 services, from surgical care to medical
14 oncology. You see here, this is a picture of
15 a linear accelerator, so radiation services,
16 obviously, and infusion care. And then there's
17 lots of supportive care. You know, a lot of
18 cancer care is provided on an outpatient basis,
19 so you'll see a lot of nurse navigators and
20 other things that happen on an outpatient
21 basis, in addition to the inpatient service.

22 **MR. SUMMER:** I beg The Court's indulgence. Thank
23 you.

24 Q: Take a look up at your women's and children's
25 care. And this specifically is for your



1 hospital, because you've just initiated a new
2 program. Tell us about that.

3 A: I'm really proud of this expansion. So several
4 years ago we realized that, again, the
5 community was growing, we had a lot of new
6 families in the area, and our need for women's
7 and children's care in our area was
8 significant. So we have, again, just finished
9 up a 53 million dollar expansion of our women's
10 and neonatal services. We've done some other
11 things in pediatric care as well from a
12 facility standpoint, but this -- the first
13 phase opened up late last year. We just
14 finished up the construction a month and a half
15 ago.

16 We've actually consolidated services. So
17 Trident Medical Center and Summerville Medical
18 Center both provided obstetric neonatal care.
19 We've combined them now in this new center.
20 And with this new project we were able to
21 really, you know, design an area both for moms
22 and babies and laboring moms and families that
23 supported that whole care process. So we have
24 a Level II NICU. We have Board certified
25 neonatologists. As we mentioned before, we've



1 got a dedicated pediatric ER. We've recruited
2 a variety of pediatric subspecialists, so
3 physicians who are Board certified in pediatric
4 subspecialty, including intensive care,
5 critical care medicine, ENT, general surgery,
6 neurology, gastroenterology, or GI,
7 orthopaedics. We established maternal-fetal
8 medicine clinic, again, that service for high-
9 risk moms and babies, and have expanded that
10 over the last several years. We've added
11 genetic and diabetic counseling for those moms.

12 We have an OB hospitalist program. And
13 what that is, is these are physicians who are
14 there in the hospital 24/7. And their sole job
15 is to take care of moms who come in and need
16 services. So if we have someone who comes in
17 and they're having an emergency, there's always
18 a physician there and an OB/GYN, Board
19 certified, who is there, ready to care for that
20 mom. And they are an incredible group.
21 They're on the ground 24/7 there at
22 Summerville.

23 So, we think, you know, actually over the
24 next year or so we'll be delivering 3,000
25 babies a year. When you look at the data,



1 we're typically one of the top five in the
2 state of South Carolina on OB volume, so really
3 proud of the work that the team has done here.

4 Q: If you turn now and just talk about the
5 physician and caregiver infrastructure that
6 Trident has developed over the last 44 years.

7 A: Yeah. Yeah. So obviously when you expand
8 service lines, when you add services, when you
9 add subspecialty care, you're not only looking
10 at the physical plant and the facility, you're
11 looking at the environment and what do we need
12 to do there and do we have the capacity and the
13 right tools, but you're looking at the
14 equipment and the resources and then, you know,
15 as importantly or even more importantly, who
16 are the physicians that are going to provide
17 the subspecialty care.

18 So over the last many years, we've
19 recruited dozens of physicians in subspecialty
20 services. Again, this is just a few.
21 Everything from neurosurgery to cardiothoracic
22 surgery, colorectal surgery, perinatology is
23 that maternal-fetal medicine or high-risk OB
24 specialty, trauma specialists across the board,
25 psychiatrists, pediatric surgeons, urology and



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

876

1 ENT, urogynecology. Again, this is just a
2 subset of the physician specialists that the
3 health system has recruited over the years. So
4 we've got a great team.

5 Q: We've heard some talk this week about
6 accreditations.

7 A: Uh-huh.

8 Q: What are accreditations in your business?

9 A: So accreditations or certifications or
10 achievements, you know, those are typically --
11 and we'll talk in a moment. So the Joint
12 Commission, for example, is a hallmark
13 accrediting agency for hospitals across the US.
14 And so Joint Commission Accreditation signifies
15 that you've met certain quality standards,
16 safety standards, resource standards, really a
17 whole array of requirements around providing
18 the environment for care and really achieving
19 metrics around the services that we offer.

20 Q: Are the various accreditations that you get a
21 benchmark or a measurement of more success and
22 your qualities?

23 A: They can be. And I think -- you know, one of
24 the things that we're really proud of is -- are
25 the number of accreditations that we have and



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

877

1 certifications that we have. And there are
2 many that you can work toward. Here you see
3 for Trident Health, and I'll just point out a
4 couple, you know, American College of
5 Cardiology, the American College of Surgeons
6 for Commission on Cancer Accreditation, we've
7 got, you know, the Lowcountry Pediatric
8 Readiness Certification. That's an interesting
9 one. That's actually from my hospital.

10 So DHEC a couple of years ago worked with
11 a task force here in the state to define what
12 it meant to be resourced appropriately and be
13 able to care for pediatric ER patients. And
14 you have the opportunity to attain a
15 certification. And actually Summerville
16 Medical Center was the first community hospital
17 in the state of South Carolina to achieve that
18 pediatric readiness or pediatric ER
19 certification. We're one of only three in the
20 state. At the moment I believe there's -- one
21 of the big hospitals here in Columbia, Palmetto
22 Richland maybe is certified, Summerville
23 Medical Center, and then Grand Strand Medical
24 Center in Myrtle Beach. So we're the second in
25 the state and the only in the Lowcountry to be



1 certified for this pediatric readiness
2 certification.

3 Q: Let's look facility specific and just talk a
4 little bit about what these accreditations mean
5 for, let's say, Trident Medical Center.

6 A: Yeah. Sure. So we'll start at the top. Joint
7 Commission Accredited. Again, that's that
8 national accrediting body that accredits
9 hospitals -- has the opportunity to accredit
10 hospitals. And so Trident Medical Center has
11 both the hospital accredited, behavioral
12 health. I should point out that our
13 freestanding ERs are also accredited under
14 Joint Commission, those two that I've
15 mentioned, Moncks Corner and Centre Pointe.
16 And our behavioral health service is accredited
17 by the Joint Commission as well.

18 Additionally, you know, the Joint
19 Commission also allows you to get specialty
20 certification. So at Trident Medical Center
21 we're also certified for advanced primary
22 stroke care as well.

23 Q: I see the American College of Cardiology,
24 that's a platinum award for AMI. Is that acute
25 myocardial infarction?



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

879

1 A: That's right. Heart attacks. That's exactly
2 right.

3 Q: Okay. And in Summerville.

4 A: And at Summerville, again, the hospital and our
5 ER services are accredited. We also have the
6 Joint Commission Certified Advanced Primary
7 Stroke Center accreditation as well. We are
8 accredited for our bariatric surgical program.
9 We are accredited for our wound care program.
10 There's hyperbaric services that we offer and
11 we're accredited by the agency that provides
12 that. And, again, the pediatric readiness
13 certification we discussed previously and you
14 can see several others as well.

15 Q: Okay. So I think this slide just depicts your
16 four physical locations. Will you be adding a
17 freestanding emergency room in Nexton?

18 A: Correct. Correct.

19 Q: And when do you break ground on that project?

20 A: So we expect to break ground in the next month
21 or two.

22 Q: Okay.

23 A: And that facility should open up next summer.

24 Q: Okay. And then if you don't mind just kind of
25 summarizing ---



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

880

1 A: Sure.

2 Q: --- where you see HCA and its commitment and
3 its mission.

4 A: Sure. Sure. So, you know, well over 40 years
5 ago the Community Advisory Counsel came
6 together and said we have a problem, we've got
7 a community problem. Dorchester County is
8 underserved, Berkeley County is underserved,
9 and those facilities that they have are not
10 sustainable. So the recommendation was to
11 build a regional hospital. To my
12 understanding, I don't think anyone else
13 stepped up, but HCA did and I'm proud that we
14 did.

15 So in 1975, Trident Regional Medical
16 Center was built, that 200-bed hospital. If
17 you think about the services in 1975, 200-bed
18 hospital, med-surg, ER, critical care, women's
19 care as the starting point; and all of the
20 hundreds and hundreds of millions of dollars
21 invested since that point, two additional
22 freestanding ERs, Summerville Hospital being
23 built, the expansion of services across the
24 board, you know, 70-plus million dollars in
25 capital just in 2018 alone; our company has



1 lived up to that community commitment. It's
2 been our mission for over 40 years. It's my
3 mission to make sure that we're serving our
4 neighbors, our community well. I think we've
5 done that. And we've continued to grow as the
6 population has grown and as the need has been
7 identified. And that's been a very methodical
8 and intentional process, because it's a
9 commitment we made.

10 And so I'm proud to say today we've got a
11 very well-developed health system across the
12 board. We've achieved quality accreditations.
13 We have added services. We've recruited
14 exceptional physicians and providers in order
15 to continue this care. It is a commitment we
16 made in the '70s and it's a commitment we have
17 today. And we're living it out every day. And
18 for me, it's one patient at a time, one family
19 at a time. But as a CEO, my job is to make
20 sure that we're continuing to look ahead. And
21 so I think we've done that very well. And I
22 think we've -- you know, we've done what we
23 said we would do.

24 Q: Let's talk about that deliberate planning that
25 you were talking about.



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

882

1 A: Sure.

2 Q: When you arrived at Summerville in 2014, was
3 the ED expansion at Summerville already on the
4 planning board?

5 A: Yeah. It's funny. So I came in May of 2014
6 and that summer we had a visit from our
7 corporate team and we were already talking
8 about what does this hospital need. And so I
9 remember in that meeting talking about the need
10 for ER expansion, you know, thinking about what
11 does this hospital need to continue to grow.
12 What am I seeing already as gaps. So we began
13 talking about ER expansion in the summer of
14 2014. That's a long process; design, funding,
15 etc. I think Trident Medical Center was
16 already kind of ahead of us in the cue, they
17 already had an ER expansion in the planning
18 processes, so we were behind them a little bit
19 in that process. But, yeah, I mean, we've been
20 looking ahead to the needs of the community and
21 frankly what we're seeing day to day in our
22 hospital really since the day I got there.

23 Q: So Trident finished its ED expansion when?

24 A: I believe about a year and a half ago.

25 Q: Okay. And why did you not want to have



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

883

1 Summerville's ED and expansion at the same time
2 Summerville -- I mean, Trident's was?

3 A: Sure. So -- yeah. So when you're thinking
4 about ER design planning, funding,
5 construction, and eventual opening, it was
6 really important to us not to have both ERs in
7 the middle of construction at the same time.
8 So, you know, the plan was let's design, let's
9 get all the things in place, let's be ready.
10 And Trident Medical Center was already well
11 ahead in that process. And so they finished up
12 their construction and then we've started our
13 construction now. And it made sense. Again,
14 we're two ERs in the same health system. We
15 didn't want to have both under construction at
16 the same time.

17 Q: So Trident Medical Center is opposing the
18 Medical University and its Certificate of Need
19 to establish a freestanding ED, correct?

20 A: Correct.

21 Q: Can you explain to The Court why your facility
22 is opposing MUSC on this particular project?

23 A: Sure. Yeah. There's lots of reasons. You
24 know, when you think about the location of this
25 ER -- proposed ER by MUSC and you look at all



1 the other ERs around it, I almost can't think
2 of a place in the three counties that has more
3 ERs surrounding it than that location. It is
4 less than one mile from the freestanding ER
5 that we have funded, approved, and are about to
6 break ground on. It's an exact duplicate of
7 that ER less than a mile away in the scope of
8 services and what it offers. It is, you know,
9 a stone's throw from three or four other ERs,
10 including my hospital ER, Summerville Medical
11 Center, Trident Medical Center. You've got
12 Roper Berkeley Hospital about to open. You've
13 got two other freestanding ERs. There
14 literally are six, seven, or eight ERs within
15 a short radius around this one site.

16 You know, I have appreciated the CON
17 process and I respect the folks at DHEC that do
18 this important work. I think in this case it's
19 not a good example of state health planning.
20 It's just simply not. It's duplicative. It's
21 not an efficient use of resources. And I don't
22 think it's needed.

23 Q: Can you talk a little bit about the two other
24 projects? There's an MUSC project in the north
25 area that's up and online and Roper is coming



1 online with a hospital. What strains or
2 problems does this freestanding ED exacerbate
3 for you as an administrator?

4 A: Yeah. So there are several. The one that
5 comes to mind at the top of the list is
6 staffing. So I don't know if you're aware, but
7 South Carolina actually ranks fourth in the
8 country for the predicted gap on nursing
9 shortage. So over the next ten to 12 years
10 there's a gap between supply and demand of
11 10,000 nurses, 10,000 nurses. Fourth in the
12 country. That's not where you want to be on
13 the list. It's not the list you want to be at
14 the top of, I should say. So there's a big
15 competition for qualified clinical staff.
16 We're already seeing it.

17 So MUSC has opened up a pediatric
18 ambulatory campus in the North Charleston area
19 near our Trident and Summerville Medical Center
20 Hospitals. We're already having staff being
21 targeted for recruitment there. Additionally
22 we have Roper Berkeley Hospital, which is
23 opening up in October and we're already having
24 staff targeted to go there. We've lost staff
25 to both. And when you add unnecessary,



1 duplicative healthcare locations like this one,
2 you are only exacerbating the gap between
3 supply and demand on staffing.

4 All of us need highly qualified, well-
5 trained, and experienced clinical staff;
6 nurses, lab techs, respiratory therapists,
7 doctors. I mean, everything. And when you
8 create a location that escalates that demand
9 without good reason, duplicate services, it
10 just makes that problem worse. That is a thing
11 that we're immediately feeling right now.

12 We know that when you add another ER,
13 you're going to have patients go there. You're
14 going to lose volume. And we -- you know, we
15 did our due diligence. We did our business
16 case. We know that -- you know, we're
17 spending, you know, 13-plus million dollars, I
18 think, on the freestanding ER for Summerville
19 Medical Center there at that Nexton location.
20 We spent 24 million dollars -- we're spending
21 it -- to expand Summerville Medical Center's
22 ER. We've spent 14 million dollars to expand
23 Trident Medical Center's ER. When you add
24 duplicative and unnecessary providers to that
25 mix, right in the middle really, I mean,



1 bull's-eye, right in the middle of all of these
2 ERs, you will lose volume. You will lose
3 volume. So your business case and your return
4 on investment and the things that you thought,
5 you know, you're going to resource this place
6 -- and we will, and we have to, but you're not
7 going to see what you -- you know, the patient
8 population that you thought you would see. So
9 ...

10 Q: Do you think this MUSC project is a good or bad
11 idea for patients?

12 A: It's an unnecessary idea for patients. We are
13 -- so, again -- make sure I'm answering the
14 question. This location is in the middle of
15 all kinds of ERs. Interestingly enough, many
16 of those ERs are expanding. Summerville
17 Medical Center is expanding capacity. We have
18 got a freestanding ER that's not yet -- that
19 will have capacity. That Roper Berkeley
20 Hospital, hasn't even opened, has capacity.

21 I don't think it helps patients at all.
22 I don't. I think there's plenty of resources.
23 We certainly have growth in our community.
24 Absolutely we're growing. We have steady
25 growth in our community. But we have lots of



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

888

1 very qualified high-quality providers already
2 there. And, again, when you look at all of
3 those ERs there, you look at the fact that
4 there's capacity that's funded, under
5 construction, and not yet opened, there is
6 plenty -- there are plenty of places for
7 patients to go for care. I don't think it's
8 necessary.

9 I'm concerned a little bit. You know,
10 freestanding ERs are ERs, typically they're
11 local ERs, they're neighborhood ERs. Patients
12 with low acuity needs or less sick patients
13 typically will go to a freestanding ER. Those
14 who have more critical needs, more acute needs
15 will go to hospital ERs. That's the way people
16 travel. And that's the way the EMS travels.
17 If they know they've got someone who's very,
18 very sick, they're going to go to a hospital
19 ER.

20 My concern is that we're going to have
21 patients coming to a freestanding ER and, if
22 they need inpatient care, if they need that
23 inpatient care, if they're too sick for a
24 freestanding ER to be discharged home, they're
25 going to be traveling, I don't know, 20, 23,



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

889

1 24, 25 miles to MUSC to seek care. So I don't
2 think it's necessary and I don't think it's
3 great for patients.

4 Q: Okay. Talk to me a little bit about your
5 current ED. I know you're under expansion.
6 But there's been a great deal of talk about
7 capacity. When we look at treatment spaces --
8 that can be called bays or treatment areas or
9 whatever. But if we're looking at the bays
10 that you had in your ED, how many visits per
11 year last year did you see?

12 A: Yeah. So last year at Summerville Medical
13 Center we averaged 2500 ER visits per bay per
14 year. And that's kind of a threshold capacity
15 metric that people use. And we know, we knew
16 -- we saw that coming, so we started on that
17 planning process. We knew that we needed more
18 capacity and hence the construction project
19 that we're under now.

20 **MR. SUMMER:** Okay. I beg The Court's indulgence.

21 Q: If you would be so kind as to answer any
22 questions some of these other attorneys may
23 have. Thank you very much.

24 A: Thank you.

25 **MR. DAYHUFF:** I'm ready to go ahead, unless Roper



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

890

1 has any questions.

2 MS. HOLLINGSWORTH: No questions.

3 MR. DAYHUFF: Thank you.

4 MS. VALENTINE - CROSS-EXAMINATION BY MR. DAYHUFF:

5 Q: Ms. Valentine, it's nice to see you again.

6 A: Good to see you.

7 Q: Ms. Valentine, let's start by talking about the
8 Trident Health System. It's my understanding
9 that Trident Medical Center, LLC is the
10 corporate entity that owns and operates the
11 Summerville Medical Center and the Trident
12 Medical Center. Is that correct?

13 A: I believe it is.

14 Q: And I understand the dba for Trident Medical
15 Center, LLC is Trident Health.

16 A: I believe it is.

17 Q: Trident Health System.

18 A: I think so.

19 Q: Okay. Well, just for -- and I think perhaps
20 your demonstratives to this do. During this
21 examination, if I use Trident Health for the
22 Trident Health System, you'll understand that
23 I'm referring to that LLC and the entire system
24 and its assets. Does that make sense?

25 A: Yes.



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

891

1 Q: Good. All right. And I want to make sure I
2 have a complete understanding of the Trident
3 Health ED resources in the Tri-County area.
4 And when I saw Tri-County area, of course we're
5 talking about Berkeley, Dorchester, and
6 Charleston, okay?

7 A: Yes.

8 Q: Good. Now, Trident Health has two hospital EDs
9 currently; is that right?

10 A: That's correct.

11 Q: One at the hospital that you're the CEO of,
12 Summerville Medical Center, right?

13 A: Correct.

14 Q: And one at Trident Medical Center. Let's start
15 with the Trident ED. What is the approximate
16 number of visits this ED experiences annually?

17 A: Yeah. You know, I don't oversee that ER at
18 Trident Medical Center, so probably Joan
19 Eccleston or Dr. Wendell might be the better
20 person to answer that.

21 Q: That's fine. If you don't have an estimate,
22 that's fine. And I don't know is a fine
23 answer. I don't know.

24 A: Okay. I don't know.

25 Q: Okay. And just to further flesh that out, we



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

892

1 heard from witnesses earlier this week that
2 sometimes folks think about ED volume as visits
3 per room per year. Do you know for the Trident
4 Medical Center ED what that volume metric would
5 be?

6 A: I do not.

7 Q: All right. Do you know whether, over the past
8 three years, volume at that ED has been
9 trending up?

10 A: I believe that it has, but that's not a detail
11 that I track.

12 Q: Fair enough. All right. Let's -- and do you
13 know how many bays, or rooms ---

14 A: I do not.

15 Q: --- are in that ED? All right. Let's move to
16 the ED that is at your hospital. What's the
17 approximate number -- do you know the
18 approximate number of ED visits you get
19 annually at the ED in your hospital?

20 A: It's just over 71,000 ED visits.

21 Q: All right. And do you know the per-room per-
22 year volume metric for your ED?

23 A: I believe last year it was 2500.

24 Q: And do you know if, over the past three years,
25 the volume at the Summerville Medical Center ED



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

893

1 has been trending up?

2 A: It has.

3 Q: And do you know the nature of that trend? Do
4 you have a percentage in mind? And if you
5 don't, that's okay.

6 A: I don't have a percentage at the top of my
7 mind, yeah.

8 Q: All right. How many rooms currently?

9 A: Today I believe we have 29.

10 Q: I know that's under an expansion plan right
11 now, right?

12 A: Correct.

13 Q: So soon to have more?

14 A: Correct.

15 Q: All right. I also understand that Trident
16 Health has two FEDs. Is that right?

17 A: Correct.

18 Q: One in Moncks Corner and one in -- called
19 Centre Pointe in North Charleston.

20 A: Correct.

21 Q: All right. The Moncks Corner FED, are you able
22 to tell me the approximate number of visits
23 this ED experiences annually?

24 A: No. It's not under my oversight.

25 Q: Then I presume you wouldn't know the number of



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

894

1 visits per room per year for that ED.

2 A: Correct.

3 Q: And would you know whether volumes have been
4 trending up or not at that ED?

5 A: Again, that's not under my oversight, so I
6 don't ---

7 Q: Fair enough.

8 A: --- don't know.

9 Q: And do you know how many rooms they have at
10 that ---

11 A: I do not.

12 Q: All right. Let's talk about Centre Pointe,
13 North Charleston. Are you able to -- and I
14 believe that was established, you said in your
15 Direct, in 2014?

16 A: Yes.

17 Q: Are you able to tell us the approximate number
18 of visits that ED experiences annually?

19 A: I can't, no.

20 Q: Okay. And you don't know visits per room per
21 year for that ED?

22 A: Do not. That's correct.

23 Q: All right. Do you know how many rooms that ED
24 has?

25 A: I believe they have ten or 12. That's



1 typically our prototype.

2 Q: Has volume been trending up at that ED the past
3 three years?

4 A: I believe that it has.

5 Q: Do you have a sense of what that trend
6 percentage-wise looks like?

7 A: No, I don't know that percentage.

8 Q: But trending up. Are there any other Trident
9 Health ED facilities that are currently
10 operating in the three-county area?

11 A: Just those four that we've discussed.

12 Q: All right. Good. Now, I recall from your
13 deposition, but let's go over this again, I
14 suppose. Trident's -- Trident Health's
15 administration did not conduct an analysis that
16 quantified an estimated loss of revenue that
17 Trident Health would experience if the MUSC FED
18 were established?

19 A: Not that I'm aware of. I've not seen any.

20 Q: All right. How about a -- did the
21 administration conduct an analysis that
22 quantified the estimated loss of volume that
23 Trident Health would experience if the MUSC FED
24 were established?

25 A: No.



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

896

1 Q: How about the administration conducting
2 analysis that quantifies potential loss of
3 market share from the MUSC FED?

4 A: No analysis. I think, however, that, you know,
5 it's pretty common sense that when you add a
6 new provider into a market, that you're going
7 to see loss of volume in market share.

8 Q: What about an analysis that quantifies the
9 estimated effect on your ability to staff your
10 EDs?

11 A: No.

12 Q: Has an analysis been undertaken on that issue?

13 A: No. Not any more than we've experienced, as I
14 mentioned earlier, with the staffing losses
15 already occurring.

16 Q: Who is Dan Sullivan?

17 A: Dan Sullivan is our -- I believe our expert who
18 provides analysis around these kinds of ---

19 Q: An expert planner that Trident Health
20 frequently uses for CON projects?

21 A: Yes.

22 Q: Other health planning projects?

23 A: Yes.

24 Q: And, while I may not agree with Mr. Sullivan's
25 health planning conclusions, I think he's an



1 excellent health planner. Do you agree?

2 A: I do.

3 **MR. DAYHUFF:** David, don't be like that.

4 Q: Did you ask Mr. Sullivan to do an analysis that
5 quantifies potential loss revenue, loss
6 utilization, loss market share, or the effect
7 on staffing that may occur as a result of this
8 MUSC FED?

9 A: I did not. I did not think it was necessary.
10 I think we're living it out as we speak. I
11 think this North Charleston Pediatric and
12 Ambulatory Campus and the OR staff that I've
13 lost over the last eight months is a prime
14 example. I think the staff that I've lost to
15 Roper Berkeley's hospital opened is a prime
16 example. And I think, again, it's pretty
17 common sense, when you add a new provider in an
18 area that is already well served, that those
19 patients will go to that new provider as well.
20 It'll simply diminish the volumes of the
21 existing providers.

22 Q: So I presume that you have not personally done
23 any analysis about the adverse effects that may
24 occur as the result of an MUSC FED?

25 A: That's correct. I haven't felt it was



1 necessary.

2 Q: But, because you believe it's common sense,
3 that these adverse effects will occur?

4 A: Yeah. So 33 years in healthcare, also in
5 strategic planning, being in markets where new
6 hospitals have opened, new competitors have
7 come into the area, I think it's pretty
8 straight forward. I don't see a need to do an
9 analysis to confirm what we already know.

10 Q: What do you already know? What is the effect
11 going to be on volume?

12 A: Yeah. Again, we're already seeing it, as I
13 mentioned before, with staffing going to other
14 folks that are new to the market. I think,
15 again, it is pretty -- you know, I hear your
16 position. I disagree with it. And I think
17 it's plain for anyone who's been in healthcare
18 for any number of years to know that you're
19 going to have an effect when you bring in a new
20 provider into an area that's already well
21 served.

22 Q: So with respect to -- and you can set aside
23 staffing for a minute. Do you believe that
24 there is going to be any effect on volume,
25 revenue, market share, any material effect if



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

899

1 the MUSC FED were established?

2 A: Yes.

3 Q: All right. Do you believe there's going to be
4 a material effect, despite -- on the Trident
5 Health ED service line?

6 A: Yes.

7 Q: Despite not having an analysis and despite not
8 personally knowing the utilization or
9 utilization trends for most of the EDs in the
10 Trident Health System?

11 A: I don't think the specifics of that detail are
12 necessary to form an opinion, which really is
13 played out in multiple markets, not just this
14 one, that when new entrants come into a market
15 and they are immediately adjacent to other
16 providers, that patients will go to that new
17 service as well, diminishing the overall volume
18 of the other existing providers. It's really
19 not an analytical question. It's a common
20 sense question. And it's a question that's
21 born out if you have years of healthcare
22 experience in markets.

23 Q: Well, it tends to be an analytical question in
24 CON cases, because there's effect -- as you
25 mentioned earlier, when a provider comes into



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

900

1 a market, there will be some effect. That's
2 the nature of a new provider. In CON we want
3 to look at material effect, substantial effect.
4 And as I understand your opinion or your
5 observation, you believe it will happen without
6 analysis and without data.

7 A: Yes. Because experience and history have shown
8 it to be true.

9 Q: Okay. That assumption, that belief that there
10 is going to be an adverse effect, doesn't
11 account for a couple of things, I think. You
12 tell me if you agree. That assumption doesn't
13 account for the significant population growth
14 and projected population growth in what we've
15 been calling the north area. And I'll just
16 define that in case you haven't heard that.
17 Berkeley County, Dorchester County, and the
18 areas around North Charleston. Does your
19 belief account for that factor?

20 A: Yes, it does. And let me tell you why. There
21 are, again, seven or eight providers in the
22 area. There is the freestanding ER that we're
23 building less than a mile away, exactly the
24 same as this freestanding ER in many ways. We
25 have added capacity at Summerville that's under



1 construction now. Roper Berkeley Hospital has
2 capacity that's yet open. Trident Medical
3 Center is adding capacity. So there is already
4 capacity in the market that is not yet online
5 that will serve thousands and thousands of
6 additional staff -- or excuse me, residents.
7 I'm sure Dan Sullivan or one of our other
8 experts could provide you a little more detail
9 around that.

10 Q: Sure.

11 A: But I don't think that that changes the fact
12 that it will have an impact. We're already
13 going to see the impact of Roper Berkeley
14 Hospital and that ER capacity on our ERs.

15 Q: Right.

16 A: So this is simply one more.

17 Q: And I heard you mention there are eight, seven
18 or eight ERs in this area. How many of those
19 seven or eight ERs are MUSC ERs?

20 A: None of those are MUSC ERs.

21 Q: How many of those are Trident Health ERs?

22 A: Four of those are Trident Health. Well,
23 actually three of those are Trident Health.

24 Q: So three of those are Trident Health.

25 A: Uh-huh.



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

902

- 1 Q: The ED at your hospital, Summerville.
- 2 A: Uh-huh.
- 3 Q: ED at Trident Medical Center.
- 4 A: Uh-huh.
- 5 Q: Summerville is building an FED in that area.
- 6 A: Uh-huh.
- 7 Q: Trident Medical Center has an ED in Moncks
- 8 Corner.
- 9 A: Uh-huh.
- 10 Q: Roper has a new hospital.
- 11 A: Uh-huh.
- 12 Q: Roper has an FED in Northwoods.
- 13 A: Uh-huh.
- 14 Q: Am I missing any? That's just six.
- 15 A: Gosh, there's probably another one in there
- 16 somewhere.
- 17 Q: There's another one.
- 18 A: Yeah.
- 19 Q: None of those ---
- 20 A: There's so many to -- there's too many to
- 21 count, isn't it?
- 22 Q: So many. And who's responsible for putting all
- 23 those EDs in that area? Trident and Roper,
- 24 right?
- 25 A: Uh-huh (affirmative response).



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

903

1 Q: Is that correct?

2 A: Yes.

3 Q: All right. Your belief that the MUSC FED that
4 would be the first FED MUSC has off the
5 peninsula, your opinion that that would cause
6 some harm here doesn't account for the fact
7 that MUSC is already serving a lot of folks
8 that live in the north area who are driving all
9 the way downtown to get their ED services.

10 A: Uh-huh.

11 Q: Right?

12 A: Correct. However, I've not seen any analysis
13 that tells us, are those patients going to come
14 to a freestanding ER or are they going to
15 continue to go downtown. Many of those
16 patients -- you know, MUSC has a wonderful
17 reputation for specialty care, quaternary,
18 tertiary care. No doubt about it. There are
19 many services they offer in the state of South
20 Carolina that others don't. There are patients
21 that already have existing physician
22 relationships and receive specialty care at
23 MUSC. I haven't seen the analysis that tells
24 me that those patients are now going to access
25 a freestanding ER, bypassing their physician



1 and their specialty care that they already
2 travel downtown to receive.

3 Q: There's no reason to believe, is there, that,
4 if we establish an FED, an MUSC FED, that
5 patients that go to that FED will not be able
6 to communicate with, have access to the other
7 MUSC providers in the system, is there? The
8 specialists, their regular doctors, all of
9 those folks would be able to interface with a
10 patient who comes to the MUSC FED.

11 A: I don't know. I don't run MUSC, so I can't
12 tell you.

13 Q: So maybe, maybe not. Even if you look more
14 closely at the smaller area, I'm talking about
15 the north area -- that's kind of a big area,
16 Berkeley, Dorchester, North Charleston. Even
17 if you look at the more small area in the
18 vicinity of our proposed FED and your soon-to-
19 be breaking ground FED in Summerville, MUSC has
20 a significant market share of ED patients in
21 that area, agree?

22 A: I believe, according to the data that has been
23 shared. It depends on what you call
24 significant.

25 Q: Well, let's look at an example. So, your FED



1 that is going to be breaking ground or -- no,
2 not breaking ground, opening in the fall of
3 2019 in Summerville, right, for the Nexton
4 area.

5 A: Correct.

6 Q: That FED had a CON application that provided
7 the health planning case for establishing an
8 FED in that area, right?

9 A: Correct.

10 Q: And that area that we're talking about is the
11 same area that we're looking at, the same
12 immediate vicinity that MUSC's FED is located,
13 right?

14 A: Correct.

15 Q: So the demographics, population, the roads, all
16 of that stuff is the same essentially for our
17 two FEDs, right?

18 A: Correct.

19 Q: All right. Let's look at Exhibit 8, MUSC
20 Exhibit 8. Now, Ms. Valentine, that appears
21 in volume two, if you want a paper.

22 A: Where is volume two?

23 Q: Behind you somewhere. I can look for it. That
24 way you can kind of, if you need to,
25 familiarize yourself with anything that's in



1 there.

2 A: Okay.

3 Q: But let me just ask a very basic question. I
4 would like you to identify this document for
5 the record. And certainly flip through it if
6 you need to.

7 A: So this is the Certificate of Need application
8 for the freestanding ER there in Summerville.

9 Q: All right. And is this a Certificate of Need
10 application that you signed ---

11 A: I believe it is.

12 Q: --- on behalf of Summerville Medical Center?
13 If we can go to page three, I think we'll see
14 it.

15 A: I believe it is.

16 Q: All right. And as we mentioned before, you,
17 your hospital, submitted this CON application
18 to provide to DHEC the health planning case,
19 the financial case for your FED in Summerville,
20 right?

21 A: Correct.

22 Q: All right. And I think we were talking about
23 at least -- well, a couple of issues I
24 suppose. We were talking about MUSC and market
25 share in the immediate vicinity. And I think



1 this CON application gets to that issue. All
2 right. So Exhibit 6 (sic) is describing the
3 Summerville FED service area, which we
4 established earlier is the same area in which
5 we are putting our FED if it's approved. What
6 does your CON application reflect is the market
7 share for MUSC in that immediate vicinity?

8 A: According to this chart, it says MUSC has 8.1
9 percent market share.

10 Q: That's a significant enough market share in
11 that immediate vicinity, which doesn't account
12 for the rest of the north area, to establish an
13 FED, isn't it?

14 A: I don't know.

15 Q: All right. We'll come back to that. Let's
16 look for a moment while we are in this
17 Summerville FED application.

18 **MR. DAYHUFF:** Let's look at page nine, Mr. Bupp.

19 Q: And before I ask a specific question, I suppose
20 -- well, so this CON application, as we noted,
21 is going to provide some of the health planning
22 case. I'd like to look at a specific part of
23 nine. The proposed facility will improve
24 access -- this is your FED in Summerville --
25 for residents and workers in the Summerville



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

908

1 area who are not in close proximity to existing
2 hospital and freestanding emergency departments
3 in the area. That's an accurate statement in
4 your CON application.

5 A: Is that a question?

6 Q: Yeah. Is that an accurate statement?

7 A: Yes.

8 Q: And in addition, the proposed FSED will reduce
9 the high levels of low acuity utilization at
10 SMC's existing emergency department in a less
11 costly and more effective manner. That's true
12 too, isn't it?

13 A: Yes. Typically in freestanding emergency
14 departments, you will see lower acuity
15 patients. That's really what that environment
16 is intended to serve. So you typically will
17 see, as we call it, level fours and fives.
18 Those are the lower acuity levels of patients.

19 Q: So that's noting two benefits of an FED in the
20 same area that MUSC proposes to establish. And
21 one is geographic access would be better for
22 patients. And two, it's going to relieve
23 volume at a hospital ED. Isn't that right?

24 A: It does both. However, in this case that was
25 not the prime reason for it. We already had



1 our ER expansion in the planning stages, so
2 that was the plan for the emergency department
3 at the hospital. Typically freestanding ERs
4 are local. You know, you're going to have
5 people drive ten to 15 minutes to a
6 freestanding ER. So they tend to serve a
7 little different patient population. Again,
8 these are not patients who ultimately would go
9 on and need high acuity inpatient services.

10 Q: All right. Well, while it may not have been
11 the primary reason, it is certainly a reason
12 that Trident Health offered to DHEC as to why
13 an additional FED should be in Summerville.

14 A: Correct. The primary plan, however, in order
15 to address hospital emergency department
16 capacity, is to expand hospital department --
17 ER capacity. So that is the plan that we put
18 into place and are under construction with now
19 at the hospital, because that's where the
20 capacity issue arose and that's where it needs
21 to be addressed.

22 Q: Let's look at page 19 of the CON application.
23 So this talks about, again, the area that you
24 are establishing an FED and the one we propose
25 to establish an FED. And it notes, this area



1 is rapidly growing with both residential
2 communities and businesses that could benefit
3 from improved access to FED services. That's
4 accurate, isn't it?

5 A: It is. And this is another example of living
6 out our mission. So in 1972 we committed as a
7 health system to provide ER -- excuse me,
8 healthcare services for the community and grow
9 those services as the community grew. And
10 we've done that over 40 years. This was
11 another example of the investment in order to
12 continue serving that community. And it's our
13 mission. You know, I don't have any apologies
14 for adding new services that our community
15 needs. It's what we've been doing for the last
16 40 years.

17 Q: And I have no question about Trident's
18 dedication to this area. But this element of
19 the CON application establishes what we all
20 know in this case, which is the north area and
21 in the vicinity of where we propose to
22 establish an FED, rapidly growing population,
23 new residential areas, new businesses. And all
24 of those things drive increased emergency
25 department visits; isn't that true?



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

911

1 A: I see it differently. And here's how I see it.
2 We have a steady growth in that area,
3 absolutely, rapidly growing as it's described
4 here. However, from an ER standpoint, there
5 are plenty of ERs. We just talked about the
6 fact that there are too many to count. And we
7 have capacity that's not yet come online both
8 at Summerville Medical Center, Roper Berkeley
9 Hospital, and the freestanding ER that we're
10 building in Nexton. So, from my perspective,
11 the addition of another freestanding ER in an
12 area that's already well served and that
13 doesn't even have new capacity online
14 calculated into that is simply unnecessary and
15 duplicative.

16 Q: But you don't dispute the fact that the area
17 that we're wanting to proceed with an FED,
18 growing rapidly, businesses, residential areas,
19 and it's increasing the number of ED visits
20 that that area is going to generate into the
21 future for the next five years.

22 A: Yes. With very high-qualified healthcare
23 already existing in that area.

24 Q: I understand. You want to continue to be one
25 of two providers that cares for the folks in



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

912

1 that area. I understand that. Let's look at
2 page -- the next page, I think it's 20. So
3 this exhibit in your CON application, the
4 Summerville FED, reflects what we were just
5 talking about mathematically, right? The
6 change in residents in the Tri-County area from
7 2012 to 2015 has increased dramatically, 17.2
8 percent, right?

9 A: That's what it says here, yes.

10 Q: And that's one of the primary reasons in your
11 CON application that you submitted to DHEC for
12 establishing your ED capacity in Summerville,
13 right?

14 A: Yes. To continue serving the community.

15 Q: Now, I want to ask a couple of more questions
16 about the FED.

17 **MR. DAYHUFF:** And by the way, before I go any
18 further, I would like to enter this exhibit
19 into evidence. This is Exhibit 8, which is
20 Trident Health's SMC FED CON application, Your
21 Honor.

22 **MR. SUMMER:** No objection, Your Honor.

23 **MS. HOLLINGSWORTH:** No objection.

24 **MR. DAYHUFF:** Thank you.

25 **THE COURT:** It's entered.



1 (Respondent MUSC's Exhibit Number 8 was admitted into
2 the record at this time.)

3 Q: Ms. Valentine, Trident applied for the
4 Summerville FED in the spring of 2017; is that
5 right? I think you have the page that gives us
6 the exact date.

7 A: Let's see. What does it say on the signature
8 line at the end? It's probably -- oh, I see.
9 April. April 2017.

10 Q: You've got a stamp date. So April 12th, 2017.
11 MUSC applied shortly thereafter in the summer
12 of 2017; is that your understanding?

13 A: That's my understanding.

14 Q: All right. So, we talked about a few reasons
15 why you established the FED in your CON
16 application. There's another reason -- or a
17 couple of other reasons that I want to talk
18 about. And I want to talk about some documents
19 that we reviewed during your deposition. And
20 I guess let me ask this question. Another
21 place we could look for Trident Health's
22 rationale, Trident Health's reasons for
23 establishing more capacity in Summerville are
24 some of those internal HCA Trident documents
25 regarding the project; is that correct?



