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UNITED STATES DISTRICT COURT  
IN THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER - NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC.,	Plaintiffs,	:	x Case No. 1:12-cv-00560-BLW
	vs.	:	
ST. LUKE'S HEALTH SYSTEM, LTD., and ST. LUKE'S REGIONAL MEDICAL CENTER, LTD.,	Defendants.	:	
		:	Case No. 1:13-cv-00116-BLW
FEDERAL TRADE COMMISSION; STATE OF IDAHO,	Plaintiffs,	:	
	vs.	:	
ST. LUKE'S HEALTH SYSTEM, LTD.; SALTZER MEDICAL GROUP, P.A.,	Defendants.	:	
		:	x

\* \* \* SEALED \* \* \*

REPORTER'S TRANSCRIPT OF PROCEEDINGS

before B. Lynn Winmill, Chief District Judge

Held on October 10, 2013

Volume 12, Pages 2071 to 2300

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A P P E A R A N C E S

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PROCEEDINGS

October 10, 2013

\*\*\*\*\*COURTROOM OPEN TO PUBLIC\*\*\*\*\*

THE CLERK: The court will now hear the continued bench trial in the matter of Saint Alphonsus Medical Center, Nampa, et al., versus St. Luke's Health System, LTD, Case No. 12-CV-00560-BLW-REB.

THE COURT: Good morning, Counsel.

Dr. Souza, I'll remind you you are still under oath.

I think, Mr. Wilson, you had an issue concerning -- that may arise later in the morning, about the use of leading questions. We'll discuss that later so we can get Dr. Souza on his way back to his work.

Mr. Sinclair, you may resume your examination of the witness.

MR. SINCLAIR: Thank you, Your Honor.

JAMES SOUZA,

having been previously duly sworn to tell the whole truth, testified as follows:

CONTINUED DIRECT EXAMINATION

BY MR. SINCLAIR:

Q. Dr. Souza, yesterday when you were going through your background I meant to ask you, and I failed to, so I want to back up just a little bit in our presentation. You indicated you were the CEO's designee to the medical staff.

What does that entail? What is that?

A. You know, I am the CEO's representative to the organized structure of the medical staff. And basically what that -- what that is is all the doctors who hold privileges at the hospital organize themselves into a governing structure that has at its top a medical executive committee which is made up of all the department and section representatives. So the medical staff divides itself into departments and sections, such as, you know, the department of medicine, the department of orthopedics, things like that.

Q. Okay. Thank you.

So when we ended yesterday you had just discussed the EICU as one example of where you had seen quality improvement since affiliating with St. Luke's. Could you give the court a couple other examples of areas where there has been improvement in quality since you affiliated with St. Luke's?

A. Yes. I have several. I'll begin with the example of group C sepsis. And sepsis is the body's response to a severe infection. It's a highly lethal condition. Group C sepsis refers to those patients who have either a low blood pressure or a high level in their blood of an enzyme called "lactic acid." The mortality rate of that condition is as high as 45 percent. It's one of the most lethal conditions

we deal with in the intensive care unit.

There is a protocol, an evidenced-based protocol, that when applied to patients saves lives. This protocol involves the rapid insertion of a catheter into the jugular vein of the neck, IV fluids to target the central venous pressure, adjustment of blood-pressure-supporting drugs, adjustment of blood products, rapid cultures, and rapid administration of antibiotics.

And the data on that is that if you do that to eight people, you will save one life. It's relatively low-tech, inexpensive, but team-based care innovation that requires, you know, a team to work together to achieve all these things in a rapid fashion and saves lives.

So, again, when we integrated with St. Luke's and were told we had income at risk for quality and were set free to go develop these targets, the group C sepsis perfect care rates, that was one of our targets. And, basically, year after year we have improved those perfect care rates, which, you know, evidence-based medicine would tell us is saving lives and improving sepsis mortality. So that was one of our better care. You know, I went back to the group, and I said, "Whatever our quality measures are, they have to meet some or multiple parts of the Triple Aim." That was one of our better care initiatives.

More powerful initiatives to potentially discuss

in terms of initiatives that met multiple aspects of the Triple Aim would include our lung nodule program, our lung nodule clinic, and our -- the work we've done in sleep medicine. So perhaps I'll start with the lung nodule.

Q. Okay.

A. A lung nodule, in plain English, is a spot in your lung seen on a CAT scan. A large number of adults who present to an emergency department with the complaint of shortness of breath or chest pain will end up having a CAT scan performed. And, you know, a lot of those folks are going to have spots on their lungs. A lot of people in this courtroom have spots in your lungs. We don't know it. They are incidental findings.

The issue with these spots is most of them are benign, but a few of them are malignant, and so the entire workup is around making that distinction.

If I think back to five years ago in my independent practice, most such cases were referred to our group for a pulmonary consult. I should make a couple of points about that.

First is that was an important revenue stream to our practice. Commercial payors would reimburse us, you know, around \$300 for such a service. And yet, it was a low-value service to the patient. And I say that because in order to make a decision about what's the best care for the

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1 patient, you really only need a limited amount of  
2 information. What you need to know is the age of the  
3 patient, the smoking status of the patient, the size of the  
4 nodule, the shape of the nodule, and then it's useful if you  
5 have any previous films. So we -- in my old practice we  
6 would see these patients and apply those standards and, you  
7 know, come up with the right plan for the patient.

8 Now, unfortunately, some of those patients in  
9 the -- five years ago they were sent to their primary care  
10 doctors, mostly got good care, but sometimes were sent for  
11 unnecessary biopsies of the lung, you know, because this was  
12 being guided by a primary care physician and not a  
13 specialist. Some of those biopsies of what were benign  
14 lesions led to complications like a pneumothorax; that's a  
15 collapsed lung. When that occurs you have to put in a chest  
16 tube.

17 When that occurs you have to admit the patient to  
18 the hospital; that generates fee-for-service revenue fee for  
19 the hospital. A few of those patients were sent to  
20 oncologists or thoracic surgeons, and, sadly, a few of those  
21 patients had no follow-up. And, you know, I don't know what  
22 the numbers would be, but, you know, very sad when you would  
23 see a patient return with metastatic cancer that's no longer  
24 curable.

25 Q. So what's different now than then?

1 A. So St. Luke's said go create quality measures.  
2 And this was one of our long-term quality targets, was the  
3 creation of a lung nodule clinic. We're very proud of that  
4 work. We were national leaders in that work. We beat  
5 National Jewish Medical Center, one of the -- probably the  
6 world's preeminent respiratory hospital in Denver, Colorado,  
7 by a year in creating this. So what we did is we created  
8 essentially a virtual clinic. We said, this seems like an  
9 area where we could improve care, get access for all the  
10 patients to a pulmonologist, and lower cost.

11 So the way it works is we have a team of docs: a  
12 St. Luke's pulmonologist, a St. Luke's thoracic surgeon, and  
13 a St. Luke's radiologist. And each week, the nodules that  
14 come out of the emergency department or, you know, ordered  
15 from an individual doctor's clinic can be referred to the  
16 lung nodule clinic. This team of doctors applied those same  
17 standards: What's the age of the patient? What's the  
18 smoking status? They can review the medical record. They  
19 can review the images, current and past, and make an  
20 evidence-based recommendation. 75 percent of those patients  
21 no longer need to see a pulmonologist.

22 So we're getting access for all patients to  
23 experts, not requiring them to be in a clinic room  
24 generating a fee-for-service charge. So there is clinical  
25 benefit to the patient, and the financial benefit is

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1 accruing to the payor. We are doing the good work in the  
2 middle.

3 Q. Why couldn't you do that as an independent?

4 A. That would -- you know, back-of-the-napkin math,  
5 in terms of lost fee-for-service revenue -- would lose us a  
6 number that approaches six figures in charges.

7 Q. So there would be an economic disincentive to do  
8 that?

9 A. Absolutely.

10 Q. Any other examples for the court?

11 A. Yeah. The work we've done in sleep. So for the  
12 court -- I think probably most people know what sleep apnea  
13 is. I think we have a lot of education to do yet. Most  
14 people don't know that it's a very powerful -- when  
15 undiagnosed and untreated, it's a very powerful risk factor  
16 for stroke, heart attack, and cardiac death, so it's more  
17 than just treating snoring.

18 Sleep apnea is also a very important revenue  
19 stream for an outpatient pulmonary clinic because it is  
20 reimbursed very well. The way sleep apnea is diagnosed is  
21 usually with a visit with a doctor, then a baseline  
22 polysomnogram, sleep study, then a CPAP titration study.  
23 These things, just so you've got ballpark numbers, Medicare  
24 reimburses for a baseline or a CPAP \$750, commercial payors  
25 usually reimburse around \$1200. So, again, we're developing

1 our quality measures, and this was another one where we  
2 thought we could meet better care and lower costs.

3 So there is a subset of the sleep apnea population  
4 where current evidence suggests you can make the diagnosis  
5 and initiate the treatment for a much -- with a much  
6 lower-cost procedure called an out-of-center sleep test.  
7 That procedure reimburses at -- it's around \$150 for  
8 Medicare, around \$350 for commercial.

9 In the same way there is also evidence that shows  
10 that for, you know, a subset of the sleep apnea population,  
11 you don't need to do a baseline study and a CPAP titration,  
12 that you can combine those studies and only get paid for  
13 one, and that's called a split study. So you spend the  
14 first part of the night diagnosing the disorder and the  
15 second part of the night applying the treatment, which is  
16 the positive pressure mask.

17 Q. That cuts the reimbursement in half?

18 A. That would cut the reimbursement in half, and, of  
19 course, an out-of-center sleep test, by the math, cuts the  
20 reimbursement to, you know, what, 15 or 20 percent.

21 So what we did is we created pathways that  
22 encouraged patients moving toward split studies, such that  
23 in three years we've gone from 4 percent split studies to I  
24 think it's 34 percent split studies. And we've done 74  
25 out-of-center sleep tests in the last year. Again, the

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1 **back-of-the-napkin math on that is about a \$650,000 loss in**  
2 **potential revenue.**

3 **So, once again, the patient is deriving a clinical**  
4 **benefit. The payor is deriving the financial benefit, and**  
5 **because our doctors are immune to the financial impact of**  
6 **that and set free to find the waste in the system -- I mean,**  
7 **this all gives me so much hope for the chances to actually**  
8 **save healthcare -- that the doctors write the orders that**  
9 **spend the money; the doctors know where the waste is. If**  
10 **you set us free to find it, we can do it. Examples like**  
11 **this give me hope that -- that clinical innovations like**  
12 **this can avoid the financial catastrophe that's coming.**

13 MR. SINCLAIR: Thank you. No other questions,  
14 Your Honor.

15 THE COURT: Mr. Ettinger, cross.

16 MR. ETTINGER: Yes, Your Honor.

17 CROSS-EXAMINATION

18 BY MR. ETTINGER:

19 **Q.** Good morning, Dr. Souza.