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

914

1 A: Yes.

2 Q: All right. I think the two of them we looked
3 at, we looked at an executive management
4 review. Do you recall that?

5 A: Yes.

6 Q: And we looked at a request for capital?

7 A: Yes.

8 Q: And so I think you explained to me the request
9 for capital comes first.

10 A: Correct.

11 Q: And then the executive management review. But
12 let's pull up the request for capital. That's
13 MUSC Exhibit 21.

14 A: Do you have that here by chance in one of these
15 many documents?

16 Q: We do. That's volume six I think.

17 **MR. SUMMER:** Your Honor, this is attorney/expert
18 eyes only, so we want to make sure that we
19 observe the same formalities that we have with
20 other documents.

21 **THE COURT:** Is this the one that you're requesting
22 that it be sealed?

23 **MR. SUMMER:** Yes.

24 **MR. DAYHUFF:** Yes. This is an attorney/expert eyes
25 only document.



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

915

1 Q: So let's just start with identifying that
2 document for the record, I suppose. But
3 identify and tell us why that document exists.
4 What is its purpose?

5 A: Sure. So this is a Request for Capital and
6 it's for the freestanding ER project. And it
7 provides a business case in justification for
8 the requested dollars.

9 Q: All right. And types of information it has in
10 it, project cost information, correct?

11 A: Correct.

12 Q: Information about market share?

13 A: Correct.

14 Q: Information about demographics that apply?

15 A: Correct.

16 Q: All right. And as we mentioned before, since
17 we're talking about the same vicinity, the same
18 area, all of this demographic information and
19 market information would apply to MUSC's FED as
20 well.

21 A: In some respects, yes.

22 Q: In some respects, certainly. Different project
23 costs and different other issues, but we're
24 talking about the same area.

25 Now, let me look just at a couple of pages



1 of this.

2 **MR. DAYHUFF:** Let's look at page four, which is THS
3 73, Dan.

4 Q: Let's look at project justification general
5 information. When we were talking about
6 utilization and trends and the like, this
7 document, which you were listed as a contact
8 person on, contains some information about the
9 growth of Trident's ED volume; do you see that?

10 A: Yes.

11 Q: In particular, in 2015 TMC grew ED volume by 14
12 percent and SMC by 16 percent over the previous
13 year's volume.

14 A: Yes.

15 Q: Is that correct information?

16 A: Yes.

17 Q: All right. And 2016 here today, your visit
18 growth was continuing to grow at both the
19 Trident Hospital and the Summerville Hospital,
20 by eight percent and 12 percent respectively.

21 A: Correct.

22 Q: Moreover, you notice -- or you note in this
23 document, that both EDs are operating at over
24 100 percent capacity. They are very busy.

25 A: Yes.



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

917

1 Q: Yes?

2 A: Yes.

3 Q: Good. Now, one of the reasons I suppose we
4 haven't mentioned yet for establishing the FED
5 in Summerville is Trident Health wants to use
6 that FED defensively to keep competitors out of
7 the area; isn't that true?

8 A: It's my position that we want to continue to
9 serve the market we've served so well over the
10 last 40 years. And to do that, we need to make
11 investments like these in order to ensure the
12 community is served.

13 Q: Well, I understand that position. But one of
14 the reasons that didn't appear in your CON
15 application that appears in your internal
16 documents for establishing the FED in
17 Summerville is to be defensive and block other
18 providers from entering that market. Isn't
19 that true?

20 A: We have a mission for the community. And our
21 goal is to make sure we continue to live that
22 mission out as we have over the last 40 years.
23 So it -- you know, as I see these investments,
24 it continues to make sure that we're living out
25 that mission.



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

918

1 Q: And I understand and respect that mission. Ms.
2 Valentine, this is a document, a request for
3 capital that your hospital sent to your
4 corporate parent on which you're listed as the
5 first contact person. And one of the reasons
6 in this document that you say to your corporate
7 parent for establishing this FED is it's
8 defensive. And by defensive, you're saying to
9 your corporate parent, to prevent, to hinder,
10 to keep other folks out of that market. Isn't
11 that one of the reasons in this document?

12 A: So in 30 years of healthcare, I don't think
13 I've ever been involved in a project that
14 didn't have offensive and defensive aspects to
15 it. And this does as well.

16 Q: Let's look a little closer.

17 **MR. DAYHUFF:** Let's look at page five, Dan, and
18 Trident Health 74.

19 Q: The most critical issue for this project is the
20 need to quickly establish this offensive and
21 defensive access point. At least here it's a
22 critical issue, right?

23 A: Yes.

24 Q: Let's look a little further. And one other --
25 before we leave that. Not only does Trident --



1 did Trident submit this application to defend
2 its area, to keep others out, it considers --
3 Trident considers competition from Roper and
4 MUSC in this area to be infiltration. Isn't
5 that true?

6 A: My opinion is, again, that we've spent hundreds
7 and hundreds of millions of dollars over the
8 last 40 plus years specifically relying on the
9 CON process and a health planning process that
10 enables us to continue to make those
11 investments and be successful. Really, without
12 a margin, we have no mission, right? If we
13 can't ensure that the new capital expansions
14 that we invest in and the services that we
15 offer and create are viable, then we can't
16 continue to live out that mission. So all of
17 these projects do have an offensive and
18 defensive component to it. And it's to ensure
19 we can live out our mission.

20 Q: And that's normal, apparently, for Trident
21 Health ---

22 A: It's normal for healthcare. It's normal for
23 healthcare.

24 Q: I'm not sure it is normal for healthcare.

25 A: With no margin, you have no mission.



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

920

1 Q: Well, I understand that. It's normal for
2 Trident Healthcare to describe -- protecting
3 its market, being on the defensive, and keeping
4 folks out and it's normal for Trident Health to
5 describe competitors as infiltrators who would
6 take what's ours. That's normal in Trident
7 Health.

8 A: That's your opinion. I disagree.

9 Q: Okay. Let's see if there is anything else.
10 Let's take a look at page three. On the top of
11 page three it's talking about the request for
12 capital still. Significant, see that,
13 competitor infiltration is occurring. So
14 that's that description I mentioned earlier,
15 describing competitors as infiltrators, right?

16 A: This is describing a community in which Trident
17 Health has served for well over 40 years when
18 no other provider chose to step up and make the
19 investment to serve the community. And it
20 reflects a commitment to the community and
21 continuing to invest in capital, staffing, and
22 resources to serve the community.

23 Q: Because you were there first in 1970, that's
24 your market.

25 A: Because we stepped forward and made the



1 investment when no one else would and built a
2 200-bed hospital that significantly was larger
3 and more capable of caring for the community
4 than the two small older hospitals that could
5 no longer provide those services to the
6 community.

7 Q: Because you made that investment, because you
8 were there first, that's your market.

9 A: That is not what I'm saying. What I'm saying
10 is we made an investment when no one else
11 would. And we relied on a CON planning and
12 state health planning process that would ensure
13 that wise healthcare decisions were made. And
14 those hundreds and hundreds of millions of
15 dollars in capital investments, resources,
16 staffing, equipment, specialists would ensure
17 the community was well served and that
18 duplicative services and unnecessary services
19 would be weeded out in the process. And in
20 this case I don't believe that it has.

21 Q: If your concern is the community, why would it
22 be bad for others to help serve that community?

23 A: In this case I think it's unnecessary. This is
24 a CON process. We have CON regulations at the
25 moment. And they have multiple requirements



1 before approvals are made. In this case I
2 think they completely missed the mark. It's a
3 duplication. It's unnecessary. There's
4 capacity already in this market. There's
5 capacity that's yet to be brought online that
6 will serve the growth that the community has.
7 In this case I think it failed. It absolutely
8 failed.

9 Q: The CON process does deal in things like need
10 and distribution and adverse impact and
11 financial feasibility. It doesn't have
12 elements related to defending markets,
13 preventing competition, or considering other
14 providers infiltrators who are somehow doing
15 something that's not appropriate, right?

16 A: That's irrelevant to the question of whether
17 the CON process and the state health planning
18 process made a good decision here in my view.

19 Q: How come the description of this is defensive
20 and the description of your fellow providers in
21 the area as infiltrators appears in the
22 internal documents, but it doesn't appear in
23 the CON application?

24 A: I don't know.

25 MR. DAYHUFF: All right. I'd like to move this



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

923

1 exhibit, which is 22 (sic), into evidence. It
2 is attorneys eyes expert (sic), so do you want
3 that in some sort of sealed manner.

4 **MR. SUMMER:** You've already asked for it. I think
5 it's already granted.

6 **MR. DAYHUFF:** Perfect. Good. Could we admit that,
7 Your Honor.

8 **MR. SUMMER:** Without objection.

9 **MR. DAYHUFF:** 21. I'm sorry, Your Honor, 21.

10 **THE COURT:** 21, okay.

11 **(SEALED: Respondent MUSC's Exhibit Number 21 was**
12 **admitted into the record at this time.)**

13 Q: Let's look at one other internal document about
14 the Summerville FED. And that is Exhibit 22,
15 which may be your next exhibit. This is a
16 document produced by Trident Health. You can
17 take a minute to look at it. We did discuss
18 it, I think, at your deposition. Before we get
19 into the details of it I suppose, what is the
20 purpose of the executive management review?

21 A: So this is a document produced by our corporate
22 office, which summarizes the project and
23 provides a budget and ultimately approval for
24 the project.

25 Q: All right. And if you look at page one,



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

924

1 justification, what's the first justification
2 listed? That's it's both offensive and
3 defensive in nature. Do you see that?

4 A: Yes.

5 Q: So we're still talking about your FED in
6 Summerville, right? The same general location
7 where we propose to go. Take a look at page
8 two. This internal document notes That large
9 residential communities have been developed,
10 Berkeley, Dorchester Counties, part of what
11 we're calling that north area, and they're
12 continuing to expand. Stratasan, who's
13 Stratasan?

14 A: I believe they're an analytics firm that looks
15 at market data.

16 Q: They note and you include in your document
17 population growth of two percent in the
18 projected areas from 2016 to 2021. That's
19 significant population growth, isn't it?

20 A: It's two percent, steady.

21 Q: All right. Steady. Job growth is expected,
22 according to this document?

23 A: Correct.

24 Q: Strong growth in the region has led to solid ER
25 volume growth as well. Since 2013, SMC and TMC



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

925

1 have averaged annual ED visit growth of 12
2 percent and eight percent respectively. That's
3 strong growth, agree?

4 A: Yes.

5 Q: And it's noting each ER is surpassing the 2400
6 visits per bed in 2016. Why is that? Is 2400
7 a special number for HCA?

8 A: That's apparently the number that was correct
9 for those facilities on that year.

10 Q: All right. In this document, as I think you
11 explained a little bit, is a document that
12 contains demographic information, population
13 information about the area in the immediate
14 vicinity of the Summerville FED, which is the
15 same area we are proposing to go to, correct?

16 A: Correct.

17 Q: All right.

18 **MR. DAYHUFF:** I'd like to move this exhibit into
19 evidence, Your Honor.

20 **MR. SUMMER:** As long as it's under seal, Your Honor,
21 I'm fine with it.

22 **MR. DAYHUFF:** I agree.

23 **THE COURT:** Okay. It's admitted, under seal.

24 **(SEALED: Respondent MUSC's Exhibit Number 22 was**
25 **admitted into evidence under seal at this time.)**



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

926

1 Q: Let's look at one more exhibit while we're
2 here, Exhibit 8. This is another CON
3 application. And it is in volume two. It's 8,
4 right? I'm looking for James Island.

5 **MR. BUPP:** 7.

6 **MR. DAYHUFF:** 7, which is in one. Okay. 7. Sorry.

7 Q: So let's start by, if you would, identify what
8 we have marked as Exhibit 7.

9 A: This is Trident Medical Center Certificate of
10 Need application for the construction of a
11 freestanding emergency department in James
12 Island.

13 Q: All right. And this was submitted to DHEC in
14 April of 2018, right?

15 A: Yes. That's the way it's stamped. Yes.

16 Q: All right. And Trident submitted this CON
17 application for an FED in James Island to
18 improve access to Trident ED services for folks
19 that live in the James Island area and the
20 Johns Island area, correct?

21 A: That's my understanding. As we talked about,
22 I think at deposition, this is not my project.
23 It's not under my scope of authority. Todd
24 Gallati, the CEO, is the individual who ---

25 Q: Fair enough. Are you not comfortable with the



1 notion that this FED was placed -- or proposes
2 to be placed in James Island in part for the
3 purpose of improving access to Trident Health
4 ED services for the folks in James Island and
5 Johns Island? Are you comfortable with that?

6 A: Again, it's not my project, but certainly it
7 makes sense, given that there's only one ER in
8 West Ashley, James Island, Johns Island area.
9 So improving access, I would assume, would be
10 one of the key points here.

11 Q: All right. Let's look at just a couple of
12 things. And this CON application was done by
13 your healthcare planner, Dan Sullivan; is that
14 correct?

15 A: Correct.

16 Q: All right. Let's just look at a couple of
17 pages in here. Let's look at 26. And this
18 Exhibit 7, the CON application, talking about
19 your James Island FED, has data on emergency
20 services market share for the areas in the
21 vicinity of the proposed FED, Charleston, James
22 Island, and Johns Island. Do you see that?

23 A: I do.

24 Q: And what is Trident Health's market share in
25 that area?



1 A: It looks to be, according to the chart 4.8
2 percent.

3 Q: All right. And we looked at MUSC's market
4 share in the Summerville FED CON application.
5 And do you recall that market share for the
6 area in the immediate vicinity of our FED and
7 your FED was 8.1 percent?

8 A: Yes.

9 Q: And I think we had a question of -- that I
10 asked you, do we have a significant enough
11 market share of the area in the immediate
12 vicinity, setting aside the rest of the north
13 area, for an FED to be appropriate there. And
14 you said, well, I'm not sure. After looking at
15 this, would you agree with me that, if Trident
16 Health can establish an FED in James Island
17 with a market share of under five percent, the
18 market share that we experience currently in
19 the immediate vicinity where we propose to go
20 in Summerville is an appropriate market share
21 that would support a CON application for an
22 FED?

23 A: You know, it's not my project, as I mentioned
24 to you in deposition. However, I've done some,
25 you know, inquiries and thought about this a



1 little bit. I think the difference here,
2 frankly, is really apples and oranges. In my
3 view, this isn't relevant to the MUSC
4 freestanding ER there in Summerville. In the
5 ER in Summerville we said seven or eight ERs,
6 in fact too many to count, and one less a mile
7 away that's exact duplicate, exact carbon copy
8 of the proposed MUSC freestanding ER. Many,
9 many, many options for patients in the
10 community and growing capacity for that steady
11 or rapid, however you want to define it, growth
12 in that area.

13 This location only has one ER that serves
14 Johns Island, James Island, and West Ashley.
15 One ER. So this would be an additional access
16 point. Again, not my project, but those are
17 just my thoughts ---

18 Q: Sure, sure.

19 A: --- about the comparisons between the two. I
20 think they're apples and oranges. I don't
21 think this is relevant.

22 Q: No ED services on James Island and the area
23 that we're looking at, lots of ED in the
24 immediate vicinity is a distinguishing factor
25 for you, the apples and oranges.



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

930

1 A: Correct.

2 Q: All right. James Island, you go across the
3 James Island connector, right, to James Island.
4 When you get off that connector, how close are
5 you to MUSC's hospital ED, Roper's Hospital ED?
6 Pretty close?

7 A: It's close. Again, in this particular area I
8 don't think there's easy access to more than
9 just one ER.

10 Q: And in fact, the data reflects -- the market
11 shares reflect that from James Island, from
12 Johns Island, that's where all the folks are
13 being served right now, 34.7 percent by MUSC
14 and 24.4 percent by Roper, right?

15 A: And 32 percent by St. Francis ---

16 Q: And another 32.9 percent. Absolutely. So just
17 so I understand, it's your opinion or
18 observation that the 4.86 percent market share
19 with this FED is an appropriate amount of
20 market share to establish one, but 8.1 percent
21 is not for the reasons you've told, the
22 distinguishing factors.

23 A: You know, you've heard the extent of my
24 opinions and knowledge on this project. It's
25 not my project, so I really couldn't comment



1 beyond that.

2 Q: Well, you're here today talking about Trident
3 Health more generally than just Summerville.
4 I get that. So that's why I'm asking you
5 questions about the entire system.

6 A: Correct. For the things that I know and
7 responsible for, of course.

8 Q: So Trident Health has been adding a lot of
9 capacity, ED capacity to the Tri-County area,
10 agree?

11 A: Correct.

12 Q: All right. Let's look at DX 44. This is a
13 list that we put together, you can tell me if
14 it's accurate or not, of the expansion
15 additions that I know about. And you've
16 discussed a few of them today. So the CON date
17 to the right is the CON application date. And
18 of course we've described the project. Now,
19 let's talk about the expansion a little bit.
20 The expansion of the ED at Trident Medical
21 Center, North Charleston, the CON application
22 was 2015. I think you said in your Direct it's
23 now complete and was completed mid 2018. Is
24 that right?

25 A: Approximately.



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

932

1 Q: It's my understanding there were eight rooms
2 added as a result of that expansion. Is that
3 your understanding?

4 A: I know they had renovations and expansion of
5 capacity. Beyond that, Joan Eccleston or one
6 of the other folks would have to give you the
7 details.

8 Q: Fair enough. The new SMC FED in Berkeley
9 County, the CON application for that was April
10 2017. We've already looked at that. That's
11 going to be online in the fall of 2019. And it
12 has ---

13 A: 2020.

14 Q: I'm sorry, 2020. And it's going to have an
15 additional -- or add an additional how many
16 rooms?

17 A: It'll be ten ---

18 Q: Ten?

19 A: --- treatment rooms.

20 Q: All right. The expansion of the ED at your
21 hospital, Summerville Medical Center, the CON
22 date for that -- the application date was
23 November 2017. And it's underway?

24 A: That's correct.

25 Q: All right. And how many additional rooms, ED



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

933

1 rooms, will you have as a result of that
2 expansion?

3 A: I believe we have 29 now and that's going to
4 46, if I have that number correct.

5 Q: So what is that, 17?

6 A: Fifteen to 17, I may be a few rooms off.

7 Q: Fair enough. And then we just mentioned, and
8 I know it's not particularly under your
9 purview, Trident Health is adding a new FED on
10 James Island. And that CON application is
11 April 2018. Has that CON application been
12 approved yet?

13 A: Again, not my project.

14 Q: Don't know.

15 A: Couldn't tell you any details of it.

16 Q: And do you know -- is it eight treatment spaces
17 for that FED?

18 A: I do not know.

19 Q: Fair enough.

20 A: Typically those are an average of ten.

21 Q: Well, if we assume it's ten, we're looking at
22 over the past couple of years an addition of
23 over 40 rooms, ED rooms in the Tri-County area,
24 fair?

25 A: Approximately.



1 Q: Trident Health has added and continues to add
2 ED capacity because there is a need for ED
3 rooms and capacity in the three-county area,
4 right?

5 A: We've seen that at our hospitals, absolutely.

6 Q: And that need is generated by, in part,
7 increasing population?

8 A: Correct.

9 Q: And we actually discussed additional planning
10 for FED that Trident Health is doing. We
11 looked at a PowerPoint slide regarding some
12 planning. Do you recall that?

13 A: Correct.

14 **MR. DAYHUFF:** All right. Let's pull up MUSC 23,
15 which is in which volume? Same as the last
16 one. Great.

17 Q: So we discussed this at your deposition. This
18 is an attorney/expert eyes only document. And
19 it -- tell us generally -- and you can flip
20 through it. There's a lot of it that's
21 redacted. This is a document produced by
22 Trident. Tell us what the purpose of this
23 document is.

24 A: It's a strategic planning summary.

25 Q: All right. And I assume, but you tell me, that



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

935

1 Trident Health and the administrators of
2 Trident Health engage in strategic planning
3 about the service lines all the time.

4 A: Sure.

5 Q: And create PowerPoints about that. And I
6 assume that the redacted parts have nothing to
7 do with the ED. Is that fair?

8 A: That would be correct.

9 Q: All right. Now, take a look at page 24. It
10 may be easier to look on the screen, because
11 I'm not sure the pages are numbered. No, they
12 are. So when we were talking about expansion
13 in addition to ED capacity and here in this
14 planning document it mentions exit 199, which
15 FED is that?

16 A: That is the Summerville Medical Center,
17 Summerville freestanding ER.

18 Q: And the Folly Road FED is -- Folly Road's on
19 James Island. We've looked at that, right?

20 A: Yes.

21 Q: And then below that there's identify a third
22 site. Now, if there is a third site, I don't
23 want to know about it, but this planning
24 document identifies that Trident Health is
25 already looking over the horizon because of



1 need in this area for yet another FED.

2 **MR. SUMMER:** I'm going to object. There's no
3 foundation to what this area means. I was --
4 our client was greatly restricted in discovery,
5 Your Honor, about not finding out about anybody
6 else's plans for any other regions. And, in
7 fact, you had to do something in camera. I
8 don't believe -- what's good for the goose is
9 good for the gander. I do not believe it's
10 appropriate for him to attempt to elicit any
11 testimony about an unidentified third site when
12 I was not allowed to do the same thing in
13 discovery with his client.

14 **MR. DAYHUFF:** That's not accurate. What we objected
15 to and what this Court didn't allow Trident to
16 go into was the locations of additional sites.
17 They were blocked out. The existence of
18 additional sites is well known. We blocked
19 those sites out, so we couldn't tell where they
20 are. So he inquired into planning generally
21 for the three-county area and FEDs and he knows
22 that we're considering additional FEDs in those
23 areas. What you prevented him from doing was
24 finding out the location. I'm not going to ask
25 the location.



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

937

1 I think it's very relevant that Trident is
2 seeking to prevent us from establishing an FED
3 when they add capacity to the market year after
4 year and they're planning to add more. That's
5 relevant and that's all the farther I would go
6 with that document.

7 **MR. SUMMER:** Here's my objection, Your Honor. That
8 third site could be in Beaufort County for all
9 we know. So he has no ability to lay a
10 foundation to make it relevant to the inquiry
11 before this Court.

12 **THE COURT:** The objection is sustained.

13 **MR. DAYHUFF:** Thank you.

14 **THE COURT:** Okay.

15 Q: For those residents in the north area, Berkeley
16 County, Dorchester County, North Charleston
17 area, who are choosing MUSC for their emergency
18 medicine services, if we establish the FED in
19 Summerville, it will improve their geographic
20 access to services, MUSC services; isn't that
21 true?

22 A: I don't believe that that is a fact. Again, as
23 I mentioned previously, there's no way to know
24 -- freestanding ERs are low-acuity ERs. They
25 are intended for ambulatory patients who need



1 lower-service care. And patients who go to a
2 freestanding ER versus a hospital ER,
3 particularly when they have healthcare needs,
4 tend to know where they need to go. What we
5 don't know is how many of those patients who
6 live out on the far reaches of Berkeley County
7 and go to MUSC's ER, that market share that you
8 referenced, we don't know if they will go to a
9 freestanding ER or if they will still need to
10 go downtown.

11 So in my view, whether MUSC has a
12 freestanding ER in that community or not, you
13 will have the general population that'll go.
14 It won't just be whoever's been to MUSC before.
15 And you'll have a number of patients who the
16 physicians at MUSC, specialty services at MUSC,
17 who will continue to go downtown.

18 Q: You don't believe that we have any at all low-
19 acuity folks who live in the north area,
20 Berkeley, Dorchester, North Charleston, who are
21 currently traveling from that area, 30, 40, 45
22 minutes, to reach an MUSC ED and get their
23 care?

24 A: When you speak about it in absolutes, certainly
25 it's not an absolute. I just think it's a very



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

939

1 low likelihood.

2 Q: All right.

3 A: Given the preponderance of ERs in that area
4 already available for low-acuity care.

5 Q: Admit rates tell us something about acuity,
6 right, admit rates from an ED. Do you agree?

7 A: They do.

8 Q: All right. What's your admit rate at
9 Summerville Medical Center's ED to inpatient?

10 A: Hospital ER?

11 Q: Right.

12 A: We run ten, 11, 12 percent ---

13 Q: All right.

14 A: --- across the board.

15 Q: That means the remaining 80 percent or more are
16 going home; they're discharged to home.

17 A: They can be. They can be under observation
18 care. They could have a surgery and go home.
19 So that admit rate that I was referring to is
20 only for inpatient admissions. But there are
21 other services that hospitals offer beyond ER
22 care that those patients may need that wouldn't
23 show up in that number. So, again, the surgery
24 care, endoscopy, interventional procedures,
25 observation visits, all of those things, those



1 23-hour stays, would not be done in a
2 freestanding ER, would be done in a hospital,
3 but are not going to show up in your admission
4 ration.

5 Q: All right. Well, what percent then of the
6 folks who come to your hospital ED are getting
7 discharged to home?

8 A: I don't -- you know, again, our expert, Dan,
9 I'm sure, has more data around that, but I
10 can't give you the details of that.

11 Q: And whatever that percentage is that are
12 getting discharged to home, it's more likely
13 than not that those are lower acuity patients?

14 A: They can be, yes.

15 Q: They can be and it's more likely than not they
16 are if they're not getting admitted or they're
17 not going to some of those other levels of
18 treatment you described.

19 A: Or transferred to another hospital for care as
20 well.

21 Q: Certainly -- certainly possible. MUSC is
22 experiencing in its adult ED an approximately
23 25 percent admit rate. A fair assumption from
24 that, as a hospital administrator, would be
25 there's a lot of folks that are going home,



1 right?

2 A: Yes. Again, I don't know what that additional
3 hospital service level percentage would be as
4 well.

5 Q: And a lot of those folks who are going home,
6 it's a fair assumption, would be lower-acuity
7 patients.

8 A: All ERs do care for low-acuity patients, yes.

9 Q: Is there a projected opening date for Trident's
10 Berkeley County Hospital?

11 A: It's not my project. I think we talked about
12 this at deposition. That's not my scope of
13 responsibility. Todd Gallati is the CEO there.
14 My understanding is That it is stalled at the
15 moment with a wetlands issue with the Army
16 Corps of Engineer. I'm not -- so I don't know
17 other than that.

18 Q: So at this point you do not know when, if ever,
19 that hospital will commence construction.
20 Fair?

21 A: Again, not my project. However, being stalled
22 with the Army Corps of Engineer, you really
23 can't do anything until that is approved, is my
24 understanding. So therefore, that's a critical
25 step to the other steps that would have to



1 occur prior to construction and opening.

2 Q: Understand. So is it fair to say that you
3 don't know when that project will start or
4 whether it will start?

5 A: That is correct, based upon the information I
6 just provided you.

7 Q: I understand. And that project is proposed to
8 have an ED; is that correct?

9 A: That is correct. All hospitals have ERs.

10 Q: That's right. In light of the uncertainty
11 surrounding that project, it doesn't make sense
12 to consider its ED in the health planning
13 analysis in this case, does it?

14 A: I really can't speak to that.

15 Q: Fair enough. If we establish an FED at the
16 location we propose, will your emergency
17 medicine physicians at Summerville Medical
18 Center and your nurses lose their ability to
19 provide high-quality emergency care?

20 A: They won't lose their ability to provide high-
21 quality emergency care. However, as we talked
22 about previously, the availability of nurses in
23 our community and our state is already greatly
24 strained and it will further strain that.

25 Q: I understood your testimony about the nursing



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

943

1 shortage. But the folks who are already there
2 working for you, emergency room physicians, if
3 we establish that FED, they won't lose their
4 skills and proficiency?

5 A: No, they will not.

6 Q: They'll still provide high-quality care.

7 A: That's correct.

8 Q: Same thing with the nurses that you retain
9 there, they'll still provide that high-quality
10 care they've always provided.

11 A: That's correct.

12 Q: Let's go back to DX 44 for a minute and we'll
13 talk about the nursing shortage. How long has
14 this nursing shortage been going on in South
15 Carolina? Is this multiple years?

16 A: Multiple years, yes.

17 Q: More than five years?

18 A: Yes.

19 Q: All right. So despite this nursing shortage,
20 that did not stop Trident from adding
21 additional ED capacity and continuing to add
22 additional ED capacity to the Tri-County area.

23 A: To meet the needs of the community, yes.
24 Really the commitment we made was to care for
25 the community and we've been doing that. And



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

944

1 that's based upon the community demand.

2 Q: So despite the nursing shortage, ED capacity is
3 being added by Trident Health.

4 A: To meet community demand, yes.

5 Q: But the ED -- the shortage of ED nurses
6 shouldn't stop MUSC from establishing an FED.

7 A: It's a factor, as I described previously, in
8 the duplication of healthcare services. And so
9 when you -- when you add new providers to an
10 area, you have to staff that new physical
11 environment. You have to staff that new ER,
12 with physicians, with nurses, with lab techs,
13 with radiology techs, all kinds of staff
14 clinically, that need to come to that new
15 facility, in addition to all of the other
16 providers in the area. So when that new entity
17 is not needed, you are making our shortage --
18 I say you -- we are making our shortage
19 greater. We know our population is increasing.
20 We know our healthcare needs are increasing.
21 We know our population is aging. And so that
22 shortage of nurses is growing going out into
23 the next decade.

24 Q: Everyone I've spoken to so far thinks the
25 decision we made to not do a CDU and helicopter



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

946

1 MUSC FED to be related to the notion of kind of
2 systematic health planning under the CON Act,
3 fair?

4 A: That is one of the reasons, yes.

5 Q: And part of that observation you made was that
6 additional capacity has been approved through
7 the CON Act for these areas. And until that
8 additional capacity is extinguished, exhausted,
9 filled up, MUSC -- there's not need for MUSC's
10 project yet, fair?

11 A: Correct.

12 Q: All right. MUSC and Summerville applied for
13 FEDs in the Summerville Nexton area at about
14 the same time; do you recall that?

15 A: That's what I understand.

16 Q: Right. And it's at least reflected for your
17 project you applied in April. We applied in
18 June. DHEC considered those projects together,
19 didn't they?

20 A: I believe they did.

21 Q: And they issued decisions on the same day in
22 September, approving both. Do you recall that?

23 A: I believe they did.

24 Q: So DHEC, the health planning agency in the
25 state, decided that there was need for your



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

947

1 facility and our facility on the same day in
2 the same general vicinity, right?

3 A: That is correct.

4 Q: After those two CON applications were approved
5 and only after that, did Summerville Medical
6 Center file to add yet more capacity in
7 November of 2017, right?

8 A: Correct. And that was for the reason of
9 hospital ER demand. So as I mentioned I think
10 earlier on this morning, we were looking at ER
11 expansion at Summerville Medical Center in the
12 hospital ER really since 2014. And that
13 analysis and planning and design and then
14 staging it with the Trident Medical Center ER
15 expansion was an important part of that
16 process.

17 Q: We looked at your CON application for the FED.
18 And one of the reasons that that FED was
19 proposed to DHEC as a good idea was it would
20 alleviate volume at your medical center. Do
21 you recall that?

22 A: That's one of the reasons, yes.

23 Q: And it was approved and we were approved. And
24 before either of those were implemented, before
25 either of those were opened, you filed to add



1 yet more capacity at your hospital and then
2 Trident Medical Center filed to add yet more
3 capacity at James Island. How was MUSC ever
4 supposed to open an FED to treat our patients
5 if we have to wait until Trident exhausts its
6 capacity or fulfills its capacity when you keep
7 following CON applications and approvals, like
8 the one we got and the one you got for
9 Summerville, with yet more CON applications?

10 A: So, again, at Summerville Medical Center in the
11 ER, we began that planning process several
12 years earlier. We saw the demand that was
13 growing. We saw the increases in the
14 population. And we saw the increases in our
15 own experiences in ER utilization. So that
16 planning process was several years in the
17 making, that design, that budgeting, all the
18 things that you do to make sure that you're
19 expanding your hospital ER, which is critically
20 important.

21 You know, there again, there are
22 differences in the types of patients that
23 should be served in a freestanding ER and a
24 hospital ER. As we've talked about before, the
25 hospital ER is going to see more critically-ill



1 patients, patients who need admission, patients
2 who need surgery, patients who need procedures
3 of different kinds, patients who need
4 observation care. So that process had been
5 going on for quite some time.

6 That, to me, is unrelated to where MUSC
7 decided to put their freestanding ER, which was
8 dead center, of, again, too many to count, but
9 seven or eight ERs and ERs that are growing
10 capacity. To me that is the -- you know,
11 that's the poster child of duplication and
12 unnecessary healthcare costs and adverse
13 effects to those who already have those
14 services in the area.

15 Q: Roper Hospital EDs are in downtown Charleston
16 and West Ashley, right?

17 A: That is correct.

18 Q: And by establishing FEDs in Moncks Corner and
19 North Charleston, Roper expanded it's
20 geographic reach and thereby improved access to
21 its ED services for its patients, right?

22 A: I presume so.

23 Q: Trident Health has EDs in North Charleston and
24 Summerville. And by establishing FEDs in
25 Moncks Corner, North Charleston, and soon to be



1 in Summerville, and soon to be in James Island,
2 you're expanding your geographic region,
3 thereby improving access for your patients to
4 your ED services.

5 A: We are. And we're expanding care for the
6 community at large. Again, going back to our
7 mission that we made more than 40 years ago and
8 every year we've continued to live up to, so
9 ensuring that the communities that we serve
10 continue to have excellent healthcare.

11 I believe the location in which MUSC has
12 chosen to have its freestanding ER is a
13 location that is completely unnecessary, given
14 that it's surrounded by ERs and ERs with
15 available capacity coming online. There are
16 many other locations that MUSC might choose
17 from. To me, from a health planning
18 standpoint, it makes no sense. I don't
19 understand it. I'm at a loss for words and
20 it's beyond the rationale or even common sense
21 that I can understand.

22 Q: You want MUSC to stay out of your area.

23 A: I don't want duplication of services.

24 Q: MUSC hospital's EDs are on the Charleston
25 peninsula. And despite having patients all



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

951

1 over the Tri-County area, MUSC currently has no
2 FEDs that expand its geographic reach to
3 thereby improve access for it's patients,
4 right?

5 A: They don't have any freestanding ERs.

6 Q: And, if Trident has its way, that situation
7 will continue, correct?

8 A: In this case I don't believe that a
9 freestanding ER is necessary in the location in
10 which it's proposed.

11 Q: One last question on nursing staff. Maybe two.
12 I don't want to over promise. You mentioned
13 that were having nursing staff issues as a
14 result of, I think, the Roper Berkeley County
15 Hospital and MUSC's pediatric outpatient
16 facility in North Charleston; is that true?

17 A: That is correct. We've had staff leave to go
18 to both, staff that have been targeted for
19 recruitment to go to both.

20 Q: How many nursing staff have you lost?

21 A: Approximately -- from a nursing standpoint in
22 Summerville Medical Center's OR we've had at
23 least 20 percent of our nursing staff in the
24 operating room targeted. We've been able to
25 retain some. Some we've lost. I don't have



1 those exact numbers. We've seen that same
2 thing at Trident. We've seen the same from
3 Roper Berkeley on the women's side as well. I
4 don't have the exact numbers, but they're
5 meaningful.

6 You know, the subspecialty clinical
7 training and experience that an operating room
8 nurse, a labor and delivery room nurse,
9 surgical techs, and others have takes years to
10 become competent. There are clinical
11 education, there's experience. Those are
12 really critically important subspecialty staff
13 that are very difficult to duplicate. And so
14 when you're talking about subspecialty care,
15 the targeting and the transition and the
16 recruitment of those staff out of those areas
17 creates a disruption and it's a problem.

18 Q: So you have no number that you can give me at
19 this point as to how many nurses?

20 A: I think I just said in the operating room at
21 Summerville Medical Center alone in the RN
22 world we've had at least 20 percent of those
23 staff targeted. We've been able to retain some
24 and we've lost some as well. I don't have the
25 details of that at my fingertips. I can tell



1 you I have personally spoken to several, both
2 in labor and delivery, both in the operating
3 room, and the leaders in those areas. And I'm
4 aware of others in the Trident Medical Center
5 that have also transitioned.

6 And, again, in these areas that are really
7 highly specialized, these are not your new
8 graduate nurses. These are nurses and surgical
9 techs and others who not only have specific
10 clinical training, but they have specific on-
11 the-job training that you can't duplicate. It
12 really takes years and years to become
13 competent in some of these critically-important
14 areas. And these are also areas where, you
15 know, you have your most critical patient care
16 being provided; labor and delivery, operating
17 room. Those are really important spaces.

18 So, yes, we have already felt the effects
19 of the new entities in the marketplace. And
20 we're doing our best, you know, to continue to
21 staff appropriately and recruit. But it's very
22 difficult. And every time you add a new
23 provider, it increases.

24 Q: Just to be clear, I understand that 20 percent
25 were targeted, but you can't give me a number



1 as to how many have been taken away today. Is
2 that true?

3 A: That is correct. I don't have ---

4 Q: Fair enough.

5 A: --- those details at my fingertips.

6 Q: Fair enough. And the folks we're talking about
7 being taken away, the number we don't have,
8 these aren't ED nurses, are they?

9 A: These are nurses thus far that we've
10 experienced that have been in those
11 subspecialty areas.

12 Q: But no ED nurses yet; is that correct?

13 A: At the moment, as I understand it. But I'm not
14 the person who would have all those details
15 around that.

16 Q: Roper Berkeley's hospital is about to open in
17 October, right?

18 A: Correct.

19 Q: And it has an ED. And you haven't lost ED
20 nurses yet to that facility?

21 A: I do not have that information. And that would
22 not be, as a CEO, the level of detail that I
23 would have. That would really fall to others
24 in the organization who oversee that service.

25 Q: But if it was really important, if it was a



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

955

1 real issue that this Court should deny a CON
2 application over, data would be something that
3 I think you would want to bring to bear on
4 issues like that.

5 A: It's one of the factors in this case.

6 Q: Fair enough. Thank you for your time.

7 A: Thank you.

8 **THE COURT:** Ms. Biggers, do you have any questions
9 for the witness?

10 **MS. BIGGERS:** No questions, Your Honor.

11 **THE COURT:** Okay. Mr. Summer.

12 **MR. SUMMER:** A few on Re-Direct. Thank you, Your
13 Honor.

14 **MR. DAYHUFF:** And Your Honor, I'm sorry. While
15 they're getting ready, I neglected to ask to
16 move the James Island CON application for
17 Trident Health into evidence.

18 **MR. SUMMER:** Without objection.

19 **MR. DAYHUFF:** Thank you.

20 **THE COURT:** It's admitted. Mr. Dayhuff, what was
21 the number for that exhibit?

22 **MR. DAYHUFF:** 7, Your Honor.

23 **THE COURT:** Thank you.

24 **(Respondent MUSC's Exhibit Number 7 was admitted into**
25 **the record at this time.)**



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

956

1 **MR. SUMMER:** Beg The Court's indulgence. Just
2 trying to talk about one slide, not 30.

3 **MS. VALENTINE - RE-DIRECT EXAMINATION BY MR. SUMMER:**

4 Q: Ms. Valentine, I think the first thing I'd like
5 to start with is the line of questioning -- and
6 I'm probably going to go in reverse order. I
7 think you'll remember Mr. Dayhuff discussing
8 with you various exhibits. The first exhibit
9 I'd like to refer to is going to be MUSC 23.
10 So, I'm going to take them backwards. But do
11 you remember MUSC 23?

12 A: Yes.

13 Q: He only made one reference to the freestanding
14 ED page in this document.

15 A: Right.

16 Q: What I'd like for you to explain to The Court
17 is how long a process and how long -- and how
18 methodical a process is, planning is with --
19 especially with a capital project in the
20 organization. So explain to The Court what
21 this document is from your standpoint as a CEO
22 and as a planning document. And this would be
23 MUSC 23.

24 A: Sure. So this is a multi-year strategic
25 planning document that incorporates data that



1 goes over volume over the course of years,
2 services over the course of years, community
3 demand over the course of years, capital
4 budgeting, specific service line details, and
5 those things that really lay out a plan for
6 expanding care to serve the community. So it's
7 a very detailed plan, but it's a roll-up of all
8 of that analysis from the beginning.

9 Q: Okay. And I'm assuming that there will be
10 maybe dozens of projects that are described in
11 that long-term planning document. Is that a
12 fair statement?

13 A: That's correct. It is a comprehensive
14 document.

15 Q: Do you remember Mr. Dayhuff talking to you
16 about this Request for Capital form?

17 A: Yes.

18 Q: Okay. And this particular Request for Capital
19 form was for the freestanding ED that is
20 planned for Nexton; is that right?

21 A: Correct.

22 Q: Okay. So first you'd have the planning
23 document and then you would go and ask for the
24 capital, right?

25 A: Correct.



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

958

1 Q: And what's the date of that planning document?

2 A: That is December 2016.

3 Q: Okay. And so you have to make a case, right?

4 A: Correct.

5 Q: Why does your company require you to do this?

6 A: Well, I mean, we're responsible to be fiscally
7 responsible. And so in this case we would have
8 spent, and I estimate, a year or more really
9 gathering the data, understanding the market,
10 looking at our own experiences with emergency
11 care. And that detailed document is required
12 to ensure that we are spending money wisely.
13 You know, this ER I think is a 13 million
14 dollar investment. And we need to be sure that
15 that is the right investment to make. You
16 know, will we have the patient population come.
17 You know, will we have it constructed
18 adequately. Will it integrate with all of the
19 other services that we offer. So it's really
20 our responsibility to make sure we're spending
21 those dollars wisely and we're making good
22 decisions around these capital investments.

23 Q: So basically you have to go beg for money.

24 A: We do. We do.

25 Q: Okay. And then the next document he asked you



1 about -- or another document he asked you
2 about, would be this document, which appears at
3 MUSC 22, correct?

4 A: Correct.

5 Q: And this says that it is the Executive
6 Management Review. Can you tell me what the
7 date of that document is?

8 A: That document is April 6th, 2017.

9 Q: Okay. So now we're in 2017. And this
10 basically comes from your corporate office.

11 A: Correct.

12 Q: All right. And what does this document do for
13 a -- for any project? Just explain to The
14 Court what this document means to you as an
15 administrator.

16 A: Sure. So it means that our company has
17 reviewed the request for capital, the reasons
18 for that, the plan, the justification, the
19 budgeting, and all of that. And that document
20 is a summary of that. And it provides approval
21 for funding. So when you receive the executive
22 management review, it summarizes the project as
23 a whole, and it provides approval for funding
24 of that particular project.

25 Q: And then are you permitted to go out and get a



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

960

1 Certificate of Need?

2 A: Correct. Very often, you know, we need to have
3 those building blocks first before a
4 Certificate of Need can be initiated or applied
5 for or finalized. Correct.

6 Q: A lot of the financial information that you
7 have to provide to corporate to justify a
8 project, would you also utilize that with DHEC
9 as well to be able to show them about financial
10 feasibility?

11 A: Correct.

12 Q: Because DHEC won't approve a project that's not
13 financially feasible, will it?

14 A: I don't believe they will. And I think there
15 needs to be a community need. I think there
16 needs to be a justification for the rationale
17 of the project. Obviously, you know, the level
18 of detail that DHEC would want follows the CON
19 regulations.

20 Q: Okay. Is it your understanding that for each
21 one of the projects that we're looking at on
22 the screen right now, the same deliberative
23 process would have to be followed for each of
24 those?

25 A: That's correct. You would start with about a



1 year or so of planning, sometimes more than
2 that, and then go through that exact process
3 that we just talked about.

4 Q: All right. I'm going to ask you to take a look
5 at Trident Exhibit 98, please.

6 **MR. SUMMER:** And can we stick that up on the board?
7 I'm going to toggle between 98 and that slide if
8 we can.

9 Q: I'm going to ask you if you can identify what's
10 been marked as Trident's 98.

11 A: So this is the Trident Medical Center's
12 Certificate of Need application, which includes
13 an ER expansion, OR and PACU expansion, and the
14 addition of a third CT scanner.

15 Q: Okay. If you'll turn over to page seven of
16 that document, please. And if you'll look at
17 the very bottom left-hand corner, what was the
18 total project cost for that project?

19 A: That was \$13,622,000.

20 Q: Okay. Is this the project that you testified
21 about at Trident that completed in 2018?

22 A: That's correct.

23 Q: Okay. Would your company have required that
24 Trident go through the same process we just
25 described; strategic planning, request for



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

962

1 capital, and then permission to spend?

2 A: Absolutely.

3 Q: Then obviously there's a Certificate of Need
4 issued for that spend.

5 A: Correct.

6 Q: Let's go now, if you don't mind, to --

7 **MR. SUMMER:** Any objection to admitting that into
8 evidence?

9 **MR. DAYHUFF:** No objection.

10 **MR. SUMMER:** I'd like to admit Trident number 98,
11 Your Honor.

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

13 **(Petitioner TMC's Exhibit Number 98 was admitted into**
14 **the record at this time.)**

15 Q: So let's take a look now at Trident number 1.
16 Do you recognize this document?

17 A: I do.

18 Q: Okay. Explain to The Court what this is.

19 A: This is the Certificate of Need application for
20 the Summerville Medical Center Hospital
21 emergency department and ancillary services
22 expansion.

23 Q: Okay. And would you turn to page seven of that
24 document?

25 A: Yes.



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

963

1 Q: Could you explain to The Court what the total
2 project cost was for this project?

3 A: So in this project it was \$24,257,056.

4 Q: Okay. Again, did you have to go through that
5 same deliberative process of plan, request,
6 approval?

7 A: Correct, absolutely.

8 Q: Okay. Let's go back, if we can, to the
9 PowerPoint, please. I don't think we need to
10 go through it again, but the freestanding ED
11 project that you have received the Certificate
12 of Need for and break ground on, that's about
13 a 13 million dollar project as well, right?

14 A: That is 13 million and change, yeah.

15 Q: All right. So we've got the Trident Medical
16 Center expansion was over 13 million dollars.
17 Your expansion was over 24 million dollars.
18 The freestanding ED in Summerville is 13
19 million dollars. So we're looking at over 50
20 million dollars worth of project.

21 A: That's correct.

22 Q: Did you apply for and receive a Certificate of
23 Need for each of those?

24 A: Correct. Yes, we did.

25 Q: Okay. And so when you are planning -- I think



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

964

1 Mr. Dayhuff asked you a number of questions
2 about the language inside that Request for
3 Capital or in that executive summary, 22 and
4 23. And he focused on language like offensive
5 and defensive and infiltration. Do you
6 remember that?

7 A: Yes.

8 Q: Okay. Is Certificate of Need a free-market
9 system?

10 A: Well, it's available to all. I don't know that
11 I would call it a free-market system.

12 Q: In order to construct any of these projects, a
13 provider has to get what?

14 A: They have to have a Certificate of Need and you
15 have to have funding available to execute on
16 that application.

17 Q: And does Certificate of Need give you some
18 assurance of a return on investment?

19 A: It should. It should. And that's one of the
20 basis for the Certificate of Need regulation,
21 is to control cost, control healthcare
22 expansion, and ensure that you don't have
23 duplication in the system.

24 Q: Okay. So in these documents for request for
25 capital, and for the executive summary, Trident



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

965

1 is basically taking advantage of the CON system
2 as offered by the State of South Carolina,
3 right?

4 A: That is correct.

5 Q: Okay. And for a provider to come to
6 Summerville and offer any of these services,
7 would they also have to have a CON?

8 A: That is correct.

9 Q: Okay. Look at James Island for a minute and --
10 so let's take a look at the Tri-County map.
11 And I'm blind, so I've got to come up here and
12 look. But James Island is down here, correct?

13 A: Yes.

14 Q: If MUSC wanted to put a freestanding ED on
15 James Island, it could have applied for it;
16 could it not?

17 A: Yes.

18 Q: If Roper wanted to put a freestanding ED on
19 James Island, were they free to apply for a
20 CON?

21 A: Yes.

22 Q: Okay. Is there any comparison to the lack of
23 resources that exists in that part of
24 Charleston County and to the lack of resources
25 that existed in 1975 when Trident first



1 started?

2 A: Yeah. I think that when you look at 1975 and
3 what was available in Berkeley and Dorchester
4 County, it really was nothing. And so Trident
5 Regional came forward and made that investment.
6 The James Island area is also one that could be
7 looked at for freestanding.

8 Q: Because it really -- there are no hospital
9 assets anywhere near James Island, are there?

10 A: It does not look that way.

11 Q: Okay. Does Trident get every Certificate of
12 Need that it applies for approved?

13 A: No.

14 Q: You've done a really good job of describing the
15 children -- the women's and children's
16 services. Do you have NICU services there?

17 A: We have Level II NICU services.

18 Q: Why don't you have Level III?

19 A: Because we were denied ---

20 **MR. DAYHUFF:** Objection. Just -- I'm going to offer
21 this. This is supposed to be a Re-Direct. I
22 think Re-Direct is supposed to address things
23 that were raised in Cross. So the NICU matter
24 is a separate matter. If he wants to get -- I
25 don't think he can get into it, but if he does,



1 it's going to perhaps necessitate us -- me to
2 have a chance to talk about the NICU case and
3 what was at issue in that case. So I would ask
4 that we limit the scope of his Red-Direct to
5 stuff that occurred in Cross.

6 **MR. SUMMER:** May I lay a little bit of foundation
7 for that, Your Honor?

8 **THE COURT:** Okay.

9 **MR. SUMMER:** Because I think I can do that.

10 **Q:** MUSC has services that nobody else has; is that
11 correct?

12 **A:** Correct. That's correct.

13 **Q:** Is Level III NICU one of those services?

14 **A:** Yes.

15 **Q:** Okay. Did MUSC oppose you getting into that
16 market?

17 **A:** Yes.

18 **MR. DAYHUFF:** Your Honor, this was not anything that
19 came up. And if he wants to get into that CON
20 application, there are lots of great reasons
21 why NICU services are the most highly
22 regionalized services in the State Health Plan.
23 And that's not at issue in this case.

24 **MR. SUMMER:** Here's what I'm trying to demonstrate.
25 There was a line of questioning about



1 protecting a market and not allowing people in.
2 This witness has direct knowledge of how that
3 exact same phenomenon occurred by MUSC against
4 Trident. And what I want The Court to
5 understand is the context. And that is, all of
6 these facilities have certain services, certain
7 regions that they primarily take care of. And
8 CON protects that. Just as CON protected for
9 NICU, CON should be protecting in the north
10 area for the services that we're talking about
11 now. So all I'm trying to do is to put that
12 into context, that each of these facilities
13 protects and seeks to protect certain market
14 share at certain services. And I think that's
15 a fair rebuttal to the painting that he tried
16 to depict about my client and what's it been
17 doing in the north area.

18 **MR. DAYHUFF:** It goes well beyond the scope of
19 cross. The NICU matter is an entirely
20 different matter, an entirely different
21 service. We were talking about ED services.
22 The NICU case, they were denied by DHEC. We
23 were not denied by DHEC in this case. They
24 brought a case challenging that denial. They
25 withdrew that case. I don't think we should



1 make this case a case about the regionalization
2 of neonatal intensive care units. I think that
3 opens up an inquiry that would not be probative
4 for this Court on the ED issue.

5 **THE COURT:** I agree with you, Mr. Dayhuff. And your
6 objection is sustained.

7 **MR. DAYHUFF:** Thank you.

8 **Q:** Let's go back to this notion about adverse
9 impact, because Mr. Dayhuff was talking to you
10 about whether or not it had been dollarized.
11 What I'd like for you to do is just to
12 summarize for The Court from your perspective
13 why you believe this project is going to have
14 a negative effect on your operations.

15 **A:** Yeah. So, again, for many reasons. We have
16 seven or eight ERs in our area now. The
17 particular location of this ER really is dead
18 center of three or four of those and less than
19 a mile from the freestanding ER, which is a
20 carbon copy for all intensive purposes, of the
21 project that MUSC is proposing. So it adds
22 another avenue for patients to go in an area
23 that already has many, many ERs and, again, ERs
24 that haven't even added the new capacity that's
25 been approved and is under construction. It



1 will -- patients will go to lots of places and
2 they'll go -- not just patients that maybe
3 would have gone downtown, but anyone in the
4 community. So it will dampen the volume and
5 the viability of our ERs and those new
6 locations.

7 It will also increase the competition for
8 available staff. The supply itself, you know,
9 on staffing is what it is and I think
10 everyone's working to try to increase that.
11 But when you add a new physical plant that
12 needs to be staffed, that's a whole new set of
13 folks that have to come in and serve that
14 particular area. And it will -- it will impact
15 the work that we're doing in the community.

16 Q: Thank you very much.

17 A: Thank you.

18 **MR. SUMMER:** That's all we have, Your Honor.

19 **THE COURT:** Thank you, Ms. Valentine.

20 **MS. VALENTINE:** Thank you.

21 **THE COURT:** Mr. Summer, who is your next witness?

22 Is it your ---

23 **MR. SUMMER:** It's Joan Eccleston, who's in the
24 courtroom.

25 **THE COURT:** Okay.



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

971

1 MR. SUMMER: I understand if you want to break for
2 lunch, because I imagine she would take at
3 least an hour. I have no idea how long Mr.
4 Dayhuff's Cross is.

5 THE COURT: Okay. We'll take -- let's reconvene at
6 1:30.

7 (Off the Record)

8 THE COURT: We are back on the record.

9 MR. THOMAS: Your Honor, Trident Health -- Trident
10 Medical Center would call it's next witness,
11 Joan Eccleston, to the stand.

12 THE COURT: Is that Nicholson?

13 MR. THOMAS: Eccleston.

14 THE COURT: Eccleston.

15 MR. THOMAS: It's E-C-C-L-E-S-T-O-N.

16 THE COURT: Okay. Ms. Eccleston, if you'll come up
17 and raise your right hand, face the court
18 reporter, she'll swear you.

19 JOAN ECCLESTON, having been duly sworn, testifies as
20 follows:

21 COURT REPORTER: Please state and spell your first
22 and last name.

23 MS. ECCLESTON: Joan Eccleston, J-O-A-N E-C-C-L-E-S-
24 T-O-N.

25 MS. ECCLESTON - DIRECT EXAMINATION BY MR. THOMAS:



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

972

1 Q: Hello, Ms. Eccleston. How are you today?

2 A: Great.

3 Q: I'm going to ask you to do it again, but could
4 you state your name for the record?

5 A: Joan Eccleston.

6 Q: Okay. Where do you work, Ms. Eccleston?

7 A: Trident Medical Center.

8 Q: Okay. What is your official title?

9 A: I am the director of emergency services. And
10 that means that I am the director of Trident
11 Medical Center's main campus and also Centre
12 Pointe Emergency Department freestanding ED and
13 Moncks Corner Medical Center emergency
14 department.

15 Q: You have some knowledge about the ED services
16 that are offered at Summerville?

17 A: Some knowledge, yes, sir.

18 Q: At this time I'd like to put up Trident 99,
19 which is Ms. Eccleston's resume. If you can't
20 read it on that screen, let me know.

21 A: Okay. I can read it.

22 Q: Okay. Where did you go to college, Ms.
23 Eccleston?

24 A: My first degree was from the University of
25 Virginia.



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

973

1 Q: You're a Wahoo?

2 A: Yes.

3 Q: Okay. Did you do anything after -- what did
4 you study in college?

5 A: I was a -- my degree is in economics from the
6 University of Virginia.

7 Q: Okay. And how about -- did you do any post-
8 graduate education?

9 A: Well, I went to -- I became a nurse after that.
10 So I received an associate degree in nursing
11 and then a master's degree in nursing.

12 Q: From where?

13 A: George Mason University in Virginia.

14 Q: Okay. Why don't you tell The Court, and you've
15 got it kind of in front of you, but a little
16 bit about your employment history in nursing?

17 A: Okay. No problem. So I began as a nurse in
18 1993 and I worked on a surgical floor for three
19 years. And then I was a nurse in the emergency
20 department for Inova Health System. And I
21 worked for Inova overall for 25 years as an ER
22 nurse in a Level I trauma center. And then I
23 worked as a ER nurse in a freestanding
24 emergency department for several years. And
25 then after that I -- and during that time, I



1 also still worked at the Level I trauma center,
2 which is Fairfax Hospital. And then I -- as I
3 grew in my career, I became involved in nursing
4 informatics and then nursing leadership. And
5 so I've been a manager and a director and a
6 senior director.

7 Q: What is -- give The Court a little description
8 about what nursing informatics is.

9 A: Well, my particular role was -- well, I think
10 nursing informatics in general is how you can
11 utilize technology to be more efficient. But
12 my particular role at Inova is we switched from
13 a paper documentation system to an electronic
14 medical record. And in order to do that, they
15 used me as an expert for work flow and things
16 like that.

17 Q: Okay. Can you -- tell us about Trident Medical
18 Center. When did you come to Trident Medical
19 Center?

20 A: I came to Trident in August of 2016.

21 Q: Okay. And why don't you -- you're a licensed
22 RN, correct?

23 A: That's correct.

24 Q: In the state of South Carolina?

25 A: Uh-huh (affirmative response).



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

975

1 Q: And I think I heard you, but have you worked in
2 both hospital-based EDs and freestanding EDs?

3 A: Yes, I have.

4 Q: Okay. From a clinical perspective?

5 A: Yes. I was a -- as a staff nurse at a
6 freestanding emergency department for several
7 years and now I'm the director of two
8 freestanding emergency departments, so I've
9 done both.

10 Q: Now, tell me, are you involved in any
11 professional organizations?

12 A: I'm a member of Emergency Nurses Association,
13 the Lowcountry chapter.

14 Q: Okay. Have you won any honors or awards in the
15 past?

16 A: I have a certification in -- I'm a Nurse
17 Executive Advanced, board certified. I've won
18 some -- at Inova I was a member of the -- I won
19 like a quality improvement award at Inova for
20 emergency department acuity and for emergency
21 department process improvement. I'm also a
22 member of the Sigma Theta Tau Nursing Honors
23 Society. And did some work in Lean, process
24 improvement.

25 Q: Well, tell us a little bit about what you do at



1 Trident Medical Center in your leadership role
2 and your nursing role.

3 A: Okay. So I'm responsible for the emergency
4 department operations, staffing, quality
5 improvement initiatives, flow of emergency
6 patients. Pretty much everything related to
7 the emergency department at Trident and Moncks
8 Corner and Centre Pointe Emergency Department,
9 I'm in charge of those -- patient care in those
10 areas. And I partner with the physicians to
11 make sure that the care is appropriate.

12 Q: Without getting too kind of in the weeds, do
13 you have the occasion to review metrics or
14 quality control measures and that type of thing
15 in your job?

16 A: Absolutely.

17 Q: And could you just briefly describe the types
18 of things that you're looking at in your day-
19 to-day leadership of Trident's EDs?

20 A: Absolutely. So we monitor a lot of throughput
21 metrics, as far as arrival to provider. So
22 door-to-greet times that Lisa referred to
23 earlier, all throughput metrics. And then we
24 also monitor our quality metrics and our
25 timeliness of care for patients and the



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

977

1 resulting mortality improvements. So
2 basically, for example, if a patient was having
3 a stroke, we monitor how long it takes to give
4 them the life-saving medications that they need
5 and their outcomes.

6 Q: Very good.

7 **MOTION TO QUALIFY AS EXPERT:**

8 **MR. THOMAS:** Your Honor, at this time I'd like to
9 ask The Court to qualify Ms. Eccleston as an
10 expert in ED nursing care, administration, and
11 leadership.

12 **MR. DAYHUFF:** No objection.

13 Q: All right. I am going to throw up a Joan
14 Eccleston demo exhibit one please. There we
15 go. Ms. Eccleston, have you seen this chart
16 before?

17 A: Yes, I have.

18 Q: Okay. And I think some of these maybe were
19 discussed with Ms. Valentine, so we're not
20 going to go over all of them. But a couple of
21 questions I have. What does it mean, in terms
22 of the emergency services that are offered at
23 Trident Health, that the American College of
24 Cardiology has accredited Trident as a Chest
25 Pain Center?



1 A: So from the emergency department perspective,
2 that is the quality of care that is provided to
3 patients with acute myocardial infarction that
4 present to the emergency department. A lot of
5 it is around timeliness of care and assessment
6 and appropriateness of care. And we have
7 achieved that at Trident.

8 Q: Okay. In terms of the Gold Plus stroke in the
9 Joint Commission Certified Stroke Center, what
10 does that mean to you in terms of what you do
11 at Trident?

12 A: So the primary stroke certification comes from
13 the governing body, the Joint Commission
14 governing body. And it means that we are able
15 to provide a certain level of care to our
16 patients who present with stroke-like systems.
17 And then being Gold Plus for stroke is a very
18 high honor related to our outcomes and our
19 achievements in stroke. Specifically, it's the
20 patients who meet the door-to-TPA timeliness.
21 And we're able to do that currently.

22 Q: Well, tell me what that means, the door-to-TPA
23 timeliness. Why is that important for a
24 patient?

25 A: Well, time is brain. And so when you're having



1 a ischemic stroke, that means there's a clot
2 blocking the blood flow to the brain. And
3 minutes really matter. Every minute is very
4 important to our patients. And I'm really
5 proud of the improvements that we've made over
6 the last several years, really. We're at the
7 Gold Plus standard. And our patients -- 100
8 percent of our patients that meet the Get With
9 The Guidelines, which I'm getting a little too
10 deep with you, meet that -- we meet that stroke
11 criteria. And we have been able to achieve
12 excellent outcomes for our stroke patients
13 because of our efficiency and all of the
14 processes that we've worked on.

15 Q: Now, I'm kind of -- maybe we do kind of want to
16 get into the weeds a little bit with things
17 like that. So in terms of this TPA timeliness
18 issue, if somebody walks into a freestanding ED
19 at either Centre Pointe or Moncks Corner
20 Medical Center and whomever is there determines
21 they're having a stroke, what does that mean
22 for that patient?

23 A: Well, we are still able to provide them that
24 treatment. We have a CAT scan there and we
25 could do -- call a code neuro. And we also



1 have tele-neurology available at these
2 locations, so they -- nurses and doctors are
3 able to activate a code neuro, which is where
4 we implement the team. We get our CAT scan
5 ready and we're able to get the patient over to
6 CAT scan immediately. And our ER doctors
7 collaborate with the tele-neurologist and can
8 order the TPA. And then if they do have -- if
9 they are having a stroke or even if they're not
10 having a stroke, we would be able to transfer
11 them over to Trident.

12 Q: Okay. So you have the telehealth services at
13 the freestanding EDs for the more complex
14 cases?

15 A: Yes.

16 Q: Okay. How about from a STEMI patient, who
17 maybe the EMS was not initially called by a
18 family member or by themselves and they present
19 to Centre Pointe or to Moncks Corner, how would
20 Trident handle that patient?

21 A: So we have a three-minute goal of door to EKG.
22 So the nurses and techs at one of -- each of
23 the freestandings would perform an EKG quickly.
24 And then if the patient is having a ST-segment
25 MI, we would partner with EMS to provide



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

981

1 transport to Trident for a cath. But we
2 activate the code STEMI right there from Centre
3 Pointe and that will activate the cath lab team
4 and we're able to get the patients over to
5 Trident timely.

6 Q: Okay. In terms of STEMI, how about just for
7 the record, what does that stand for?

8 A: ST-segment myocardial infarction.

9 Q: So a heart attack is ---

10 A: Yeah, a heart attack.

11 Q: It's a fancy acronym for heart attack.

12 A: Uh-huh (affirmative response).

13 Q: All right. Are you familiar with the
14 expansions that have taken place at Trident
15 Medical Center?

16 A: Yes. Oh, yes.

17 Q: Can you tell The Court a little bit about
18 those, maybe with a little bit more detail,
19 since Ms. Valentine is CEO of Summerville?

20 A: So you're talking about the ED specific
21 expansion?

22 Q: Yeah, kind of what was done and ...

23 A: Okay.

24 Q: Yeah.

25 A: Yeah. So when I first got there, it hadn't



1 started yet, so I was there for the entire
2 project. And we added a 16-space fast track
3 area to our front end. And some of that we've
4 converted to main beds now. So we have a 12-
5 bed low acuity or fast track area. And then we
6 have five additional treatment spaces in that
7 area. And in the back we have several other
8 additional treatment spaces. And then we also
9 have a new unit for our behavioral health
10 patients. That's a three-room unit, that can
11 -- we can accommodate multiple patients in that
12 area as well.

13 Q: And speaking of the mental health patients, is
14 that a high-volume thing for Trident?

15 A: Yes, very much. I feel like we are able to
16 provide a great service to our community for
17 mental health. We have a great need in that
18 area. And we see about 100 to 120 patients
19 every month from Summerville and then we see
20 about 400 -- probably around 350 to 400 at
21 Trident main. And one of the things that we've
22 implemented that I'm really proud of is a tele
23 -- it's not -- it's a tele-process as well for
24 behavioral health patients. So anyone who
25 presents to any of the Trident emergency



1 departments is able to receive a counseling --
2 CIT is our crises intervention team. And
3 they're able to, usually around -- within an
4 hour or so, meet with the patient after they've
5 been medically cleared and communicate with
6 them. And some of those patients are able to
7 be discharged safely back into the community.
8 But if they do require admission, then we can
9 transport them over to Trident for an inpatient
10 stay or for further evaluation by the
11 psychiatrist. But we see around 400 a month --
12 or I think the number is actually around 350,
13 but in the emergency department at Trident. So
14 we serve a big portion of the community with
15 our behavioral health services.

16 Q: And has the behavioral health services at
17 Trident and how you dealt with it, has it
18 greatly impacted like say your door to provider
19 time at all?

20 A: Well, the behavioral health -- I would say that
21 our door-to-provider time at Trident for the
22 entire time I've been there has always been
23 exceptional, so it's not really been an issue.
24 So I don't really think that that specifically
25 has had much of an impact on the door-to-



1 provider time.

2 Q: And just while we're talking about it, what is
3 kind of the average door to provider time at
4 Trident these days?

5 A: So our goal is less than ten minutes and we
6 always meet that. I would say it's probably
7 around eight minutes is our door-to-provider
8 time.

9 Q: Okay. And in terms of -- we've kind of touched
10 on this a little bit, but I want to talk about
11 the concept of throughput. What does ED
12 throughput mean to you?

13 A: It's everything for patients. I think that
14 it's really important to be able to see them
15 immediately when they get there, provide that
16 medical screening exam. And so throughput
17 allows you to have the resources available,
18 because you've gotten the patients through the
19 system, if you will. So throughput could mean
20 admission patient throughput or also discharge
21 patient throughput.

22 So one of the things that I feel like I'm
23 an expert in is efficiency and process
24 improvement. And so partnering with the team
25 health providers and, you know, just the



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

985

1 Trident administration, we've done a really
2 good job of improving that throughput through
3 the hospital. And so we're able to -- we have
4 less than two percent of our patients leave
5 without being seen. We have like a 1.5 percent
6 left without being seen. And I feel like
7 that's a really important way to measure how
8 efficient your services are.

9 Q: We've been calling the left without treatment
10 the LWOT.

11 A: Okay.

12 Q: Just another acronym.

13 A: Right.

14 Q: Now, you talked a little bit about the TMC,
15 Trident Medical Center, renovation expansion.
16 And I know you don't work specifically at
17 Summerville. Do you know a little bit about
18 that expansion?

19 A: Yes, I do.

20 Q: Okay. Tell The Court a little bit about that.

21 A: Well, they've added ten treatment spaces to
22 their -- I know there's six new adult -- or six
23 pediatric. And so they've added additional
24 space, because they were seeing about 2500
25 patients per room. And the ten additional



1 rooms they're adding will have a big impact.
2 So I apologize. They've added four pediatric
3 and six adult rooms.

4 Q: Okay.

5 A: Something like that. I'm sorry.

6 Q: And in terms of the services that will be
7 offered at exit 199, that freestanding ED that
8 Trident Health is going to establish there,
9 what services in general will be offered there?

10 A: It will be very similar to Centre Pointe
11 Emergency Department. And it will have ten
12 treatment spaces, it will have the ability to
13 do CAT scans, laboratory physician there. So
14 I think -- it's going to be a full-service
15 emergency department, will be able to provide
16 TPA if needed, medications, any type of
17 services that are needed in the emergency
18 department.

19 Q: And is Trident Health -- or Trident Medical
20 Center, does it have a trauma designation?

21 A: Trident Hospital is a Level II trauma center.

22 Q: Okay.

23 A: That's correct.

24 Q: And what could that mean for patients who, you
25 know, maybe wonder into Centre Pointe or Moncks



1 Corner or are taken there by somebody else?
2 Not EMS, because I know there are protocols and
3 we've talked about that. But what does that
4 mean for a patient that would happen to come
5 and, you know, I don't know, with some type of
6 traumatic event and they present to those
7 freestanding EDs?

8 A: Well, based on the acuity of their trauma,
9 they're evaluated by a emergency room physician
10 first. And then if they need to be evaluated
11 by a trauma surgeon -- not every trauma patient
12 is that traumatic. You could just hurt
13 yourself. But if you meet Level I or Level II
14 trauma criteria, then you would be transported
15 to Trident and you'd would be a trauma
16 activation, so we would be prepared for you
17 when you arrive.

18 Q: And just -- so I think exit 199 is where
19 Summerville is located. Do you know the exit
20 for Trident?

21 A: 205-B.

22 Q: 205-B. So that's about six miles away ---

23 A: That's correct.

24 Q: --- from this freestanding ED ---

25 A: Uh-huh (affirmative response).



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

988

1 Q: --- that you're establishing? Now, let's talk
2 a little bit about staffing. I want to ask you
3 about how Centre Pointe is staffed. What's
4 that staffing model look like at Centre Pointe?

5 A: I have six nurse shifts a day and two tech
6 shifts a day. So, I have about 14 nurse, 14
7 full-time equivalent nurses, and five techs
8 total.

9 Q: And I believe MUHA is going to have seven ED
10 rooms and five fast track rooms, a lab, a CT
11 scanner, and an X-ray. What do you have in
12 terms of services at Centre Pointe right now?

13 A: Very similar to what you're telling me that the
14 Medical University is going to have, lab, CT,
15 we have some outpatient lab as well.

16 Q: Okay. Well, so in terms of Summerville Medical
17 Center's freestanding ED, and we'll -- you
18 know, going to be about a mile away from the
19 proposed site with MUHA. Are those facilities
20 similar, dissimilar?

21 A: I think that they are exactly the same.

22 Q: Very similar.

23 A: Very similar.

24 Q: Okay. Now, one thing I'd like you to do -- and
25 I think it's maybe already opened.



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

989

1 A: Okay.

2 Q: Just turn to page -- and you should be there.
3 It's the Medical University Hospital
4 Authority's CON for the development of a
5 freestanding ED. And it's page CON 88. I
6 believe it's ---

7 A: Okay. I see it.

8 Q: --- already in evidence. How many -- and I
9 just want to look at nurses -- RNs does MUSC
10 have in its FTE budget there?

11 A: 19.1.

12 Q: Okay. And do you believe that's a reasonable
13 FTE counts for nurses for a freestanding ED
14 that's going to do 15,000 patients a year?

15 A: That's a very high number. I think that we see
16 about over 20,000 at Centre Pointe, and we have
17 14. So that's a significant amount more.

18 Q: Okay. So how about the 44 FTEs over all to
19 staff the freestanding EDs? Does that sound
20 reasonable to you, based on your experience
21 with Centre Pointe?

22 A: I don't see any lab people here, but I don't
23 know why they would need pharmacy and -- I'm
24 not sure what an administrative specialist is,
25 unless that's a lab person. But that's a lot



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

990

1 of people. We don't have that many at Centre
2 Pointe at all.

3 Q: Do you have any opinions as to how MUHA's
4 freestanding ED may affect the staffing of
5 Trident's ED services in the north area?

6 A: Well, in addition -- I know that there's
7 another ER that's opening up closer to Trident.
8 And that, I've had -- I've lost two nurses so
9 far and I have two other nurses that are
10 interviewing there. It hasn't opened yet,
11 though ---

12 Q: Which one is that?

13 A: It's the one -- the Roper -- the hospital
14 that's opening up.

15 Q: Okay. Roper Berkeley.

16 A: But their ER hasn't opened yet. That's
17 correct. So their ER hasn't opened yet and so
18 I think that once it opens, it potentially
19 might impact us.

20 Q: And do you have difficulty with hiring like
21 competent and well-experienced ED nurses?

22 A: Yes. I have a very difficult time finding
23 experienced nurses in this area. I'm only
24 three years into the area, so I've mostly hired
25 new graduate nurses since I've been here. I



1 have hired some experienced nurses. I've also
2 been utilizing travel nurses. In addition to
3 an increased cost for travel nurses, the
4 quality of the care that they're providing is
5 a little bit less. It's kind of like having a
6 renter versus an owner in my opinion. So I
7 think that that's kind of one of my biggest
8 frustrations, is finding competent, skilled
9 nursing staff.

10 Q: Well, can't you just hire someone right out of
11 nursing school and put them in a freestanding
12 ED?

13 A: No. We -- it's really challenging in a
14 freestanding ER, because especially at night
15 and during the day, just -- in the morning and
16 at night you only have two nurses. And so you
17 need to have both of them be experienced
18 nurses. Occasionally you can put maybe
19 somebody with a little bit of less experience
20 during the day, but that's very -- it's very
21 tricky. Because if you have any type of issues
22 with critically-ill patients, they have to be
23 somewhat more experienced.

24 Q: And the acuity of patients at Centre Pointe, is
25 that fair comparison to what SMC's freestanding



1 ED is going to be?

2 A: I think so. I think so. Centre Pointe is
3 located near other hospitals as well, so our
4 acuity is pretty low there. And I imagine that
5 that's how it would be at Summerville Medical
6 Center's freestanding emergency department.
7 Every now and then you get somebody who doesn't
8 recognize that their symptoms are sick -- are
9 severe, but for the most part we see lower-
10 acuity patients at Centre Pointe.

11 Q: Okay. And would you expect the same kind of
12 acuity levels at a freestanding ED at exit 199?

13 A: Absolutely. Occasionally at Moncks Corner our
14 patients are a little bit sicker because it's
15 remote and that's sort of -- there's not a lot
16 out there, so it's a little bit -- the patients
17 are a little bit sicker sometimes or more
18 chronically ill and underserved. However, at
19 Centre Pointe that's not really the case and I
20 don't imagine it would be like that at
21 Summerville.

22 Q: Okay. And in terms of the admission rates, I
23 can't remember if Ms. Valentine specifically
24 stated admission rates or maybe even deferred
25 to you.



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

993

1 A: Okay.

2 Q: Can you give The Court kind of an average
3 admission rate from, say, a Centre Pointe-type
4 freestanding ED?

5 A: So we have about -- less than two percent of
6 our patients from Centre Pointe are admitted to
7 the hospital.

8 Q: Would you expect a similar admission rate from,
9 say, SMC's freestanding ED?

10 A: I have no reason to believe otherwise. I can
11 imagine that. At Moncks Corner our admission
12 rate's a little bit higher. It's about four
13 percent. But our volume is very low, so to get
14 to four percent doesn't take very many.

15 Q: Okay. Let's go to demonstrative exhibit number
16 two please for Ms. Eccleston. Okay. This is
17 a demonstrative exhibit we put together with
18 the different EDs.

19 A: Okay.

20 Q: And I'd like you to just kind of explain what's
21 going on here.

22 A: Okay. So at Trident, the treatment areas are
23 referred to spaces where you can take care of
24 a patient. And so we have -- you know, we have
25 36 treatment spaces that I'm referring to with



1 head walls and, you know, suction and medical
2 gas and things like that. And then we also
3 have 12 additional fast track spaces that are
4 chairs. Patients -- we do see a lot of
5 patients in there, but those are our patients
6 who don't need like necessarily like a medical
7 gas or -- you could be usually level fours and
8 fives, but you could still be a level three
9 patient as long as you don't need oxygen or
10 suction or something like that.

11 And then Summerville Medical Center has
12 35, but that is including their pediatric ER as
13 well. Centre Pointe has 12 and Moncks Corner
14 has eight.

15 Q: Okay. And then just briefly, I know Mr.
16 Dayhuff had asked Ms. Valentine about some
17 volumes ---

18 A: Okay.

19 Q: --- which she deferred to you. For 2018, can
20 you just give us the same run down of the
21 volumes there?

22 A: Sure. So we saw about 64,000 patients at
23 Trident main campus and 77,000 at Summerville
24 Medical Center. Our acuity is a little bit
25 higher at Trident and Summerville also sees a



1 lot of pediatric patients because they have a
2 peds ED. Centre Pointe saw 20,000, and Moncks
3 Corner 14.

4 Q: Okay. So about a total of 176,000 patients?

5 A: Yes.

6 Q: Okay. Now, let's talk a little bit about the
7 capacities for the rooms.

8 A: Okay.

9 Q: You've got 1850 at Trident. Why is that one
10 less?

11 A: Well, like I said earlier, we do see sicker
12 patients at Trident. We have -- you know, we
13 provide a lot of services that aren't provided
14 at other area hospitals, so the patients do
15 come there and sometimes stay a little bit
16 longer. A lot of admission rate -- our
17 admission rate at Trident is about 25, 26
18 percent of our patients. So when you're
19 admitting patients, it does take a little bit
20 longer than just seeing and treating and ---

21 A: Sure.

22 Q: --- treating and seeing patients quickly, yeah.

23 Q: And SMC's 22 and the -- as are the freestanding
24 EDs?

25 A: Uh-huh (affirmative response).



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

996

1 Q: Can you explain a little bit about where those
2 numbers came from?

3 A: So Summerville Medical Center sees about --
4 they have about a ten percent admission rate,
5 so they're able to see their patients quicker
6 and discharge them more expeditiously. Centre
7 Pointe as well, same thing; we see about 2200
8 patients. Well, we see about -- we see 20,000
9 patients and we have 12 rooms, so our capacity
10 is not 100 percent utilized there as well. And
11 the same at Moncks Corner.

12 So at the freestanding ERs, your patients
13 can be seen and discharged. Our average length
14 of stay at the freestanding emergency
15 departments for level four and five patients is
16 usually in the 60-minute range. So you can see
17 a lot patients that way.

18 Q: Got you.

19 A: We have a lot of efficiency in our processes.

20 Q: Right. It looks to me that the functional
21 capacity, that's wrong. I just noticed the
22 number of Summerville. Their volume in 2018 is
23 77,000. Their functional capacity is 2200 of
24 77,000. It's actually 100 percent, isn't it?

25 A: Right.



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

997

1 Q: Okay. But Summerville, are they doing
2 something about that?

3 A: Right. So that's why they have a ten-bed
4 expansion, that they'll be able to see a
5 significant increase in patients. And they
6 also have the freestanding emergency department
7 coming on board, so they'll be able to see an
8 additional potentially 22 or even 25,000
9 patients.

10 Q: Okay. So it looks like the future ED resources
11 is going to expand functional capacity by about
12 74,000 visits a year; is that right? If you
13 look at the future ED resources below.

14 A: Yes.

15 Q: Okay. And -- bear with me. Now does HCA use
16 a kind of different standard for what they --
17 when they'll actually say let's expand?

18 A: I think -- I believe they use a 2500 visits per
19 bed before they say definitely we need to
20 expand the size of this department.

21 Q: Okay. So has the 2200 been a more conservative
22 number?

23 A: Absolutely.

24 Q: You talked a little bit earlier about quality
25 metrics and that you kind of stay on top of



1 that. What type of quality metrics are you
2 measuring?