20 **A.** Good morning.

21 **Q.** We were fortunate enough to get a transcript of  
22 what you said yesterday, and I'm going to ask you about some  
23 of your exact words which we're going to put up on the  
24 screen.

25 **A.** Okay.

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1 **Q.** We'll start with those as soon as it's up.

2 So let me begin by going to recruitment. At page 207  
3 of your transcript yesterday -- Keely, if you could pull it  
4 up -- you said -- it would be about line --

5 **A.** Can I make mine any bigger?

6 THE COURT: They're going to blow it up for you, I  
7 believe.

8 MR. ETTINGER: We're going to blow it up.

9 THE WITNESS: Thanks.

10 THE COURT: If not, I'll ask them to.

11 THE WITNESS: Middle age is hitting hard.

12 MR. ETTINGER: Sure. I'd be the same way.

13 BY MR. ETTINGER:

14 **Q.** At lines 12 through 16, why don't we blow those  
15 up.

16 You see there you said, quote, You couldn't recruit,  
17 close quote. Do you see that?

18 **A.** Yep.

19 **Q.** And you were referring to when IPA was an  
20 independent group?

21 **A.** Yep.

22 **Q.** And are those words literally true, yes or no?

23 **A.** We did recruit.

24 **Q.** You recruited nine pulmonologists in nine years,  
25 didn't you, Doctor?

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1 **A.** We needed many more.

2 **Q.** You recruited at the same rate, basically, that  
3 you have recruited since you were acquired by St. Luke's;  
4 isn't that right?

5 **A.** Not true.

6 **Q.** First of all, let's be clear. You did, in fact,  
7 recruit nine in nine years; correct?

8 **A.** I did recruit nine in nine years.

9 **Q.** And your group in total was only 14; correct?

10 **A.** Yes.

11 **Q.** And how many pulmonologists did St. Luke's have in  
12 the Treasure Valley when your group was acquired?

13 **A.** Ten.

14 **Q.** And how many does it have today in the Treasure  
15 Valley?

16 **A.** I believe 17. It may be 16.

17 **Q.** Okay. And that was --

18 **A.** And Saint Alphonsus has also successfully  
19 recruited.

20 **Q.** Doctor, my question is about St. Luke's. Thank  
21 you.

22 **A.** Got it.

23 **Q.** Now, you said just a minute ago that what  
24 St. Luke's does is set the doctors free. Is that -- is that  
25 fair?

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1 **A.** Those were my words, yes.

2 **Q.** Okay. Why don't we take a look at Exhibit 1357.  
3 And do you recall this -- and we have -- should we -- do we  
4 have the book for Dr. Souza if he has trouble reading?  
5 We've got hard copies for you.

6 **A.** I can read it, sir.

7 **Q.** Okay. Well, if you need one on any of these,  
8 we'll be happy to do it.

9 So this is -- the middle email is from Dr. Bathina to  
10 Gary Fletcher, Re: Saltzer. Do you recall seeing this in  
11 your deposition?

12 **A.** I do.

13 **Q.** And Dr. Bathina is the vice president of St.  
14 Luke's Idaho Cardiology Associates; is that right?

15 **A.** He is the site medical manager.

16 **Q.** And he's a physician --

17 **A.** Yes.

18 **Q.** -- like you, who works for St. Luke's?

19 **A.** Yes.

20 **Q.** And he says in that email to Gary Fletcher, who is  
21 the -- by the way, Gary Fletcher is the COO of the  
22 St. Luke's Health System?

23 **A.** Yes.

24 **Q.** And he says, quote, Just had a conversation with  
25 Jim Souza. I am sure you know that he is very disappointed

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1 with the way things have happened.  
 2 Do you see that language?  
 3 **A. Yep.**  
 4 **Q.** And in the next paragraph he says, quote, He and I  
 5 and likely some other physicians are feeling like this whole  
 6 physician-led mantra is a bunch of propaganda without real  
 7 meaning. Why are we working on standards and expectations  
 8 for the system when the system is making decisions based on  
 9 dollars and strategy regardless of quality, question mark.  
 10 Did I read that correctly?  
 11 **A. You did.**  
 12 **Q.** And did you also testify that St. Luke's does not  
 13 in any way push you to keep referrals within the system; is  
 14 that correct?  
 15 **A. That is correct.**  
 16 **Q.** And in the fourth paragraph, Dr. Bathina says,  
 17 referring to Saltzer, "It will be very disappointing to us  
 18 doctors who work on the west side to have to refer to these  
 19 guys, because they are now part of Luke's, when we are fully  
 20 aware that they offer a far inferior product to what our  
 21 colleagues at IPA can provide, close quote.  
 22 Did I read that correctly?  
 23 **A. Yep.**  
 24 **Q.** Now, it's your view -- actually, I'm sorry. Let  
 25 me -- I was going to do one other thing. In fact, the

1 agreement with Saltzer was contingent on the Saltzer  
 2 physicians obtaining privileges at St. Luke's; isn't that  
 3 right?  
 4 **A. No.**  
 5 MR. ETTINGER: Why don't we play the cross clip  
 6 No. 19. Your Honor, that's 156, line -- I think it's page  
 7 157, line 1 through 23.  
 8 THE COURT: All right. Thank you.  
 9 (Video clip played as follows:)  
 10 **Q.** "Why was the agreement with the Saltzer  
 11 physicians contingent on them obtaining  
 12 privileges?  
 13 **A.** "I think that's part of all of St. Luke's  
 14 employment agreements, that if you're going to  
 15 be employed by the hospital, you have to have  
 16 privileges.  
 17 **Q.** "In order for the Saltzer physicians to  
 18 admit patients to St. Luke's, they would have  
 19 to have privileges; right?  
 20 **A.** "For them to admit patients, absolutely.  
 21 **Q.** "So it was complicated -- it was  
 22 contemplated in the Saltzer agreement that the  
 23 Saltzer physicians would be admitting patients  
 24 to St. Luke's; right?  
 25 **A.** "Yes."

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1 (Video clip concluded.)  
 2 BY MR. ETTINGER:  
 3 **Q.** Doctor, was that your testimony?  
 4 **A. Yes, but it's wrong.**  
 5 **Q.** Doctor, in fact, you went to St. Luke's, you chose  
 6 to affiliate with St. Luke's in significant part because in  
 7 your view St. Luke's is better positioned to become the  
 8 dominant player in the market for the foreseeable future;  
 9 isn't that right?  
 10 **A. I find it ironic that we're talking about --**  
 11 **Q.** Doctor, I'd like you to please answer my question  
 12 "yes" or "no."  
 13 THE COURT: Let me just explain. Dr. Souza,  
 14 Mr. Sinclair is going to give you a chance to explain all of  
 15 this.  
 16 THE WITNESS: Sorry, Your Honor.  
 17 THE COURT: That's fine.  
 18 Go ahead, Mr. Ettinger.  
 19 BY MR. ETTINGER:  
 20 **Q.** Would you like me to repeat the question?  
 21 **A. I would love that.**  
 22 **Q.** Isn't it true -- I'm more than happy to -- isn't  
 23 it true that you chose to affiliate with St. Luke's in  
 24 significant part because in your view St. Luke's is better  
 25 positioned to be the dominant player in the market for the

1 foreseeable future?  
 2 **A. Those were my words that I wrote to myself, yep.**  
 3 **Q.** Thank you. Now, you said yesterday that the  
 4 situation you were in before you were acquired by St. Luke's  
 5 was a sad state of affairs in terms of medical quality. Is  
 6 that your view?  
 7 **A. It is my view.**  
 8 **Q.** In fact, isn't it true that before your group was  
 9 acquired by St. Luke's, under your group's contract with  
 10 Saint Alphonsus, there were substantial lengthy quality  
 11 metrics for which the group could be compensated up to  
 12 \$250,000 per year; isn't that right?  
 13 **A. I'd have to see the actual -- yeah, we had quality**  
 14 **metrics as part of our critical care contract, which took 18**  
 15 **months to negotiate.**  
 16 **Q.** How long did it take to develop the quality  
 17 metrics at St. Luke's? Can you tell me the time period?  
 18 **A. About a month.**  
 19 **Q.** From start to finish? When were the quality  
 20 metrics first adopted after you were acquired by St. Luke's?  
 21 **A. I don't recall.**  
 22 **Q.** Okay. Now, you said some things about call, and I  
 23 wanted to ask you about call, Doctor. Before your group,  
 24 your physicians were acquired by St. Luke's, you provided  
 25 call at four different hospitals; is that correct?

2092

1 **A. That's correct.**  
 2 **Q.** And that was 14 doctors sharing call at four  
 3 hospitals?  
 4 **A. That's correct.**  
 5 **Q.** And then ten of the doctors went to St. Luke's;  
 6 right?  
 7 **A. Yes.**  
 8 **Q.** And the ten doctors still share call at three  
 9 hospitals; correct?  
 10 **A. Yes.**  
 11 **Q.** Let's talk about eClinicalWorks. Doctor, you,  
 12 yesterday -- I'd be happy to show you the language if you  
 13 like -- but you called it, quote, a horse-and-buggy system,  
 14 close quote --  
 15 **A. I did.**  
 16 **Q.** -- do you recall that?  
 17 **A. Yeah.**  
 18 **Q.** Is that fair, do you think?  
 19 **A. In my experience, it is fair when compared with**  
 20 **Epic.**  
 21 **Q.** Now, you're aware that a number of significant  
 22 groups in this community use eClinicalWorks; correct?  
 23 **A. I am.**  
 24 **Q.** Primary Health does; correct?  
 25 **A. I am.**

2093

1 **Q.** Idaho PM&R does, for example?  
 2 **A. I didn't know that.**  
 3 **Q.** You know Saltzer did before this acquisition?  
 4 **A. Yes.**  
 5 **Q.** Do you know even approximately how many physicians  
 6 around the United States use eClinicalWorks?  
 7 **A. I don't know that.**  
 8 **Q.** Would it surprise you if 80,000 physicians seem to  
 9 find eClinicalWorks useful?  
 10 MR. SINCLAIR: Your Honor, I would object. He  
 11 just testified he does not know.  
 12 THE COURT: Well, I think the question is would  
 13 you be surprised.  
 14 THE WITNESS: No, I wouldn't be surprised. We got  
 15 here by this kind of work.  
 16 BY MR. ETTINGER:  
 17 **Q.** Now, what was -- what was the last time you used  
 18 eClinicalWorks, Doctor?  
 19 **A. June of 2012.**  
 20 **Q.** Your group was on eClinicalWorks until June of  
 21 2012?  
 22 **A. Yes.**  
 23 **Q.** What version of eClinicalWorks was your group on  
 24 in June of 2012?  
 25 **A. I do not know, sir.**

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1 **Q.** Are you aware that the current versions of  
 2 eClinicalWorks -- strike that.  
 3 Now, you made some comments yesterday about how when  
 4 you used eClinicalWorks, for example, you had to remember to  
 5 send a note to the primary care physician if you wanted her  
 6 to see what you had found; is that right?  
 7 **A. Yes.**  
 8 MR. SINCLAIR: Your Honor, may we approach?  
 9 THE COURT: Yes.  
 10 (Sidebar commences as follows:)  
 11 MR. SINCLAIR: I'm anticipating that they're going  
 12 to attempt to call up that same document that we objected to  
 13 yesterday, which I was able to find on the internet last  
 14 night. It's a news release from approximately a month ago  
 15 about revisions to the systems of Epic and eClinicalWorks.  
 16 MR. ETTINGER: Actually, I'm not.  
 17 MR. SINCLAIR: Okay.  
 18 THE COURT: Well, that makes it easy. All right.  
 19 Very good.  
 20 (Sidebar concluded.)  
 21 THE COURT: Proceed, Mr. Ettinger.  
 22 MR. ETTINGER: Thank you, Your Honor.  
 23 BY MR. ETTINGER:  
 24 **Q.** And you said part of the problem was that you  
 25 could forget to send the note; isn't that right?

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1 **A. Yes.**  
 2 **Q.** Are you aware that under the current versions of  
 3 eClinicalWorks, there could be an automated process that  
 4 automatically sends information to the primary care  
 5 physician?  
 6 **A. No.**  
 7 **Q.** And you mentioned that the physician might not  
 8 find the test results that you performed; is that right?  
 9 **A. Depended on their detective skills, yes.**  
 10 **Q.** And are you aware that under the current version  
 11 of eClinicalWorks, there is an automated feature that can  
 12 send those test results to the primary care physician?  
 13 MR. SINCLAIR: Your Honor, I'm going to object to  
 14 this unless they're planning on calling a witness to put in  
 15 the foundation of what they're trying to question this  
 16 witness about.  
 17 MR. ETTINGER: Your Honor, the witness offered  
 18 opinions about eClinicalWorks that suggests that it is  
 19 inefficient to use it, and the question is what does he know  
 20 about it.  
 21 THE COURT: I'm assuming -- but, again, the  
 22 question assumes facts not in evidence. I think that's  
 23 really the basis of the objection. I'm going to allow it,  
 24 but if it's not tied in with some evidence about, in fact,  
 25 that eClinicalWorks does that, then I think the questioning

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1 really has no relevance.  
2 I'm going to allow you to proceed, but if you don't tie  
3 it in on rebuttal or through cross-examination or through  
4 some exhibit to demonstrate that, then I think the  
5 questioning then has no purpose with this witness because it  
6 does assume facts not in evidence. Proceed.

7 MR. ETTINGER: I understand, Your Honor, and  
8 that's our plan.

9 THE COURT: All right.

10 BY MR. ETTINGER:

11 Q. Are you aware that eClinicalWorks has an automated  
12 feature that can send test results automatically to the  
13 primary care physician?

14 A. No.

15 Q. By the way, you mentioned yesterday that you send  
16 notes in Epic, don't you?

17 A. Notes in Epic -- I know you want a yes/no, but  
18 I've got to clarify -- notes in Epic are automatically in  
19 the chart. What I can do is attach a note to a note and  
20 then send that.

21 Q. And that's what you were referring to yesterday?

22 A. Yes.

23 Q. And you've got to remember to send that note,  
24 don't you, Doctor?

25 A. It's usually front of my mind that I'm needing to

1 communicate an urgent issue to someone when I send such a  
2 communication, yes.

3 Q. So you don't have a -- you've never had a big  
4 problem remembering to send notes to primary care  
5 physicians, have you?

6 A. Routine notes, yes, I have.

7 Q. Oh, but the Epic notes are not routine notes; is  
8 that what you're saying?

9 A. No. What I'm saying, sir, is when I have an  
10 urgent issue that demands clinical integration with a  
11 primary care doctor and other specialists, that Epic gives  
12 me the power to do that without calling an office, sitting  
13 on hold, waiting for the -- oh, that doctor is not in this  
14 office today. You understand, I hope, the efficiencies that  
15 would gain you.

16 Q. Are you aware whether you could --

17 THE COURT: Let me just inquire to make sure I  
18 understand. I think what you're saying is that Epic has  
19 built into it kind of an integrated note feature -- or not  
20 even really a note feature, but whatever action you take is  
21 automatically communicated or available to the primary care  
22 physician; but if there is something that requires immediate  
23 attention, that is -- you have the ability to add a separate  
24 note which creates kind of an alert.

25 THE WITNESS: That's right. That's not part of

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1 the progress note, but it's physician-to-phys- -- or  
2 physician-to-provider, I should say, communication, yes.

3 THE COURT: Mr. Ettinger, I just wanted to clarify  
4 in my mind. I thought that's what the witness was saying.  
5 Go ahead.

6 MR. ETTINGER: Your Honor, and that's helpful to  
7 me. I'm going to ask a follow-up question on that.

8 BY MR. ETTINGER:

9 Q. And isn't it true that under the current version  
10 of eClinicalWorks, eClinicalWorks can send jelly beans that  
11 light up and tell the primary care physician, "This is  
12 something you really want to look at right away"?

13 A. You know, sir, I'm going to tell you that I have  
14 no idea what eClinicalWorks does today because I haven't  
15 worked in it since June of 2012.

16 Q. Thank you.

17 A. You're welcome.

18 Q. Why don't we go to page 206 of yesterday's  
19 transcript, Doctor. I want to ask you about one other  
20 thing, and I don't want to fracture it by just reading it.

21 A. Okay.

22 Q. The major paragraph -- Keely, second first  
23 paragraph, "The last thing I would say."

24 Doctor, you say here, "The last thing I would say is  
25 that in eClinicalWorks, I could not" -- I gather -- "find

1 out how many 50-year-old female patients in my practice with  
2 a body mass index less than 25 have" -- and the court  
3 reporter wasn't quite there on the rough transcript, as I  
4 certainly wouldn't be -- "had a hemoglobin A1c greater than  
5 8.5." Did I fracture that too badly?

6 A. No. It's perfect except for "metformin" is the  
7 word.

8 Q. I skipped it over; I didn't know what to say  
9 there.

10 THE COURT: Why don't you spell that just to make  
11 it easier on the court reporter.

12 THE WITNESS: M-E-T-F-O-R-M-I-N.

13 THE COURT: All right. Thank you.

14 THE WITNESS: You're welcome.

15 BY MR. ETTINGER:

16 Q. Now, if you had this information, am I correct  
17 that what you contemplate is doing some kind of -- making  
18 some kind of judgment about correlation between these  
19 variables?

20 A. What this information would be used for would be  
21 to target my interventions on that group of patients. If  
22 I'm not meeting my targets, the question for the clinician  
23 is why, what about my practice is not providing the care  
24 that these people need.

25 Q. And by focusing on some particular group like

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1 this, you would be inferring something about the  
2 relationship between, say, body mass index and these test  
3 results for this group of patients; correct?

4 **A. These would be thin patients who I'm still not  
5 meeting their goal, yes.**

6 **Q.** Are you an epidemiologist, Doctor?

7 **A.** No.

8 **Q.** Are you a statistician?

9 **A.** No.

10 **Q.** And people who do medical studies gather vast  
11 amounts of data, do careful statistical work to try to  
12 gather conclusions about correlations; correct?

13 **A.** Yes.

14 **Q.** And you wouldn't try to do that with some subset  
15 of your patients just using Epic, would you?

16 **A. I would always try to improve my clinical practice  
17 based on evidence base, using whatever tools I have. That's  
18 my job. That's what I do.**

19 **Q.** Would you agree that a physician, not trained in  
20 epidemiology or statistics, drawing conclusions from  
21 statistical -- small samples of statistical evidence from  
22 his patients might be a little more dangerous for those  
23 patients than somebody who relies on national studies?

24 **A. I don't agree with the premise of your question.**

25 **You're suggesting that individual physicians can't improve**

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1 **the care of their patients, and I disagree with that so  
2 fundamentally that -- no.**

3 **Q.** I'm not -- I don't want to engage in a debate  
4 here, though at some other time we might, but let me just  
5 ask you this: Isn't the whole premise of evidence-based  
6 medicine that individual physicians should not be making  
7 their own judgments and should be relying on scientific  
8 results that have been tested in peer-reviewed journals. Is  
9 that correct?

10 **A. No. What about this is not following  
11 evidence-based medicine?**

12 **Q.** So you disagree with my question; is that right?

13 **A. I really don't understand your question as it  
14 pertains to the paragraph that's in front of me. I would  
15 want my diabetics to have a hemoglobin A1c less than that  
16 number. And if I don't measure that number and I don't know  
17 about it, I can't possibly address it.**

18 **Q.** Well, you measured -- that number is measured by  
19 tests on individual patients, is it not, Doctor?

20 **A. It is, but the question is: Are there subsets of  
21 my patients that I take good care of and some that I've got  
22 a miss on and other things that I can do to meet these  
23 patients' needs? More education, more -- you know, whatever  
24 it might be. You can't fix a -- what gets measured gets  
25 managed, and what gets managed gets done.**

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1 **Q.** Doctor, you said yesterday you would cut -- you  
2 would have cut your own throat if you had gone along with an  
3 EICU system --

4 **A. That was colorful.**

5 **Q.** -- and you were under contract.

6 Excuse me?

7 **A. That was too colorful of language. Sorry.**

8 **Q.** Well, I wasn't suggesting that you meant it  
9 literally, Doctor. But I gather you did -- your point was  
10 that you would lose a tremendous amount of money, and  
11 therefore you never would have done it; is that right?

12 **A. It would take 2.4 FTE physicians generating no  
13 fee-for-service revenue and losing subsequent  
14 fee-for-service volume, so, yes, that would be financial  
15 suicide for my practice and the people I employed.**

16 **Q.** Now, those dollars -- if St. Luke's employs your  
17 group and St. Luke's is not getting reimbursed, just like  
18 the doctors wouldn't for that --

19 **A. Right.**

20 **Q.** -- under a fee-for-service system, St. Luke's is  
21 losing those very same dollars; correct?

22 **A. But we believe -- yes, but --**

23 **Q.** Would you please answer my question. Is that  
24 correct?

25 **A. Yes.**

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1 **Q.** And in every single example you have given where  
2 you say as an independent group you would have lost money,  
3 today St. Luke's is losing that very same money; correct?