3 A: So we measure a lot around sepsis. Sepsis, the
4 care of patients who present with an acute
5 infection. We want to make sure that we
6 provide timeliness of care to them, so we
7 measure one-hour antibiotic times on arrival.
8 We measure mortality rates for our patients.
9 We measure our door-to-TPA times that I
10 mentioned before. We measure our door-to-EKG
11 times. So ...

12 Q: And how do those measures stack up against,
13 like say, national benchmarks?

14 A: So we are -- I know that Trident Medical Center
15 is in the top with HCA as far as our -- we're
16 in the 90th percentile or the top ten percent
17 for as far as timeliness of care for stroke
18 patients. And I believe -- I don't necessarily
19 know what the national standards are, but I
20 know that HCA is -- we're very high in that
21 area as well.

22 Q: And HCA is a healthcare hospital system with
23 hundreds of hospitals?

24 A: That's correct. Two hundred eighty I believe.

25 Q: Do you feel like that Trident Health has



1 delivered -- delivers high-quality ER services
2 to its freestanding EDs and its emergency --
3 hospital-based emergency departments?

4 A: Absolutely.

5 Q: Do you feel -- is it your opinion as a nurse
6 manager, a clinician, that the community is
7 adequately served with emergency services in
8 the north area?

9 A: Yes, sir.

10 Q: Do you feel that there is adequately capacity
11 now and what is being built out that will be
12 able to serve the community?

13 MR. DAYHUFF: I've let a lot of this go. This
14 sounds like leading to me.

15 MR. THOMAS: It's an open-ended question.

16 MR. DAYHUFF: I object to leading.

17 MR. THOMAS: It's yes or no. She could burn me.

18 MR. DAYHUFF: I suppose so. It doesn't sound like
19 an expert rendering opinions. It sounds like
20 Mr. Thomas. But that's my objection, leading.

21 THE COURT: The objection is ---

22 MR. THOMAS: It's an open-ended question.

23 THE COURT: Yeah, yeah. I'm going to sustain the
24 objection. Just rephrase the question.

25 MR. THOMAS: Okay. Do you believe there's ---



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

1000

1 **THE COURT:** And also, Mr. Thomas, before you go any
2 further ---

3 **MR. THOMAS:** Yes.

4 **THE COURT:** --- I neglected to recognize Ms.
5 Eccleston as an expert in the areas that you
6 listed.

7 **MR. THOMAS:** Oh, I apologize.

8 **THE COURT:** So let me make sure that is on the
9 record.

10 **MR. THOMAS:** Okay. Thank you, Your Honor.

11 **MR. DAYHUFF:** You'll just have to start over.

12 **MR. THOMAS:** I noticed Mr. Dayhuff didn't object to
13 that. I'm sorry.

14 Q: Do you feel that there is adequate capacity in
15 the north area to treat anybody who needs ED
16 services?

17 A: So in -- not just my opinion, but in reality we
18 have a lot of capacity at our Moncks Corner ED
19 to see more patients, we have more capacity to
20 see patients at Centre Pointe Emergency
21 Department for sure, and definitely at Trident
22 as well, so those three areas. I am concerned
23 about the new hospital opening up, the Roper
24 Berkeley Hospital, because they will have
25 additional capacity. And those patients that



1 -- I believe that the patients who live there
2 may choose to go to that emergency department,
3 so maybe our -- will have even more capacity.

4 So I believe that there's plenty of
5 capacity with what we have now, especially with
6 Summerville opening a freestanding emergency
7 department, can see an extra 25,000 patients a
8 year or 20,000 easily. So I believe that will
9 more than adequately manage the -- and in
10 addition to that we also have multiple
11 freestanding -- multiple urgent cares opening
12 up, so that can also meet the needs. We have
13 -- from all different companies have opened up
14 urgent cares in the area.

15 Q: And just for the record, Roper Berkeley is
16 going to have how many treatment spaces per
17 this ---

18 A: Fifteen.

19 Q: And I believe Ms. Huntington testified 2,000
20 was an adequate number there. So that's
21 another 30,000?

22 A: That's a conservative estimate above capacity,
23 I would say. But for sure that's ...

24 **MR. THOMAS:** I have no further questions, Your
25 Honor.



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

1002

1 MR. DAYHUFF: I'm ready, Your Honor.

2 THE COURT: Okay. You may proceed.

3 MR. THOMAS: Oh, I did want to do one thing, if I
4 didn't. Mr. Dayhuff, if you'll indulge me. I
5 just want to admit Trident Exhibit -- was it 99
6 for Ms. Eccleston?

7 MR. DAYHUFF: I will indulge you.

8 MR. THOMAS: Thank you.

9 THE COURT: It's admitted.

10 (Petitioner TMC's Exhibit Number 99 was admitted into
11 the record at this time.)

12 MS. ECCLESTON - CROSS-EXAMINATION BY MR. DAYHUFF:

13 Q: Ms. Eccleston, nice to see you again. How are
14 you?

15 A: Wonderful. How are you?

16 Q: Excited about this, are you?

17 A: Yes.

18 Q: I knew you were. So let's talk about -- we had
19 a nice talk at our deposition, so I'll try to
20 make this a nice talk.

21 A: Okay.

22 Q: To the extent I'm able.

23 A: Thank you.

24 Q: Healthcare delivery model FED, I want to talk
25 about it generally. We had a nice discussion



1 about that. FEDs provide emergency medicine
2 care more efficiently and quickly than hospital
3 EDs as a general proposition, agree?

4 A: In general, that can be true. That can be
5 true.

6 Q: And right now we're talking -- you're an
7 expert, so we're talking in terms of
8 generalities about this model. And certainly
9 disagree if you'd like. We went through this
10 in your deposition and that was one of the
11 things that we established was, you know, FEDs
12 are quickly and more efficient just because of
13 the nature of the size of the facility and the
14 lower acuity of the patients, right?

15 A: Yes. That's usually the case. That's correct.

16 Q: Okay. And FEDs, as a general proposition,
17 improve geographic access for patients, agree?

18 A: It depends where you live. If you live closer
19 to the freestanding, then it improves
20 geographic access. But if you don't, then it
21 doesn't improve geographic access.

22 Q: Right. So, if you ---

23 A: It has the potential to improve geographic
24 access.

25 Q: It does. Like if you have a county with just



1 one hospital ED ---

2 A: Uh-huh.

3 Q: --- and you put another one out there ---

4 A: Right.

5 Q: --- it improves access, right?

6 A: Fair enough, yes.

7 Q: Okay. Good. All right. And FEDs, as a
8 general matter, can alleviate capacity issues
9 or help alleviate them at hospital EDs, right?

10 A: Certainly.

11 Q: In fact, we looked at your Summerville FSED
12 application with Ms. Valentine. I think you
13 were here, right?

14 A: Yes, I was.

15 Q: And one of the things the application said was
16 we're going to establish that FED and it's
17 going to help alleviate volume at the
18 Summerville Medical Center ED. Remember that?

19 A: I remember that the application said that, yes.

20 Q: Good. You mentioned something to me that I
21 hadn't heard actually on this list before, but
22 I think it's a good idea -- or a good opinion.
23 FEDs are good for EMS. Explain that.

24 A: Well, if a patient does have a low-acuity
25 complaint, then they can take them -- if the



1 patient that is calling 911 is right near
2 there, they can just drop them off there and
3 get back out on the street.

4 Q: So if they call 911, they get an ambulance and
5 that ambulance can then drop off that patient
6 quicker ---

7 A: If they're closer to the freestanding.

8 Q: Right. If there are some freestandings around
9 where they could drop off.

10 A: That's correct.

11 Q: And then you added that emergency EMS resource
12 can do what?

13 A: Get back out the street.

14 Q: Get back out on the street and help other
15 people.

16 A: That's correct.

17 Q: Now, these benefits of the FED model are
18 benefits no matter who is operating the FED,
19 right?

20 **MR. THOMAS:** Objection, Your Honor. Mr. Dayhuff is
21 asking my witness to speculate on the operator.
22 I don't know that it's been established that
23 all operators are the same.

24 **MR. DAYHUFF:** We're talking about the FED as a
25 model. And the benefits of the FED model don't



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

1006

1 really depend upon who is operating it. The
2 model does these things as a model. I think
3 that's an appropriate question.

4 **THE COURT:** Okay.

5 Q: Go ahead.

6 A: As long as they do a good job running it, then
7 they could benefit the patient.

8 Q: Good point. So the FED needs to be well run.

9 A: That's correct.

10 Q: I'll give you that. If it's well run, it
11 doesn't matter if it's Roper running it or
12 Trident running it or MUSC running it, it's
13 going to provide those benefits that we just
14 outlined above.

15 A: Yes.

16 Q: Agree?

17 A: Uh-huh (affirmative response).

18 Q: Now, I want to talk about fast track for a
19 minute.

20 A: Okay.

21 Q: You talked a little about it. Fast track, if
22 I understand it correctly, is -- you know, FEDs
23 are fast and efficient, but fast track in an
24 FED is even faster and more efficient. But you
25 explain fast track for me.



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

1007

1 A: I don't think fast track in an FED is really
2 any different than most of the other patients.
3 I mean, at my EDs, we don't have a specific
4 fast track. We just have all of our rooms can
5 treat patients regardless of what their
6 complaints are. Fast track is usually -- well,
7 I've worked at several different hospitals and
8 it's been kind of run differently, but it
9 usually provides that vertical space for
10 patients so they don't have to, you know, get
11 too comfortable in the room, you can go in and
12 see the provider and be discharged. It just
13 depends what the complaint is as far as fast
14 track goes.

15 Q: Okay. And I guess I thought a fast track is
16 patients maybe with a lower acuity ---

17 A: Uh-huh.

18 Q: --- that could be treated more quickly and
19 maybe in a less sophisticated emergency
20 department space and then discharged. Is that
21 accurate?

22 A: I think so. I think that -- I mean, fast track
23 is really just a space that doesn't have
24 cardiac monitors. You can just see the
25 patient. And regardless of really what's



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

1008

1 wrong with them, they still get the same nurse
2 and doctor.

3 Q: Right. Same emergency medicine physician, same
4 RN, maybe less equipment. Do fast track rooms
5 generally have the medical gases or not?

6 A: Not usually.

7 Q: Not usually.

8 A: Mine don't. But my other hospital did, so here
9 they don't.

10 Q: Could do it either way. And the reason you
11 wouldn't have medical gases in the fast track
12 maybe at a facility is less acuity.

13 A: Right. They don't -- that's for sure.

14 Q: Got you. Trident Health EDs: The two hospital
15 EDs that we've mentioned, two FEDs, one in
16 Moncks Corner and one in north Charleston,
17 correct?

18 A: That's correct.

19 Q: And I think on your demonstrative you told us
20 the rooms or made it clear that Moncks Corner
21 had eight -- has eight?

22 A: Yes.

23 Q: And the North Charleston that's called Centre
24 Pointe has 12; is that right?

25 A: Yes.



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

1009

1 Q: All right. Now, when we were at the
2 deposition, you offered opinions about
3 capacity. And I think you said generally,
4 look, we've got capacity across our entire
5 system, but the focus of your capacity analysis
6 at the deposition was on the FEDs that you
7 manage. Do you recall that?

8 A: If you're saying -- I don't remember exactly
9 what I said at the deposition.

10 Q: We can get it out.

11 A: Yeah.

12 Q: You said, in fact, you felt more comfortable
13 talking about the ED -- the FED in Moncks
14 Corner and the FED Centre Pointe.

15 A: As far as capacity ---

16 Q: Yes.

17 A: --- versus the capacity ability at Trident.

18 Q: Yes.

19 A: Okay.

20 Q: And I think it was related to the beds all
21 being the same or the nature of the beds. Do
22 you recall that? Or the rooms.

23 A: Well, I think that we have more capacity at
24 Centre Pointe and Trident -- and Moncks Corner
25 because they're not utilized as much as Trident



1 is.

2 Q: All right. So while you believe the entire
3 system has capacity, your opinion focus is, to
4 an extent, on the excess of capacity you have
5 in Moncks Corner and at Centre Pointe?

6 A: Right. And we do have additional capacity at
7 Trident, as I said.

8 Q: Understood, understood. Now, Centre Pointe,
9 when we talked about that, the numbers were
10 different. Yu did it a different way on your
11 demonstrative. You told me at the deposition,
12 you know, how many you were doing and how many
13 more you could do.

14 A: Okay.

15 Q: So Centre Pointe 21,000 a year?

16 A: Between 20 or 21, yes.

17 Q: Okay. And you could do about 30?

18 A: Yes.

19 Q: So another 9,000. And Moncks Corner I think
20 you told me you were doing 15,000
21 approximately.

22 A: I think. Or about 14 something.

23 Q: Okay. Fourteen something. And you could do
24 20. Fair?

25 A: I believe that's correct.



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

1011

1 Q: All right. So that's another 5,000 more of
2 those FEDs. Now, how long has the Moncks
3 Corner FED been around?

4 A: It's been around a while, longer than me for
5 sure. I think it's probably been around 15
6 years. I don't know for sure.

7 Q: Is this the first FED or was Centre Pointe? It
8 was the first ---

9 A: No. Centre Pointe's been around five years.
10 So Moncks Corner's been around longer than
11 Centre Pointe.

12 Q: All right. So maybe roughly 15 years. And
13 Centre Pointe -- that's right. Centre Pointe
14 ---

15 A: Five.

16 Q: --- was established in 2014.

17 A: Right. So five years for sure.

18 Q: Okay. All right. Now, has Moncks Corner ever
19 -- well, let's not say ever, because you
20 weren't around.

21 A: Right. I've only been here three ---

22 Q: How long have you been around?

23 A: Three years.

24 Q: Three years. In the last three years has
25 Moncks Corner hit 23,000 visits?



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

1012

1 A: No. Not that I know of, no. We haven't had a
2 lot of volume growth in Moncks Corner yet.

3 Q: All right. And do you believe prior to that
4 Moncks Corner would have hit 20,000 visits?

5 A: I have no idea.

6 Q: No idea.

7 A: Yeah.

8 Q: Okay.

9 A: I don't think so.

10 Q: I mean, generally I suppose things ramp up,
11 would be the nature of utilization.

12 A: I would imagine. I mean, Moncks Corner has had
13 essentially the same volume since I've been
14 here.

15 Q: Okay. It's been very stable.

16 A: That's correct.

17 Q: All right. About 15,000 a year, maybe 14,000
18 a year.

19 A: Uh-huh.

20 Q: Got it. Now, Centre Pointe, has it in the last
21 -- I guess you've been around three years --
22 hit the 30,000 number that would be the excess
23 capacity number that you provided?

24 A: No.

25 Q: No. It's still got ---



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

1013

1 A: Centre Pointe has grown in their volume, so
2 last year was our highest volume.

3 Q: Okay. And the Summerville Medical Center ED,
4 I think, but you tell me, isn't that the
5 closest Trident ED resource to our proposed
6 FED?

7 A: The Summerville Medical Center ED?

8 Q: ED.

9 A: Well, I know it's about seven miles from
10 Trident. And I'm not exactly sure how far it
11 is from Summerville. Do you know how far it is
12 from Summerville?

13 Q: I know it's near the Chick-fil-a.

14 A: I know.

15 Q: Do you know where the Chick-fil-a is?

16 A: I do, actually. And I know how far it is to
17 get from Trident to Summerville, but I'm not --
18 I'm from Virginia, so I know you have to go up
19 and over. So I would say it's either
20 equidistant or as -- or just a little bit
21 closer to Summerville.

22 Q: Okay. And so just to be fair, our FED is
23 either equidistant to SMC's ED and Centre
24 Pointe?

25 A: No, Trident.



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

1014

1 Q: No, Trident, okay. Or Summerville's a little
2 closer.

3 A: I think it is.

4 Q: Fair?

5 A: Yeah.

6 Q: Okay. Summerville, according to that
7 demonstrative, is at 100 percent capacity.

8 A: Well, that's right. And that's why we've
9 applied for the expansion. And so we have
10 already started that and so we'll have an
11 additional ten rooms at Summerville Medical
12 Center, so they will be able to easily
13 accommodate another 2200.

14 Q: That's great. And I want you to be able to
15 expand. And you filed that expansion CON after
16 we got CON approval for our FED in Summerville.

17 A: That is so above my pay grade. I have no idea.

18 Q: See, that part bothers me, so I just wanted to
19 mention it.

20 A: Okay.

21 Q: Okay. So you're applying for more capacity and
22 it was after we got DHEC approval to add beds.
23 Now, so I guess this capacity thing also
24 bothers me. It seems like we have to wait
25 until you get more capacity at Moncks Corner or



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

1015

1 Centre Pointe before we can go ahead and get an
2 FED to serve our patients. And what troubles
3 me even more is Moncks Corner has not gotten
4 20,000 ---

5 **MR. THOMAS:** Your Honor, I'm going to object. He's
6 testifying right now.

7 **THE COURT:** Yes. Sustained.

8 **MR. THOMAS:** I'd love to hear a question.

9 **THE COURT:** It's sustained.

10 **MR. THOMAS:** And I also object to this notion of our
11 patients. I don't think that MUSC has patients
12 signed up or owned or anything like that as
13 well.

14 **MR. DAYHUFF:** Well, we have patients that utilize
15 our ED and the data shows that. So they're not
16 our patients, but they're patients who seek us
17 out for emergency care. But I appreciate that
18 -- I will ask a question as opposed as talk as
19 much.

20 **THE COURT:** Thank you.

21 Q: So Moncks Corner hasn't hit that number that's
22 the capacity number you provided, 15,000, in
23 the three years you've been here?

24 A: That's correct.

25 Q: So if they haven't hit it, they may never hit



1 it, right?

2 A: I have no -- I am not -- I'm not a health
3 planner.

4 Q: Yeah. And Centre Pointe hasn't hit that number
5 we talked about, the additional 5K more; may
6 never hit it.

7 A: Well, Centre Pointe has increased in volume
8 each year.

9 Q: Good.

10 A: So potentially they could. And I don't have a
11 -- I don't know exactly, but Centre Pointe
12 emergency department's volume is increasing.

13 Q: I guess I worry that if that capacity analysis
14 is the analysis, we may never see certain of
15 your facilities hit their capacity and then we
16 don't get an FED, is that the effect of your
17 analysis?

18 **MR. THOMAS:** Objection, Your Honor. I don't think
19 she's made an analysis about that. She just
20 talked about the capacity. She's an expert in
21 nurse leadership. She's a clinician. She's
22 not a health planner. We've put that witness
23 up for tomorrow.

24 **MR. DAYHUFF:** She offered an expert opinion on
25 capacity, Your Honor. And if we want to



1 stipulate that she's offered no opinions on
2 capacity, I guess we could do that. But I
3 heard one, they have excess capacity.

4 **MR. THOMAS:** She's just talking about the capacity
5 in their ED. She's not talking about whether
6 or not there's going to be growth in the area
7 or whether or not MUSC should be able to, you
8 know, apply for a spot here. I think he's just
9 getting the health planning opinions and that's
10 all that she does for a living.

11 **MR. DAYHUFF:** She finished her testimony by saying
12 there is enough capacity in the area already.

13 **MS. ECCLESTON:** Based on my knowledge of the
14 capacity that we have, not of an analysis of
15 the capacity that I've done. I'm just saying
16 right now we have enough space to accommodate
17 the patients.

18 **Q:** Fair enough. So you haven't done a capacity
19 analysis?

20 **A:** Well, I've done a capacity analysis based on my
21 capacity at Trident, Moncks Corner, and Centre
22 Pointe.

23 **Q:** Fair enough. So you haven't done an area-based
24 capacity analysis.

25 **A:** That's correct.



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

1018

1 Q: All right. And wouldn't offer the opinion that
2 the area needs more capacity or doesn't?

3 A: Well, I believe that we do need more capacity
4 and that's why we are growing our Summerville
5 Medical Center's emergency department and also
6 have put forth the capacity -- or put forth the
7 capital to create a freestanding emergency
8 department next to the Chick-fil-a.

9 Q: Okay. Maybe I can wrap this up with a
10 question.

11 A: Okay.

12 Q: So it's not your opinion that MUSC's FED has to
13 wait until your FEDs That you outlined up there
14 achieve the capacity -- their ultimate capacity
15 numbers that you offered us today.

16 **MR. THOMAS:** Object again. He keeps saying -- he's
17 asking about something that's not in her
18 purview as an expert. He keeps saying MUSC has
19 to wait. Well, Your Honor, MUSC could have put
20 a freestanding ED in West Ashley, James Island,
21 Mt. Pleasant. They chose to put one in the
22 most saturated area of EDs in possibly the
23 state of South Carolina. But he's asking her
24 an opinion that she's not -- didn't render and
25 that she can't about MUSC and what they can do



1 and how long they've got to wait.

2 **MR. DAYHUFF:** Your Honor, I was making it clear that
3 she wasn't offering that opinion. He qualified
4 her as an expert.

5 **MR. THOMAS:** Asked and answered.

6 **MR. DAYHUFF:** I haven't been able to get an answer
7 to these questions.

8 **MR. THOMAS:** You've asked the same question three
9 times, Mr. Dayhuff.

10 **MR. DAYHUFF:** I think it's been different. But I'll
11 -- Your Honor, I'll take your guidance. I'm
12 ready.

13 **THE COURT:** Okay.

14 **MR. DAYHUFF:** Mr. Thomas and I can go on and on.

15 **THE COURT:** Yeah, I'm seeing that. Okay. I
16 understand, Mr. Thomas, what your objection is,
17 but I'm hearing some things from her that makes
18 me think that she can answer. At least if she
19 can't answer it, she can say she can't.

20 **MR. THOMAS:** That's true.

21 **THE COURT:** Okay. So ...

22 Q: So, I think that last question was, if I
23 remember ---

24 A: I can't remember it either, so.

25 Q: Tell me if I forget. Is you're not opining,



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

1020

1 are you, the MUSC -- you aren't offering an
2 opinion that MUSC must wait to establish an FED
3 in the north area until your resources achieve
4 those ultimate capacity numbers that you
5 offered in your demonstrative, are you?

6 A: So, what I am saying is that it's very
7 challenging to staff emergency departments
8 right now. And Summerville Medical Center --
9 not Joan Eccleston, but Summerville Medical
10 Center and the whole HCA have decided to put a
11 freestanding emergency department to meet the
12 patients' needs at exit 199 that's going to
13 need 14 nurses to work there and I already
14 struggle to find nurses to work in my emergency
15 department. Moncks -- Berkeley -- all these
16 names are new to me. But the one that's just
17 opening up, up a ways a little bit, Roper
18 Berkeley, is going to open up a freestanding --
19 like a real -- a hospital. And I already told
20 you I've lost two night nurses to a hospital
21 that's not even open yet. And then I have two
22 other nurses -- and they're leaving there
23 because it's up there. It's closer to their
24 home. And I get it. It's not because they
25 don't want to work at Trident anymore. So for



1 MUSC to open up another freestanding emergency
2 department right next to the one Summerville
3 has, that's, I guess, my concern, that that's
4 going to be a lot of duplicated resources. And
5 I feel like there's a lot of other -- we've
6 already demonstrated that we can efficiently
7 manage the patient care and volume.

8 Q: I understand all of that. So, that's staffing
9 and that's you can handle the volume.

10 A: Uh-huh.

11 Q: My question is much more specific.

12 A: Okay.

13 Q: You've created these capacity numbers.

14 A: Okay.

15 Q: You told us about Moncks Corner and told us
16 about Centre Pointe. You told us what their
17 kind of top capacities are. It's not your
18 opinion, is it, that we have to wait until
19 those capacities are achieved before it would
20 be appropriate for us to place an FED in the
21 Summerville area, are you? That's not part of
22 your opinion, is it?

23 A: Well, it is my opinion that we shouldn't create
24 two of the same thing at the same time, not
25 knowing what the volume is going to be. So, I



1 don't think that it sounds reasonable to put
2 two freestanding ERs right next to each other.
3 I don't under -- I don't know -- I'm not an
4 expert on population growth or things like
5 that. So it doesn't seem that that is a good
6 utilization of resources. There's a lot of
7 other resources that this area needs as far as
8 just access to service. There's a lot of other
9 access issues, and ---

10 Q: So these capacity numbers are an observation
11 that you're making, not an opinion that they
12 need to be achieved before MUSC ---

13 A: I didn't ---

14 **THE COURT:** Mr. Dayhuff, I agree with Mr. Thomas,
15 that you're getting into an area where this
16 witness has not been qualified as an expert in
17 that area.

18 **MR. DAYHUFF:** Fair enough. I'll move on, Your
19 Honor. Thank you.

20 Q: You're concerned the MUSC FED may impact your
21 staffing, right, ED staffing?

22 A: It might. That's correct.

23 Q: Right. It might. You don't know, do you?

24 A: Well, it hasn't even been -- no. I mean, it's
25 not going to impact my staffing today, because



1 it's not even there. But I think in general,
2 there is definitely a nursing, a nursing
3 shortage.

4 Q: Right. And you were very candid about this in
5 your deposition. It may happen. You hadn't
6 done an analysis related to this issue, right?
7 But you're concerned.

8 A: That's correct.

9 Q: All right. I understand that. You manage 30
10 ED nurses in three ED locations that you
11 manage; is that correct?

12 A: No.

13 Q: How many ED nurses do you manage in the ED
14 locations?

15 A: I have 14 at Centre Pointe, probably 12 at
16 Moncks. And then I have 60 at Trident.

17 Q: Okay. That must be the FED locations?

18 A: Okay. Yeah. I have probably around 25 nurses
19 at the freestandings and 60 at Trident.

20 Q: Got you. All right.

21 A: But I could use a lot more than 60. I'll be
22 honest with you. Some of them -- I have
23 travelers and I have some open positions.

24 Q: Understood. And MUSC could try to recruit
25 those nurses for its FED, and maybe pay them



1 more and that could potentially hurt your
2 staffing. We talked about that.

3 A: Okay.

4 Q: Do you recall talking about that?

5 A: I don't know about the salary structure for the
6 medical university, but they could try to
7 recruit them. That's correct.

8 Q: All right. And you told me, you hadn't lost an
9 ED nurse to MUSC in the three years you've been
10 at Trident Health; isn't that right?

11 A: Right. And I told you that's because the
12 location of where my nurse's live is not really
13 something where they want to drive down to the
14 Medical University and park and the whole pay
15 to park and that kind of thing. I have -- but
16 I feel like, since I've never lost a nurse to
17 MUSC, but I am starting to see some interest in
18 this new Roper Berkeley.

19 So it's my belief, maybe I'm being overly
20 -- you know, I'm not really thinking too much
21 about it, to be honest with you. That since
22 another emergency department is opening up
23 close by, the nurses might say, hey, I could
24 work there and the parking's free and I could,
25 you know -- so that may impact my staffing.



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

1025

1 Q: Understood. And you've got 85 nurses under
2 your management; is that the ---

3 A: About, yeah.

4 Q: And so far the Roper Berkeley ED that opens in
5 a few months ---

6 A: Uh-huh.

7 Q: --- has taken two.

8 A: Right. Because they're not open. They haven't
9 really staffed yet. But I'm telling you, I
10 have two other nurses that are going. So, that
11 would be four. And at night I have about -- so
12 I have 50 nurses at Trident. So, I would say
13 four over 50 is about eight percent roughly

14 Q: I'm thinking -- I don't know. You may know
15 this. Isn't Roper recruiting right now? I
16 mean, they don't wait until they're ---

17 A: No, actually they're not. They are waiting to
18 see if they have -- I've been told that they're
19 trying to open their ERs with their current ER
20 staff, so that they can have -- so maybe
21 they're recruiting at their other ERs, but
22 they're going to be maybe backfilling in their
23 other ERs. But they clearly are trying --
24 they've reached out to several of my nurses and
25 they're starting. But they don't open yet, so



1 they haven't hired -- I think it would be hard
2 for them to take on 20 new nurses if they don't
3 have a place to put them to work.

4 Q: Well, it would actually be a good thing for
5 your ED staffing, right, if they do backfill?
6 Maybe less effect on you.

7 A: It will have an effect on me ultimately though
8 because the other ER -- maybe the nurses that
9 I have that live in West Ashley will want --
10 could be recruited to work at Roper St. Francis
11 or things like that. Most of my nurses live in
12 the suburbs, so I feel like these additional
13 hospitals and freestandings in the suburbs
14 might impact my staffing.

15 Q: So your staffing concern is obviously not MUSC-
16 specific. I mean, you're worried about Roper,
17 too, right?

18 A: That's correct. It's in general to the
19 lowcountry, I think. And any type -- whether
20 it was Roper that was opening a freestanding,
21 or the Medical University, as long as it's a
22 different company, then yeah, that would be
23 concerning to me.

24 Q: Any additional EDs, rooms, capacity in the Tri-
25 County area could conceivably make it harder



1 for you to find RNs.

2 A: That's correct.

3 Q: And harder to keep RNs, right?

4 A: Potentially, yes.

5 Q: Okay. And Trident Health plans to add an FED
6 in James Island. And they plan to add an FED
7 in Summerville, right?

8 A: I know I'm familiar with the Summerville
9 project, because it's been approved. And I
10 think the James Island one is also something
11 that I've heard some discussion about.

12 Q: And maybe even today you heard Ms. Valentine
13 talk about it, right?

14 A: That's right.

15 Q: So did anyone from Trident's administration
16 come to you and consult with you about adding
17 those two FEDs and the effect it could have on
18 your ability to staff?

19 A: No, they did not.

20 Q: You mentioned an opinion about our staffing --
21 or our proposed staffing for the FED. I put up
22 on the screen, I think the number was 19.1.

23 A: Uh-huh.

24 Q: Is that an FTE number?

25 A: Let's see. Freestanding emergency department.



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

1028

1 I think so. I'm assuming 19.1, since you can't
2 be .1 of a person, it must be an FTE.

3 Q: That would be odd, wouldn't it?

4 A: That would be odd. So I would imagine that
5 19.1 is the registered nurse FTEs.

6 Q: You know, I wish I didn't ask that question,
7 but it's too late. So, the 19.1 FTEs that we
8 propose is too much, right?

9 A: Well, I think it's just -- I think it's very
10 generous. That's more than -- that's making
11 the assumption that you'll see a lot of
12 patients, so.

13 Q: What would be a reasonable assumption for FTE
14 for the FED of the nature that we're proposing?

15 A: Well, my experience we have 14.

16 Q: So maybe five a little bit heavy, if you will?

17 A: Or 25 percent too many.

18 Q: That sounds worse. All right. Well, if we
19 actually staff it with less RNs ---

20 A: Uh-huh.

21 Q: --- than appears in that document, that's a
22 good thing for you from the perspective of
23 being concerned about the number of nurses in
24 the area, right?

25 A: Yes, that's correct.



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

1029

1 Q: So we talked a little about diversion when we
2 got together.

3 A: Uh-huh.

4 Q: And I think you told me one facility or two had
5 gone on diversion at some point in the past few
6 years?

7 A: Yes.

8 Q: Tell me about diversion. When have you
9 experienced it and where?

10 A: At Trident we've gone diversion a couple of
11 times since I've been there. We've had some
12 issues with some of the nursing homes closing
13 down and we had some weather concerns. And
14 just when the -- when we have a hard time
15 sometimes getting our patients discharged from
16 the inpatient areas, then we experience some
17 patients holding in the emergency department.
18 And so we never go on diversion for trauma,
19 STEMI, or stroke, or dialysis patients. But if
20 patients have something maybe just like a
21 medical complaint that's not necessarily
22 somewhere they need our specialized services,
23 then we encourage EMS to take them to either
24 the nearest facility or to Summerville Medical
25 Center if possible.



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

1030

1 Q: Got you. And when you're on diversion status

2 ---

3 A: Uh-huh.

4 Q: --- all your ED beds are full.

5 A: Yes.

6 Q: Right?

7 A: Well, not all -- like not necessarily like our
8 fast track stuff, but people that -- like our
9 cardiac monitors, we would always have a couple
10 -- at least our trauma rooms open. But we're
11 trying to let EMS know that just for a little
12 while, if we could try to get a little bit more
13 patients admitted or discharged.

14 Q: And has that happened two or three times?

15 A: At least two, possibly three. I've been there
16 about three years, so yes.

17 Q: So, I think you understand that MUSC -- from
18 our prior talk, MUSC's proposed FED is about a
19 mile from Summerville's FED. Is that right?

20 A: That's what I've been told.

21 Q: All right. So for all intents and purposes,
22 it's about in the same place, right, the same
23 area?

24 A: Yes.

25 Q: All right. And you're going to open -- I was



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

1031

1 a little confused. When is the Summerville FED
2 going to open?

3 A: It's a 14-month construction project. And it's
4 supposed to start -- it has not broken ground
5 yet. So 14 months after they break ground, it
6 will open.

7 Q: Okay. And they're breaking ground ---

8 A: I believe soon.

9 Q: --- in the fall.

10 A: Uh-huh. Yeah. just right ...

11 Q: And as we discussed earlier, that FED was
12 designed in part to alleviate some volume
13 issues at SMC main, right?

14 A: That's what I was told today.

15 Q: All right. When you open the FED in
16 Summerville, it will not negatively affect the
17 volumes at your Moncks Corner FED, will it?

18 A: I can't imagine that it would.

19 Q: Because it's too far away.

20 A: I think so. I don't think people drive from
21 Summerville to Moncks Corner that I know of.
22 But unfortunately I did not prepare my ZIP code
23 data analysis for Moncks Corner.

24 Q: When you were with me at your deposition, you
25 also noted that when SMC opens up its FED, it



1 will not negatively affect volumes at Centre
2 Pointe because Centre Pointe gets its patients
3 from North Charleston, right?

4 A: I believe so, yes.

5 Q: So MUSC's going to go into the same place. So
6 isn't it likely that MUSC will not have a
7 material effect on either Moncks Corner or
8 Centre Pointe?

9 **MR. THOMAS:** I'm going to object. That's a planner
10 question. She's a nurse administrator and
11 clinician. He's asking her to make a rendered
12 opinion on adverse impact of MUHA's
13 freestanding ED and he has not asked her if
14 she's reviewed ZIP code data where MUSC is
15 drawing its patients from, so on and so forth.
16 I just think it's a little outside the scope.

17 **MR. DAYHUFF:** She's testified about this in her
18 deposition, Your Honor. This is the last
19 question I'll ask on this topic and then we can
20 move forward. But I think -- she's been
21 qualified as an expert. She's offered opinions
22 about capacity. This is an opinion that's
23 appropriate for her to respond to -- or a
24 question that's appropriate for her to respond
25 to.



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

1033

1 **THE COURT:** Only if -- if she has some knowledge in
2 that area, that would be one thing. But I
3 don't know that I've heard anything that will
4 convince me that she has the ---

5 **MR. DAYHUFF:** Let me try to lay some foundation.
6 And if I can't ---

7 **THE COURT:** Okay.

8 **Q:** In your role, Ms. Eccleston, as the ED director
9 in charge of Moncks Corner and Centre Pointe
10 and Trident --

11 **A:** Yes, sir.

12 **Q:** -- you know -- have an idea where your patients
13 coming, don't you?

14 **A:** I think I do. Yes, sir.

15 **Q:** Yeah. You kind of know for each of those where
16 they kind of draw their patients from, right?

17 **A:** That's correct.

18 **Q:** Right. So you would know whether Summerville,
19 when it goes in the FED there, would
20 substantially overlap with these other places
21 such that it would create a decrease in volume
22 at those other places.

23 **A:** Well, I think that the Summerville freestanding
24 emergency department will have an impact on the
25 Summerville and Trident emergency department



1 volume. I think it will sort of low-level that
2 volume a little bit and add capacity at both
3 places. And I think it's nice for our patients
4 that they have a freestanding option. So I
5 don't necessarily think that whoever builds
6 something in exit 199 is going to impact
7 something very far away, if what they are
8 searching out is a freestanding emergency
9 department.

10 Q: Okay. Fair enough. Mr. Thomas discussed some
11 ED operational metrics with you. And I want to
12 discuss those few I suppose. Let's see. Your
13 door-to-doctor time, I guess -- was that across
14 your system or just the ones you supervise when
15 you gave that figure ---

16 A: Well, he asked me about Trident and so that was
17 the answer I gave him.

18 Q: Okay. So that door-to-doctor time of eight
19 minutes was for the Trident Hospital and the
20 two Trident FEDs combined?

21 A: It's usually lower at the freestandings, but
22 yes, sir.

23 Q: I was going to ask that. What's your
24 freestanding look like, door-to-doctor?

25 A: Well, I think it's -- so I' have to look at the



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

1035

1 -- I didn't -- it's usually -- it's always less
2 than ten minutes, so I don't know if it's eight
3 or five or six or something like that, but it's
4 definitely less than ten minutes.

5 Q: And throughput is everything. That's door-to-
6 discharge or door-to-admit, right?

7 A: Yes, sir.

8 Q: And what are you looking like, if you know,
9 Trident or if you just ---

10 A: I do, actually. I just had to submit that to
11 my administration. We're at 155 minutes for
12 door-to-discharge patients for Trident main,
13 155.

14 Q: Okay.

15 A: Then at the freestandings, I think we're -- I
16 mean, we're usually probably in the 80-minute
17 range, but I haven't reviewed that data in the
18 last few months. But the freestanding ED
19 volume, their goals for low -- you know, if the
20 patients are fours or fives, it's less than 60
21 minutes. And we do meet that metric as well.
22 So I don't know the overall length of stay for
23 the freestandings, but I just know for Trident
24 we're at 155.

25 Q: I'm sorry, what was your target metric there?



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

1036

1 A: For discharge patients?

2 Q: Yes.

3 A: I think it's probably like 130 or something
4 like that, but ...

5 Q: And do you know Summerville? And If you don't,
6 it's okay.

7 A: I'm sorry. I don't.

8 Q: And you're left-without0treatment, LWOT, is 1.5
9 percent?

10 A: Well, I reviewed the data just yesterday for
11 July for administration and it was 1.4 percent.
12 But I know we're always below two percent on an
13 annual basis.

14 Q: And that's your target, two percent or below?

15 A: Two percent or below. Yes.

16 Q: If you have an ED with times for these metrics
17 that are far in excess of the targets that we
18 just talked about, that's an ED that is likely
19 experiencing capacity constraints.

20 A: Or inefficiency. Not necessarily. I think
21 that there's a lot of opportunity. I've worked
22 in other emergency departments that had
23 capacity, but they had throughput issues
24 related to inefficiency.

25 Q: So it could be either one, inefficiency or



1 capacity constraints.

2 A: It could be. I've never worked in an ED that
3 had inefficiencies, other than just not through
4 ---

5 Q: Yeah, just ---

6 A: One might think that you have capacity issues
7 and you need to grow. But really when you look
8 at your processes, there might be opportunities
9 for improvement just based on throughput and
10 efficiency.

11 Q: Understood. But as a general proposition, if
12 you have an ED that's experiencing those
13 metrics much higher than the targets you
14 described to me, that ED is either
15 inefficiently operating or it's got some
16 capacity constraints or both.

17 A: It's got something, right, for sure.

18 Q: Something's not right.

19 A: Uh-huh, something's not right.

20 Q: All right. Capacity constraints can be caused
21 by many different things. I'll just go through
22 a list. You tell me yes or no.

23 A: Okay.

24 Q: High visit volume.

25 A: Yes.



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

1038

1 Q: High volume of mental health patients.

2 A: Yes.

3 Q: Poorly configured ED space.

4 A: Yes, I assume.

5 Q: Boarding of patients.

6 A: Well, boarding of patients is usually -- yes,
7 it could cause capacity issues for sure.

8 Q: Yeah. And how about higher acuity patients
9 that will require more evaluation, management,
10 and treatment?

11 A: Yes.

12 Q: Any one of those could cause an ED to
13 experience a capacity constraint.

14 A: They could.

15 Q: Put many of them together, it could cause an ED
16 to experience capacity constraint, agree?

17 A: It could be, yes.

18 Q: Sure. If one ---

19 A: Yeah, for sure.

20 Q: --- could cause a capacity constraint, if we do
21 three, I'll be it gets worse. You tell me.

22 A: I think, yes, it could potentially cause a
23 capacity issue.

24 Q: If an ED were experiencing all of those at
25 once, I bet it would have a capacity constraint



1 issue.