4 **A. Clinical benefit to the patient, financial benefit  
5 to the payor; correct.**

6 **Q.** One thing about this EICU example, you were not  
7 saying, were you, that if the patient is not extubated  
8 during the night that that creates complications and more  
9 work; that wasn't your point, was it?

10 **A. I don't understand your question.**

11 **Q.** I think that wasn't your point. Okay.

12 You mentioned that the out-of-center sleep testing and  
13 the EICU and the lung nodule clinic are innovations. None  
14 of those are at all unique to St. Luke's, are they?

15 **A. Nobody has put them all together, but each as  
16 individual innovations, no, they're not.**

17 **Q.** In fact, hundreds of hospitals around the country  
18 are doing all these things, aren't they?

19 **A. I don't know.**

20 **Q.** The EICU comes from a company that is offering it  
21 that has already set it up in 350 hospitals in America;  
22 correct?

23 MR. SINCLAIR: Object.

24 THE WITNESS: Correct. The first in Idaho,  
25 though -- second in Idaho, first successful in Idaho.

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1 BY MR. ETTINGER:  
 2 **Q.** And do you know how many of those hospitals  
 3 involve independents in their work?  
 4 THE COURT: Just a moment. Mr. Sinclair, I think  
 5 you were trying to make an objection, but I'm not sure if  
 6 you withdrew it --  
 7 MR. SINCLAIR: My mic was off. I'll withdraw it.  
 8 THE COURT: All right. Thank you.  
 9 Proceed.  
 10 MR. SINCLAIR: I turned my mic on, though.  
 11 BY MR. ETTINGER:  
 12 **Q.** Do you know, even approximately, how many of those  
 13 hospitals are working with independent physicians in  
 14 establishing an EICU?  
 15 **A.** I don't.  
 16 **Q.** And lung nodule screening -- let me ask you about  
 17 that. First of all, you have no evidence that your efforts  
 18 in that area have reduced utilization at all; correct?  
 19 **A.** What do you mean by "evidence"?  
 20 **Q.** Why don't you play clip 15, Keely, please.  
 21 (Video clip played as follows:)  
 22 **Q.** "How does SLIPA measure utilization  
 23 control to do this lung nodule screening?  
 24 **A.** So I asked about that some months ago,  
 25 you know: Do we have any evidence that this is

1 actually decreasing utilization? And the  
 2 answer is I don't have that evidence.  
 3 (Video clip concluded.)  
 4 THE WITNESS: That was May 30th, sir.  
 5 THE COURT: Counsel, we need a page and line  
 6 number.  
 7 MR. ETTINGER: I'm sorry, Your Honor. That is  
 8 page 138 of Dr. Souza's deposition, lines 18 to 23.  
 9 BY MR. ETTINGER:  
 10 **Q.** Was that your testimony when your deposition was  
 11 taken?  
 12 **A.** On May 30th.  
 13 **Q.** Now, isn't it true that many hospitals have  
 14 interdisciplinary committees to screen for lung nodules  
 15 before any biopsy is done?  
 16 **A.** I don't know.  
 17 **Q.** Now, you talked about sepsis. There are  
 18 nationwide guidelines for sepsis from the Society of  
 19 Critical Medicine, aren't there?  
 20 **A.** There are.  
 21 **Q.** And you don't know how many hospitals around the  
 22 country are following those guidelines, do you?  
 23 **A.** I don't.  
 24 **Q.** And St. Luke's is not in the top 5 percent of  
 25 hospitals nationwide in avoiding sepsis mortality, is it?

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1 **A.** I don't know.  
 2 **Q.** Do you know whether Saint Al's has accomplished  
 3 more than St. Luke's in this area?  
 4 **A.** I don't know.  
 5 **Q.** In fact, St. Luke's did not hit its targets for  
 6 sepsis; correct?  
 7 **A.** What targets are you referring to?  
 8 MR. ETTINGER: Why don't you play clip 21, please,  
 9 Keely.  
 10 THE COURT: Page and line.  
 11 MR. SINCLAIR: Your Honor, I would object. He  
 12 simply asked for clarification as to what targets. I don't  
 13 know how you can impeach him asking what targets he is  
 14 referring to.  
 15 MR. ETTINGER: Your Honor, because he uses the  
 16 word "target" in the clip and says they're not meeting it.  
 17 So it seems to me that if the witness used it, it's  
 18 impeaching his suggestion that it's somehow ambiguous. Just  
 19 like in the last clip, where he didn't know what I meant by  
 20 "evidence," and he used --  
 21 MR. SINCLAIR: Your Honor, I'd object to this  
 22 commentary, as well.  
 23 THE COURT: Well, counsel needs to, I think,  
 24 explain his position. I'm going to overrule the objection  
 25 and allow it to be played.

1 Go ahead. But I need a page and line number; I'm not  
 2 sure you've provided that.  
 3 MR. ETTINGER: I'm sorry, Your Honor. It's page  
 4 115, lines 3 through 22.  
 5 (Video clip played as follows:)  
 6 **Q.** "How frequently do you receive reports on  
 7 your score for the group C sepsis perfect care?  
 8 **A.** "So those now come fairly frequently. I  
 9 want to say the group gets a monthly update on  
 10 that. Moreover, we've baked into the program  
 11 now that if I have a miss in a group C sepsis  
 12 patient, so I have a patient where I didn't get  
 13 the follow-up lactate, I am pinged with an  
 14 e-mail by the sepsis coordinator that says,  
 15 "You missed." Also, if I achieve perfect care  
 16 on a sepsis group C patient, I get an e-mail  
 17 that says, "Thank you. You achieved perfect  
 18 care."  
 19 "So there's an immediate feedback loop,  
 20 and then there's a slightly more drawn-out  
 21 feedback loop, and then there's an annual  
 22 report. And I know that by late in the year we  
 23 were not hitting our target, and I think we did  
 24 not achieve the target on that measure for last  
 25 year.

1 **Q.** "For 2012?  
 2 **A.** "Yeah."  
 3 (Video clip concluded.)  
 4 BY MR. ETTINGER:  
 5 **Q.** Dr. Souza, was that your testimony?  
 6 **A.** On May 30th.  
 7 **Q.** Do you believe you were practicing poor quality  
 8 medicine before your group was acquired by St. Luke's?  
 9 **A.** No. But I didn't measure it.  
 10 **Q.** The metrics that were included in your contract  
 11 with Saint Al's were, in fact, measured in making decisions  
 12 as to whether to make the payments; correct? Is that right?  
 13 **A.** There would have been -- yes.  
 14 MR. ETTINGER: No further questions. Thank you.  
 15 THE COURT: Mr. Sinclair, is there any -- I am  
 16 assuming --  
 17 MR. SU: No, Your Honor.  
 18 THE COURT: Thank you, Mr. Su.  
 19 Mr. Sinclair.  
 20 REDIRECT EXAMINATION  
 21 BY MR. SINCLAIR:  
 22 **Q.** Dr. Souza, when Mr. Ettinger referred to your  
 23 trial testimony last year where you said, "We need to  
 24 recruit, but you couldn't recruit. The doctors coming out  
 25 of training knew that the old model was unsustainable, and

1 recruit the necessary doctors has improved?  
 2 **A.** Most definitely.  
 3 **Q.** And Saint Al's as an organization has recruited  
 4 doctors that are pulmonologists, as well?  
 5 **A.** Absolutely.  
 6 **Q.** How many independent pulmonologist groups have  
 7 recruited in the Treasure Valley in the last five years, if  
 8 you know?  
 9 **A.** There are no more independent pulmonary groups in  
 10 the Treasure Valley.  
 11 **Q.** So all the pulmonologists in the Treasure Valley  
 12 have opted to be part of a system?  
 13 **A.** That's correct.  
 14 MR. ETTINGER: Objection; leading, Your Honor.  
 15 THE COURT: Sustained.  
 16 MR. SINCLAIR: I was simply restating what he just  
 17 testified to, I thought, Your Honor, just summarizing.  
 18 MR. ETTINGER: There was a little more to it, Your  
 19 Honor.  
 20 THE COURT: I agree, and I sustained. But the  
 21 answer will stand. You know, the issue of leading and  
 22 questions, to me, is generally -- I won't say much ado about  
 23 nothing, but much ado about something that's not that  
 24 significant. As long as counsel is not putting words in the  
 25 witness's mouth, I'm going to give leeway.

1 they wanted to be employed with the health system, so we  
 2 were struggling with recruitment."  
 3 At what point in time were you indicating that you were  
 4 having difficulties recruiting?  
 5 **A.** We had difficulties recruiting throughout all of  
 6 that time. If you look at what's happened in this valley  
 7 since our group unanimously decided to seek employment,  
 8 we've, at St. Luke's, added six physicians, and Saint  
 9 Alphonsus has added four.  
 10 MR. ETTINGER: Your Honor, the question was about,  
 11 and my question was about, the independent group's  
 12 difficulty recruiting. I think the witness is going beyond  
 13 the question and the scope of the redirect.  
 14 THE COURT: The witness also -- during the  
 15 cross-examination, whether it was asked or not, a comment  
 16 was made about the number that had been added before and  
 17 after, and I think it's fair redirect. I'll allow it.  
 18 THE WITNESS: So the community, that's what we all  
 19 should be talking about here, what does the community need.  
 20 The community needed ten more doctors. We could not meet  
 21 that need as an independent group. The model was  
 22 unsustainable. We recruited in a trickle when we needed to  
 23 just open the faucet more widely.  
 24 BY MR. SINCLAIR:  
 25 **Q.** So since joining St. Luke's your ability to

1 But I think we went a little bit over the edge on that,  
 2 Mr. Sinclair, but let's go ahead and proceed.  
 3 MR. SINCLAIR: Fair enough.  
 4 BY MR. SINCLAIR:  
 5 **Q.** You referred to the email that you had with  
 6 -- actually you weren't part of the email. Dr. Bathina was  
 7 discussing matters in an email that you weren't part of;  
 8 correct?  
 9 **A.** That's right.  
 10 **Q.** And he referenced -- and we actually went over  
 11 this in your video presentation, that you weren't here  
 12 during that -- plaintiffs --  
 13 **A.** Yeah.  
 14 **Q.** -- played during the first part of the trial. But  
 15 in order to bring it back into context -- because you  
 16 explained it in the deposition. Could you explain what your  
 17 recollection of this comment about "physician-led mantra"  
 18 was about?  
 19 **A.** So that -- that's a painful chapter in my history.  
 20 So the email that Dr. Bathina sent followed a conversation  
 21 in which I was very emotional. It involved a physician that  
 22 we had previously had a relationship with, and, you know,  
 23 truth be told, it wasn't my brightest moment as a physician  
 24 leader. It was a self-centered comment, and it was not  
 25 focused on the needs of the organization or the people we

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1 serve.  
 2 This organization has far exceeded my expectations  
 3 in terms of physician leadership. It has created physician  
 4 leadership bodies. It has invested in physician leadership  
 5 in terms of education. You can't take doctors and just say,  
 6 "Go be leaders." And I guess I'm an example of that culture  
 7 of physician leadership. I hope I'm a good example. I  
 8 don't know.