2 A: It could. But it could also fix some of those
3 issues.

4 Q: That's right. It could. They could perhaps --
5 tell me if these measures are reasonable ---

6 A: Okay.

7 Q: --- to try to fix some issues. How about if
8 you had those issues that I mentioned causing
9 those ED metrics to be too high. Tell me if
10 these things would be a reasonable way to try
11 to resolve them. You could implement and
12 revise your ED protocols and processes to
13 improve operations.

14 A: That might help, yes.

15 Q: Wouldn't you start there, I mean, start with
16 process?

17 A: Right.

18 Q: You could implement an e-visit program to try
19 to treat some of the low-acuity folks that are
20 coming to your ED via telehealth, so they don't
21 have to come to your ED. That would be a
22 reasonable measure, wouldn't it?

23 A: I've never been part of an e-visit, so I'm not
24 really an expert on that.

25 Q: You're not sure about that?



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

1040

1 A: I would imagine that it's not -- I mean, I'm
2 not really an expert on telehealth as far as e-
3 visits go and not having at least a clinician's
4 hands on the patient.

5 Q: Fair enough. No opinion about that.

6 A: Checking vital signs, things like that.

7 Q: All right. You could implement a high-tech bed
8 board to closely monitor availabilities of beds
9 in the inpatient setting and maybe the psych
10 setting.

11 A: That might help.

12 Q: You could improve discharge at the hospital, or
13 try to, to make more room ---

14 A: Yes.

15 Q: --- in the hospital for your ED folks.

16 A: Uh-huh. That would help.

17 Q: You could spend some money on ED renovations.
18 That would be reasonable.

19 A: If the renovations improved efficiency, then
20 that would be helpful.

21 Q: You could create and fund ten, 15, 20 crisis
22 stabilization beds as a place that you could
23 send the folks who are appropriate to be sent,
24 the mental health folks ---

25 A: Uh-huh (affirmative response).



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

1041

1 Q: --- and take them out of the ED setting.

2 A: Sure.

3 Q: And lastly, you could explore ways to get more
4 capacity, more ED rooms, whether at the ED in
5 question or elsewhere to help with volume.

6 A: Okay.

7 Q: Okay, agree that that's ---

8 A: Sure, that could ...

9 Q: All right. When patients come to your Moncks
10 Corner FED for example and they need a higher
11 level of care that can be provided there. In
12 those cases you stabilize and transfer that
13 patient?

14 A: That's correct.

15 Q: All right. Some transfers go to Trident
16 Medical Center, I'll bet.

17 A: That's correct.

18 Q: Some go to Summerville?

19 A: That's correct.

20 Q: Do some go to MUSC?

21 A: Yes.

22 Q: Are you able to stabilize those folks, transfer
23 them safely and appropriately without
24 compromising care?

25 A: Well, I mean, sometimes patients -- like if



1 you're having a baby, you know, we try to get
2 them to the place they can go to right away,
3 because ---

4 Q: Right.

5 A: And sometimes you have to look at the benefits
6 of -- benefits and risks of transfer. So, we
7 have been very successful in safely
8 transporting our patients who present to
9 freestanding EDs to a higher level of care.

10 Q: Right. Your doctors do that well. Your nurses
11 do that well. You get them there safely.

12 A: Yes, sir.

13 Q: And if you establish your FED on James Island
14 that we heard about today, you will be able to
15 transfer patients safely from there to MUSC, to
16 Trident Medical Center, right?

17 A: I imagine that we would. We would probably use
18 similar processes that we have now. Because I
19 know that like the hospital in Moncks Corner,
20 the Roper freestanding ED in Moncks Corner,
21 they have not been able to successfully
22 transport their patients downtown. So, they're
23 using Trident now for their STEMI patients,
24 because it doesn't meet the guidelines for the
25 90 minutes to get the patient to cath lab, so



1 they transfer their patients to Trident now.

2 Q: I got you. So, perhaps -- and I suppose that
3 could work at James Island, right? You have
4 somebody with a STEMI situation maybe taking
5 them all the way to Trident wouldn't work.

6 A: Right.

7 Q: But you go to Roper ---

8 A: No, no.

9 Q: --- or MUSC.

10 A: That's correct. And we currently send patients
11 to other -- we send patients to the Medical
12 University that need the services there. So,
13 we would never compromise a patient based on --
14 just to send them to Trident Health.

15 Q: It's your understanding that there are no plans
16 to build a Trident Health Hospital in Moncks
17 Corner, right?

18 A: Well, you asked me that at the deposition. And
19 I didn't really know very much about that,
20 because it wasn't really something that -- I
21 know that it's been talked about. Some of the
22 nurses at Moncks Corner asked for that, when
23 are we going to get a hospital. And do they're
24 really excited and proud of Moncks Corner. And
25 so the answer that I had heard was well, we



1 don't have a plan right now. And so I inquired
2 a little bit more about that. I talked to Lisa
3 about it. I talked to some other people at
4 Trident about it. And they informed me about
5 the Army Corp of Engineers issue. I wasn't
6 aware of that. So that's not something I was
7 aware of at the time, but I have become more
8 aware. There's some sort of issue with the
9 environment and the water or something like
10 that. I don't know exactly what it is. But I
11 know that like there's no -- I've never seen a
12 schematic or how many beds it would be, so I
13 think it's still in the planning phase.

14 Q: So you have no sense, do you, after talking to
15 Lisa, that it's coming soon?

16 A: I don't imagine. I mean, if we have a
17 groundbreaking ceremony for Mocks -- for
18 Summerville freestanding and it's not coming
19 for another year, I guess it depends on what
20 you think soon is.

21 Q: Okay.

22 A: But it's definitely not in the next year or
23 two.

24 Q: And do you know how many ED rooms that proposed
25 hospital would have?



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

1045

1 A: I do not.

2 Q: Fair enough. Telehealth services, we mentioned
3 just a little bit. My understanding is that in
4 the Trident System, you use telehealth in the
5 EDs for psych consults and neuro consults?

6 A: Yes.

7 Q: Anything else?

8 A: Not that I know of.

9 Q: Fair enough. Thank you.

10 MR. THOMAS: I've just got one question for you.

11 MS. BIGGERS: No questions.

12 MS. ECCLESTON - RE-DIRECT EXAMINATION BY MR. THOMAS:

13 Q: Is there a nursing shortage in the Tri-County
14 area?

15 A: Yes, there is.

16 MR. THOMAS: That's all I have.

17 THE COURT: Thank you.

18 MS. ECCLESTON: You're welcome.

19 MR. THOMAS: Your Honor, I'd like to ask that The
20 Court release this witness.

21 THE COURT: If ---

22 MR. DAYHUFF: No objection.

23 THE COURT: No objection? She's released.

24 MR. THOMAS: Can we take a quick break before ---

25 THE COURT: Yeah. We'll do ten minutes.



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

1046

1 MR. THOMAS: --- the next one?

2 THE COURT: Yes.

3 (Off the Record)

4 THE COURT: Mr. Thomas, are you ready to ---

5 MR. THOMAS: Yes, ma'am. I'd like to call Preston
6 Wendell, M.D. to the stand ---

7 THE COURT: Okay.

8 MR. THOMAS: --- on behalf of Trident.

9 THE COURT: Before you take your seat, face the
10 court reporter, raise your right hand, she will
11 swear you in.

12 PRESTON WENDELL, M.D., having been duly sworn,
13 testifies as follows:

14 COURT REPORTER: Please state and spell your first
15 and last name.

16 DR. WENDELL: Richard Preston Wendell, R-I-C-H-A-R-D,
17 Preston, P-R-E-S-T-O-N, Wendell, W-E-N-D-E-L-L.
18 And I go by my middle name, Preston.

19 DR. WENDELL - DIRECT EXAMINATION BY MR. THOMAS:

20 Q: Dr. Wendell, why don't you, again, state your
21 name for the record.

22 A: Richard Preston Wendell.

23 Q: And where do you reside, Dr. Wendell?

24 A: Mount Pleasant, South Carolina.

25 Q: And what is your occupation?



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

1047

1 A: So I'm a physician, emergency medicine
2 physician. My current title is as the regional
3 medical director for TeamHealth.

4 **MR. THOMAS:** Okay. And why don't we put up Trident
5 Exhibit 100, which is Mr. -- or Dr. Wendell's
6 resume.

7 Q: Dr. Wendell, if you want to look at -- can you
8 read your screen okay there?

9 A: Yes.

10 Q: Okay. And that's -- and I know if there's --
11 it's a two-pager.

12 A: Yeah.

13 Q: But why don't we do this: Did you prepare your
14 resume?

15 A: Yes.

16 Q: And is it accurate and up to date?

17 A: Yes.

18 Q: Okay.

19 A: Well, actually, not 100 percent. The regional
20 medical director title is relatively new. I
21 assumed that role just a couple months ago.

22 Q: Okay. And we'll talk about that.

23 **MR. THOMAS:** But I'd like to admit this Trident 100
24 into evidence.

25 **MR. DAYHUFF:** No objection.



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

2 **(Petitioner TMC's Exhibit Number 100 was admitted**
3 **into the record at this time.)**

4 Q: Okay. Dr. Wendell, let's just kind of take it
5 from college forward for me, if you don't mind.

6 A: So I went to college at Wake Forest University
7 where I majored in biology. I went directly
8 into medical school at the Medical University
9 of South Carolina and graduated from medical
10 school in 2005. I did residency, emergency
11 medicine residency at Palmetto Health Richland
12 in Columbia. That's a three-year program. And
13 then I stayed one more year and did emergency
14 medicine fellowship and ultrasound. So
15 graduated from that, residency program and
16 fellowship in 2009, and took a job as an
17 emergency medicine physician at Summerville and
18 Trident with a group there in 2009. I worked
19 in Summerville, Trident, Moncks Corner at the
20 time, and then Centre Pointe clinically as an
21 emergency physician for -- since then, so ten
22 years. I've worked at other places as well
23 moonlighting, Colleton Medical Center more
24 recently, Providence Medical Center here in
25 Columbia, as well as, you know, Palmetto Health



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

1049

1 when I was a resident -- or sorry, a fellow and
2 then also a little bit after that.

3 Q: Let me stop you there real quick.

4 A: Sorry.

5 Q: How about -- do you have any other degrees kind
6 of that are outside of the medicine realm?

7 A: Yes. I did recently do a physician executive
8 MBA program at the University of Tennessee. I
9 completed that in December of 2018.

10 Q: Okay. Very good. And where are you licensed
11 to practice medicine?

12 A: For now just South Carolina as far as states
13 go.

14 Q: Okay. And are you Board certified in emergency
15 medicine?

16 A: Yes, sir.

17 Q: Okay. And let's talk a little bit -- you also
18 practiced at Palmetto Health as well, right?

19 A: Yes.

20 Q: As a resident?

21 A: Yes. Mainly as a resident. Yes.

22 Q: Is that -- is Palmetto Health considered an
23 academic medical center?

24 A: Yes. I think that term, academic medical
25 center, you know, again, it can be -- I don't



1 know if the right word is misleading a little
2 bit. Again, some medical centers that, you
3 know, traditionally do tons of research and
4 teach residents, you know, can be called
5 academic medical centers. But, again, training
6 program, educating residents, that can happen
7 in a lot of settings from places like Palmetto
8 Health Richland that are community centered --
9 community hospitals with lots of residency
10 programs, to the university programs, to
11 programs like, again, familiar Grand Strand
12 Medical Center, which has residency programs,
13 Trident Medical Center, which has a family
14 medicine residency program. So when you say
15 academic, traditionally that means maybe a
16 larger facility and a research facility. But
17 residents are trained in all kinds of
18 facilities and research of various forms can be
19 done at all kinds of different hospitals.

20 Q: Very good. Do you have any publications to
21 your name?

22 A: I did do a paper on brown recluse spiders when
23 I was a med student, which is, I think, maybe
24 one of the only ones that's actually been in a
25 journal. I did a large paper for my MBA



1 program on scribe use, which, you know, was a
2 whole-year project. I've worked on, you know,
3 work products for my professional organization,
4 for, you know, my job, for my hospital. You
5 know, those aren't publications, but, you know,
6 they're fingers-to-the-keyboard all the same.

7 Q: Let's talk a little bit. What professional
8 organizations do you belong to?

9 A: So emergency physician's main organizations are
10 -- one of our main professional organizations
11 is the American College of Emergency Physician,
12 which I've been a member since residency. And
13 then the South Carolina College Emergency
14 Medicine Chapter, which I've been on the board
15 and president of in the past. And I've also --
16 one of my niches outside of clinical practice
17 has been with policy and advocacy. So I have
18 served with our legislative committee for the
19 South Carolina College and the American College
20 of Emergency Medicine. I've visited
21 Washington, D.C. every year to learn about
22 policy issues, visited legislatures. I helped
23 start our Legislative Day here in South
24 Carolina, where our emergency physician groups
25 come and visit the State House and meet with



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

1052

1 members of the legislature. I'm sorry, I
2 always try -- the South Carolina House members
3 don't like to call them congressman, they're
4 legislatures.

5 Q: I've heard that.

6 A: Yeah.

7 Q: Now, are you in a leadership role now with your
8 -- with TeamHealth?

9 A: Yes. So I can kind of elaborate on that
10 transition. So in 2012, we -- our group,
11 Trident Emergency Physicians, I became the
12 Summerville Medical Center Emergency Director.
13 And that was sort of a defacto, second -- you
14 know, second in command for our group, which
15 was run by our managing partner and the medical
16 director of Trident Medical Center. Her name
17 is Dr. Karen Kriza. In 2014 we were acquired
18 by TeamHealth, which is a provider of emergency
19 services. It staffs a lot of emergency
20 departments and hospitalist programs. And in
21 that capacity I stayed on as the medical
22 director of Summerville. My mentor and
23 director, Dr. Kriza, moved on to other
24 responsibilities, so I became the assistant
25 medical director for all of the hospital's



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

1053

1 emergency departments within Trident; was also
2 the medical director for both Moncks Corner and
3 Summerville. And then since then have also
4 become the regional medical director for
5 TeamHealth for facilities, Colleton being an
6 additional facility in South Carolina and then
7 several hospitals in Georgia.

8 Q: Okay. And then in terms of your clinic admit
9 time, what's your split these days?

10 A: So these days I'm doing more administrative
11 time. So three to four clinical shifts a
12 month, which is probably around 25 percent
13 clinical time I would say. That's about 40
14 hours. And a full-time person -- minimum full
15 time is usually 120, hundred and -- you know,
16 120 hours. Some people obviously do more than
17 that. But I've practiced clinically, you know,
18 every month obviously since residency. I've
19 never stopped practicing. And I've got a shift
20 tomorrow morning starting at 5:00 a.m.

21 Q: Very good.

22 A: Be there tomorrow and Saturday.

23 Q: We're going to get you out today, I promise.

24 A: Yeah.

25 Q: Have you done any teaching in emergency



1 medicine?

2 A: Yes. So as a fellow -- as an emergency
3 medicine ultrasound fellow, I was an attendee
4 at Palmetto Health Richland, so I was over the
5 residents for that one-year time after I
6 graduated residency. We had family medicine
7 residency -- residents. It's a shared
8 residency program between MUSC and Trident at
9 Trident. And those residents rotate through
10 the emergency department. It's not a lot,
11 usually one or so a month. So, you know,
12 occasionally I'll get a shift with them. We've
13 had PA students come through. I've given
14 lectures on emergency ultrasound to CME
15 courses. So, you know, I've done a fair amount
16 -- or a little bit of that.

17 Q: Do you serve on any committees at Trident
18 Medical Center?

19 A: Yes. I mean, the two major -- again, as my
20 regional responsibilities have grown, so have
21 my day-to-day responsibilities at the
22 individual facilities have lessened. But I
23 still serve on the chair of the credentials
24 committee, which I've done now I think for four
25 or five years. I can't remember. And then the



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

1055

1 medical executive committee, which has been, I
2 think, at least six years at Trident.

3 Q: So you're involved in credentialing physicians
4 who have privileges at Trident Medical Center?

5 A: Yes. And then when I was medical director at
6 Summerville and Moncks Corner, obviously I was
7 on the sepsis committee and other committees
8 that are more, you know, local hospital-based
9 committees.

10 Q: Okay. In terms of emergency -- the types of
11 emergency departments, have you worked in
12 hospital-based emergency departments?

13 A: Yes.

14 Q: Okay. How about freestanding EDs?

15 A: Yes. I work at Moncks Corner on Saturday.

16 Q: Okay. And how many shifts would you say you've
17 actually pulled in a freestanding ED?

18 A: That's a good question. I mean, since 2009 at
19 least -- you know, from 2009 to probably 2017
20 at least two to three a month. And then, you
21 know, probably one a month since then. I try
22 to work a shift -- now that I work less shifts,
23 I try to work usually one shift in each of our
24 emergency departments. So I try to diversify
25 where I work in my current role.



MOTION TO QUALIFY AS EXPERT:

MR. THOMAS: Your Honor, at this time I'd ask that Dr. Wendell be qualified as an expert in emergency medicine and ED administrations and operations.

MR. DAYHUFF: No objection, Your Honor.

THE COURT: He's recognized as an expert in those areas.

MR. THOMAS: Thank you, Judge.

Q: Dr. Wendell, would you consider yourself and the ED physicians who work at Trident -- and I guess those are TeamHealth physicians, correct?

A: Yes.

Q: Would you consider yourself and the folks you work with to be up to date on the latest ED treatment methods?

A: Yes. We have an excellent group of emergency physicians at our facility.

Q: And most of them are Board certified?

A: They're all Board certified emergency medicine, yes.

Q: Okay. And just explain to The Court, because, you know, we -- as lawyers we go to something called CLEs.

A: Correct.



1 Q: Continuing Legal Education. What do emergency
2 physicians to keep up with the latest
3 techniques and treatments in emergency
4 medicine?

5 A: So I think, you know, each physician has their
6 own, you know, learning plan. The State of
7 South Carolina actually I think only requires
8 40 hours of CME over the course of a two-year
9 period to maintain a state license. But other
10 groups and hospitals can have additional
11 requirements. So Trident, being a trauma
12 center, any physician there has to have a
13 certain amount of trauma CME. We also have,
14 you know, anything from conferences that we go
15 to, to newsletters we may receive, or podcasts
16 that we can do that can earn CME. TeamHealth,
17 my company, actually has what we call mind
18 shift -- or mine field navigator shifts, where
19 it goes through clinical cases. There's
20 usually six of them, which take a couple of
21 hours a piece, which focus on high risk, high
22 areas of importance that are mandatory for our
23 providers every year. And, yeah, so there's a
24 lot available. Again, a physician, who maybe
25 is practicing not at a hospital, not with a



1 TeamHealth, maybe on their own, and, again, not
2 saying they're not getting what they need, but
3 we add additional education for our physicians
4 by being part of our organizations.

5 Q: Very good. Now, we've already established that
6 Trident operates -- Trident Health operates two
7 hospital-based EDs and two freestanding EDs.

8 A: Correct.

9 Q: And it's going to operate a third once it is
10 built out in the 2020.

11 A: Yes.

12 Q: From a medical perspective -- because you've
13 heard Ms. Eccleston, who's a nurse and a
14 clinician. From a medical perspective of a
15 physician, ER physician, tell me about the
16 various services, so The Court understands,
17 that are offered in these various locations.
18 Kind of high level, but ---

19 A: Right.

20 Q: --- so that you can identify ---

21 A: So -- yeah. So I think a lot of what can be
22 offered and what can be done is up to the
23 physician. A lot is about the circumstance and
24 a lot is about the patient that presents. So
25 I think where we've done a good job of serving



1 the communities in our different facilities,
2 it's not just it's a freestanding or it's a
3 hospital based, but how we work and connect
4 together. So a good example of that is if
5 someone were to go into our emergency
6 department at Moncks Corner or Centre Pointe,
7 again, we have necessary medications, necessary
8 treatments to help them out in an acute
9 emergency. Obviously you can't always have
10 everything that a hospital has from services
11 and supplies and medicines, but we're able to
12 plan for what's needed by being connected to
13 the main hospital and being closer in proximity
14 to that hospital allows us to access resources
15 there. Whether it's transporting the patient
16 there. Sometimes if we need a medication, we
17 can actually have it emergency couriered to us.
18 If we work up a patient and then have them --
19 they need more attention, more services, we can
20 transport them from one to the other. And
21 because we're all connected, it literally --
22 while there's an ambulance ride in between, it
23 literally can happen just like handing off a
24 patient at shift change. The physician working
25 at Trident can see the tracker and electronic



1 records at Moncks Corner, they can see what
2 I've done, they can access that, they can
3 connect with that patient, and then we can
4 seamlessly work together if we need to to share
5 resources.

6 Q: Okay. And Trident's a Level II trauma center.
7 MUSC's a Level I. What's kind of the main
8 difference there?

9 A: So and my understanding is the main difference
10 between a Level I and a Level II is research
11 would be one of the main differences. From a
12 clinical capacity, I don't think there's much
13 difference. We have neurosurgery available.
14 We -- you know, 24/7 in house trauma surgeons,
15 trauma orthopaedics. And, again, there's very
16 little that we can take care of (sic) and very
17 little from a trauma perspective that we
18 transfer out.

19 Q: And in terms of being an accredited Chest Pain
20 Center, and this is -- you know, I think you
21 saw whatever was up on the screen ---

22 A: Right.

23 Q: --- with Ms. Eccleston, but from the American
24 College of Cardiology, discuss from a medical
25 perspective what that means for patients that



1 either utilize and access Trident's
2 freestanding EDs or the Trident hospital-based
3 EDs.

4 A: Yeah. So accreditations like stroke or chest
5 pain, I mean, really means that you've asked an
6 independent -- or you've invited or had an
7 independent third party come in and evaluate
8 your program. And it allows you to give -- you
9 know, open your doors to have honest assessment
10 on what you need to do, what resources you
11 need, how you need to get better. And so I
12 think rather than, you know, maybe thinking
13 you're doing a certain service line the right
14 way, you invite in another third party who has
15 access to other hospitals, other best practices
16 and they come in and give you an assessment.
17 So I think it gives you a -- you know again, it
18 allows someone else to assess how you're doing,
19 give you improvement. And if you pass that,
20 then, again, that says something about how
21 you're performing on those measures and those
22 patient populations.

23 Q: And so Trident Medical Center is roughly, what,
24 about six miles away from the future
25 Summerville freestanding ED?



1 A: Yes.

2 Q: In terms of -- differentiate a little bit about
3 kind of the patients you're more likely to see
4 in a freestanding ED than a hospital-based ED.

5 A: Right. So the freestanding emergency
6 department generally is going to see lower-
7 acuity patients, walk-in patients. And, again,
8 not that EMS can't come into a freestanding
9 emergency department, but if an EMS picks up a
10 patient, that's a qualified provider and
11 emergency medicine technician who's going to
12 evaluate that patient. And if they identify
13 them to have a need that's not available at the
14 freestanding, then they're going to take that
15 patient to the place that they feel that
16 they're best served. So generally speaking,
17 again, someone's going to come in and, just by
18 the nature of the location, they're going to be
19 lower acuity, usually walk-in patients, less
20 ambulance traffic.

21 Q: In your experience as an ED physician, do
22 patients kind of have the tendency to self-
23 select where they're going to go based on how
24 they feel?

25 A: Right. You know, again, every -- we try



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

1063

1 through community education, through -- you
2 know, I'm sure every healthcare professional
3 tries to educate their patients on how to
4 choose best when you're going to go and where
5 you're going to go. It's not always perfect.
6 That's why a freestanding emergency department
7 differs from an urgent care, in that we're open
8 24/7 and we have these more -- you know, we
9 have plenty of resources, medicines, supplies
10 that we literally never use, but they're there
11 because we're an emergency department and we're
12 prepared for when a patient comes in and they
13 are really sick and we need to tend to them.

14 Q: You heard Ms. Eccleston talk a little bit about
15 ED metrics from her perspective.

16 A: Uh-huh, yes.

17 Q: Which ones -- let me first ask, do you track ED
18 metrics?

19 A: Yes.

20 Q: Okay. Which ones do you pay close attention
21 to?

22 A: Well, I think obviously some of the big
23 throughput ones, as she mentioned, door to what
24 we call MSC or physician greet, low-acuity
25 length of stay, discharge length of stay, admit



1 length of stay. They also monitor turnaround
2 times on key services that complement the ER,
3 that are necessary to the ER; lab, radiology.

4 Q: Okay. And we may talk a little bit more about
5 these, but how are those metrics at Trident
6 Health these days?

7 A: So I think we do very well for our size and
8 sort of for the -- for the patients we see.
9 We're always improving. That could be a small
10 tweak here or there or it could be, you know,
11 a more large-scale performance improvement
12 project. But we're always looking, always
13 trying to improve.

14 Q: So on an exhibit that I think we've showed
15 earlier that Mr. Dayhuff asked Ms. Eccleston
16 about, some volumes. But I understand is we're
17 doing about 35,000 or so in the freestanding
18 EDs and 140,000 in hospital base. Do those
19 numbers sound right to you?

20 A: Yes.

21 Q: Do you characterize that as a fairly robust ED
22 service?

23 A: Yes. Two 70,000 volume EDs are very large. I
24 think, you know, Moncks Corner has been fairly
25 steady. And then Centre Pointe is growing and



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

1065

1 is a, you know, busy freestanding emergency
2 department.

3 Q: Okay. In terms of the trauma services that we
4 were talking about, how does this service
5 offering, if at all, complement Trident
6 Health's freestanding EDs?

7 A: Say that question again, please.

8 Q: Yeah. It was kind of disjointed. In terms of
9 the trauma-based services at Trident Medical
10 Center, how do those, if at all, complement the
11 services that are offered at the freestanding
12 EDs and the services that will be offered at
13 Summerville's freestanding ED?

14 A: Right. So having -- you know, having those
15 comprehensive services at the main emergency
16 department absolutely provide critical access
17 to services for patients that were to, you
18 know, arrive at a freestanding ED. And it's
19 not just that they're there and they have them,
20 but also the shared connections, the shared
21 leadership, the shared emergency department
22 staff. So it's not just about getting a
23 patient, you know, from one place to another.
24 It's the fact that we've worked together, we've
25 talked about these scenarios, we've prepared



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

1066

1 for these scenarios, and so that we try to do
2 that in the most timely and efficient manner.

3 Q: So the patient who comes to the exit 199
4 location for Summerville, how far -- if they --
5 if it is determined that a trauma activation
6 needs to take place, how far away are they from
7 Trident Medical Center?

8 A: Again, I'd have to map it out exactly, but,
9 again, they're -- it, you know, sounds like no
10 more than six, seven, eight miles, and that
11 would be a very quick transfer.

12 Q: And has that ever happened before?

13 A: Yes. So we routinely transfer patients from
14 our freestandings to our main EDs.

15 Q: Okay. Do freestanding EDs typically treat a
16 trauma patient?

17 A: So, you know, again, a minor trauma, you know,
18 someone falls, breaks an ankle or, you know,
19 has a minor injury, yes. And so the physician
20 there will see them, make the evaluation of
21 whether they need help. That could be
22 immediately activating a trauma activation to
23 get the patient out right away. That could be
24 calling the surgeon to ask a question, to
25 review an x-ray, to review a study, and just



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

1067

1 getting an opinion. Or, again, it could be
2 transferring the patient after some work-up has
3 been done after the freestanding ED.

4 Q: And the closest trauma center from the
5 Summerville freestanding ED area would be what?

6 A: Trident.

7 Q: Okay. What about STEMI and stroke patients?
8 Do those often present to freestanding ED
9 locations?

10 A: Not often, but they do.

11 Q: Okay. And how are those patients handled from
12 a medical perspective?

13 A: Similar. From the time I greet the patient to
14 the time I get the services started, almost
15 identical. I'm going to get an EKG, which will
16 identify a ST-elevation MI or a type of
17 immediate heart attack, I'm going to get a CT
18 scan. If it's a stroke, I'm going to get my
19 tele-neurologist involved to help evaluate the
20 stroke patient for what's called TPA or clot-
21 busting medication. And then I'm going to work
22 to transfer that patient from the freestanding
23 ED to -- for those patients would go to Trident
24 for further evaluation and care.

25 Q: Okay. And in terms of the overall level of



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

1068

1 patients that are typically seen, a triage
2 level at a freestanding ED, do you have an --
3 or an observation on that ---

4 A: Yeah. Generally speaking our patients are low
5 -- are overall less percentages of the high-
6 acuity level one, level two and more of the
7 three, four, and five than the hospital-based
8 emergency departments.

9 Q: Okay. Now, we talked a little bit about your
10 work at TeamHealth.

11 A: Uh-huh.

12 **MR. THOMAS:** Permission to approach, Your Honor?

13 **THE COURT:** Yes.

14 Q: If you go to Tab 83 here.

15 A: Can I move this?

16 Q: Yeah, we can move this.

17 **MR. THOMAS:** If you get Trident Exhibit 83 on the
18 screen.

19 Q: Okay. Do you recognize this document, Dr.
20 Wendell?

21 A: Yes.

22 Q: And can you -- generally, did you create this
23 document?

24 A: Yes.

25 Q: Okay. What is this document?



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

1069

1 A: This was a lecture I was asked to give to our
2 Board of Trustees on -- you know, on high-
3 performance emergency departments, highlighting
4 our performance in our emergency departments.

5 Q: Let's quickly take The Court through this.

6 A: Okay.

7 Q: It's an interesting -- go to the next page,
8 Trident 83, number two. Okay. What's going on
9 here?

10 A: Yeah. So that's certainly I think what maybe
11 comes to mind traditionally for emergency
12 departments. And, you know, I think that set
13 the stage for how we're thinking about doing
14 these differently, focusing on patient-centered
15 care, patient experience, and how we're -- you
16 know, again, how we're thinking about things
17 differently in the emergency department.

18 Q: Next page. All right. Tell The Court about
19 this slide here.

20 A: Yeah. So that takes people -- I think most
21 people don't realize that emergency medicine is
22 one of the youngest specialties, you know,
23 formed. You know, you can see there in 1961
24 some of the first physicians that decided to
25 practice emergency medicine and then the



1 specialties and the professional societies
2 formed and then emergency residency programs.
3 But now it's actually one of the more popular
4 and robust specialties we have. But, you know,
5 30 -- 40, 50 years ago it was -- emergency
6 departments were, you know, staffed by medical
7 students and people who were not trained
8 specifically in emergency medicine.

9 Q: Kind of scary. Let's go to the next page, if
10 we could. And you can turn in that.

11 A: Okay.

12 Q: I think it's entitled EMTALA 1986. What does
13 this slide mean?

14 A: So that -- that EMTALA slide, I think you
15 skipped a little bit ahead on the PowerPoint.
16 So I guess to indulge The Court, that slide
17 depicts the EMTALA language, which was the
18 Emergency Medicine Treatment and Active Labor
19 Act in 1986, I think was part of larger
20 legislation, but it was the anti-dumping bill,
21 which, you know, really made ---

22 Q: Patient dumping bill.

23 A: Patient dumping. Which really mandated that,
24 if a patient presents to the emergency
25 department, that they needed a medical



1 screening exam, they had to be seen regardless
2 of ability to pay. And the gentleman, Dr. Art
3 Kellermann, who spoke on that, in his inner-
4 city hospital in Memphis, kept seeing patients
5 coming in on gurneys from ambulances that had
6 other hospital's bracelets on. And he said in
7 a six-month period he asked all of his nurses
8 -- he was going to buy -- you know, give them
9 a prize or a dinner, whoever collected the most
10 bracelets. And in a six-month period he had,
11 you know, a trash bag full that he, you know,
12 brought to congress that he collected from
13 patients who were seen and then sent to their
14 emergency department because they hadn't paid a
15 bill or they had a, you know, outstanding
16 balances or didn't have insurance. So that was
17 a landmark legislation for emergency medicine.

18 Q: Thirty-three years ago it became against
19 federal law to ---

20 A: Right.

21 Q: --- dump a patient or transfer a patient just
22 because they couldn't pay.

23 A: Right. And we have to see everyone and do a
24 qualified medical screening exam and regardless
25 of ability to pay, with any -- no barriers to



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

1072

1 that. And that's the difference between
2 emergency departments, both freestanding and
3 hospital based, and -- but not necessarily the
4 case of an urgent care or other, you know,
5 places that are not under EMTALA.

6 Q: Sure. So, you've got to take all comers ---

7 A: Yes.

8 Q: --- to the freestanding ED and the hospital EDs
9 alike?

10 A: Yes, correct.

11 Q: Next page, five. Okay. Tell The Court about
12 practice made perfect.

13 A: Yeah. So TeamHealth is the company I work for.
14 We, I think, have 20,000 clinicians across the
15 country doing mainly emergency medicine,
16 hospitalist medicine, anesthesia, and then some
17 other services. That our group, Trident
18 Emergency Physicians, was acquired by Team
19 Health in 2014. And, you know, really was very
20 positive for us, helped us. You know, as the
21 challenges in healthcare become harder, more
22 difficult, they really helped us meet those
23 challenges and have tons of resources for us,
24 from education, to support, to leadership
25 development, recruiting all kinds of resources.



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

1073

1 It's been a good transition for us and good for
2 our patients in the health system.

3 Q: Let's go to the next page, six. Tell us about
4 Trident Exhibit 83, page six. There it is.

5 A: So this is, you know, just forgive me, bragging
6 a little on the providers we have.

7 Q: Sure.

8 A: So, you know, I'm -- past president and several
9 board members of our South Carolina ACEP
10 program, our managing partner at the time, Dr.
11 Karen Kriza, was the ACEP director. So that's
12 the national ACEP -- won the ACEP Medical
13 Director of the Year for all of the country in
14 2016. We have several national leaders a part
15 of the organization that are well known. And
16 then as far as our just focus on the ground
17 providers, the EMS director, myself and another
18 provider, ultrasound trained. One of our
19 providers is a masters in medical informatics.
20 Several former, you know, military officers.
21 And, again, just really proud of the group we
22 have. And ---

23 Q: How about for pediatrics?

24 A: So, yes. We do have a pediatric emergency
25 department at Summerville. And we have I think



1 five full time Board certified peds emergency
2 physicians. So they see the patients directly
3 at Summerville. But also, if a patient -- a
4 peds patient comes in to Trident or in the
5 freestanding, they can be helpful as well.
6 And, you know, I think it's really -- we get --
7 emergency physicians who are not peds emergency
8 medicine board certified, certainly see lots of
9 pediatric patients. Peds are a specialty of
10 ours as well, but it's a nice complement to
11 having one with extra training and focus to
12 help us -- help the whole group to be the best
13 we can.

14 Q: It states that you partner with a leading
15 Emergency Scribe Company. I'm not sure if The
16 Court's aware of what that means.

17 A: Yes.

18 Q: It's an interesting area.

19 A: Scribes have been increasing in prevalence
20 since the onset of the more electronic health
21 records. And a scribe is essentially a person
22 who follows alongside the physician or the PA
23 and does documentation for us. So they document
24 for us and then we certify their documentation.
25 That can help the provider, free them up to do



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

1075

1 more clinical work, less paperwork, spend more
2 time with the patient.

3 Q: Okay. Next page. And this one is kind of ---

4 A: Sorry. A little bit of a ---

5 Q: Yeah. I don't know why it's like that, but
6 maybe you can explain a little bit about what's
7 going on, 7. All right.

8 A: This was just -- you know, patient experience
9 is something that is extremely important and
10 sometimes a challenge. And this is really just
11 an attempt to look at the numbers, when you
12 look at -- you know, what you can see, I'll
13 just kind of go ahead and show the ones that
14 are highlighted there. You can see that red
15 box in the middle of the page. It says 73.5.
16 That is the percentage top box. So just like
17 a car dealership, we only get credit if they
18 give us an absolute all good. And we don't get
19 any credit if they say we were okay or not.
20 And just showing how that ranking. So if you
21 look at the blue numbers across to the right,
22 the 77, that would be the 77th percentile in
23 all of the Press Ganey or the survey database.
24 And when you look down at the one below, the
25 67.9, you see someone's rank drops all the way



1 to 50. So that's just really a look at how we
2 focus on patient experience. It's a
3 challenging metric, because a little bit of a
4 drop in that percent of top box drops you in
5 the ranking pretty heavily. So, you know,
6 that's one we focus on a lot and care about and
7 spend a lot of work on.

8 Q: Understood. And page nine. I think that is
9 eight. Oh, okay, maybe I skipped page eight.
10 How about page eight?

11 A: Just a testament that we have -- I think for
12 the Trident system we have about 80 providers
13 and, you know, honestly have had very little
14 turnover. Physicians have had -- been very
15 stable throughout my tenure there and APCs as
16 well. We continue to recruit and grow and add
17 quality physicians.

18 Q: All right. How about this -- I think this
19 one's fairly self explanatory.

20 A: Yeah. Just, again, highlighting our overall
21 visits and pediatric visits to the health
22 system.

23 Q: Do you know who the first largest provider for
24 pediatric is?

25 A: I don't. I don't.



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

1077

1 Q: Next page, please, 11. And this is what looks
2 like to be a bar graph.

3 A: So, again, this is just the companies we work
4 for and the some of the resources behind us to
5 help us improve.

6 Q: Oh, yeah. I missed ten again. I'm sorry. The
7 way this thing is printed out. So this is Big
8 Company/Big Support.

9 A: Yeah.

10 Q: So tell us about the support HCA provides.

11 A: Right. So, you know, certainly a lot of
12 analytics and data. If we need something at
13 the hospital, there's division and other
14 resources to help from performance improvement
15 teams to data analytics. And, you know, we're
16 always being able -- we're always able to
17 connect to other hospitals that, you know, may
18 have solved a problem that we're struggling
19 with.

20 Q: Very good. All right. Tell us about this one.

21 A: So this is data that shows some of the key
22 performance metrics on emergency departments
23 and just showing the average minutes in the ED
24 before inpatient admission and does show,
25 obviously, based on volume. And shows that,



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

1078

1 you know, TeamHealth is performing certainly
2 well, better than, you know, the United States
3 and state of South Carolina averages.

4 Q: Twelve.

5 A: Similarly, the next one would be arrival to
6 discharge. And, again, similar to showing
7 comparison in local and national benchmarks.

8 Q: Okay. Thirteen.

9 A: And this would be the arrival to greet time,
10 again with the same -- showing that -- that's
11 that ten minute, less than ten minute greet
12 time that we've worked hard to achieve.

13 Q: Okay. Then there's 14. It's got the Starbucks
14 logo on it.

15 A: If anyone wants some Starbucks break now, I'm
16 not opposed. You know, one of our key
17 initiatives has been what's called a provider
18 in triage. So in the past in the emergency
19 department, you think, oh, you come in, you got
20 evaluated, and triaged by a nurse. And we sort
21 of changed that a triage as a verb. It's not
22 a noun. It doesn't have to happen our front.
23 And so at times of surg, you know, while
24 triage, you know -- let me back up. When we
25 aren't busy, when we have rooms available, we



1 don't triage out front. We do what's called
2 direct bedding. So a patient comes directly
3 back to a room and everyone sort of swarms
4 together, physician, nurse, to evaluate them,
5 get things started early. And when we do have,
6 you know, maybe a surg or we have some -- you
7 know, we're in a busier time in the ER, then
8 patients may begin to be triaged by a nurse,
9 which is an important step, but we've also been
10 able to put physicians or other providers,
11 often PAs, out with the nurse to evaluate the
12 patient. So you get that eyeball on a patient
13 to -- and a quick evaluation to see if there's
14 any test that can be done, to see if they may
15 be sicker than as thought. And then you're
16 able to, you know, really parallel process a
17 patient, as opposed to just serially process
18 them. And that allows you to increase
19 efficiency and capacity. And the thing that
20 always brings a smile to my face is when I'm in
21 a line at Starbucks and the barista says, hey,
22 what can I get started for you. And they allow
23 my drink to get started while I pay and then
24 it's ready for me. And so, you know, kind of
25 a similar process.