9 Q. Also in that email there was a reference to  
 10 recruiting. Do you recall that?

11 A. I don't.

12 Q. I'm just looking for it in my --

13 A. I don't recall that.

14 Q. I believe it was Exhibit 1357 in the fourth  
 15 paragraph. That's not the right paragraph.

16 A. The one above?

17 Q. "Physician-led mantras" and then -- I can't find  
 18 it, unless you see it. Then we'll move on.

19 A. Sorry. I don't.

20 Q. No problem.

21 Mr. Ettinger asked you about your use of the word  
 22 "dominant." We went over this previously, as well, but  
 23 could you address what you meant by "dominant."

24 A. Yes. You know, it's really ironic to me that  
 25 we're talking about the meaning of the word "dominant" when

1 in my -- in a trial in which, I guess, I/we are accused of  
 2 being anticompetitive, when it's actually competition that  
 3 creates dominance, of course. You know, I believe that the  
 4 clinical innovations we are trying to introduce are exactly  
 5 the competitive innovations that this market and healthcare  
 6 in general need.

7 Everybody has seen my CV. I'm a -- I'm a  
 8 biologist and a physician by training. I am not an  
 9 epidemiologist. You can look up the word. Competition  
 10 creates selective pressures that create dominance. And  
 11 dominance is defined -- dominance is surviving. It's being  
 12 here tomorrow so that as an organization you can fulfill  
 13 your mission and vision, or as a population you can continue  
 14 to grow, or as an individual you can put your genes into the  
 15 next generation's pool. Dominance is not conquering the  
 16 world. That's the way I used the word. That's how I meant  
 17 it. I wanted to be in an organization that was still here  
 18 tomorrow.

19 Q. And since you've joined St. Luke's, has your call  
 20 schedule been lighter than it was when you were covering  
 21 four?

22 A. It has.

23 Q. So that did address that concern?

24 A. It did.

25 Q. Now, there were all these questions about what

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1 eClinicalWorks does today and whatnot. At the time that you  
 2 were deciding on which electronic medical records system to  
 3 purchase, did you talk to any other physician groups in the  
 4 Treasure Valley to see what they were using?

5 A. Sure.

6 Q. And was one of them Primary Health?

7 A. Yes.

8 Q. And what was your experience with interfacing with  
 9 Primary Health's eClinical system at that point in time?

10 MR. ETTINGER: Your Honor, I think the question is  
 11 calling for hearsay unless the witness actually sat down on  
 12 Primary Health screens. I don't think that's what the  
 13 question is seeking.

14 THE COURT: Well, I took it to be a question about  
 15 his actual experience in interfacing with Primary Health's  
 16 clinical system.

17 MR. SINCLAIR: That's correct. If you don't have  
 18 any experience, then just tell us that.

19 MR. ETTINGER: Then I'm incorrect, Your Honor.  
 20 I'm sorry.

21 THE WITNESS: Sorry, sir. Would you repeat the  
 22 question?

23 BY MR. SINCLAIR:

24 Q. Do you have any experience in regards to how the  
 25 information from eClinical's -- from Primary Health's

1 eClinical system would populate with your eClinicalWorks  
 2 system?

3 A. Sure.

4 Q. What was your experience at the time you were  
 5 using eClinicalWorks?

6 A. At the time I was using eClinicalWorks, it was  
 7 basically an electronic paper chart. So my note would be  
 8 scanned in essentially like a PDF into their record, and  
 9 then my individual note could be looked for and, you know,  
 10 called up and viewed.

11 Q. Just like you described yesterday when you were  
 12 describing your experience with eClinicalWorks?

13 A. Yes. And, you know, when we -- one of the things  
 14 we, you know, at the time liked about eClinicalWorks is it's  
 15 hard to change, and we went from paper charts to an  
 16 electronic chart, and what was nice is that it was basically  
 17 an electronic paper chart, so we didn't have to change very  
 18 much.

19 THE COURT: Just so I'm clear, when you refer to  
 20 an electronic paper chart, it's like a PDF; in other words,  
 21 it's a -- I mean, I review briefs electronically as a PDF --  
 22 basically a snapshot of a written page. That's what you're  
 23 referring to?

24 THE WITNESS: That's what I'm referring to, yes.

25 THE COURT: Proceed, Mr. Sinclair.

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1 MR. SINCLAIR: Thank you, Your Honor.  
 2 BY MR. SINCLAIR:  
 3 **Q.** Now, there were some questions about  
 4 epidemiologists and statisticians. Do you -- what is your  
 5 belief in regards to whether it would be a good way to  
 6 improve practice to wait and hear what an epidemiologist or  
 7 a statistician said about the condition of your patient?  
 8 **A.** Well, I'll just -- I'll come back to the example  
 9 that was shown to me. Evidence-based medicine says it's not  
 10 okay to have your diabetics running around with hemoglobin  
 11 A1c's of 8.5. Epidemiologists and statisticians don't tell  
 12 us about how to fix that; they tell us what are the effects  
 13 of that, what's the evidence that says that that's a bad  
 14 number. I think it's up to teams of providers and  
 15 individuals to -- you know, and especially in an individual  
 16 clinic patient population -- find the best way to engage  
 17 that patient, meet their needs and then help them achieve  
 18 that target. I don't know if I answered your question.  
 19 **Q.** You did. Now, you testified as to the lung nodule  
 20 screening and the benefits it had, and then Mr. Ettinger  
 21 showed page 130, lines 18 through 23, which was back in May  
 22 of 2013 and your testimony at that time. Has your knowledge  
 23 base changed since May of 2013?  
 24 MR. ETTINGER: Your Honor, objection. I think  
 25 we've been through this with other efforts on my part to

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1 introduce evidence postdeposition, and obviously we didn't  
 2 have a way to test that or find out about it, and so -- so I  
 3 think it's inappropriate to raise it now.  
 4 MR. SINCLAIR: Well, the distinction here is he  
 5 testified as to that. They let it in. They didn't object  
 6 upon it as was done earlier when people were trying to  
 7 testify to something that was post when a deposition was  
 8 taken. He testified to it. And then he tries to impeach  
 9 him based upon a set of information that was earlier.  
 10 MR. ETTINGER: That's not at all what happened,  
 11 Your Honor.  
 12 THE COURT: Well, if the witness -- it's a  
 13 difficult situation if a witness in their normal work  
 14 acquired additional information, not preparation for trial  
 15 or not trying to acquire additional information. I don't  
 16 think it's terribly significant in any event, because what  
 17 the witness understood at the time of his deposition,  
 18 apparently in May, is what it is, and if there is some  
 19 additional information that suggests that he was mistaken or  
 20 misunderstood, then I think that's fair game. But what I  
 21 will not allow is for the witness to offer his testimony and  
 22 then essentially to run a new test or a new study or inject  
 23 something new into the case.  
 24 MR. SINCLAIR: Fair enough.  
 25 THE COURT: So with that understanding, I'll allow

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1 you to go ahead and proceed, but I'm assuming this is simply  
 2 a witness being asked something during a deposition, making  
 3 a statement, realizing later, based upon things that either  
 4 occurred in his practice or just out of curiosity he checked  
 5 into it, and found out he was wrong. He can correct those  
 6 kinds of mistake.  
 7 So go ahead and proceed.  
 8 BY MR. SINCLAIR:  
 9 **Q.** First of all, at the time of your deposition you  
 10 indicated that you did not know the information that they  
 11 were asking for; correct?  
 12 **A.** Yes.  
 13 **Q.** And in your practice, not in preparing for this  
 14 trial or anything I asked you but just in your practice,  
 15 have you become more aware of more current information in  
 16 regard to that?  
 17 **A.** As a routine part of reporting in the practice,  
 18 yes.  
 19 **Q.** And that's what you testified to yesterday or this  
 20 morning?  
 21 **A.** Yes.  
 22 **Q.** And that's true with regards to sepsis, as well?  
 23 I have asked Dr. Souza not to testify if somebody  
 24 stands up.  
 25 THE WITNESS: If somebody stands up.

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1 MR. SINCLAIR: Mr. Ettinger stood up.  
 2 THE COURT: Mr. Ettinger.  
 3 MR. ETTINGER: I'm sorry, Your Honor. As I  
 4 understand what I am hearing, he's talking about new  
 5 evidence that was accumulated after the deposition, though  
 6 it's a little unclear, I've got to admit, from the questions  
 7 and answers.  
 8 THE COURT: Again, it's a difficult problem  
 9 because we don't live in a world that just freezes as of a  
 10 moment in time. But what I think is unfair, as I have  
 11 noted, is for a party to, in essence, change their answer or  
 12 a witness to change their answer by undertaking some  
 13 additional evaluations. But if the witness has acquired in  
 14 his -- the normal course of his clinical work -- and I think  
 15 that's what he just indicated -- some additional  
 16 information, I'll allow it, particularly if he is clarifying  
 17 a statement that he made mistakenly during his deposition.  
 18 MR. SINCLAIR: Thank you.  
 19 THE COURT: Proceed.  
 20 BY MR. SINCLAIR:  
 21 **Q.** Finally, Dr. Souza, Mr. Ettinger asked you whether  
 22 you had hit your targets on sepsis, and then he played a  
 23 clip from your deposition. In your deposition, did you  
 24 describe the types of things that you were being rated on  
 25 and whether or not you had reached those?

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1 **A.** I mean, I don't recall specifically, but the  
 2 reason we haven't hit our -- we hadn't hit our targets --  
 3 and actually I was being honest, I don't think we're going  
 4 to hit the target this year -- is because they are very  
 5 aggressive. And I started on this, I think yesterday,  
 6 perhaps it was today. It's all blending together.  
 7 But when you are administering these boluses of  
 8 intravenous fluids to a patient with septic shock, one of  
 9 our measures is that we must achieve a certain central  
 10 venous pressure goal. There is a group of us human beings  
 11 that you can't raise the pressure on. You can squeeze in 1  
 12 liter, 2 liters, 5 liters, 10 liters, and their kidney turns  
 13 on, and they just evacuate the fluid that you're dumping in.  
 14 So we -- we -- by intent, because we're trying to  
 15 be physician leaders, we do not choose to set targets that  
 16 are meatballs. We want targets that are difficult to  
 17 achieve. We've constructed the quality incentive as a  
 18 takeaway, not an add-on. And that's really important in  
 19 terms of human behavior. We're a lot -- we're a lot more  
 20 upset when a hundred-dollar bill falls out of our pocket and  
 21 blows away as if we find one on the sidewalk. So we've  
 22 constructed it as a takeaway. We've made the target  
 23 meaningful and real because if -- we want to continuously  
 24 improve.