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

1080

1 Q: To kind of moves things along ---

2 A: Sorry.

3 Q: No. That's okay. Not at all. I just want my
4 paralegal to go to 83-17 if you would, instead
5 of the very next one, because there's a lot of
6 slides in here. All right. Tell us a little
7 bit about the emergency department resources.

8 A: So, yeah. Lots of resources. We have tele-
9 stroke, in-house OB/GYN laborists, in-house
10 hospitalist program, again, the trauma, the
11 dedicated PED and ICU. All of this has helped
12 us grow and expand to treat our patients. I
13 mean, ultrasound available 24/7, that is a
14 tremendous resource. You know, some places
15 don't have that. That can't just be -- that's
16 done by a specialized technician. You know, if
17 you have a blood clot in your leg or you think
18 you might have a gallbladder attack, we're able
19 to do that appropriate test 24/7 at our
20 facilities. And in fact we're able to connect
21 to the freestandings as well. So if I see a
22 patient at the freestanding I feel like I need
23 that ultrasound, I can transfer the patient
24 quickly, actually, from our freestanding to our
25 main ED, get that ultrasound done. And what,



1 you know, may have had a patient been seen, not
2 been able to get done, they have to come back
3 the next day to get the test done, we're able
4 to do it, you know, that night, even if they're
5 at one of our facilities that doesn't have that
6 capability.

7 Q: Very good. Let's talk about page 18. And I
8 think we'll probably conclude with this one.
9 Tell us a little about the quality initiatives.

10 A: So, as Joan Eccleston said, our nurse director,
11 we're always focusing on quality initiatives to
12 improve, you know, pediatric readiness. We
13 were one of the first community emergency
14 departments to achieve pediatric readiness
15 certification in the state of South Carolina.
16 We do tons of specialty-specific case review.
17 Again, teams around sepsis, stroke, cardiac
18 teams to help always improve quality and
19 performance. Behavioral health team as well,
20 that's been a huge focus of Trident to where
21 we've added behavioral health beds, we've added
22 behavioral health resources to help move
23 patients more efficiently and take care of
24 patients.

25 Q: And do you actually have MUSC-trained



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

1082

1 physicians from medical school and residency
2 working with TeamHealth in the Trident ---

3 A: Yeah. We have -- you know, we probably don't
4 have a day where we don't have someone who
5 either did residency or med school at MUSC.
6 And we even have providers that have worked in,
7 currently work at the facilities.

8 Q: In your opinion -- and, you know, you've worked
9 at Trident and Palmetto and I guess as a
10 medical student you were at MUSC ---

11 A: Uh-huh.

12 Q: --- doing a turn in the ED. But what are the
13 quality of ED services like at the Trident
14 Health facilities?

15 A: You know, I think we do an excellent job. We
16 have, you know, committed staff, nursing, and
17 physicians, and PAs, and, you know, great
18 support systems behind us to help us always
19 provide the best care possible.

20 Q: And how are, you know, from a benchmark
21 perspective, the door-to-provider metrics?

22 A: Yeah. I think our metrics, you know, we do
23 very well. Certainly for the size of our
24 facilities do very well and they are constantly
25 sometimes beating benchmarks that are, you



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

1083

1 know, for smaller hospitals as well.

2 Q: And I assume Trident Medical Center gets its
3 share of complex cases.

4 A: Yes. Yes. We have, like Joan said, a 25
5 percent admission rate. We are -- you know, we
6 transfer very well out. We're a referral
7 center for not only our Trident system, but
8 other facilities as well.

9 Q: Has Trident had to make some changes to its EDs
10 in order to deal with growing patient
11 populations and volume?

12 A: Yes, absolutely.

13 Q: And I'm not going to ask you, but the expansion
14 -- how did the expansion of the ED at Trident
15 assist with patient volumes and that sort ---

16 A: Right. So expanding the ED helps give us
17 alternative treatment spaces, you know, see
18 more patients, see patients more efficiently.
19 But I think we also have a holistic approach to
20 the -- to throughput. ED throughput is not
21 just an ED issue. It's a hospital issue. And
22 the whole hospital has to be behind that,
23 because if the whole hospital is -- you know,
24 we can't stop patients from coming through the
25 front door, right? That's actually very



1 predictable. The volume, when it's going to
2 come in, the days that it's busy, it is very
3 predictable. But what we can do is control
4 barriers once that happens. And it's not just
5 the ED. It's the whole hospital. And we've
6 added resources, capacity changes across the
7 health system to help us meet the growth.

8 Q: You weren't hear on Monday, but Dr. Hall
9 testified that the practice of emergency
10 medicine is the same kind of no matter which
11 type of ED you practice in. Do you agree with
12 that?

13 A: I would agree that as a specialty I'm very
14 proud of the physicians and providers we have,
15 that we are all going to do our best in the
16 situations and hospitals we're in to provide
17 great care. And -- yes.

18 Q: Are there standard protocols that ED physicians
19 use kind of across the board?

20 A: So I would say protocol is not -- it's a little
21 bit of a strong words. But I would say yes, we
22 are all in tune to practices -- the best
23 practices and committed to implementing those.
24 So a good example would be STEMI care. You
25 know, ten or 15 or 20 years ago that might have



1 been -- you know, there might not have been a
2 hard-wired process to get people into a cath
3 lab with a heart attack in 90 minutes. You
4 know, now almost any facility is going to have
5 that. And we've all, you know, worked together
6 to implement those best practices. You know,
7 the process is different for a freestanding ED
8 and maybe different for a rural facility and
9 maybe different from a facility that has a cath
10 lab. But we're all working for that same goal.

11 Q: And if a STEMI patient presents to a
12 freestanding ED ---

13 A: Uh-huh.

14 Q: --- where should that patient generally go?

15 A: They should go to the closest cath lab.

16 Q: And does Trident have a 24-hour, seven day a
17 week staffed cath lab?

18 A: Yes. Yes.

19 Q: What about a stroke patient?

20 A: Yes. Absolutely. They should go to the
21 closest patient -- and I mean a good example of
22 that is in the Lowcountry we had a
23 collaborative model where we teamed with MUSC
24 to have neuro interventionalists, which are
25 essentially caths for the brain, for those



1 providers -- where we shared resources with
2 their providers and they were staffed at not
3 only our facility, but Roper, so that we could
4 take patients from outlying areas and perform
5 those procedures closest to where those
6 patients were presenting, rather than, you
7 know, coming necessarily all to one place. And
8 so that was a collaborative effort to best
9 utilize resources.

10 Q: Okay. Are you aware of the -- I think Ms.
11 Eccleston talked about the expansions at
12 Summerville, so I'm not sure ---

13 A: Yes.

14 Q: --- so sure that we need to get into that. But
15 is that something that is important to you?

16 A: Yes. I've been involved in the planning and
17 preparation for that. And I think we, you
18 know, not only are expanding our pediatric
19 emergency department, but our main emergency
20 department to help better care for patients.

21 Q: Okay. And so why -- what's your understanding
22 of why Trident decided to build a freestanding
23 ED in James Island?

24 A: So my understanding is that that's an area that
25 doesn't have a freestanding emergency



1 department and would be an access for patients
2 in that community.

3 Q: Now, did you have a chance to review the MUHA
4 or MUSC -- it's Hospital Authority for South
5 Carolina. But their CON application?

6 A: Yes.

7 Q: And did you -- are you aware kind of the new
8 location, the services that are going to be
9 offered there?

10 A: Yes. I don't recall the exact address, but I
11 know it's very close to our emergency
12 department and very similar in rooms and scope
13 and abilities.

14 Q: Okay.

15 A: Or should I say Summerville's emergency
16 department.

17 Q: Right.

18 A: Freestanding emergency department.

19 Q: To your knowledge, are there going to be any
20 significant differences between the Summerville
21 Medical Center freestanding ED and what MUHA is
22 proposing on the other side of exit 199?

23 A: No.

24 Q: Okay. While you have been the medical director
25 for ED services at Trident Health, in your



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

1088

1 opinion have the ED resources located in
2 Berkeley, Dorchester, and North Charleston been
3 able to meet the needs of the community?

4 A: Yes. I think we've done a good job of growing
5 smartly and steadily to meet the needs of the
6 community.

7 Q: Now -- and are you aware of what new resources
8 are coming online in the north area as well?

9 A: I mean, from what was described here and from
10 review, there's the emergency department for
11 Roper and there's the Summerville freestanding
12 emergency department and then the emergency
13 department expansion at the Summerville main
14 hospital campus.

15 Q: And those will be able to accommodate a
16 significant -- you know, tens of thousands of
17 additional visits a year?

18 A: Yes.

19 Q: Now, Trident has -- from time to time makes
20 transfers to MUSC, correct?

21 A: Yes.

22 Q: What are some reasons for those?

23 A: So, reasons before would be a service we don't
24 have. Sometimes, again, a complicated patient
25 or a patient that has an established provider



1 down there, we're happy to -- you know, we want
2 to do what's best for the patient and often
3 send patients. I mean, a good example of one,
4 when I started at Summerville, that we sent a
5 lot would be like a pediatric orthopaedic
6 patient. We didn't necessarily -- we didn't
7 have pediatric orthopaedists. So that's a
8 specialty where, you know, certain injuries,
9 the age, you know, some subjective factors make
10 a patient not able to be seen by an adult
11 orthopaedist. But now we actually have two
12 pediatric orthopaedists at Summerville that
13 will help us care for those patients. So that
14 would be a patient that we don't -- or where
15 we've added resources and capability to help
16 manage at home.

17 Q: And if a patient who -- do you typically
18 transfer more patients from the hospital-based
19 EDs or the freestanding EDs to another medical
20 center?

21 A: Well, I mean, I wouldn't know the percentage,
22 but just based on the sheer numbers and the
23 complexity, that, yes, more patients are going
24 to be transferred from the main EDs to an
25 outlying facility. Just -- there's very few



1 patients in general that are transferred from
2 the freestanding EDs, because most patients are
3 seen and treated and sent home.

4 Q: Okay. What, if any, concerns do you have about
5 staffing your freestanding EDs with the new
6 kind of Roper and the proposed MUSC
7 freestanding ED at exit 199?

8 A: Right. I think the main concern would be on,
9 you know, nurse and other support staff
10 resources. So that would be nurses, you know,
11 radiology techs, lab technicians. I mean, I
12 think the difference is, if you add a
13 freestanding ED, whether you see one patient or
14 100 patients, you have to have, you know, a
15 couple of nurses, a night nurse, a night tech,
16 you know, all of these resources.

17 If you just add a wing to a hospital and
18 that doesn't work out, then, you know -- or you
19 only need -- you know, it's only running at
20 five or ten percent capacity, then the
21 providers that are already there can
22 potentially help absorb that, as opposed to
23 having, you know, when you open the doors of
24 that new facility, there is a minimum number of
25 staff that have to be there regardless of how



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

1091

1 many patients come through the door. And so
2 that is the difference between, you know, maybe
3 an expansion on a hospital-based campus versus
4 a freestanding emergency department.

5 Q: Do you believe that the Summerville Medical
6 freestanding ED, which I believe Ms. Eccleston
7 testified be very similar to Centre Pointe,
8 will be a good resource in terms of emergency
9 medical services for the folks in that general
10 vicinity?

11 A: Yes. Absolutely.

12 MR. THOMAS: I don't have any further questions for
13 this witness. Please answer any that Mr.
14 Dayhuff has for you.

15 MR. DAYHUFF: Your Honor, are you ready for me?

16 THE COURT: Yes.

17 DR. WENDELL - CROSS-EXAMINATION BY MR. DAYHUFF:

18 Q: Doctor, it's nice to see you again. How are
19 you doing?

20 A: Yes. Good. How are you?

21 Q: Good. So were you here for Ms. Eccleston's
22 testimony today?

23 A: I was.

24 Q: All right. Did you hear her testimony on all
25 those ED operational metrics?



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

1092

1 A: I did.

2 Q: Door to discharge, door to doctor, and LWOT?

3 A: Yes.

4 Q: At least I think I asked her about some of
5 those.

6 A: Yes.

7 Q: And maybe her counsel as well. Did she have
8 those statistics correct?

9 A: Yes.

10 Q: Okay. And I think you offered a few too. So
11 here's what I gathered.

12 A: Okay.

13 Q: And I looked at your PowerPoint too. That was
14 great. You guys are doing great in all of
15 those statistics, right?

16 A: I think we do a good job.

17 Q: Yeah. And you're proud of that, right?

18 A: Yes.

19 Q: And the reason you're doing great on that is
20 multi-factorial, I bet.

21 A: Yes.

22 Q: Tell me if these are factors as to why you're
23 doing great. You have good emergency medicine
24 physicians?

25 A: Yes.



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

1093

1 Q: In fact, you have low turnover in your
2 emergency medicine physicians, right?

3 A: Yes.

4 Q: You have good processes.

5 A: Yes.

6 Q: And maybe protocols is too strong. Do you have
7 good protocols too or do you like the
8 processes?

9 A: I like to use processes.

10 Q: All right. Because they're less determinative,
11 restrictive?

12 A: As a physician -- or as an emergency physician,
13 I don't -- you know, absolutes are never good.
14 So protocol is something you follow 100 percent
15 of the time in a process.

16 Q: More discretion.

17 A: Yes.

18 Q: All right. So you have good processes. I'm
19 sorry to ---

20 A: That's all right.

21 Q: Your facilities are well configured to provide
22 care.

23 A: I think they are well configured and we've had
24 to -- yes.

25 Q: And you've had to take steps to reconfigure



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

1094

1 them, right?

2 A: Correct.

3 Q: And that was great. That made them better ---

4 A: Yes.

5 Q: --- with respect to flow.

6 A: Yes.

7 Q: All right. Well equipped.

8 A: (No verbal response).

9 Q: Yes?

10 A: Yes.

11 Q: Okay. Last but not least, you have the
12 capacity to do a great job on those metrics.
13 You have enough rooms.

14 A: I -- yes. I think we have enough rooms and
15 we've got some coming online that are going to
16 help even more.

17 Q: Right. I mean, certainly you wouldn't opine
18 that, you know, I don't need enough rooms to do
19 a good job. I mean, that's a key part ---

20 A: It is a key part.

21 Q: --- of the equation.

22 A: Yes.

23 Q: But at the end it's multi-factoral and I get
24 that. And in fact, you guys have added lots of
25 ED capacity over the last five years, right?



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

1095

1 A: Yes. We've had expansions in Summerville for
2 the pediatric ED, as well as some, what we
3 would call, low-acuity spaces, as well as the
4 new area of Trident. Yes.

5 Q: Expansion and addition of spaces at Trident
6 Medical Center.

7 A: Yes.

8 Q: Expansion and addition of spaces at Summerville
9 Medical Center.

10 A: Yes.

11 Q: Added an FSED at Centre Pointe North Charleston
12 in 2012.

13 A: Correct. 2014.

14 Q: '14, sorry. And you plan to add more, James
15 Island and Summerville, right?

16 A: So Summerville -- yes, James Island has been
17 planned. I don't know the status of that. But
18 Summerville has certainly been approved.

19 Q: Fair enough. Now, because you have all those
20 -- that multi-factorial list ---

21 A: Uh-huh.

22 Q: --- that's a reason why you've got great ED
23 metrics, all of those put together, right,
24 fair?

25 A: Yeah.



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

1096

1 Q: All right. Do you know Dr. Greg Hall?

2 A: I do not.

3 Q: All right.

4 A: We may -- I should say we may have met before,
5 but ...

6 Q: Well, just by way of trying to move this along.

7 A: Yes.

8 Q: Dr. Hall testified on Monday.

9 A: Yes.

10 Q: It seems like a long time ago. And he
11 testified -- he's the director of the adult
12 main ED ---

13 A: Yes.

14 Q: --- at MUSC.

15 A: Yeah.

16 Q: Did you get to practice some there as a med
17 student?

18 A: So as a med student, I wouldn't call it
19 practice. I didn't have a license. But, yes,
20 I spent time there.

21 Q: Good distinction.

22 A: There you go.

23 Q: I've been hanging around lawyers too long. So
24 Dr. Hall testified that his ED is experiencing
25 -- I'm just going to go through this.



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

1097

1 A: Yes.

2 Q: High visit volume, high volume of psych
3 patients.

4 A: Yes.

5 Q: Boarding by patients waiting for appropriate
6 psych placements or inpatient beds.

7 A: Right.

8 Q: He has patients with complex conditions who
9 require complex, time consuming work-ups.

10 A: Yes.

11 Q: And, last but not least, he described his MUSC
12 ED as compartmentalized ---

13 A: Yes.

14 Q: --- in a way that hindered operations, okay?

15 A: Yes.

16 Q: That's what he said.

17 A: Yes.

18 Q: I don't expect you to vouch for that, because
19 you're not there.

20 A: Right.

21 Q: But he also said, and I think we saw in your
22 PowerPoint, those conditions in the ED caused
23 him to have a door-to-doctor time of 45
24 minutes, a door-to-discharge time of 220
25 minutes, and an LWOT of five percent. So first



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

1098

1 question is: I looked at your PowerPoint
2 today.

3 A: Yeah.

4 Q: What was the date of that PowerPoint? Do you
5 remember?

6 A: I think it was in 2017, maybe.

7 Q: So he was giving us 2019. It looks like things
8 have gotten worse.

9 A: At MUSC.

10 Q: Yes.

11 A: Okay.

12 Q: On those metrics.

13 A: Right.

14 Q: Right? If what I told you is accurate, they
15 have gotten worse, right?

16 A: I don't know why. I mean, if that's the
17 reasons he's saying they've gotten worse, then
18 I don't have any reason to say that's not it.

19 Q: Right. Well, again, I'm not asking you to
20 vouch for and conditions.

21 A: Right.

22 Q: But if we make the safe assumption that he's
23 telling us the truth about what's going on
24 there, that ED is experiencing capacity
25 constraints.



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

1099

1 A: Right.

2 Q: Right. And in fact, you have a little bit of
3 actual experience that you told me about in
4 your deposition with our capacity issues. You
5 have to call up MUSC ---

6 A: Yes.

7 Q: --- for transfers.

8 A: Yeah.

9 Q: And there have been times when they've told
10 you, look, we can't accommodate your transfer
11 right now because our main adult ED is full and
12 we have boarding problems, right?

13 A: Yes.

14 Q: You've experienced that. You also understand
15 that mental health holds are a particularly
16 difficult problem at MUSC.

17 A: Yes.

18 Q: And, again, we looked at your data a minute
19 ago. And if you were faced with the issues Dr.
20 Hall talked about ---

21 A: Yes.

22 Q: --- if you assume those were accurate ---

23 A: Correct.

24 Q: --- you would look at a lot of things to make
25 a fix, right? Process changes?



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

1100

1 A: Yes.

2 Q: Maybe staffing changes?

3 A: Yeah.

4 Q: Maybe work on the inpatient side and psych side

5 ---

6 A: Yes.

7 Q: --- to get more placements. But you'd also

8 look -- it would be reasonable to look at

9 capacity too.

10 A: Yes.

11 Q: Transfers. We talked a little about this with

12 Mr. Thomas. Patients come to your FEDs,

13 Trident's FEDs ---

14 A: Yes.

15 Q: --- in need of high-level care. And I thought

16 it was interesting. You will get trauma

17 patients that come there, right? And you can

18 treat them.

19 A: To Trident or to the freestanding?

20 Q: To the freestanding.

21 A: Yes.

22 Q: Right. And so that treatment, if it's a lower-

23 level trauma, could be some care. Well, it's

24 care, but could be some treatment.

25 A: Right.



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

1101

1 Q: If it's a higher-level trauma, what do you do?

2 A: For any higher-level trauma or high-level
3 patient we would transfer the patient.

4 Q: Stabilize I guess, right?

5 A: Yes.

6 Q: And then transfer.

7 A: Correct.

8 Q: And when we -- stabilizing is care, right?
9 You're providing care.

10 A: Yes.

11 Q: Emergency medicine care. And those transfers
12 from your FEDs in Moncks Corner and North
13 Charleston, you transfer to Trident Medical
14 Center.

15 A: So we have obviously arrangements and
16 agreements with -- I mean, we're part of
17 Trident. So, as you probably know, a
18 freestanding emergency department is just
19 what's considered a hospital outpatient
20 department. It is a part of the main hospital.
21 If a patient has care somewhere else, you know,
22 has had recent treatment somewhere else, then
23 we would transfer that patient to the other
24 hospital. And we actually have worked
25 collaboratively with Roper and MUSC with an



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

1102

1 electronic health exchange locally, so we're
2 able to access records and actually review
3 things collaboratively in that case too.

4 Q: And, yeah, so I guess you're distinguishing
5 there between if they come to the Moncks Corner
6 FED, it's not a transfer; they're already at
7 your hospital. Is that what you're saying?

8 A: Well, practically speaking you're still calling
9 someone up, getting acceptance, putting them on
10 an ambulance.

11 Q: Physically transferring.

12 A: Yes.

13 Q: Not changing hospital systems.

14 A: Correct.

15 Q: Okay. Got you. So you're able to safely
16 transfer -- stabilize and transfer folks with
17 trauma conditions, cardiac conditions, stroke
18 conditions, from your FEDs to the Trident
19 Medical Center, Roper, or MUSC?

20 A: So if a STEMI patient came into Moncks Corner
21 and needed a heart cath and their cardiologist
22 was at MUSC or Roper, I would 100 percent
23 recommend them to go to Trident, because that's
24 the closest facility and time is muscle. And
25 if they decided not to do that, I would respect



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

1103

1 that decision, but I would strongly disagree
2 with that decision because of the time. You
3 know, even if it's 20, 30, 40 more minutes.

4 Q: True.

5 A: If a patient is stable and been evaluated,
6 then, yes, you're able to make more of a
7 determination on where they go and factor in
8 patient preference as a reasonable -- you know,
9 as a factor that's very important.

10 Q: Understood. And if we assume that James
11 Island's going to come online, and we heard
12 some testimony about that, it would work that
13 way in James Island. If you had somebody with
14 a STEMI or cardiac condition, if they were
15 stable enough to make a choice ---

16 A: Uh-huh.

17 Q: --- you may send them to Trident Medical
18 Center, way up the road, right, for their
19 cardiac care or you may send them across the
20 James Island connector to Roper or MUSC.

21 A: Actually, I would say, and I told this to our
22 leaders, that I think if we had a hospital on
23 James Island or a freestanding emergency
24 department, while many patients, like any
25 freestanding, would be seen and treated and



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

1104

1 released, that more than likely most of our
2 patients, if they were admitted, would go to
3 Roper or MUSC because we would honor what would
4 likely be previous-care relationships.

5 Q: That's right.

6 A: Yeah.

7 Q: Because if you look at the data on James
8 Island, those folks are predominantly getting
9 their care from those two institutions.

10 A: Right. I would think so, yeah.

11 Q: Fair enough. MUSC provides high-quality ED
12 services, right?

13 A: No reason to ...

14 Q: Right. You talked a little about residency
15 programs. I just want to be clear that I
16 understand. So there's not a formal residency
17 program -- residence program -- residency
18 program at TMC or SMC in the specialty of
19 emergency medicine, is there?

20 A: Not currently. We are in planning stages for
21 having one.

22 Q: Great. Okay. So not now. So there aren't
23 residents training, getting taught currently in
24 your EDs by your emergency medicine providers?

25 A: Emergency medicine residents?



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

1105

1 Q: Correct.

2 A: No. There are family medicine and transitional
3 -- transitional year residents that rotate
4 through and students.

5 Q: I'm just focused on emergency medicine in this
6 case.

7 A: Yeah.

8 Q: I get that you have family practice. I suppose
9 I'll ask the emergency medicine physician this,
10 though I think a horse -- beating a dead horse
11 probably would come to mind. We don't have a
12 helipad or a CDU in the FED we proposed to
13 establish. That's not a problem, is it?

14 A: So a CDU -- observation is a status, it's not
15 a place. So you can do observation in any
16 room. So, you know, could turn any three, four
17 rooms into an observation unit. You don't have
18 to call it a CDU.

19 Q: So we wouldn't need a separate segregated
20 additional bank of CDU spaces in an FED from
21 your perspective? You could do observation in
22 a bed?

23 A: Correct. Observation is a status the patient
24 is in, not a place.

25 Q: Got it. What about the helipad?



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

1106

1 A: Generally speaking, urban transport, ambulances
2 can provide fairly quick transport. However,
3 you know, with traffic and other issues -- you
4 know, traveling from, let's just say for
5 example, a MUSC freestanding emergency
6 department in Summerville to downtown could be
7 problematic, flooding, traffic, come to mind.
8 So transfer -- the farther you're away from the
9 place you're transferring, obviously, the more
10 issues can come up.

11 Q: So it may be good to have a helicopter be able
12 to land in the parking lot, maybe designated
13 zone, for the rare occasions when that's
14 needed?

15 A: You know, I'm not -- again, a health planner.
16 But I think most emergency departments have
17 some sort of helicopter option or plan I would
18 think. But I don't know that 100 percent for
19 certain.

20 Q: The Trident Health FEDs in North Charleston and
21 the one proposed for Summerville, the one
22 proposed for James Island don't have helipads.

23 A: Again, most times in urban areas you don't need
24 helicopter transport, because ground transport
25 is just as fast.



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

1107

1 Q: If MUSC gets to establish its FED, your ED
2 physicians will not lose so much volume that
3 they're unable to practice at the standard of
4 care of emergency medicine, will they?

5 A: Right. So, I think the question at hand when
6 -- you know, with healthcare resources in
7 general and why we have a Certificate of Need
8 is because any additional resource, such as a
9 hospital or a freestanding emergency
10 department, again, has to have a minimal number
11 of staff and physicians and nurses to operate
12 it. And that is, you know, taken into account
13 more seriously than, you know, other businesses
14 or sort of other healthcare resources.

15 Q: I understand. So my specific question is, if
16 we get to establish this, will it cause your
17 emergency medicine providers in any of your
18 locations to cease providing high-quality
19 emergency medical care?

20 A: So my emergency physicians would provide high-
21 quality care whether, you know ---

22 Q: Regardless.

23 A: --- the patients they were seeing. But, again,
24 I think the reason there is a Certificate of
25 Need process is because ...



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

1108

1 Q: I understand.

2 A: Right.

3 Q: We consider resources. I'm just asking if it's
4 going to have an effect on the care you guys
5 provide if we establish this. And I think the
6 answer is no; we provide good care now and
7 we'll provide good care after.

8 A: Right. Yes.

9 Q: If we get to establish an FED. The FEDs that
10 you have, let's just talk about Centre Pointe,
11 I suppose, does it see pediatric patients?

12 A: Yes. Emergency departments see anyone who
13 walks through the door.

14 Q: Right. So there's no reason to believe that,
15 if we establish the FED in Summerville MUSC,
16 that we would (sic) see some pediatric
17 patients?

18 A: There's no reason to believe that you would
19 see?

20 Q: Would not see.

21 A: Yes, you would see ---

22 Q: They will walk through the door.

23 A: Correct. Often carried.

24 Q: I'll bet. The nursing shortage that we've
25 heard a lot about.



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

1109

1 A: Yes.

2 Q: Despite the nursing shortage, Trident Health
3 has added capacity at Centre Pointe recently?

4 A: Uh-huh (affirmative response).

5 Q: They're adding more at Summerville and they are
6 adding more at James Island.

7 A: Yes.

8 Q: Despite the shortage.

9 A: Yes.

10 Q: Nothing further. Thank you, Doctor.

11 A: Thank you.

12 MR. THOMAS: A couple of wrap-ups, Your Honor.

13 THE COURT: Let's make sure -- Ms. Biggers?

14 MS. BIGGERS: No questions, Your Honor. Thank you.

15 DR. WENDELL - RE-DIRECT EXAMINATION BY MR. THOMAS:

16 Q: Just a couple, because I ---

17 A: Okay.

18 Q: --- need to get you out of here and get you
19 home, especially since you've got to wake up at
20 5:00 a.m. -- before 5:00 a.m. You got to be
21 there at 5:00. Mr. Dayhuff asked you about,
22 you know, compartmentalized downtown at MUSC.

23 A: Right.

24 Q: When did you do your medical school training at
25 MUSC?



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

1110

1 A: So I was there from 2001 to 2005.

2 Q: Was it compartmentalized back then too, the ED?

3 A: Yes. I mean, I think the pediatric and adult
4 were separated. And it was a fairly large
5 footprint from what I can remember.

6 Q: To your knowledge, has MUSC done anything to
7 address the reconfiguration or renovation of
8 the facility since you've been in medical
9 school?

10 A: I don't have firsthand knowledge of that. I've
11 been there once as a family member visiting and
12 I think there's been some changes medically,
13 but I don't know of any substantial changes
14 that have been done there.

15 Q: You haven't heard of any through -- in the
16 community?

17 A: No.

18 Q: Okay. Dr. Hall -- Mr. Dayhuff mentioned many
19 things that Dr. Hall testified about.

20 A: Correct.

21 Q: Various issues confronted MUSC. But Dr. Hall
22 also said he felt that the ED was considered
23 somewhat of a redheaded stepchild at MUSC. Do
24 you feel like the EDs at Trident Health are
25 considered by the administration as a redheaded



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

1111

1 stepchild?

2 A: No. I feel we are well supported and
3 appreciated as the front door of the hospital
4 and we, you know, are well respected by our
5 colleagues. And, you know, I wish -- I hope
6 every emergency department is like that,
7 because we see patients on weekends and nights
8 and holidays when, you know, no one else is
9 there. And it's a tough job. And, you know,
10 I hope every emergency physician has the
11 support and respect that I feel.

12 Q: And Trident Health has spent millions and
13 millions on their EDs the last five years,
14 haven't they?

15 A: Yes.

16 **MR. THOMAS:** No further questions. Your Honor, I'd
17 ask that this witness be released.

18 **MR. DAYHUFF:** No objection.

19 **THE COURT:** Okay. Thank you for coming, Dr.
20 Wendell.

21 **DR. WENDELL:** Thank you.

22 **THE COURT:** You're released.

23 **MR. THOMAS:** That's our final witness of the day,
24 Your Honor. So I think we're doing Mr.
25 Sullivan tomorrow, right?



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

1112

1 **MR. DAYHUFF:** Right. This -- we plan to do only Mr.
2 Sullivan tomorrow, so I hesitate to say it may
3 be a short day, but ---

4 **THE COURT:** I don't think it will be a short day.

5 **MR. DAYHUFF:** Yeah. I don't want to over promise
6 and not deliver, so. And then we follow that
7 up with DHEC on Monday; is that correct?

8 **MS. BIGGERS:** That's correct.

9 **MR. DAYHUFF:** Followed by MUSC's case, Dr. Cawley,
10 first thing Tuesday morning, followed by Dr.
11 Louder.

12 **THE COURT:** Okay.

13 **MR. DAYHUFF:** And then Mr. Levitt on Wednesday.

14 **THE COURT:** Okay. And those are your witnesses.
15 Those are your witnesses.

16 **MR. DAYHUFF:** Yes. So Dr. Cawley, Dr. Louder, Mr.
17 Levitt.

18 **THE COURT:** Is the last witness that you'll be
19 calling?

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

21 **THE COURT:** Okay. Then, Ms. Hollingsworth, you'll
22 be ---

23 **MS. HOLLINGSWORTH:** And we would only, I'm certain,
24 just have Ms. Platt for whatever reply we would
25 need. She would be the only witness we would



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

1113

1 offer.

2 **MR. THOMAS:** Same with Mr. Sullivan. I believe he'd
3 be the only rebuttal witness.

4 **THE COURT:** The only -- okay. Very good. Okay.
5 Thank you all and we'll see you in the morning.

6 **(Thursday, July 25, 2019 administrative hearing ended**
7 **at 4:15 p.m. and reconvened on Friday, July 26, 2019**
8 **at 9:10 a.m.)**

9 **DAY FIVE - JULY 26, 2019**

10 **MR. SUMMER:** Morning, Your Honor.

11 **THE COURT:** Okay, we're ready to get started with
12 this very short day?

13 **MR. SUMMER:** My parts going to be short. The rest
14 is up to these guys.

15 **THE COURT:** Oh, Mr. Dayhuff promised.

16 **MR. DAYHUFF:** Remember, I was worried about over
17 promising and under delivering.

18 **THE COURT:** Okay. Mr. Summer, call your next
19 witness.

20 **MR. SUMMER:** At this point Trident would like to
21 call its next witness, Mr. Daniel J. Sullivan.

22 **THE COURT:** Mr. Sullivan, if you'll raise your right
23 hand, face the court reporter, she'll swear you
24 in.

25 **DANIEL SULLIVAN,** having been duly sworn, testifies as



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

1114

1 follows:

2 COURT REPORTER: Please state and spell your first
3 and last name.

4 MR. SULLIVAN: Daniel Sullivan, D-A-N-I-E-L S-U-L-L-
5 I-V-A-N.

6 COURT REPORTER: Thank you.

7 MR. SULLIVAN - DIRECT EXAMINATION BY MR. SUMMER:

8 Q: Mr. Sullivan, tell The Court a little bit about
9 your background. Where did you grow up,
10 where'd you go to school?

11 A: I grew up in Charleston, South Carolina and I
12 went to high school -- Bishop England High
13 School. And then I fled the state to go to
14 college and went to Duke University in Durham,
15 North Carolina.

16 Q: Okay. And what was your undergraduate degree
17 in?

18 A: I got an undergraduate degree in economics and
19 public policy studies.

20 Q: Okay.

21 A: And then subsequently went back to graduate
22 school at Duke and got a master's in health
23 administration.

24 Q: Okay. I'm going to start referring to Exhibit
25 96, assumes all counsel has --



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

1115

1 **MR. SUMMER:** This would be Trident's Exhibit 96,
2 Your Honor, it's his CV.

3 Q: Tell us a little bit about your work
4 experience.

5 A: Sure. Immediately after undergraduate school I
6 went to work at Duke University Medical Center
7 in a variety of administrative roles at Duke.
8 Towards the end I was more involved in sort of
9 planning and internal, you know, relationships
10 between the various pieces of the medical
11 center. And then when I graduated from the MHA
12 program in 1980, I went to work for a company
13 called Amherst Associates, Inc., which was a
14 national healthcare management consulting firm.
15 I was in the Atlanta office of Amherst and was
16 with Amherst for approximately eight years.
17 And at Amherst we were involved in doing a
18 variety of planning and financial types of
19 engagements, exclusively for healthcare
20 clients. On the planning side, we did
21 strategic planning. We did market analysis for
22 various types of services. This was fairly
23 early on in the Certificate of Need process,
24 genesis. And we got involved in writing
25 Certificate of Need applications. And then on



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

1116

1 the financial side, we were doing financial
2 feasibility studies, both for public
3 consumption for use and tax exempt bond issue
4 perspective offerings and for internal uses by
5 our healthcare clients. And over the course of
6 doing that work, I did get involved in
7 providing expert testimony, primarily in
8 administrative proceedings like this, but
9 occasionally in state and federal proceedings
10 as well. Amherst was acquired in 1988 by the
11 firm of Ernst & Whinney, which became the firm
12 of Ernst & Young. And I was with them for
13 about two years and then decided to set up my
14 own company. And in 1990 I had started
15 Sullivan Consulting Group and that is where I
16 am today. And Sullivan Consulting Group does
17 largely the same types of activities in terms
18 of healthcare planning and healthcare finance
19 that I did, you know, throughout my career with
20 Amherst and Ernst & Young.

21 Q: Okay. Tell The Court a little bit about your
22 experience and Certificate of Need cases?

23 A: Sure. As I said, we -- the Certificate of Need
24 was a relatively novel thing at the time I got
25 started. And we were involved in a number of



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

1117

1 different states in a number of different types
2 of projects. But over the course of my career,
3 I think I've been involved in just about any
4 kind of service that Certificate of Need
5 regulates, whether it's hospitals, new
6 hospitals, additions to hospitals, nursing
7 homes, home health agencies, hospice agencies,
8 a variety of different kinds of healthcare
9 services. Freestanding emergency services are
10 a relatively new idea in the healthcare
11 industry, probably over the last 20 years.
12 Really it's been -- it's been the growth in
13 that particular industry. And I've been
14 involved in a number of applications,
15 specifically for freestanding emergency
16 departments.

17 **MR. SUMMER:** Your Honor, at this time, I'd like to
18 move to admit Petitioner's Exhibit 96 into
19 evidence.

20 **MR. WESTBROOK:** No objection.

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

22 (Petitioner TMC's Exhibit Number 96 was admitted into
23 the record at this time.)

24 **MOTION TO QUALIFY AS EXPERT:**

25 **MR. SUMMER:** And also, Your Honor, I would like to



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

1118

1 qualify Mr. Sullivan as an expert in the areas
2 of health planning, healthcare finance in the
3 South Carolina Certificate of Need program.

4 **MR. WESTBROOK:** No objection.

5 **THE COURT:** He's recognized as an expert in those
6 areas.

7 **MR. SUMMER:** Thank you, Your Honor.

8 Q: What I'd like to do is kind of help The Court
9 understand how you approach a case like this --
10 -

11 A: Sure.

12 Q: --- and the work that you've done in this case.
13 So if you would, just start back with the
14 application process and kind of work The Court
15 through what you have done during the life of
16 this case.

17 A: Sure. And my involvement in this case was a
18 little different because at the time this all
19 started there were two applications that were
20 under review by DHEC. Summerville Medical
21 Center had an application for a freestanding
22 emergency department, as well as Medical
23 University. And so I was involved in the
24 preparation of the CON application for
25 Summerville Medical Center. At the same time



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

1119

1 I was reviewing the application by the Medical
2 University, because I wasn't sure how the
3 Department was going to look at these two
4 applications together. We assumed that they
5 would be viewed as competing applications and
6 so we were evaluating the relative merits of
7 the two projects. I mean, ultimately I think
8 we've heard that DHEC decided not to review
9 these competitively and to review them as
10 independent projects. And so during the course
11 of the initial review process, I had the
12 opportunity to review all of the information
13 submitted by the Medical University, including
14 their application, additional information. I
15 attended the project review meeting, which took
16 place I believe in September of 2017. I
17 offered comments at that meeting, both about
18 the Summerville project and about the Medical
19 University's freestanding ED project. There
20 was -- I prepared a letter subsequent to that
21 project review meeting, which outlined some of
22 the issues that were raised during that meeting
23 and expressed some concerns about the Medical
24 University's project. And then I reviewed the
25 Department's decision, which I believe came out



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

1120

1 later in September, essentially approving both
2 projects. After the -- after the initial
3 departmental decision, there was sort of a
4 hiatus, I guess if you will, and there was some
5 -- I guess some legal wrangling going on about
6 a settlement and so forth. And ultimately I
7 was sort of re-engaged to be involved in this
8 proceeding where Trident Health -- Summerville
9 and Trident Medical Center would be opposing
10 the approval of the application for the Medical
11 University. And during the course of that
12 preparation, I reviewed discovery materials
13 from all of the parties in this case; Roper,
14 Medical University and the Trident facilities.
15 I've reviewed deposition testimony of a number
16 of witnesses, I believe all of the witnesses
17 who are going to testify on behalf of the
18 Medical University here. I've sat through the
19 deposition of Mr. Levitt, who is the expert for
20 Medical University. I listened by phone to
21 most of Ms. Platt's deposition. And then later
22 on I was able to access documents that were
23 produced by HFPP, I think there's been some
24 discussion about that, the Health Facilities
25 Planning Partners, who assisted Medical



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

1121

1 University in the preparation of the
2 application, and by Intuitive Health, which I
3 think we've heard a lot already, who was
4 involved in advising the Medical University
5 subsequent to the initial Departmental decision
6 on the application. And in addition, I
7 undertook some analysis of data that was
8 provided, for example, by the Medical
9 University in discovery. They provided a
10 couple of relatively large databases of
11 information about their emergency patients. I
12 also gathered information from external sources
13 like the National Center for Health Statistics,
14 from the Census Bureau, from an organization
15 that's called -- it's called many different
16 things, but basically it's Claritas, which is
17 a national demographic company that markets
18 information on population and income and so
19 forth. And really looked at a whole range of
20 different things, trying to get a clear
21 understanding of what the Medical University
22 was actually attempting to do with their
23 project. And that did change a couple of times
24 during the discovery process, but -- and then
25 also to try to provide some analysis that would



1 frame my opinions about whether or not there
2 truly was a need for the project the Medical
3 University has put forth and whether it was in
4 compliance with the other relevant review
5 criteria in the State Health Plan.