25 **Q.** Okay. And after the judge's last ruling I

1 actually didn't go back and let you answer the question that  
 2 was on -- that was pending in front of you, and that is in  
 3 regards to the improvements in sepsis. Was the information  
 4 that you testified to this morning more current than what  
 5 you knew at the time of your deposition?

6 **A.** Yes.  
 7 MR. SINCLAIR: Thank you, Your Honor. That's all  
 8 I have.

9 THE COURT: Mr. Ettinger?  
 10 MR. ETTINGER: No questions, Your Honor.

11 THE COURT: You may step down, Dr. Souza. Thank  
 12 you.

13 THE WITNESS: Thank you.  
 14 THE COURT: Call your next witness.

15 MR. STEIN: Your Honor, we'll be calling Dr. Brian  
 16 Fortuin.

17 MS. DUKE: Your Honor, while Dr. Fortuin is  
 18 coming, may I just publish the depositions of John Kee and  
 19 Dr. Priest?

20 THE COURT: If you would hand that to --

21 MS. DUKE: I will do so. Thank you.

22 THE COURT: Mr. Metcalf, could you help us with --  
 23 just hand that to Ms. O'Larey.

24 Dr. Fortuin, if you'll step forward. Watch the cord  
 25 there. I can't believe we're allowing that in a court of

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1 law, but --

2 MR. POWERS: I'm trying, Judge.

3 THE COURT: Ms. O'Larey will administer the oath  
 4 to you.

5 BRIAN WALLACE FORTUIN,  
 6 having been first duly sworn to tell the whole truth,  
 7 testified as follows:

8 THE CLERK: If you'll please state your full name  
 9 for the record and spell your name.

10 THE WITNESS: Brian Wallace Fortuin F-O-R-T-U-I-N.

11 THE COURT: All right. Before we actually begin  
 12 the examination, Ms. O'Larey, why don't you announce the  
 13 publication of those depositions so we have that cleared up  
 14 for the record.

15 THE CLERK: The deposition of John Kee, dated  
 16 May 15th, is now published. And the deposition of Marshall  
 17 Priest, dated 6-05-2013, is now published.

18 (Depositions of John Kee and Marshall Priest  
 19 published.)

20 THE COURT: All right. Thank you.  
 21 You may proceed.

22 DIRECT EXAMINATION

23 BY MR. KEITH:

24 **Q.** Good morning, Dr. Fortuin. By whom are you  
 25 employed?

1 **A.** I am in a partnership that is a group of  
 2 internists in Twin Falls, Idaho, that has a contractual  
 3 relationship with St. Luke's Medical Center.

4 **Q.** And what's the nature of your medical practice?

5 **A.** So I'm a practicing internist. I spend most of my  
 6 time in a clinic. I spend six to eight, maybe ten weeks of  
 7 the year doing hospitalist work.

8 **Q.** And how long have you practiced in Twin Falls?

9 **A.** Since 1997.

10 **Q.** Why don't you step back and give us your  
 11 educational history post high school.

12 **A.** After high school I got a bachelor's in English at  
 13 University of California Santa Barbara; from there I went to  
 14 Duke University Medical School, I got my medical degree  
 15 there; and went to the University of Washington in Seattle,  
 16 where I did my internal medicine internship and residency.

17 **Q.** And where did you go after your residency?

18 **A.** I came to Twin Falls, Idaho, directly after  
 19 residency in 1997.

20 **Q.** And did you join a group at that time?

21 **A.** Yeah. The name of the group was the Twin Falls  
 22 Clinic and Hospital, which was a multispecialty group.

23 **Q.** And did that group also own a hospital?

24 **A.** That's correct. It had a clinic and hospital. It  
 25 was a full-service, like a community hospital.

1 Q. And at that time, was the Twin Falls Clinic and  
2 Hospital independent of any other hospital system?

3 A. That's correct.

4 Q. Did there come a time when that changed, when Twin  
5 Falls Clinic and Hospital joined with another hospital  
6 system?

7 A. Yes. In 2001 and finally in 2002, the Magic  
8 Valley Regional Medical Center purchased the Twin Falls  
9 Clinic and Hospital.

10 Q. And could you just describe the circumstances  
11 around Twin Falls Clinic and Hospital joining Magic Valley  
12 Regional Medical Center?

13 A. Yeah. At the time, the Twin Falls Clinic and  
14 Hospital was having financial troubles, really. There were  
15 a variety of factors contributing to that, and we were  
16 looking to sell the operation because the physicians and the  
17 leadership were tentative about the future, and our  
18 financial situation at the time was not very good. So we  
19 joined conversations with what was Magic Valley Regional  
20 Medical Center at the time, who then purchased the Twin  
21 Falls Clinic and Hospital.

22 Q. And was Magic Valley Regional Medical Center the  
23 only hospital that expressed an interest in acquiring Twin  
24 Falls Clinic and Hospital?

25 A. So prior to that, there was conversations with

1 Saint Alphonsus about acquiring the Twin Falls Clinic and  
2 Hospital.

3 Q. Do you use an electronic health record in your  
4 practice?

5 A. Yes.

6 Q. And what system or what electronic health record  
7 is it?

8 A. So it's called "Centricity."

9 Q. Can you explain for the court the ways in which  
10 you use Centricity and how that relates to achieving  
11 St. Luke's goal of the Triple Aim?

12 A. So traditionally in my practice, I would use a  
13 paper chart where I would document by dictating or writing  
14 notes on my patient encounters, and in that chart would be  
15 lab and X-ray and other notes, what have you. The  
16 electronic record is -- it can be just a repository for that  
17 information, but what we've done with the analytics teams is  
18 use the Centricity medical record in a way to capture  
19 discrete data elements so that we can then -- we call it  
20 "mine," we can get those data elements later to show whether  
21 or not a patient has had a test or a procedure.

22 So in daily practice, I put data into the record  
23 with the patient, and then I use the record, as well, to get  
24 information about the patient, whether it be lab or X-ray or  
25 other reports from other physicians, et cetera, but at the

1 same time I'm putting it into the record in a way that  
2 allows me to get that data later. So for example, if I see  
3 you in six months, then I would be able to look back and see  
4 what I've done over the past year for your blood pressure or  
5 your diabetes or whatever it might be.

6 Q. And does use of the Centricity tool facilitate  
7 communications among physicians who are also on that same  
8 record?

9 A. Yes. Physicians on the same record, yes.

10 Q. And can you give us an example of how that ability  
11 to communicate through Centricity addresses St. Luke's goals  
12 of the Triple Aim?

13 A. So there are many examples in my practice of how  
14 that happens. Some are more, I guess, more illustrative  
15 than others. The one that comes to mind is a patient of  
16 mine who came from Elko, a 50-year-old gentleman who  
17 was -- had been a smoker, had heart disease, but he came  
18 in -- he drove up from Elko to see me and had blood in his  
19 urine.

20 And so using the electronic record, I, you know,  
21 can access information. There's a program called UpToDate  
22 that it can link to. And in UpToDate it can tell me what  
23 optimal tests are for a 50-year-old with blood in his urine.  
24 So by using UpToDate, I was able to determine that there  
25 were a handful of tests that were appropriate. But what's

1 nice about the Centricity record, I was able to send what's  
2 called a "flag," which is like an email within the record  
3 itself, so it includes the patient health information that's  
4 protected.

5 So I can send that to the urologist. And I asked  
6 Dr. Bates in this example, who is the urologist, you know,  
7 "What do you recommend as the best test? I see there is a  
8 few different possible options."

9 And he said to do a CT urogram, which is a CAT  
10 scan protocol that specifically looks at the kidney, the  
11 ureters, the bladder, and the urethra, which he then did,  
12 and which I then was able to do that very same day. And the  
13 CT urogram came back, and there was a subtle abnormality in  
14 the bladder, and the radiologist wasn't sure what to make of  
15 it, and I didn't know what to make it.

16 So I sent another note to Dr. Bates, who then,  
17 later in that same day, say in midday, looked at the CT scan  
18 himself, and we talked about it, and he said, "Well, that  
19 shows an abnormality, and he needs a cystoscopy," which is a  
20 procedure where he takes a scope through the urethra and can  
21 look at the bladder and actually take a sample of whatever  
22 the abnormality was. Which that very same day the patient  
23 underwent and was found to have a very early bladder cancer  
24 that was then, you know, subsequently treated with excision  
25 and treatments.

1 The point of the story is that the patient who  
2 showed up that morning saw me, got expert advice from a  
3 urologist through the record, got a CAT scan that the  
4 urologist was able to review through the record, and then a  
5 procedure that made the definitive diagnosis and started the  
6 treatment without having to drive back and forth to Elko,  
7 without having to travel to different clinics or make other  
8 appointments or any of that.

9 So I think that points up the efficiency of a  
10 shared medical record in an integrated environment.

11 Q. And the urologist you're referring to, is that  
12 person a St. Luke's clinic physician?

13 A. That's correct.

14 Q. And was St. Luke's able to bill for the  
15 consultations that the urologist did?

16 A. So when I called the urologist on the flag, using  
17 the flag through the record -- and I use that with urology,  
18 pulmonary, cardiology -- there's no billing that's  
19 associated with that; that's all not -- in the current  
20 payment environment, there is no way to be reimbursed for  
21 those services. But it's something we do as being in part  
22 of the group.

23 Q. Do you hold any leadership positions within  
24 St. Luke's?

25 A. Yes.

1 Q. And what are those?

2 A. So I'm a member of the St. Luke's Health System  
3 Clinical Leadership Council, which is a physician leadership  
4 group that partners with the system administration. I'm  
5 also a member of the Magic Valley Physician Leadership  
6 Council. I chair that committee. And that committee  
7 partners more so with the Magic Valley administration, and  
8 that's, again, a physician leadership committee that has  
9 that partnership. I'm on a System Formulary Work Group,  
10 which is actually a subcommittee of the System Clinical  
11 Leadership Council, and that's looking at formulary  
12 standardization across the health system.

13 Q. Directing your attention to the Magic Valley  
14 Physician Leadership Council, can you give me an example of  
15 how that group has taken action that addresses St. Luke's  
16 Triple Aim?

17 A. So an example would be the Physician Leadership  
18 Council has three subcommittees that do a lot of the work,  
19 so there's a division medical director committee, and that  
20 is more operational. There's an IT steering committee that  
21 is -- works with the electronic record and the proper use of  
22 the electronic record. And there's a clinical integration  
23 committee. And the clinical integration committee looks at  
24 clinical processes and technologies and treatments and  
25 evaluates those based on, really, the Triple Aim and whether

1 or not those functions that we perform as physicians or as  
2 an enterprise meet the Triple Aim are warranted.