6 Q: Did you also review and rely upon the 30(b)(6)
7 deposition transcript from Intuitive Health?

8 A: I did. I'm sorry, I should have mentioned
9 that. That was probably the recent thing that
10 I reviewed, Mr. Thomas Herrmann, who was -- I
11 believe he's the president of Intuitive Health.
12 And I reviewed his deposition and all of the
13 accompanying exhibits to that deposition.

14 Q: Okay. And did -- did those documents that were
15 attached as exhibits one through 71 to the
16 Intuitive deposition provide you with new
17 information that you had not seen before?

18 A: It did. In fact, you know, the documents that
19 were a part of that Intuitive Health discovery
20 kind of wove a tale, if you will, that sort of
21 described the process that Intuitive Health
22 went through with the Medical University. And
23 it explained some of the underlying reasons why
24 the Medical University changed its project from
25 what was in the application originally, to what



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

1123

1 we have before us today.

2 Q: All right. Well, let's -- let's do this.
3 Let's start, if you will, by discussing the
4 Certificate of Need program and what you do,
5 what it means. What's the purpose of the
6 Certificate of Need Act in the state of South
7 Carolina?

8 A: Fortunately, I have it right in front of me, so
9 I can -- I can talk about it. It really has
10 four different purposes. It's to promote cost
11 containment, to prevent unnecessary duplication
12 of healthcare facilities and services, guide
13 the establishment of services which meet the
14 public needs, ensure high-quality services are
15 provided. So those are four components and
16 those are typically of most states' Certificate
17 of Need laws.

18 Q: Is the healthcare industry in South Carolina a
19 free market industry or a regulated industry?

20 A: It is a regulated industry for many types of
21 services. There are certain things that are
22 outside of the Certificate of Need program.
23 But by in large, most of the significant things
24 that go in the healthcare industry are covered
25 by the Certificate of Need program.



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

1124

1 Q: Is most of that bricks and mortar?

2 A: The bricks and mortar is the thing most
3 commonly regulated, but there are certain
4 services, for example, home health services and
5 things like that, that are also regulated.

6 Q: Okay. What are the benefits of having a
7 Certificate of Need program?

8 A: Well, the healthcare industry really doesn't
9 work like the normal economy. You know, in the
10 normal economy you have buyers and sellers and
11 prices are negotiated, you know, on an open
12 market between buyers and sellers. And the
13 healthcare industry doesn't work that way.

14 You have -- you have some aspects of the
15 industry that the payors, if you will -- which
16 is sort of a novel concept from an economic
17 standpoint. Rather than having the consumer
18 directly pay for services, in many cases it's
19 a third party who's paying for the services;
20 Medicare, Medicaid, a health insurance company.

21 And those companies, in the case of Medicare
22 and Medicaid, they dictate what they're going
23 to pay for various types of services, so there
24 is no negotiation between the buyer and the
25 seller. The federal government says these are



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

1125

1 the rates we're going to pay, take it or leave
2 it. For private insurance companies, they have
3 -- they negotiate. They do negotiate rates
4 with healthcare providers to a certain extent,
5 but also they have a fair amount of market
6 power and so they can dictate to a larger
7 extent how far they're going to go in terms of
8 what they're going to pay. And so the consumer
9 is somewhat insulated from what the price of
10 the services are. And as a result, people
11 don't consume healthcare services in the same
12 way as they do other types of services. If
13 you've got great insurance, you don't really
14 think much about going to the hospital and
15 receiving services, because if you've got a
16 Medicare plan and you've got a Medicare
17 supplement, you know, 90, 95 percent of the
18 cost may be picked up by the -- by your
19 insurance programs. And so pretty early on the
20 federal government realized, if we're going to
21 be a major payor of these services, we need to
22 make sure that these services are being
23 rendered in a cost-effective way so that people
24 aren't taking advantage of the federal programs
25 in particular. And that's how the Certificate



1 of Need got started.

2 And so they said, you're going to -- we're
3 going to set up certain principles that are
4 going to govern whether or not certain services
5 are needed and we're going to allow the states
6 to develop their own programs and they can
7 develop their own guidelines and standards and
8 so forth. But there was some overarching
9 principles that were laid out in 1978 for the
10 development of CON programs.

11 And I don't want to go too deep into this,
12 but basically the purpose of the Certificate of
13 Need program is to ensure that the services
14 that are being provided are appropriate for the
15 needs of the population. And that, in some
16 cases where services are very complex, that you
17 only provide the services in sufficient number
18 that the services can be provided in a high-
19 quality way. For example, open-heart surgery.
20 It wouldn't be good if every hospital did open-
21 heart surgery because there's only a finite
22 number of open-heart surgery patients out
23 there. And there's studies that say that the
24 more open-heart surgery procedures you do, the
25 better outcomes you have. And so the



1 Certificate of Need program tries to balance
2 access to those services with ensuring quality
3 and the cost effectiveness of service.

4 Another problem with having too many of
5 something is that, you know, to build a
6 facility, for example, a hospital, a nursing
7 home, a freestanding emergency department, you
8 have a lot of fixed cost associated with
9 building those facilities. You know, you've
10 got the cost of the building. As someone
11 testified yesterday, you've got a certain
12 amount of staff that has to be there whether
13 you have one patient or a 100 patients. And so
14 it's much less efficient if you have too many
15 facilities in a small geographic area that are
16 competing for the same patient pool, because
17 those fixed costs get spread over a fewer
18 number of patients. And so it's less efficient
19 to serve patients in that manner.

20 And so with the CON folks and DHEC and
21 they have a tough job. I mean, they have to
22 balance improving access to care with ensuring
23 that the services are going to be provided in
24 an efficient manner, which is why the State
25 Health Plan -- I'm sorry, the CON statute talks



1 about preventing unnecessary duplication.
2 Unnecessary duplication means we're approving
3 too many services to serve the population.

4 Q: You've been doing Certificate of Need now since
5 the 1980s?

6 A: Yes.

7 Q: Is there anything unusual about the evolution
8 of this case in your career?

9 A: It is unusual. Typically when you're going to
10 file a CON, you do, you know, a fair amount of
11 planning before you submit your Certificate of
12 Need application. And you try to get all your
13 sort of ideas lined up in advance in terms of,
14 you know, where you want to put the project,
15 how you want to deliver the services, you know,
16 how we're going structure this, how it's going
17 to fit best into our organization, how it's
18 going to best meet the community needs. You
19 try to do all that on the front end.

20 Q: Were you here for Ms. Valentine's testimony
21 yesterday?

22 A: I was.

23 Q: And did you hear the line of questioning
24 regarding a strategic plan, a request for
25 capitol, for approval, that deliberative



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

1129

1 process, that internal process?

2 A: Yes.

3 Q: Okay. Is that what you're talking about?

4 A: Yeah. And with many of my clients, they follow
5 a similar path. You know, it's -- you know, it
6 starts with a idea and then goes through
7 preliminary planning and then you begin to
8 gather information about cost and site
9 acquisition and so forth. And then your file
10 your CON and you've got a pretty good idea
11 about what you want to do.

12 In this case, it seems that the
13 application was filed somewhat prematurely,
14 that the Medical University had not fully
15 decided what it wanted to do with the project.
16 And I say that because it applied for one thing
17 -- and it's already been talked about a lot,
18 but they applied to build a freestanding ED in
19 the Nexton development in conjunction with a
20 medical complex that was being developed by
21 Palmetto Primary Care and they expressed all
22 the reasons why this was a, you know, ideal
23 site and so forth. But within a couple of
24 months of the CON approval being granted by
25 DHEC, they went down a different path.



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

1130

1 They engaged Intuitive Health and they
2 began to look at a different model of care
3 delivery. And Intuitive Health, I think, based
4 on what I've reviewed in Dr. Cawley's
5 deposition and in Mr. Herrmann, the Intuitive
6 Health president's, deposition had sort of
7 taken them to -- like the location you have is
8 probably not ideal if your goal is to capture
9 as many patients as you want and to capture
10 patients who are of the right income
11 characteristics as you want. And we don't
12 think that the model that you have, in terms of
13 just having emergency services, we think you
14 need to add urgent care services to it. And we
15 think your facility is too large and you've got
16 some expensive things in there, like a CDU and
17 a helipad. We think you ought scrap those
18 ideas.

19 And so ultimately, the Medical
20 University, in my view, abandoned their
21 original project and said, let's do something
22 different. Let's build this hybrid model that
23 has both emergency services and urgent care
24 services in it at a new location down where the
25 old Applebee's was on the other side of the --



1 of I-26.

2 Q: Is that the hybrid model that's described by
3 Dr. Cawley in his sworn affidavit to The Court
4 in February of this year?

5 A: It is.

6 Q: Okay.

7 A: And so and then at some point during the
8 process, I believe that there was some
9 discussion between Medical University -- and
10 this is just inferred from some of the
11 depositions and I guess we'll hear more about
12 it when Dr. Cawley testifies next week, that
13 they were not comfortable with having urgent
14 care services co-located with emergency
15 services in the same facility. And so we
16 received an email relatively recently, I think
17 it was in June of this year, that Dr. Cawley
18 says, well, we're not doing the hybrid model.
19 We're going back to just doing emergency
20 services, but we're going to have something
21 called fast track in there. And so the parts
22 were changing.

23 And not only that, you know, from the
24 standpoint of what the facility was, but how
25 the facility was going to be structured was



1 changing. The application was that the Medical
2 University Hospital Authority was going to
3 develop this facility and was going to finance
4 this facility in conjunction with a group
5 that's called, Equity, LLC. And they were
6 going to provide the funding for the
7 construction of the building and the site
8 preparation. That went by the boards when they
9 decided to go to a new site.

10 And so they then decided that they were
11 going -- that a -- not a subsidiary, but a
12 related corporation to the Medical University,
13 Strategic Ventures, was going to ground lease
14 the land where the old Applebee's was and then
15 they were going to construct a new facility on
16 that site. The source of financing is still
17 unclear to me today as to who is going to fund
18 the construction of that site.

19 But the bottom line is that what was put
20 in the CON application is a much different
21 project than what is before us today in this
22 proceeding. And based on all the changes that
23 were made, I mean, it's clear to me as a health
24 planner that the Medical University wasn't
25 fully certain at the time they filed the



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

1133

1 application that they wanted to proceed with
2 the project as it was set forth in the
3 application.

4 Q: Okay. I want to hand you what's been marked as
5 Trident's Exhibit Number 76. See if that
6 refreshes your recollection regarding the
7 timing of the affidavit -- excuse me, of the
8 email from Dr. Cawley, yet again changing the
9 nature of the project. Have you seen that
10 before?

11 A: I have. I'm sorry, it was actually July the
12 2nd that that email came out.

13 Q: That's this month?

14 A: That's this month, yes, sir.

15 Q: So do you have an opinion regarding all these
16 changes that you've gone through regarding this
17 continually-evolving project?

18 A: I do. I mean, the bottom line is, I think that
19 the changes that have been made are so
20 substantial that they really constitute a
21 different project. And I think that DHEC
22 really needs to review this again. I mean,
23 typically what happens -- but I'm not a lawyer.
24 I'm not trying to give a legal opinion, just
25 from a health planning standpoint. When you



1 make changes of large magnitude, you would
2 generally withdraw your application and re-file
3 it and have DHEC review the changed project.
4 But in this case, I mean, we're proceeding
5 along with this project, but I don't believe
6 it's the same project that DHEC evaluated.

7 Q: You've reviewed the DHEC record, which was
8 Joint Exhibit Number 1. And you've -- I assume
9 you have either heard or read DHEC's
10 deposition, Ms. Maggie Murdock; is that
11 correct?

12 A: I did.

13 Q: Okay. Was there any time during the evolution
14 of this case that these changes were submitted
15 to the Department for an official review and
16 comment?

17 A: Not to my knowledge. Ms. Murdock indicated
18 that she had had at least one meeting with the
19 Medical University personnel where they sort of
20 posed potential changes to the project, but
21 there was nothing submitted formally in writing
22 to my knowledge. I certainly didn't see it in
23 the discovery materials. And there was no
24 specific ruling by DHEC that the changes that
25 were being proposed were acceptable or



1 constituted a substantial change.

2 Q: Sir, have you found any decision by DHEC
3 regarding these changes that this Court could
4 formally review?

5 A: I have not.

6 Q: Let's get down to the health planning criteria
7 as well as the State Health Plan. Explain to
8 The Court what DHEC's job is to review an
9 application. What regulations apply? What is
10 the plan? And how is it relevant?

11 A: Sure.

12 Q: Explain that process.

13 A: Sure. Ms. Platt went into great detail, so I
14 won't go all the way through all that again.
15 But essentially, the Department has an
16 application form that's been adopted as a
17 regulation. Applicant's have to fill that out.
18 And then the Department has to review that
19 application. And the application has to first
20 be consistent with the South Carolina Health
21 Plan, it must be consistent with the Health
22 Plan. And then it should be consistent with
23 the other review criteria. And DHEC will
24 identify what it views as the most important
25 criteria in the review of the project. And



1 there's usually a letter that's sent out at the
2 time the application is accepted for review
3 that list those criteria.

4 Q: All right. Let's talk about that letter.
5 We'll start first with DHEC Joint Exhibit page
6 545. All right. Do you have the joint record
7 in front of you by any chance?

8 A: I'm sure I do somewhere.

9 Q: If you'll turn to page 545.

10 A: I am there.

11 Q: Okay. Is this the letter that you're referring
12 to about these ordered criteria?

13 A: It is.

14 Q: Okay. And would you explain to The Court just
15 briefly what the effect of that is during the
16 review process?

17 A: These -- the listing of these criterion, based
18 on testimony I've heard from DHEC witnesses
19 many times in the past, is to say what DHEC
20 considers to be the most important
21 considerations in the review of the
22 application. Not that the other criteria
23 aren't looked at and -- but what it does is it
24 says that in this case community need
25 documentation is the number one concern of the



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

1137

1 Agency and that would be given the highest
2 weight. And that distribution, medically
3 underserved groups, and financial feasibility
4 would be sort of the secondary criteria of that
5 would be reviewed.

6 Q: Okay. I don't -- we don't need to jump back
7 and forth on this, but I did want to -- it just
8 occurs to me that's it's probably a good
9 question to ask you at this stage of the game.

10 **MR. SUMMER:** I beg The Courts indulgence, because
11 pagination changes constantly from State Health
12 Plan to State Health Plan.

13 Q: If you'll remember in the State Health Plan --
14 this project began under the 2015 State Health
15 Plan, right?

16 A: It did. Been testimony there were two days
17 left before the new plan took effect.

18 Q: Okay. And right now you're talking about these
19 ordered criteria. And those criteria appear in
20 Regulation 61-15; is that right?

21 A: That's correct.

22 Q: Okay. But the State Health Plan also mentions
23 relative importance for certain criteria; do
24 they not?

25 A: They do.



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

1138

1 Q: Okay. And that is on Roman numeral page --
2 it's Roman numeral XI dash what?

3 A: XI-5.

4 Q: And that's for freestanding emergency rooms,
5 right?

6 A: It is.

7 Q: And I'm just curious as to why DHEC didn't
8 follow the State Health Plan and consider
9 resources. Do you understand why they dropped
10 that?

11 A: I do not. And I know that -- I believe Ms.
12 Murdock said in her deposition that the
13 Department feels that they have the right to
14 deviate from the criteria that are identified
15 in the State Health Plan. But it -- you know,
16 just from a health planning standpoint, it
17 would seem that resource availability would be
18 an important consideration in this particular
19 circumstance.

20 Q: Is nursing staff a resource for these
21 facilities?

22 A: Sure. Nursing staff and other sort of highly-
23 trained clinical personnel.

24 Q: And have you been present for the testimony
25 regarding the nursing shortage in South



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

1139

1 Carolina?

2 A: I have. Both from Roper and from Trident
3 witnesses.

4 Q: So why would the Department deviate from the
5 State Health Plan and drop resources from their
6 analysis?

7 A: I'm not certain. It would seem to be --
8 particularly given the fact that we have such
9 a concentration of providers offering emergency
10 services, either existing or approved, in the
11 area immediately surrounding the proposed
12 Medical University site and the fact that Roper
13 Berkeley is a new hospital that's going to be
14 opening in the next couple of months and is
15 going to obviously draw a lot of resources out
16 of that market, it seemed to me that would be
17 a relevant consideration.

18 Q: Okay. And so in this letter where they're
19 ordering a criteria of this project, they've
20 added one that's not in the State Health Plan.
21 It certainly appears in the regulations, I
22 understand that. But they've added medically
23 underserved?

24 A: Well, no. I think medically underserved was
25 also in -- was it -- I'm sorry, you took the



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

1140

1 State Health Plan away from me. Yeah, that is
2 -- that was added, I'm sorry.

3 Q: Okay. We'll get to this notion of whether or
4 not there are any medically underserved issues
5 in downtown Summerville later. But I just
6 wanted to point out to The Court the deviation
7 from the State Health Plan here. All right.
8 Then the next letter, this of any import, is
9 what?

10 A: Well, it would their decision letter.

11 **MR. SUMMER:** Okay. That's going to appear in the
12 DHEC record I believe at 551, just so The Court
13 understands where that's located.

14 Q: Is that the letter you're referring to?

15 A: It is.

16 Q: Okay. And does -- how does the ordered
17 criteria -- does it or does it not tick and tie
18 with the grounds set forth in the decision
19 letter?

20 A: The ordered criteria from the State Health
21 Plan, it -- you know, they still did not
22 consider the criteria as set forth in the State
23 Health Plan. They dropped resource
24 availability. They did add the medically
25 underserved groups. And one other criterion



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

1141

1 that they did not address in here, even though
2 it's in the State Health Plan, and that is
3 adverse effects on facilities.

4 Q: Okay. And if you don't mind just reading the
5 language for adverse effects, that again
6 appears in the State Health Plan where?

7 A: On page XI-5.

8 Q: Roman numeral XI-5. And what is the adverse
9 impact?

10 A: Well, it says the benefits of improved
11 accessibility will be equally weighed with the
12 adverse effects of duplication in evaluating
13 Certificate of Need applications for this
14 service.

15 Q: Okay. And can you find anywhere in the DHEC
16 record where that was done?

17 A: No.

18 Q: Okay. All right. So let's talk about each of
19 these criteria. We'll go back to your
20 PowerPoint now. Well, let's talk about no
21 community need from MUHA's project, is that
22 your conclusion?

23 A: It is.

24 Q: Okay. And explain that, why that is so to The
25 Court?



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

1142

1 A: Yeah, I mean, it's hard -- it would be hard to
2 envision a part of the state of South Carolina
3 where there would be less need for a
4 freestanding emergency department than where
5 the Medical University is proposing to put
6 theirs. And I don't want to repeat all of the
7 testimony that Ms. Platt went through, but
8 essentially you have five freestanding EDs,
9 either existing or approved, Summerville
10 freestanding -- Summerville Medical Center
11 freestanding ED being the one that's approved,
12 located within about -- I guess I would say
13 about a 15-mile radius around the Medical
14 University site. There are two existing
15 hospitals that are reasonable proximity to the
16 Medical University site. You have Summerville
17 Medical Center that's about seven miles away
18 and Trident's about six miles away from the
19 proposed location. And we know that Berkeley
20 Hospital is less than four miles, the new Roper
21 Berkeley Hospital that would be open on -- I
22 think somebody testified October 4th of this
23 year, will be less than four miles away.
24 That's a full-service hospital with a full-
25 service emergency department. And so you have



1 an abundance of access to emergency services
2 for residents who live in this area that's
3 around the Medical University site.

4 And so, you know, just from a pure health
5 planning standpoint, you know, one of the first
6 things you do when you're getting ready to
7 develop a Certificate of Need application is
8 you map where the existing facilities are. You
9 try to look at whether or not these facilities
10 -- there's a, if you will, a hole in the
11 network of service delivery in any given
12 market. You know, is this an area where
13 patients really don't have good access, you
14 know, because of roads or because of geographic
15 barriers or just driving distance, it's so far
16 to the next provider? So in this case it
17 doesn't appear that the Medical University gave
18 any consideration to the other providers in the
19 market. In fact, their application did not
20 address any of the existing providers in the
21 market. Their maps show the Medical University
22 and the Medical University's proposed site.
23 Ignores all the hospitals and freestanding EDs
24 that are surrounding that particular site.

25 So as a starting point, this is a crowded



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

1144

1 area, if you will, for providers of emergency
2 services generally and even for freestanding
3 emergency services. I don't know of any other
4 place in the state of South Carolina where you
5 would have five freestanding emergency
6 departments located within about a 15-mile
7 radius of a particular location.

8 Q: Okay. Who filed for this service first? Was it
9 Trident or was it MUSC?

10 A: Trident. I think Trident filed approximately
11 two months before MUSC.

12 Q: What's the concept of batching for competition
13 purposes?

14 A: That basically -- and I may not get this
15 exactly right. But if an application is filed,
16 once it's accepted for review and published in
17 the State Register, then I believe that a
18 competing project has to be filed within, I
19 want to say 30 days of that publication of
20 notice.

21 And so, you know, once the Summerville
22 application was filed and the Department began
23 to review it, then in order for somebody else
24 to be batched with that and be reviewed
25 competitively with that particular project,



1 they would have to get in within the time frame
2 set forth in the regulations.

3 Q: Okay. And were you present for Mr. Levitt's
4 deposition?

5 A: I was.

6 Q: And did he explain to you that was a concern at
7 the time for MUSC?

8 A: It was. That they were -- they were under the
9 impression that the two projects might be
10 reviewed as competing.

11 Q: Okay. And so if they are reviewed as
12 competing, what does -- explain to The Court
13 what that means?

14 A: Competing applications, that means that they're
15 viewed as being mutually exclusive, that you
16 can approve one or the other project, but not
17 both projects. So a determination that these
18 are competing projects means that there's a
19 finite amount of need and only one of the
20 projects can be approved.

21 I mean, most often you see competing
22 applications when there's a need for additional
23 acute-care beds. For example two hospitals
24 both want those beds and the state can only
25 approve a certain number of beds. And so they



1 would say, we're only going to approve one of
2 you and, you know, we'll weigh and balance your
3 applications to come up with a determination on
4 which one should be approved.

5 In this case, I think -- yeah, I know that
6 -- I thought on behalf of Summerville Medical
7 Center's ED that these would be considered
8 competing projects. I think MUSC was under the
9 same impression. But ultimately the
10 determination was made by the Department not to
11 view these as competing.

12 Q: Have you ever heard articulated any rationale
13 for why they weren't deemed to be competing?

14 A: I have not.

15 Q: Okay. So what are your conclusions regarding
16 community ...

17 A: Well, you know, the ...

18 Q: So what are your conclusions regarding
19 community need?

20 A: That there's not a community need in the sense
21 that there's a shortage of emergency services
22 available to serve the population in the area
23 that MUSC proposes to locate its application.

24 Now, we heard -- and in the application
25 and we've heard, you know, in deposition



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

1147

1 testimony that another rationale for the
2 approval of the project in the Medical
3 University's view is that they have capacity
4 problems downtown and that they want to solve
5 those capacity problems by offloading some of
6 their lower acuity emergency volume to a
7 freestanding ED. I guess my opinion as a
8 health planner would be, if your goal is to
9 offload a significant amount of capacity, you
10 don't build a freestanding ED 23 miles away.
11 There's a -- I mean, a general principle, not
12 only in healthcare, but I think in business
13 generally, that the farther away you get from
14 something, the less likelihood, you know, it's
15 going to have a significant impact on it. In
16 this case, the Medical University identified a
17 site that is not likely to draw very many
18 patients away from its existing hospital. And
19 we'll get into more depth about that I think
20 later on and why I believe that's the case.
21 And so it's not a very compelling way to
22 offload capacity, if indeed the Medical
23 University does need additional capacity
24 downtown.

25 And so I think the project just didn't



CREEL COURT REPORTING, INC.
1230 Richland Street / Columbia, SC 29201
(803) 252-3445 / (800) 822-0896

1 have a foundation with respect to improving
2 throughput at the Medical University downtown
3 by building a freestanding emergency department
4 so far away. Now, if they had built one, say,
5 West of the Ashley within five or six miles of
6 the Medical University or in Mount Pleasant
7 where they have a much larger market share of
8 emergency patients, that type of project might
9 have had a greater impact on their facility.
10 But this -- in my view, this freestanding ED is
11 going to have very small impact in terms of
12 reducing the number of patients who are
13 traveling to the Medical University for
14 emergency services.

15 Q: Okay. I'd like to talk to you a little bit
16 about the relationship of the State Health
17 Plan to the process. Is DHEC allowed to
18 approve any project that is not consistent with
19 the State Health Plan?

20 A: They are not. I mean, that's -- the statute,
21 I believe, states that it must be consistent
22 with the State Health Plan.

23 Q: Okay. So that's kind of your benchmark or your
24 touchstone in this process?

25 A: Right. I mean, you -- if you don't meet that,



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

1149

1 then you don't get to pass go.

2 Q: And then the plan is updated every year or two;
3 is that the way this process works?

4 A: Yeah. I mean, theoretically every two years.
5 But, as Ms. Platt said, more often they've been
6 trying to do updates on an annual basis.

7 Q: So talk to me about how and if this project
8 from the Medical University is consistent with
9 the State Health Plan?

10 A: Well, the -- I believe that the relevant
11 standard in the State Health Plan is Standard
12 6 in the 2015 State Health Plan. And that was
13 the plan that was in effect at the time the
14 application was filed. And basically it
15 requires the applicant to demonstrate the need
16 for the service by documenting where potential
17 patients for this proposed service will come
18 from and why they're not being adequately
19 served by the existing services in the area.
20 Medical University really failed to address
21 that standard directly. All the Medical
22 University talked about was its own patients.
23 It didn't talk about existing services in the
24 area. It didn't talk about any problems with
25 patients who live in that area not being



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

1150

1 adequately served by existing providers.

2 It's -- you know, it's difficult to fathom
3 that they could demonstrate that putting a
4 facility so far away from where the hospital --
5 where their existing hospital is located in an
6 area where they have a relatively small
7 presence in the market is somehow going to
8 address a broad community need for emergency
9 services.

10 Q: Okay. Earlier you looked at the provision in
11 this State Health Plan that requires the
12 balancing between access and adverse impact?

13 A: Right.

14 Q: And you said that the record is devoid of that
15 analysis?

16 A: It is. Both from the standpoint of the Medical
17 University and from the standpoint of DHEC.
18 The Medical University's position is that they
19 will only serve patients who otherwise would
20 have gone to the Medical University.

21 Q: Okay. And we'll talk about that ---

22 A: We will.

23 A: --- in a little bit. But I think the point I'm
24 trying to make is, you've identified at least
25 two instances where the record is devoid of



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

1151

1 compliance with the State Health Plan. Is that
2 true?

3 A: It is true.

4 Q: Okay. One would be failing to look at existing
5 services and the other would be adverse impact?

6 A: Correct.

7 Q: Okay. And was the Department required by law
8 to make those assumptions or analyses?

9 **MR. WESTBROOK:** Object.

10 **MS. BIGGERS:** Objection.

11 **MR. SUMMER:** I'll rephrase it. I'll rephrase it.

12 Q: Under -- in order to be consistent with the
13 State Health Plan was the Department required
14 to make those analyses?

15 A: I mean, in order to -- yeah. In my view, in
16 order -- from a health planning perspective, in
17 order to demonstrate compliance with the State
18 Health Plan you first would have to show that
19 there was a need in the area proposed to be
20 served. And, two, you would have to show that
21 the benefits of improved accessibility
22 outweighed the adverse effects.

23 Q: And were those required analyses done?

24 A: No.

25 Q: Okay. Talk to me -- or explain to The Court



1 what your thoughts are regarding the 2017-2018
2 Plan?

3 A: Well, you know, this project has changed so
4 much from the original application. I think
5 arguably you could say that, once these changes
6 started, it really constituted a new project.
7 And my understanding is that in this
8 proceeding, The Court has the ability to
9 consider later health plans. They don't have
10 to, but they have the ability to consider later
11 health plans. And I think the later health
12 plans articulate a little more clearly the type
13 of analysis that would be beneficial to the
14 Department in evaluating freestanding emergency
15 department applications.

16 Q: Okay. Well, you want to share your thoughts on
17 that?

18 A: Sure. And on this slide that's up now it
19 quotes the language in the 2017-2018 Plan,
20 which I believe is the same language in the
21 2018-2019 Plan. And it says that applicants
22 must demonstrate need for this service by
23 documenting capacity constraints within
24 existing emergency departments in the service
25 area and/or a travel time of greater than 15



1 minutes to an existing emergency department in
2 the service area. And Medical University
3 presented no analysis of capacity constraints
4 in the area. In fact, as I said before, they
5 simply ignored the presence of existing
6 providers in the market. And with all of the
7 existing and approved capacity in the market,
8 I don't believe there's any way that the
9 Medical University could have demonstrated that
10 there were capacity constraints.

11 Q: Okay. Well, I'm going to turn now to your work
12 or analysis regarding MUSC's need for
13 additional capacity. And explain to The Court
14 what your analysis has been on this.

15 A: Well, we've -- you know, throughout the
16 depositions that I reviewed from the Medical
17 University folks, they talked about the
18 problems that they had with their emergency
19 department. And we heard a lot of discussion
20 about long times of service and patients
21 leaving without treatment and things like that.
22 So I wanted to drill down a little bit into the
23 numbers and look at what the true story was.
24 And they have three emergency departments or
25 branches of the emergency department, however



1 you want to characterize that, on their campus
2 in downtown Charleston. They have the main
3 adult ED. They have the chest pain ED. And
4 then they have the pediatric ED. And they
5 also, in terms of capacity, have been
6 preliminarily approved for a new hospital in
7 Nexton, which is about six miles away from the
8 proposed freestanding ED, which will also have
9 an emergency department. So I think we have to
10 kind of look at this as a whole, not just, you
11 know, in looking at the downtown.

12 Q: Talk to us about what the numbers reveal.

13 A: Okay. Well, this is an analysis that was
14 produced in the trial exhibits by Medical
15 University. I assume Mr. Levitt might be
16 talking about this. And it looks at the 67 ED
17 bays that Dr. Hall testified about. It uses a
18 capacity per bay of 1250 visits annually. And
19 then it looks at the total number of visits and
20 then it calculates what percent utilization of
21 capacity.

22 Q: I'm wondering what your thoughts are when you
23 heard Ms. Valentine discuss yesterday that
24 they're doing 2,500 visits per bay in her
25 hospital. Why is the utilization so low at



1 MUSC?

2 A: I don't know. I mean, 1250 is a low number to
3 use for measuring what your capacity is. If
4 you -- there's a -- in my deposition there was
5 a fair amount of discussion about what a
6 reasonable capacity target is. And I believe
7 I testified that, based on my review of the
8 literature, that 1500 is a number that's often
9 cited as a standard. Certainly I have clients
10 who do well more than 1500 visits annually.
11 HCA, when I was working with them on a project
12 in Tennessee, was using a metric of 1800 visit
13 per ED bay. And I know that hospitals
14 routinely operate above 2,000 visits per ED
15 bay. So 1250, even for an academic medical
16 center, in my view, seems too low, particularly
17 given the fact that they have separate EDs for
18 pediatric patients and adult patients and for
19 chest pain patients. They have some ability to
20 sort of screen patients and put them in the
21 right place to begin with. And so, I -- the
22 1250 number gave me some pause as being a too
23 low a standard in terms of measuring capacity.

24 **MR. SUMMER:** Okay. Your Honor, I don't believe that
25 MUSC Trial Exhibit 46 is in, but since he's



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

1156

1 relied on it to some extent in his opinions, is
2 there any objection if we admit that exhibit?

3 **MR. WESTBROOK:** No objection.

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

5 **MR. SUMMER:** Thank you, Your Honor.

6 **(Respondent MUSC's Exhibit Number 46 was admitted**
7 **into the record at this time.)**

8 Q: So, if you would, explain to me why you believe
9 there are no existing ED constraints for MUSC.

10 A: Well, you know, we heard that they have 67
11 existing ED bays. Dr. Hall testified about the
12 fact that the Shawn Jenkins Children's Hospital
13 is going to open an emergency department with
14 20 new ED bays. He also said that four of the
15 existing -- I think what he referred to was E
16 pods -- four existing rooms that are currently
17 being used for pediatric patients will be taken
18 out of service. But that leaves a net addition
19 of 16 ED bays to the Medical University's
20 overall compliment downtown, just downtown
21 without considering the Nexton Hospital. And
22 so I believe that, if you take into account
23 these additional ED bays, then you would see
24 that there is plenty of capacity at the Medical
25 University to serve the patients.



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

1157

1 Q: Did you hear Dr. Hall's testimony about the
2 fact that they had 1200 children per year that
3 were going to utilize those bays? Did that
4 make any sense to you?

5 A: Well, he -- I think what he said is that the 12
6 pediatric rooms that are in the pediatric ED,
7 that the current plan was they would put
8 pediatric mental health patients over there.
9 And he estimated that would be about 100 per
10 month. And so that would mean that you're
11 putting about three patients a day in a 12-bed
12 unit at the same time that you have very busy
13 emergency room utilization in other parts of
14 the campus. I mean, to me, as a health
15 planner, that didn't make a lot of sense. I
16 mean, it would seem that it would be more
17 appropriate to utilize those ED bays for adult
18 patients.

19 Q: Okay. Shawn Jenkins Hospital is going to open
20 when?

21 A: I believe at the end of next year.

22 Q: I'll let the testimony stand for what it was,
23 but is it possible it could be opening up this
24 fall?

25 A: It could. I mean, I've driven by it. I can't



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

1158

1 -- the shell is complete. I don't know what's
2 happening inside. So I missed that testimony,
3 if that was made.

4 Q: All right. Well, explain to The Court your
5 analysis for capacity with the addition of
6 those beds.

7 A: Well, if we look at the current ED bays of 67
8 and we assume 20 new ones with the opening of
9 the children's hospital, closing the four
10 mental health bays, Medical University will
11 have 83 bays at their disposal to treat
12 emergency patients. If we use Dr. Hall's
13 number of 1250, which I think is too low. And
14 we use the 2,018 ED visits -- and I'm using
15 2,108, because the number of ED visits at the
16 Medical University has been declining in recent
17 years. So I'm not projecting forward that
18 they're going to continue to go down, I'm just
19 keeping it level at the 2,018 level. And even
20 using the low capacity number, they're at about
21 75 percent utilization using that 1250 per bay.
22 And that's good utilization, but it's not at
23 the point where, you know, you're bursting at
24 the seams as a hospital. Again, I have
25 hospital clients that operate at far higher



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

1159

1 rates of utilization of their ED capacity. But
2 if we use 1500, which I think is appropriate
3 for an academic medical center, particularly in
4 light of the fact that we have evidence of
5 community hospitals that are operating at a
6 1,000 visits per room higher than that, then
7 their utilization of these bays, once the
8 children's hospital opens, will only be about
9 63 percent. So you can see that with the
10 opening of the children's hospital -- and
11 there's no mention of the children's hospital
12 or the additional ED bays in the application.
13 So, you know, everything was frozen in time as
14 of right now without taking into consideration
15 how this new capacity in the future might
16 impact their ability to accommodate emergency
17 patients. They would only be utilized at about
18 63 percent. So they would have plenty of
19 capacity throughout the whole system to be able
20 to accommodate. And, you know, specifically
21 with respect to pediatric patients, you know,
22 they're going to -- they should be well served
23 with 20 rooms to serve 24,000 ED visits. I
24 think was the testimony, that would be about
25 1,200 per room, so.



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

1160

1 Q: What have you noted about utilization at -- for
2 ED services at the MedU?

3 A: That there really hasn't been a tremendous
4 amount of change. It's -- it went up a little
5 bit between '15 and '16 and then it's declined
6 by a small percentage in fiscal years '17 and
7 '18.

8 And there was some questions yesterday I
9 think of Ms. Valentine about the significant
10 growth that's occurred in ED volume in the Tri-
11 County area. And I agree with that. I mean,
12 I think we sited that in the Summerville
13 freestanding ED application. But that growth
14 hasn't been at the Medical University.

15 And the other thing that struck me is that
16 Dr. Hall testified that the number of patients
17 who are leaving without treatment has gone up
18 in recent years. But that's at a time when the
19 volume has not been increasing, it's actually
20 gone down a little bit. And so there wouldn't
21 be any -- I wouldn't think it would be a
22 capacity reason why there would be an increase
23 in patients leaving without treatment. There
24 must be another explanation for why the number
25 of patients leaving without treatment has



1 increased in recent years. It wouldn't be
2 driven by capacity because they really haven't
3 been utilizing more of their capacity over
4 time.

5 Q: Well, as a health planner, what are some of the
6 things that could be contributing to that
7 phenomenon?

8 A: I mean, part of it might be staffing. That's
9 often a significant concern in emergency
10 departments. One, having enough emergency
11 medicine physicians on call. And, two, having
12 enough nurses to be able to accommodate the
13 patients and move the patients expeditiously
14 through. Another aspect of it is process. I
15 mean, just overall process in terms of how you
16 facilitate the patients moving from one point
17 in the treatment process to the next and doing
18 it as quickly as possible. There could be
19 delays in ancillary departments, for example.
20 Many patients who go to an ED department need
21 a CAT scan, a CT scan, or an ultrasound or
22 something like that. And if there are delays
23 at the -- on the ancillary department end, that
24 could be a problem. And, I think, Dr. Hall,
25 specifically talked about the problem with



1 having bed availability, having enough acute-
2 care beds. And I think that there is some
3 relief for that coming because I think the
4 children's hospital is going to increase
5 overall bed capacity. And I believe that
6 Medical University has also applied for
7 additional acute-care beds for adults.

8 And so -- you know, so there are many
9 different constraints in the system and all of
10 them don't relate to the number of ED bays you
11 have. You can have all the bays in the world,
12 but if you don't have the process in place to
13 move the patients through, it's not going to
14 make any difference.

15 Q: Having languished in an ED bay myself because
16 there was no bed availability upstairs, explain
17 to The Court, if you would, what that does to
18 an ED when they can't get the patient upstairs
19 to a bed.

20 A: Sure. You know, if a patient is deemed, you
21 know, acutely ill enough to require inpatient
22 hospitalization, then you want to move that
23 patient into a inpatient bed as quickly as
24 possible to be able to began treatment of that
25 patient. And when you can't move the patient



1 out of the ED, that ties up a room in the ED
2 that then prevents the next ED patient from
3 coming in and being seen and treated, you know,
4 in that particular room. And I think Dr. Hall,
5 when he talked about the fact that they had to
6 move some patients into hallways and, you know,
7 on different floors and things like that, and
8 hospitals unfortunately have to do that, and
9 that's -- you know, when they start talking
10 about patients boarding in the emergency
11 department, that's when they just are there for
12 an extended period of time because they can't
13 get them into an appropriate unit. And I think
14 it's a problem at the Medical University I
15 think both for mental health patients as well
16 as for adult patients. And Medical University
17 does have relatively high occupancy rates of
18 both its mental health and its acute-care beds.
19 And so, you know, I think that might be one way
20 to address the problem. It doesn't have
21 anything to do with the ED capacity.

22 Q: Okay. I've had a client before describe it
23 from an analogy perspective as a clogged pipe.
24 And the only way to unclog the pipe is to
25 discharge patients in the hospital. Is that a



1 fair analogy?

2 A: Yes. I mean, obviously -- and I think -- I
3 don't remember who -- whether it was in a
4 deposition or in these hearings. Someone
5 talked about the fact that they instituted some
6 sort of new bed control process at the Medical
7 University to try to expedite the discharge of
8 patients from the bed and to allow additional
9 patients to come from the emergency department.
10 But, yeah, there is a way to focus on that
11 process because, if you've ever been in a
12 hospital, you know, one of the most
13 frustrating things is getting discharged. You
14 know, you're waiting for the doctor to come by
15 and write the orders and you're waiting for the
16 folks to come by and transport you down. And
17 so improving that part of the pipeline does
18 make a big difference.

19 Q: Okay. Looking at your slide 13, the source
20 document you're referring to here is MUSC Trial
21 Exhibit 34. Is that data from MUSC?

22 A: It is. It was a chart that was in the MUSC
23 exhibits that showed the trend in the ED
24 utilization.

25 MR. SUMMER: Any objection to admitting MUSC Trial



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

1165

1 Exhibit 34?

2 **MR. WESTBROOK:** No objection to admitting any MUSC
3 exhibits.

4 **MR. SUMMER:** Just want to make sure that what he
5 relied upon is in the records. And, Your
6 Honor, we would move for the admission of MUSC
7 Trial Exhibit 34, please.

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

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

10 **(Respondent MUSC's Exhibit Number 34 was admitted**
11 **into the record at this time.)**

12 Q: Going to turn to another health planning
13 concept and criteria. And that would be
14 unnecessary duplication. Talk to me about what
15 your analysis has been regarding unnecessary
16 duplication of services as it pertains to this
17 MUHA freestanding ED.

18 A: Sure. Well, first of all, I've already talked
19 about all of the existing and approved
20 facilities in the area. And so adding another
21 facility there in my view is almost the
22 definition of unnecessary duplication. You've
23 already got significant available capacity. At
24 the time that the application for the
25 freestanding ED was filed, I did not know that



1 the Medical University was soon to file an
2 application for a new hospital in Nexton, which
3 would be, I believe, at exit 197. This
4 project's going to be at exit 199. So
5 basically two miles up the road to the Nexton
6 development. And the first thing I thought
7 about when I saw that they filed a hospital
8 application is, well, why did they file an
9 application for a freestanding ED if they were
10 planning to build a hospital two exits away?

11 Q: And explain to The Court what is the
12 requirement in South Carolina; does a hospital
13 have to have an emergency department?

14 A: It does. You cannot be licensed as an acute-
15 care hospital in South Carolina without an
16 emergency department. And so I -- the first
17 thing I did when I got the hospital application
18 is I flipped through it and then I saw a
19 notation there that indicated that, at the time
20 that the new hospital opened in Nexton, that
21 the freestanding ED would be closed down and
22 re-purposed for some other use. And to me that
23 seemed highly wasteful and certainly highly
24 duplicative. Why would you spend -- at that
25 point I thought they were spending over 13



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

1167

1 million dollars. They've since reduced that
2 amount down to 11.3 million.

3 You know, in some cases I've worked with
4 clients who built freestanding EDs before
5 they've built a new hospital, but they
6 generally put it on the campus where they want
7 the new hospital to go and then they
8 incorporate the freestanding ED into the
9 hospital itself when it opens. I think Mr.
10 Levitt could talk about that a little bit in a
11 case we had down in Florida.

12 ut in this case it seemed that -- and MUSC
13 had to know at the time they filed this
14 application that they were filing an
15 application for a new hospital. So it makes
16 the sort of underlying planning that went into
17 the freestanding ED application even more
18 puzzling, is why would you file for a
19 freestanding ED in close proximity where you
20 were going to open a hospital and essentially
21 be competing with yourself for emergency
22 department patients? I mean, it didn't make
23 any sense.

24 Q: I'm realizing that various iterations of what
25 may or may not be built by MUSC. But is the



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

1168

1 latest iteration more or less duplicative of
2 what Summerville Medical Center's going to
3 building in Nexton in its freestanding ED?

4 A: Well, my understanding from reading the
5 depositions of Dr. Cawley -- I can't remember
6 if anybody else opined on this -- that there's
7 no definite plan to shut down the freestanding
8 ED when the Nexton Hospital opens now. And so
9 it may in fact -- you may in fact be operating
10 a freestanding ED and opening a brand new
11 hospital within two and a half miles of each
12 other. And both the freestanding ED and the
13 Nexton Hospital project said that they didn't
14 intend to take patients from any other
15 provider; that they were just going serve the
16 patients who were going to the Medical
17 University downtown now. And so how does that
18 work? I mean, how do you not impact existing
19 providers if you have two different facilities,
20 both trying to serve the same population within
21 a very short geographic distance?

22 Q: And my question was specifically towards
23 Trident Summerville's project to build a
24 freestanding ED. Is what's being proposed now
25 by MUHA more duplicative than what was done at



1 project review?

2 A: Sure. Because at the time of project review we
3 assumed that there was only going to be one
4 freestanding ED approved. We thought it would
5 be either Summerville's freestanding ED or
6 Medical University's. Now we know that
7 Summerville Medical Center is moving forward
8 with the development of its freestanding ED.
9 And so this Medical University ED is going to
10 be located less than a mile away from the
11 Summerville freestanding ED. And so I don't
12 know how you could be more duplicative than
13 that, than to build two facilities that offer
14 virtually the same services, serving the same
15 geographic area, located that close together.

16 Q: During the review -- I don't want to go through
17 the project review PowerPoint.

18 A: Right.

19 Q: But it's in the record and The Court will look
20 at that. But you were present, were you not,
21 at project review?

22 A: I was.

23 Q: Okay. Was the CDU proposed by MUSC a
24 distinguishing factor between these two
25 projects?



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

1170

1 **MR. WESTBROOK:** Objection. Leading. He's been
2 leading quite a bit. I've let him go on. And
3 if I get the same latitude with my expert
4 witness. But that was a pure leading question.

5 **MR. SUMMER:** Your Honor, I was going to take the
6 privilege as long as I had it, but I'll
7 rephrase my question.

8 **Q:** Okay. What, if any, effect did this CDU
9 phenomenon have on the project review?

10 **A:** It was touted by more than one witness, but
11 specifically by Sarah Bacik, who is the vice
12 president of strategic planning I believe at
13 the Medical University, as being a major
14 differentiator between its project and the
15 Summerville project. In fact, it would be the
16 only freestanding ED in the state of South
17 Carolina that would have a clinical decision
18 unit in it and it would allow them to provide
19 to provide a higher level of care for the
20 patients who would come to the freestanding ED.

21 **Q:** Okay. Now that the project's been downsized,
22 have all of those CDU beds been eliminated?

23 **A:** They have.

24 **Q:** Okay. Is that similar or different from what
25 was proposed at DHEC?



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

1171

1 A: It's different. The CDU was an important
2 element of the argument that the Medical
3 University made to DHEC in terms of why its
4 project should be approved. And now that's no
5 longer part of it.

6 Q: What, if any, difference was discussed at
7 project review regarding the helipad at MUSC's
8 project?

9 A: Again, what was discussed at project review by
10 the Medical University witnesses -- or not --
11 or speakers was that the helipad would, again,
12 allow them to serve a higher level of patients
13 because they could rapidly transport any
14 patient who required admission downtown to the
15 Medical University via helicopter. And so
16 that's another piece that's obviously not part
17 of the project.

18 Q: All right. Next, I want to turn your attention
19 to this concept about only serving our own
20 patients. What are your opinions regarding
21 that argument by MUSC?

22 A: Well, I mean, as a health planner, that's a
23 difficult concept to accept. If you were
24 building something next door to your hospital,
25 then maybe you could make that argument, but --



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

1172

1 you know, because you're not really changing
2 the distribution of healthcare facilities in
3 the market. You're putting something -- you
4 know, let's say they decided to go across
5 Calhoun Street and put a freestanding ED in
6 downtown Charleston and they say we expect to
7 serve mostly our -- only our own patients. I
8 might be able to buy that assumption in that
9 case. But when you go 23 miles away, you're
10 changing the distribution of services.

11 One of the significant factors that
12 patients are influenced by in terms of where
13 they choose to receive services and healthcare
14 is location. And to me it's obvious. If
15 something is closer to you than another
16 provider, you're more likely to go to that
17 provider who's closer.

18 In almost every circumstance in which I've
19 reviewed projects where a new facility went
20 into a new area, market shares shifted among
21 existing providers. And so, you would not have
22 -- you know, let's say for example Medical
23 University right now has about a 7.4 percent
24 market share of the ZIP codes right around the
25 proposed freestanding ED site. I would expect



1 their market share of those ZIP codes to go up
2 because all of a sudden there's a facility
3 that's very close to where these people live.
4 And before, if they wanted to go to MUSC,
5 they'd have to drive 23 miles downtown or
6 farther in some cases.

7 And so it doesn't make valid health
8 planning sense to assume that you can put up a
9 new facility in a new location particularly so
10 distant from the existing facility and not
11 expect there to be a redistribution of patients
12 among providers. I mean, I just -- I've never
13 seen that happen in my experience. I've been
14 doing this for 40 years almost. And it doesn't
15 make any sense. And it doesn't make any sense
16 in this case for a number of other reasons too.

17 Q: Okay. Talk to me a little bit about how or if
18 the Intuitive information that was gleaned from
19 the 30(b)(6) deposition last week informs your
20 opinion on this?

21 A: Sure. You know, I think that the deposition
22 and particularly the exhibits to the
23 deposition, you know, I think painted a pretty
24 clear picture of what Intuitive's approach was.
25 And ultimately it was the Intuitive approach



1 that the Medical University adopted. And that
2 is that Intuitive wanted to put the facility
3 in a location that would have the greatest
4 potential in terms of the highest volume of
5 population and in terms of the quality of the
6 population, in terms of demographics, in terms
7 of having more affluence in that population.

8 And Intuitive, if you read the Intuitive
9 documents, there's never a mention in any of
10 the Intuitive documents about how many patients
11 Medical University serves from this geographic
12 area, how many patients can be redirected from
13 Medical University to the freestanding ED. All
14 it's about is, if we put a freestanding ED in
15 this area, this is how much market we can
16 capture. And so it's all about this is a
17 reasonable market share for us to capture.
18 Now, some portion of that market share might be
19 patients who went to the Medical University
20 historically. But by in large those are going
21 to be patients who went to Trident facilities
22 or Roper facilities.

23 Q: Okay. When you looked at the Intuitive
24 documents, what, if any, information did you
25 glean regarding drive times that Intuitive



1 recognizes for drawing patients?

2 A: Mr. Herrmann, the Intuitive president, said
3 that their typical drive time is about 13
4 minutes surrounding the proposed site. And
5 they had some documents that looked at 10
6 minutes, 15 minutes, and 20 minutes. He said,
7 I don't know why 20 minutes is in there, we
8 never use 20 minutes, that's too far. And so
9 his expectation was that the patients who would
10 be drawn to the facility would come from within
11 a very short 13 to 15-minute drive time around
12 the proposed site. And if we look at that
13 area, there's no way that MUSC could attract
14 over 15,000 emergency visits that otherwise
15 would have gone downtown to its existing
16 facility.

17 Q: Okay. Using that 13-minute drive time, if
18 you're a Berkeley County resident and you work
19 on the peninsula in downtown Charleston, are
20 you more likely to go to MUSC'S emergency room
21 or get in your car and drive all the way back
22 home if you're sick?

23 A: Well, if you -- if you work downtown and you're
24 a Berkeley County resident and you get sick
25 during work, you're going to go to the downtown



1 facility, you know. And if you -- and that, in
2 fact, may be part of the volume that the
3 Medical University is counting in its patients
4 who live in Berkeley County or live in
5 Dorchester County who they think would be
6 redirected.

7 Q: I think you've covered this, but let's talk now
8 about the service area and what your
9 observations are regarding those proposed
10 service area?

11 A: Well, these are the ZIP codes that they
12 identified as their service area in the
13 application. I mean, they -- well, first of
14 all they said that their service area was the
15 three counties; Charleston, Berkeley and
16 Dorchester counties. But then they refined
17 that a little bit after project review and
18 said, well, these are the ZIP codes that we
19 specifically expect to draw patients from.
20 And they made certain assumptions that we get
21 75 percent of all the patients who are
22 traveling downtown to go to the new facility
23 from certain ZIP codes, 60 percent from some
24 and, you know, and so forth. They had a scale.
25 But if we look at this service area, I mean,



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

1177

1 one, if you look at the star that's on here
2 that says, MUSC freestanding ED proposed ---

3 Q: Is that right here?

4 A: Right next -- yeah, right next to the big red
5 dot, which is the Summerville facility. You
6 can see that for patients to get to them from
7 the upper reaches of Berkeley County, that's
8 going to be a pretty good drive, particularly
9 given the road system and the traffic up there.
10 And if you look at the southern part of their
11 service area, you can see that the folks who
12 live in that part of the service area were
13 already surrounded by existing hospitals and
14 freestanding emergency departments. And so
15 patients who are traveling from those ZIP codes
16 to MUSC aren't traveling there because of lack
17 of access, they're traveling there because they
18 choose to go to MUSC, for whatever reason they
19 choose to go there.

20 And so the service area, just from my
21 initial impression when I saw this data, is
22 it's far too broad for a freestanding ED. And
23 Mr. Herrmann's testimony in his deposition
24 confirmed that. And it would really be a much
25 smaller geographic area that they would expect



1 to draw the majority of their patients from.

2 Q: Okay. Take a look at some of the information
3 that was provided by MUSC project review.
4 Discuss with The Court your concerns regarding
5 this proposed shift of patients.

6 A: Yeah. And just to maybe step back a second.
7 What Mr. Levitt did, I believe, is he looked at
8 how many visits that MUSC got from each of
9 these ZIP codes. And you see the visit column
10 there, it's the second column in the -- on the
11 left-hand side. And then he said, okay, what
12 percent of those patients from that ZIP code do
13 we think that we can convince to go to the
14 freestanding ED? And you can see the
15 percentages ranged from, I believe, 25 percent
16 up to 75 percent. And then he calculated how
17 many visits potentially that would produce for
18 the freestanding ED.

19 Q: Do you remember Mr. Herrmann's testimony about
20 their proprietary algorithm that is utilized by
21 Intuitive? Do you remember that testimony?

22 A: I do.

23 Q: Okay. Which my understanding was a very
24 precise mathematical calculation. Was that
25 your understanding?



1 A: Yeah. He -- what they did is they looked at a
2 geographic area and they had a number of
3 underlying data points. And he wouldn't
4 disclose what all of those were, but I'm
5 assuming it's population, population income,
6 traffic counts, and things like that that would
7 go into that type of model.

8 Q: Explain to me what Mr. Levitt's mathematical
9 calculation or algorithm was to come up with,
10 say, 50 percent coming from a given ZIP code.

11 A: As far as I can determine based on his
12 deposition, there was no mathematical model
13 that was used. It was simply Mr. Levitt's
14 estimates looking at the ZIP code and kind of
15 looking at where it was relative to the
16 proposed freestanding ED and then just making
17 a best estimate of what the shift would be. So
18 there really is no underlying base other than
19 his judgment.

20 Q: Just an assumption?

21 A: Yes.

22 **MR. WESTBROOK:** Objection. He has just
23 mischaracterized what his own witness said.
24 His witness said it was an estimate and then
25 Mr. Summer transformed that word into an



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

1180

1 assumption. That wasn't what Mr. Sullivan
2 said.

3 **MR. SUMMER:** I'll withdraw that question and I'll go
4 through another line of questions to get there.

5 Q: Did Mr. Levitt offer any mathematical basis or
6 statistical basis, for example picking for ZIP
7 code 29436, 50 percent shift of patients?

8 A: No.

9 Q: As a planner, would it be just as reasonable to
10 assume that that number could be 20 percent?

11 A: Sure.

12 Q: Would it be just as reasonable to assume that
13 it could be 60 percent?

14 A: I'm not sure that would reasonable. I think
15 the higher you get, the less reasonable it
16 becomes because, again, these are patients.
17 In many cases some of these ZIP codes are not
18 immediately proximate to the freestanding ED.
19 And secondly, these are folks who have been
20 traveling downtown, driving past multiple
21 existing providers to go downtown to receive
22 services. So it'd lead one to believe that
23 maybe there's something more than just
24 geography that's dictating why they're going to
25 the Medical University.



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

1181

1 Q: Absent of mathematical formulas, is this any
2 more than guesswork?

3 A: It is a guess. I mean, it's -- I mean, that's
4 really what it -- I mean, he had to -- he had
5 to make certain basic assumptions about what he
6 thought the shift was going to be and that's
7 what this shows.

8 Q: Okay. Talk to The Court a little bit about
9 service area shift and other facility
10 locations.

11 A: Sure. Like this is another one of MUSC's trial
12 exhibits. And it shows the -- a color-coded
13 way the service area and what the, I guess what
14 I would call, bands of percentage shift that
15 Mr. Levitt assumed. And so the salmon colored
16 or reddish colored ZIP codes are 75-percent
17 shift ZIP codes. The gold color, there's not
18 a whole lot of those, are a 60-percent shift.
19 The darker blue are a 50-percent shift. And
20 the lighter blue are a 20-percent shift.

21 And so I think it -- this really presents
22 sort of a stark picture of how these
23 assumptions come into play. For example, if
24 you're over in ZIP code 29471, which is the
25 extreme western ZIP code in this map, if you



1 see that, they'd assume 75 percent of those
2 patients are going to go to the freestanding
3 ED, even though the freestanding ED is a
4 considerable distance away. And if a patient
5 was going to get in their car and drive, they
6 might want to go to a full-service hospital at
7 that point, rather than go to a freestanding
8 ED.

9 And if we look at the extreme eastern
10 portion of the service area, the 29452 -- I
11 think that's -- or maybe it's a three. I'm
12 sorry. 29453, that light blue ZIP code, those
13 folks are way up Highway 17 and Highway 41 from
14 Charleston. And why would they drive over to
15 North Main Street in Summerville to get their
16 emergency services?

17 So I think that just sort of highlights
18 the fact that the service area is much too
19 broad for a freestanding ED.

20 Q: Okay. Is this supported by -- and I'm looking
21 -- this is MUSC Trial Exhibit 42. Is this
22 supported by or contradicted by Intuitive's
23 formula?

24 A: Well, Intuitive's formula would say that the
25 area would be a very small geographic area



1 around the proposed site. So the Intuitive
2 model would contradict this service area.

3 Q: Any other observations you've got regarding
4 this ED patient shift?

5 A: Well, for example, I'll just point to one other
6 one. And I don't want to belabor this. ZIP
7 code 29406 happens to be the ZIP code where
8 Trident Medical Center is located. Trident, I
9 think you heard testimony yesterday, is a Level
10 II trauma center, a full-service hospital that
11 has a comprehensive cardiac program. That's
12 going to be the ZIP code that's going to
13 provide the greatest number of visits to the
14 freestanding emergency department. It's not
15 the closest ZIP code to the freestanding
16 emergency department. It's some distance away.
17 But it's going to have the greatest number of
18 patients that are going to be provided to the
19 freestanding ED.

20 Again, if patients are living in that ZIP
21 code, they not only have good access to
22 Trident, but they have good access to
23 Summerville. They have good access to the
24 Centre Pointe freestanding emergency
25 department and they have good access to the



1 Northwoods, Roper Northwoods freestanding
2 emergency department. So, again, I think the
3 expectation that you're going to shift a
4 significant number of those to a brand new
5 freestanding ED I just think it's unrealistic.

6 **MR. SUMMER:** Okay. Just for housekeeping purposes,
7 when we were looking at the ZIP codes and
8 percentages that appears in the project review
9 presentation by MUSC, which I just wanted to
10 note for the record, is in the Joint Exhibit.
11 I'd also like to move forward the admission of
12 MUSC Trial Exhibit 42.

13 **THE COURT:** It's entered.

14 **MR. SUMMER:** Thank you, Your Honor.

15 **(Respondent MUSC's Exhibit Number 42 was admitted**
16 **into the record at this time.)**

17 **Q:** Let's try and drill down a little bit on this
18 shift and talk a little bit about the service
19 area and age group visits.

20 **A:** Okay. The -- one of the things that Dr. Hall
21 mentioned in his testimony is that he thought
22 -- and I don't want to mischaracterize his
23 testimony, but I think he said a significant
24 number of pediatric patients he expected to
25 continue to travel downtown, particularly with



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

1185

1 the opening of the brand new pediatric
2 emergency department at the Shawn Jenkins
3 Children's Hospital. And so one of the things
4 I wanted to check was, well, what percentage of
5 the total visits that MUSC is assuming will
6 shift are related to pediatric patients? As
7 far as I could tell, there were no adjustments
8 made to the visits in the application. They
9 just assumed all emergency visits from that
10 market were, you know, fair game to go to the
11 freestanding emergency department. And in this
12 case, almost 30 percent of the emergency visits
13 to the Medical University from the specific ZIP
14 codes that were defined as the service area for
15 this project were pediatric patients. And so,
16 my expectation would be that a significant
17 percentage, let's just say half, 15 percent of
18 those patients would not go to a freestanding
19 ED. And potentially even a greater percentage
20 than that.

21 And so right off the top you would reduce
22 the pool of available patients by some number,
23 15, 20 percent for pediatric patients and say
24 let's not count those as potential patients to
25 go to the freestanding ED. So that would be



1 sort of the first adjustment that I would look
2 at.

3 Q: And that's consistent with Dr. Hall's
4 testimony, correct?

5 A: Yes.

6 Q: Okay. I think you just covered ---

7 A: Yeah, I just covered that.

8 Q: Okay. All right. In a similar fashion, did
9 you have observations regarding an account
10 class?

11 A: Yes. We received a -- I guess just in terms of
12 the source of this data, there was a large
13 file, a data file that was produced to us by
14 the Medical University. And it's MUSC 3919.
15 And it's not -- it's not in a format that I
16 could bring it here today. I think as Ms.
17 Platt talked about, it's hundreds of thousands
18 of lines of patient records and would probably
19 fill up several notebooks if we printed it out.
20 But it is a data source that was used I think
21 by Ms. Platt and by myself in analyzing some of
22 the data.

23 But, you know, another consideration, I
24 think Dr. Hall testified about the fact that
25 his adult population that comes through the



1 emergency department, about 25 to 26 percent of
2 those patients are admitted to the hospital.
3 Okay. So those patients are fairly sick
4 patients if they require admission to the
5 hospital. I believe that the testimony
6 yesterday from the Trident witnesses was only
7 about two to three percent of the patients at
8 the Trident facilities -- and that's consistent
9 with my experience at other freestanding EDs --
10 end up getting admitted to the hospital because
11 they tend to serve lower-acuity patients.

12 Q: Explain the concept of acuity to The Court.

13 A: Sure. You know if a patient -- you know, and
14 I thought Dr. Hall did a really good job. I
15 mean, you know, if a patient comes in and
16 they're in a life-threatening situation where
17 they have the potential to die or suffer
18 serious, you know, disability as a result of
19 what's going on, those would be the highest
20 acuity patients. Those would be what's called,
21 immediate patients that have to be treated
22 immediately.

23 And then on the other end of the scale
24 there would be the patients who come in
25 sprained ankle, he talked about prescription



1 refill, you know, things that aren't life
2 threatening, maybe don't really need to be in
3 an emergency department, but they're there and
4 they have to treat them. And so that would be
5 the lower end of the scale.

6 And you would expect in a freestanding
7 emergency department, you're not going to get
8 a lot of patients at the very high end of the
9 scale, the patients who require immediate
10 attention or the patients who are even in a
11 highly urgent situation where maybe they aren't
12 going to die immediately, but they have a
13 serious condition that requires -- you know,
14 for example, they're having a gallbladder
15 attack and they need to have their gallbladder
16 taken out. That might be a situation where
17 they'd want to go to a hospital-based emergency
18 department. Remember that the freestanding
19 emergency department is only going to have some
20 x-ray and lab capabilities. It's not going to
21 have the ability to treat these patients
22 directly. They're going to have to be sent
23 somewhere else for treatment.

24 Q: So when we heard these witnesses talking over
25 the last few days about ones and twos and



1 threes and fours and fives, that's a spectrum
2 of acuity; is that right?

3 A: That's right. Yeah. One being the highest
4 level of acuity and five being the lowest level
5 of acuity.

6 Q: So one is sickest and five is least sick?

7 A: Right. But, you know, I'm -- I'll get to that
8 in a second, but another thing I wanted to look
9 at was, how many patients in this pool of
10 patients that come from the service area that
11 MUSC has defined require admission to the
12 hospital? And this is looking at the total
13 population of patient, not just the adults.
14 And it's a little bit lower. It's about 22
15 percent. And so my expectation is, if only two
16 to three percent in a freestanding ED get
17 admitted, the material portion of these
18 patients that are going to MUSC now will
19 continue to go to MUSC. And, again, there's a
20 lot of factors that determine, you know,
21 whether they'll actually show up at the
22 freestanding ED or not. But my expectation is
23 if somebody's really sick, they're probably
24 going to go downtown.

25 And so rather than -- but there was no



1 adjustment made for the percentage of
2 inpatients. But if 22 percent of the
3 population is getting admitted and the
4 expectation for the freestanding ED is only
5 about three or four percent of the patients
6 being admitted, then I think you would have to
7 say that maybe another 10 or 15 percent of the
8 volume has to be taken off of the available
9 patients who could go to the freestanding ED.

10 **MR. SUMMER:** Beg The Court's indulgence.

11 Q: There was a specific exhibit to the Intuitive
12 deposition that dealt with basically self
13 assessment by patients. This is Exhibit Number
14 2 to the Intuitive deposition and it's page
15 456. Is that consistent with your testimony?

16 A: It is. I mean, this shows, again, the -- kind
17 of on a scale, you know, with heart attack
18 being at the far end of the scale of being
19 somebody who obviously needs immediate
20 treatment, that, you know, 97 percent of those
21 folks are going to go to an ER. Only two
22 percent are going to go to urgent care. Stroke
23 and so forth, again, would be on the high end
24 of the scale. And then you have, you know,
25 cold, flu, fever, and those sort of things



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

1191

1 being on the lower end of the scale. And so
2 that's consistent, that you would expect, you
3 know, more people to seek care at an emergency
4 room for the more serious conditions.

5 Q: Okay. I think you've addressed all this,
6 haven't you?

7 A: I have.

8 Q: Okay. Next, let's go to MUHA volumes by
9 procedure code for this patient population.
10 What did you do here?

11 **THE COURT:** Mr. Summer?

12 **MR. SUMMER:** Yes, ma'am.

13 **THE COURT:** Before you move to your next -- the next
14 stage of your questions, let's do a 10-minute
15 break.

16 **MR. SUMMER:** Thank you, Your Honor.

17 **(Off the Record)**

18 **THE COURT:** Mr. Summer, you may continue.

19 **MR. SUMMER:** All right.

20 Q: Mr. Sullivan, let's pick up with your procedure
21 code analysis on this patient population.

22 A: Sure. Another way of looking at acuity is
23 based on the procedure codes. These procedure
24 codes are basically used for billing purposes,
25 you know, to Medicare and other types of



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

1192

1 insurers. And they describe the level of care
2 that was provided, you know, during the
3 emergency visit, you know, from brief, limited,
4 intermediate, comprehensive, critical care,
5 extended. And so I thought that would be
6 another way to look at, you know, what
7 proportion of the patient population would
8 potentially go to a freestanding ED with the
9 high-end patients, the critical care, the
10 comprehensive, the extended perhaps being less
11 likely to go to a freestanding ED, while the
12 brief, limited, intermediate would be likely to
13 go.

14 Q: So this is like segregating heart attacks from
15 hang nails?

16 A: Yeah, yeah.

17 Q: Okay.

18 A: And one thing that led me to look at this is
19 that the group that MUSC utilized to help them
20 prepare their application, this HFPP group, had
21 used this data in a analysis that they had done
22 on the front end. I don't know that it was
23 actually used in the CON application, but they
24 focused on how many of the visits fell within
25 the brief, limited, intermediate categories.



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

1193

1 And if you look at this chart, that's only
2 about 33 percent of the total visits that went
3 to the emergency department at Medical
4 University.

5 And so, again, what this leads me to
6 believe is that there's a material percentage
7 of the patients, 67 percent would fall into the
8 more intensive category. And some of those
9 will go to the freestanding ED, but certainly
10 a portion of them will not. And, again, there
11 was no adjustment made to the potential patient
12 population that could go to the freestanding ED
13 of MUSC'S existing patients.

14 And if you go to the next slide, it's kind
15 of hard to read, but this was the HPP analysis.
16 Somehow the source, it had gotten cut off in
17 this document. But it was in the production
18 materials and maybe we can go to break and find
19 the exact page in the production materials from
20 HFPP. But you can see that they looked at the
21 categories of brief, intermediate, and limited
22 in assessing the patient population. And so,
23 I mean, at this -- I'm not saying this is all
24 that will go to the freestanding ED, but
25 certainly it's an indication that, assuming



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

1194

1 that 75 percent of the patients who go to MUSC
2 now will go to the freestanding ED, certainly
3 seems to be questionable.

4 Q: Okay. So summarizing, are the patients that
5 are currently coming down from Berkeley County
6 now higher acuity or lower acuity based upon
7 your analysis?

8 A: They would fall in the -- two thirds of them
9 would fall in those higher acuity categories.

10 Q: Okay. Sicker patients?

11 A: Yes.

12 Q: Is this just another way of phrasing or
13 depicting what we've been talking about?

14 A: Right. You know, what we've just looked at was
15 the billing information. And I think Dr. Hall
16 said that that's determined after the fact and
17 the acuity level is determined at the front end
18 when the patient first comes into the emergency
19 department. And, again, the immediate ones,
20 number one, the left-hand side of this chart,
21 would be the most acutely ill. And then the
22 right-hand side, the fives, would be the least
23 acutely ill. And I think, Dr. Hall agreed that
24 you would not have very many ones and two's
25 going to a freestanding emergency department.



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

1195

1 We may have an occasional patient show up, but
2 they're not going to be a significant portion.
3 The three's, I think the testimony has been
4 that some of those might be appropriate for a
5 freestanding ED, but some are not. And you've
6 got 59 percent of the total volume coming out
7 of that service area that are in the urgent
8 category. And then the less urgent is 22 and
9 the non-urgent is 3.3.

10 So, again, I think it's more likely than
11 not that the majority of patients who are going
12 from that area to MUSC now would not
13 necessarily be likely to utilize a freestanding
14 ED that's located, in some cases, no closer to
15 them than other providers and certainly even
16 MUSC downtown.

17 **MR. SUMMER:** Okay. Your Honor, this witness has
18 been relying upon a data set that appears as
19 Trident Number 44 and was produced by MUSC.
20 Any objection to that being admitted into
21 evidence?

22 **MR. WESTBROOK:** I'm assuming you're talking about
23 the MUSC 3919?

24 **MR. SUMMER:** Yes.

25 **MR. WESTBROOK:** No objection.



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

1196

1 **MR. SUMMER:** Thank you.

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

3 **MR. SUMMER:** It will appear in the record as Trident
4 Exhibit 44, Your Honor. My understanding it is
5 admitted?

6 **THE COURT:** Yes, it is.

7 **(Petitioner TMC's Exhibit Number 44 was admitted into**
8 **the record at this time.)**

9 **MR. SUMMER:** Thank you very much.

10 Q: So let's summarize what this patient shift
11 analysis. What are your summaries?

12 A: Let's go to the next one. If we look at these
13 different categories that I've talked about, we
14 have pediatric patients 30 percent of the
15 population, a substantial portion of those are
16 not going to utilize the new facility.
17 Patients requiring admission to the hospital;
18 22 percent of all patients, 26 percent -- 25,
19 26 percent of the adult patients require
20 admission. That's a much higher percentage
21 than you'd expect to see in a freestanding. So
22 some portion of that population would not go.
23 Patients who acuity is most appropriate for a
24 freestanding versus a hospital is only going to
25 be a portion, somewhere between 30 and 55



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

1197

1 percent. And then there's another category
2 that wasn't taken into account. And I
3 understand why it wasn't in the application,
4 but it hasn't been since the time that the
5 Nexton hospital application was filed. And
6 that's the patients who are going to go to the
7 new Nexton hospital as opposed to the
8 freestanding ED.

9 So all these things taken together would
10 mean that you're left with a relatively small
11 pie, if you will, of patients who are going to
12 MUSC right now, who are likely to go to the
13 freestanding ED. And that doesn't even take
14 into account a number of other factors. For
15 example, a patient who lives in Berkeley County
16 now may be going to the freestanding -- I mean,
17 I'm sorry, may be going downtown to the MUSC
18 ED. For example, they're a cancer patient and
19 their oncologist is located downtown at the
20 Hollings Cancer Center. And so if they're
21 going to go to an emergency department, they
22 want to go downtown where their oncologist can
23 come and see them. And similarly, if somebody
24 was a cardiac patient, you know, that had
25 serious cardiac disease and their cardiologist



1 was located on the peninsula, they might want
2 to go downtown. So there's a number of
3 reasons.

4 And the fact that, again, this is 23 miles
5 away, just creates this situation where you're
6 not likely have a dramatic shift. And so, in
7 my view, the only way the Medical University
8 can achieve the projected utilization levels
9 they have in their application is if they take
10 those patients away from other providers,
11 primarily from Trident, into a lesser extent
12 from Roper.

13 Q: This might be a good time to differentiate
14 between patients and visits. You may have been
15 present when we had some objections about
16 referring to patients, when what we're really
17 looking at are ED visits. Can you explain why
18 that's relevant?

19 A: Well, there are some patients who go to the ED
20 more than one time. There's some they call
21 frequent flyers, who show up in the ED quite
22 often, you know, for in some cases legitimate,
23 in some cases not legitimate reasons. And so
24 when we're talking about -- you know, and
25 generally I should probably characterize this



1 all as visit data, because that's what it is.
2 It's individual patient visits. But the number
3 of unique patients that are in there is
4 something less than the total number of visits,
5 because some of these folks, because of health
6 reasons or whatever, may have gone to the
7 emergency department more than once in a given
8 period of time.

9 Q: Well, I think you made reference to oncology
10 patients, especially when they're in chemo.
11 Are they more likely to go several times a year
12 to an ED?

13 A: Sure. Because they're going to have
14 complications.

15 Q: Let's get back to this Intuitive data and how
16 it has -- what relevance to your analysis.

17 A: Yeah. Again, I think if you read Mr.
18 Herrmann's deposition and you look at the
19 exhibit's that are attached to that, I think it
20 paints a pretty clear picture that this
21 facility, the choice of location, the design of
22 the facility that ultimately was adopted by
23 MUSC was not focused on serving MUSC's existing
24 patient base. It was focused on serving
25 patients who fell within a relatively narrow



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

1200

1 geographic area, the 13 to 15-minute drive time
2 around the proposed site. And it was about
3 capturing a share of the market more so than it
4 was about trying to redirect patients from MUSC
5 downtown.

6 Q: Okay. Turning attention to -- this is from the
7 Intuitive deposition. What does this chart
8 depict?

9 A: Well, what this shows is -- and there are -- I
10 believe it's five-mile circles drawn around
11 different locations. And Mr. Herrmann
12 described this as the output of the model that
13 they utilized in terms of identifying
14 appropriate sites. And it's a little bit hard
15 to read, but if you look at the legend, the
16 yellow dot at the very top of the legend is for
17 the folks that are in the -- those are the most
18 desirable locations, if you will, that's the
19 highest percentile in terms of the factors that
20 they looked at.

21 Q: And this mathematical algorithm that Intuitive
22 uses, that's the top quartile, the yellow dots
23 are top quartiles. What are the factors, the
24 targets that they're looking for?

25 A: He described it as being population density and



1 affluence. And so if you see an area that has
2 a lot of yellow dots in it, that's a good area
3 from a retail standpoint. You know, it has
4 good demographics, it has a lot of traffic, and
5 it has enough population density that would
6 support the development. And so he was looking
7 at various shopping centers and retail
8 locations around the Charleston area.

9 And if you can kind of look at this, I
10 think, closely, you can see there are a number
11 of yellow dots that are located along I-26 in
12 the northern part of the service area. There
13 are also a number of yellow dots located in Mt.
14 Pleasant, which is kind of a southeastern
15 portion of this. And then -- and where the
16 proposed facility is going to go is near the
17 top -- I'm sorry, near the top of that map
18 where that blue circle is. And there are a
19 number of yellow dots and there's one, you
20 know, very close to the site that they're
21 proposing for their facility.

22 Q: What did Mr. Herrmann testify to about the
23 highest likelihood of success on the return on
24 investment? What color was the most important?

25 A: Yellow.



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

1202

1 Q: In other words, you'll make of those money
2 there?

3 A: Yeah. And obviously that's -- Intuitive is a
4 for-profit company and that was their focus.

5 Q: Okay. This is also from the Intuitive
6 deposition. It appears at Intuitive 301.
7 Explain to The Court what this document is.

8 A: This is just an effort to map the area around
9 the site. And they used 10-minute, 15-minute,
10 and 20-minute drive times around the proposed
11 site. And then they looked at various
12 characteristics of the sites. And they looked
13 at population growth, population per ER,
14 population per physician, population per urgent
15 care center, how much commercial insurance was
16 in that market. And you can see that for site
17 one and for site two it's a pretty highly
18 commercially insured population, which
19 generally means a higher level of affluence.

20 Q: Okay. So if I'm reading this right, let's look
21 at site number two. It says in that 15-minute
22 line, within 15-minute drive time would be how
23 many people in that area?

24 A: There would be -- within that area, there would
25 be 84,844.



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

1203

1 Q: Okay. And their immediate income would be
2 what?

3 A: Fifty-six thousand and change.

4 Q: And then it talks about growth in population.

5 A: At 10 percent growth.

6 Q: Okay. Is there any mention in this about
7 medically underserved folks?

8 A: There is not.

9 Q: Is the site that MUSC has picked, the most
10 recent site, is that within a medically
11 underserved area as defined by Health and Human
12 Services?

13 A: It's not.

14 Q: Okay. Can you explain to The Court how Health
15 and Human Services identifies medically
16 underserved areas?

17 A: Sure. There's really kind of two different
18 definitions. And one is what's called a
19 medically underserved area. And that would be
20 an area that -- there's a number of factors to
21 look at -- that don't have resources in terms
22 of physicians or facilities to serve that
23 population. And there are a couple of what we
24 call MUAs, medically underserved areas, that
25 are located, nut those are sort of in the



1 extreme northern part and eastern part of
2 Berkeley County, not close to the proposed
3 site.

4 There's also something called, health
5 professional shortage areas where they look at
6 the availability of all kinds of health
7 professionals like physicians and dentists and,
8 you know, all kinds of things. Again, there's
9 no health professional shortage areas anywhere
10 near the proposed site of this project.

11 Q: I think this also came from Intuitive, it's
12 part of their file. What is this?

13 A: This is just another cut at it. And it's
14 looking at using eight minutes, 10 minutes, and
15 12-minute drive times around the site that
16 appears to be either the site that's chosen or
17 somewhere close to that site. And, again, it
18 just shows that their concentration is on a
19 very narrow geographic area.

20 Q: So is this larger or smaller than the proposed
21 area that MUHA had described during the course
22 of discovery?

23 A: It's significantly smaller.

24 Q: As we're going through and talking about
25 different criteria that DHEC should evaluate