3 So, you know, an example would be there was a  
4 recent need for pulmonary rehab. So the clinical  
5 integration committee looked at the evidence behind  
6 pulmonary rehab for pulmonary patients and found that the  
7 evidence supported it. The -- that that would result in  
8 better treatment for our pulmonary patients of Magic Valley.  
9 And working with the Treasure Valley pulmonary rehab that  
10 committee then, through the PLC, I guess, you know, endorsed  
11 to the administration to support, would be one example that  
12 comes to mind of how we are trying to get better care in the  
13 Magic Valley for our patients.

14 Q. And does the clinical integration committee or  
15 subcommittee of the Magic Valley PLC review requests for new  
16 technology or equipment?

17 A. Yes. So that would -- yes.

18 Q. And can you give us an example of how that work  
19 has resulted in decisions that help achieve the Triple Aim?

20 A. So an example of achieving the lower-cost portion  
21 of the Triple Aim, the clinical integration committee has  
22 reviewed certain spinal cord stimulators, certain  
23 implantable devices. And there are a variety of these  
24 devices that are used to treat people with chronic back  
25 pain. And the device industry is continuing to make new or

1 supposedly better devices; however, they have not been shown  
2 to have an improved outcome, but they do result in a much  
3 higher cost.

4 So that committee reviewed the medical evidence  
5 for a new device that one of the proceduralists wanted to  
6 implant in the patients and was able to sort of -- to look  
7 at the evidence for it critically and recognize that there  
8 was no clinical benefit to the procedure, but there was  
9 substantially increased cost to the procedure. Consequently  
10 we are not providing that device to our patients at Magic  
11 Valley because of the work of the various clinical  
12 integration committees.

13 Q. You mentioned that you serve on a subcommittee of  
14 the System Clinical Leadership Council that is tasked with  
15 identifying what pharmaceuticals ought to be used in the  
16 St. Luke's Clinic. Can you give us an example of decisions  
17 that have been made by that subcommittee that help achieve  
18 the Triple Aim?

19 A. So one of the -- yes, I can.

20 One of the objectives of the System Formulary Work  
21 Group is to standardize the pharmacologic treatments that we  
22 use across our system. And one of the very expensive things  
23 that we do is use brand-name medications when there are  
24 equally effective generic medications available. So many of  
25 the projects that we've done at the System Formulary Work

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1 Group have been targeting using the equally effective  
2 generic medicines in place of the more expensive branded  
3 medicines when the evidence supported that the effect was  
4 the same.

5 So an example would be the cholesterol medicines,  
6 the stomach acid reflux medicines, the blood pressure  
7 medicines that are used throughout the system, we've  
8 standardized those and narrowed the number of choices, if  
9 you will, to the agents that we know work well but are very  
10 inexpensive, you know, thereby providing as good or better  
11 care to the patients at a significantly reduced cost.

12 **Q.** Can you describe to the court how these various  
13 physician leadership structures interrelate, how information  
14 flows up and down?

15 **A.** So that's actually critically important because if  
16 the leadership structure is making decisions in a vacuum,  
17 then none of the -- none of those things get to the bedside.  
18 So there needs to be communication from the leadership,  
19 which would be the Clinical Leadership Council down to the  
20 physicians that are practicing in the exam room at the  
21 bedside.

22 So the way that works is the Clinical Leadership  
23 Council is comprised of divisional medical directors, which  
24 are physicians over divisions or service lines; that might  
25 be primary care or cardiology or other service lines. And I

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1 was just thinking Dr. Souza might have gone over this,  
2 because he's part of this whole leadership structure. I  
3 didn't want to be redundant.

4 But in any case, those divisional medical  
5 directors talk to the site medical managers that work in the  
6 individual clinics, and the site medical managers then talk  
7 to the practicing physicians, so if there was something  
8 going -- so an example would be -- and this is sort of  
9 ongoing remiss this -- so an orthopedist in Magic  
10 Valley -- or Treasure Valley recognized that a certain  
11 injection we were using for knee arthritis was, you know,  
12 did not have evidence to support its use. It didn't benefit  
13 patients.

14 And so what he did is he moved this information up  
15 through the -- in this case, the Clinical Integration  
16 Committee up to the Clinical Leadership Council that using  
17 this certain injection was not optimal for patients and was  
18 a procedure that may not be necessary and at a cost that was  
19 not -- didn't bring forth benefit. So the orthopedist  
20 brought it up through to the leadership structure, and then  
21 from the leadership structure we're in the process of  
22 disseminating that information down so that all the  
23 physicians across the system are -- are using the same high  
24 standard of care for their patients.

25 So the point I'm trying to make is that the

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1 information flows up and down from the bedside to the top  
2 and then from the top down to the bedside so that we can be  
3 sure that we're all executing on the same mission.

4 **Q.** Turning to a different topic, is there a tool that  
5 you use to analyze the quality of care you provide and the  
6 cost effectiveness of the care you provide?

7 **A.** Yes. We use a WhiteCloud Analytics tool called  
8 "the clinical integration scorecard," which takes the  
9 information from the electronic health record and other data  
10 repositories to present it back to the providers and the  
11 physicians in a meaningful way.

12 **Q.** Who developed the clinical integration scorecard?

13 **A.** I don't know the exact individual, but WhiteCloud  
14 Analytics is the company.

15 **Q.** And when did the clinical integration scorecard  
16 become available to you?

17 **A.** I think the first time I saw it might have been in  
18 November of last year or December of last year.

19 **Q.** And was that the time at which the tool rolled out  
20 to every St. Luke's clinic provider?

21 **A.** Over the ensuing few months, yes, it did roll out  
22 to everybody.

23 MR. KEITH: Alyson, I'd ask you to publish the CI  
24 scorecard on the screen.

25 Your Honor, we have a demonstrative with screen shots

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1 of the pages that we plan to show the witness that is  
2 Exhibit 5105.

3 THE COURT: All right. Counsel, just so we're  
4 clear, this again is a -- you've given screen shots, but  
5 this is an actual online demonstration of the WhiteCloud  
6 scorecard?

7 MR. KEITH: Exactly, Your Honor.

8 BY MR. KEITH:

9 **Q.** Dr. Fortuin, can you tell the court what we're  
10 looking at here?

11 **A.** So this is one of the opening pages of the  
12 clinical integration scorecard, and you can see, I  
13 think -- okay, so up here it -- this is all the system  
14 groups throughout the St. Luke's Health System. And over  
15 here is the -- the percent of total possible points that can  
16 be achieved based on the various metrics that we're using,  
17 these items that we're measuring to determine  
18 our performance, how well we're doing with the scorecard.

19 **Q.** And how -- do you have an individual scorecard  
20 within the system?

21 **A.** Right. So the tool has been developed so that we  
22 can navigate to my scorecard. So if we go here to Magic  
23 Valley, within Magic Valley you can see that our percent is  
24 73 percent of the total score of the Magic Valley possible.  
25 And if we go to my peer group, we can see -- there it

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1 goes -- we can scroll down to internal medicine, which is my  
2 group. And we can go further still and show -- there is my  
3 scorecard there. And so now we're looking at just my  
4 scorecard, not the entire system, so I can see my data.

5 **Q.** And for the record, this is page 1 of Exhibit  
6 5105, or at least there is actually two pages that it takes  
7 to do the screen shots. That's pages 1 and 2. So why don't  
8 you walk us through what we're looking at, or why don't you  
9 walk the court through what we're looking at here on your  
10 screen.

11 **A.** So you can see that top bar has the number of  
12 points available and how many points I'm getting. Each of  
13 the clinical measures that we're looking at -- and we'll go  
14 over those a little bit -- have been attributed a point  
15 score based on the, I guess, how important we feel they are  
16 in terms of the care of the patient or the population. So  
17 you can see my score is 441 or 89 percent of the total  
18 possible. The blue line represents -- here, I'll see if I  
19 can trace it -- the blue line represents my score compared  
20 to the triangles, and each triangle represents the average  
21 score for other doctors in my specialty. So of the  
22 internists, there's my blue line --

23 THE COURT: Your specialty within your practice  
24 group?

25 THE WITNESS: So this represents, I believe,

1 across the entire system.

2 THE COURT: All of the St. Luke's?

3 THE WITNESS: All of St. Luke's Internal Medicine.  
4 So I can see as a comparator -- and you will see how that  
5 becomes useful.

6 THE COURT: Could I just ask, I notice scores by  
7 category. It appears better care, lower cost, and I'm  
8 assuming there are some more categories, as well. So the  
9 metrics that are being used here do include -- I guess,  
10 better care would be the care of whatever the current  
11 condition is; lower cost would be a consideration of what  
12 the relative value is of a particular treatment that's being  
13 ordered; patient-centered I'm assuming has something to do  
14 with being sort of an advocate for the patient in terms of  
15 comfort, care, et cetera; better health would be long-term  
16 health improvements? So these are all factored in?

17 THE WITNESS: So I can go through -- yes, you're  
18 exactly right. What we did is took the various measures and  
19 put them in these four buckets so that -- so Alyson could  
20 open "better care."

21 MR. KEITH: Alyson, why don't you expand "better  
22 care."

23 THE WITNESS: Under "better care" we can scroll  
24 down and you can see -- a good example would be the diabetes  
25 care. So these are measures of diabetic care in my

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1 patients. And we feel that this goes under the better care  
2 bucket. So the hemoglobin A1c, which I can -- so hemoglobin  
3 A1c is a measure of the average blood sugar that a diabetic  
4 has over the preceding three months, and it's a  
5 well-established marker of the severity as well as control.

6 So we know that diabetics whose hemoglobin A1c is less  
7 than 8, and even closer to 7, have better long-term outcomes  
8 than diabetics whose A1c, like in this case, are greater  
9 than 9. And so I can see at a glimpse that 72 percent of my  
10 diabetics are currently treated to the kind of standard. I  
11 have 9 percent of my diabetics that are struggling with the  
12 treatment. And the top number here, this 42 percent, that  
13 is an -- those 42 percent of the diabetics have each one of  
14 these metrics are -- are to goal. So at a single glance, I  
15 can see -- see what -- how I'm performing or how my patients  
16 are doing. And each month I get the reupdate on this data.

17 MR. KEITH: And just a quick point, Your Honor, I  
18 want to make sure for the record that this is -- what we're  
19 looking at now is more or less covered by page 5 of the  
20 demonstrative 5105. Unless Your Honor has another question.

21 THE COURT: No. Go ahead.

22 BY MR. KEITH:

23 **Q.** Where does the data come from that underlies the  
24 scores we're seeing here?

25 **A.** So the tool's been developed so that if I hit that

1 info button, I can determine where the data are from. They  
2 come from different places.

3 Can you hit this one, Alyson? Okay, good.

4 They come from different places depending upon  
5 what they are. In this case, you can see right down here it  
6 says -- where does it say it, Alyson? Usually, it says down  
7 here somewhere that it's -- the data are from Epic or  
8 Centricity, which are the two main electronic health records  
9 that we use in the system.

10 **Q.** Why don't we -- Alyson, if you will, close the  
11 "better care" category and open the next, "lower cost."

12 THE COURT: Doctor -- I was going to say you seem  
13 to know how to remove the markings or someone  
14 else -- Mr. Keith, thank you.

15 BY MR. KEITH:

16 **Q.** Why don't you explain to the court what appears  
17 here under "lower cost"?

18 **A.** So getting at the lower cost part of the equation  
19 has been difficult, but one of the easy things to look at in  
20 terms of lower cost is the generic prescription rates. So  
21 this -- these data come from claims data from one of our  
22 local payors, and it shows what percent of my patients are  
23 on these different medicines. So statins are cholesterol  
24 medicines, a PPI is a stomach medicine, steroids,  
25 antidepressants, and these are categories of medicines where

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1 there are a huge number of inexpensive, very effective  
2 generic medications that work as well as the very expensive  
3 branded medicines.

4 So we've decided that a good way to lower cost for  
5 the patients, for the payors, for the whole system is by  
6 using generic medicines whenever possible. So the amount of  
7 money we save by doing that can be quite dramatic.

8 MR. KEITH: For the record, this is page 13 of  
9 Exhibit 5105.

10 THE COURT: Has there been any effort to identify  
11 specific tests -- and perhaps it would be impossible to do  
12 that, but perhaps there are unnecessary tests being ordered,  
13 and I -- I guess I'm trying to get my head around how you  
14 could do it. Maybe the answer is you can't do that. It  
15 would be very difficult to set up kind of a metric or  
16 standard that would gage using certain types of tests that  
17 are less expensive, but yet it would give you the necessary  
18 information. Does that become just too patient-specific to  
19 actually kind of measure?

20 THE WITNESS: So it can be, but I'll give you an  
21 example. There is a test called a CT pulmonary angiogram.  
22 That's a CT scan that is a specific pulmonary test that  
23 looks for blood clots in the lungs. So that's a very  
24 expensive test which also exposes patients to radiation and  
25 contrast dye. So it's very hard to determine whether those

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1 a means by which we could display that information to the  
2 clinician in a meaningful way. So as a nonobstetrician, I  
3 would look at my hemoglobin A1c rate and compare that to the  
4 national average.

5 THE COURT: Mr. Keith, I have become curious, and  
6 I'm not sure you're going to go there, and I'm not sure I  
7 should worry about my curiosity and I should worry more  
8 about the issues counsel wants to present, but it -- anyway,  
9 go ahead.

10 THE WITNESS: To be fair, it's -- for me it's very  
11 exciting because in medicine, to date -- and we'll get into  
12 this, I think, later -- we haven't had this kind of  
13 information. And without this information, we really have  
14 no way of taking our own pulse and vital signs of how I'm  
15 doing as a physician. So this -- I mean, this is really, in  
16 my mind, groundbreaking because I couldn't really compare  
17 myself in terms of am I giving better care or not. I mean,  
18 I could say I'm a good doctor because I feel good about  
19 myself, but in actual fact I really had no way of comparing  
20 myself to how I ought to be. So, I mean -- I guess I'm just  
21 a little enthusiastic. I apologize.

22 BY MR. KEITH:

23 **Q.** Can you tell us, using the screen that we're  
24 looking at now, what the triangles on each metric represent  
25 and the dash lines represent?

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1 tests are being ordered too much or too little because there  
2 are specific reasons why that test should be ordered.

3 So what we've done, and it's not in this tool, but it  
4 would be in development, is looking at the -- so take an  
5 emergency room physician who orders that test a lot, is you  
6 can take the emergency room physicians and show who is  
7 ordering what number of tests, because over a long period of  
8 time, you would expect that they see a similar number of  
9 patients.

10 THE COURT: So you can track it, but you can't do  
11 it in this particular --

12 THE WITNESS: That has not been developed in this  
13 tool yet, but it could be.

14 THE COURT: There was a discussion -- perhaps in  
15 this trial or something I read -- about ordering C-sections  
16 or having more C-sections performed than perhaps would  
17 normally be indicated. You would compare that against kind  
18 of a national -- and Mr. Ettinger got into this with  
19 Dr. Souza -- more of a national -- I don't know if  
20 epidemiological study, but at least a statistical analysis  
21 of how often it should be used and under best practices so  
22 you could compare that, as well, with your OBGYN and any  
23 family doctors who are performing deliveries, as well?

24 THE WITNESS: That's correct. That would be  
25 available, and WhiteCloud would be -- and this tool would be

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1 **A.** If I could use another screen maybe. I'll do  
2 that. So if you look at -- so take generic prescriber. And  
3 you can see I'm not quite getting an A in that class. My 96  
4 percent is right next to that triangle. It's a little bit  
5 more glaring right here. But my performance is the bar, the  
6 yellow bar. My peer performance is the triangle right  
7 there, so that little triangle. And that's the -- so I can  
8 see how I compare to other doctors in my same -- in my same  
9 specialty.

10 And what's kind of nice about this is I'm  
11 comparing apples to apples. So I'm comparing other doctors  
12 in Twin Falls, Idaho, using the same data draw, the same  
13 claims data, as opposed to if I use this to compare myself  
14 to national numbers, like in your C-section rate. Then  
15 there is always a lot of room for me to say, well, they used  
16 a different measure, or they had a different denominator, a  
17 different numerator, or that doctor operated at different  
18 hospitals. There is a lot of ways to wiggle around the  
19 data. But when I'm comparing myself to the guy next door to  
20 me in my office and my triangle is below his bar or vice  
21 versa, it's very hard for me to not accept the fact that  
22 there is something about my practice right here that I need  
23 to fix.

24 **Q.** What about the dashed lines, the vertical dashed  
25 lines that you see?

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1 **A.** So those are predetermined that we've agreed as a  
2 system, these are sort of the standard. That's where we  
3 hope to go, and that's where you get the points. If I go  
4 above the dashed line, I get 20 points. If I'm below it  
5 within a close range, like in this -- sorry, let's just  
6 clear this. Let's clear this. So if I'm in a close range,  
7 like in this one, I get 13 out of the 20 points. But if you  
8 can see, if there was a red bar that was very low, I would  
9 get zero of the 20 points, and that rolls up into the  
10 composite score that I have at the very top.

11 **Q.** So, Alyson, can you close "lower cost" and expand  
12 the category of "patient-centeredness," "patient-centered."

13 **A.** So, Your Honor, this will get -- do I have to  
14 answer a question?

15 **Q.** That's a good question, Dr. Fortuin. Let me give  
16 you another one in response. What are we looking at here,  
17 Dr. Fortuin?

18 **A.** So this is the patient centeredness more  
19 granular -- that you'd sort of alluded to, Your Honor -- and  
20 this is actually 15 questions that a patient -- we have a  
21 patient survey that we've developed that patients in our  
22 offices submit the survey or they are given the survey, and  
23 then we submit the data here so that I can see how -- what  
24 my patients really think of me.

25 And so, for example, am I communicating well?

1 Well, 92 percent of my patients or 92 percent of the time  
2 they say I communicate well. And so you could say, well,  
3 access to specialists, I'm 78 percent, and you can see my  
4 peer is higher than that, so why is it that my patients  
5 don't feel that they have the proper access to specialists  
6 that they need? So one of the things that allows me to  
7 do -- maybe we can do this, if we can hit that triangle and  
8 go to "performance" up here.

9 So if we hit these -- if we hit this field down  
10 here, it allows me to see this guy, Jared Helms, 100 percent  
11 of his patients feel that he has access to specialists. And  
12 I know Jared, he's across down from me, he's a good  
13 internist. And I can call Jared and say, "Jared, you know,  
14 your patients really have access to specialists. Can you  
15 help me out here, because you can see I'm not really doing  
16 very well." And it gives us an opportunity to collaborate  
17 and see what is his practice and how do I change my practice  
18 so that my patients have the proper access that they need to  
19 specialists when they need it.

20 **Q.** So why don't we minimize "patient-centered" and  
21 expand the category of "better health." Dr. Fortuin, can  
22 you explain to the court, generally speaking, what we're  
23 looking at on this screen?

24 **A.** So this is the better health category of the  
25 scorecard.

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1 If can you scroll up just a little bit, Alyson, so  
2 we can see the banner.

3 So this is under "population health." And this to  
4 me represents a deviation from traditional medicine as I  
5 knew it. And that is, I would consider myself a doctor who  
6 when you get sick you come see me, and I'll try to help you  
7 get through your illness. That's the kind of doctor I would  
8 say I used to be. But I think the new era and the Triple  
9 Aim era of healthcare is I'm really responsible for all of  
10 your health.

11 So, you know, fall screening is one of the things  
12 we're measuring. Am I screening my patients for falls. So  
13 in other words, rather than waiting for the patient to fall  
14 and me take care of them after they have their hip fracture,  
15 or what have you, if I can take the initiative to try to  
16 help them prevent a fall, or any one of these things, then I  
17 actually am taking better care of their health in general.  
18 Because obviously a patient who has never broken their hip  
19 is a healthier patient than one that broke their hip.

20 So philosophically this is a deviation from the  
21 traditional practice of medicine. I'll be honest with you,  
22 I -- I see myself as pretty adaptive, and I feel like I've  
23 been pretty, you know, willing to change. I've heard the  
24 Triple Aim, I've wanted to do these things, but it wasn't  
25 until I really had the data in front of me that I

1 recognized, boy, you know, my patients -- and I can -- if  
2 you hit "fall screening," Alyson, for example.

3 Nobody tell anyone else about this. So if you  
4 look at my trend line, if you can look back here, I was  
5 doing a pretty bad job when I first got this. In fact, I  
6 was doing a terrible job. But today I can be proud of the  
7 fact that I'm doing a really good job of screening for  
8 falls. So if I can prevent one fall in my practice by  
9 screening for falls better, it seems to me that's had a  
10 dramatic improvement in the health of my patients in my  
11 clinic. So if that unfortunate elderly patient who fell and  
12 broke their hip never fell, think of the cost implications,  
13 the better care for that patient, the better health for  
14 them.

15 And this is true of depression, as well, and  
16 mammography, all of these things. The better I do with  
17 these sorts of things in the -- like immunizations,  
18 et cetera, the healthier my patients are going to be, the  
19 fewer illnesses I'm going to have to treat as a "fix me/I'll  
20 fix you when you're sick" type of doctor, more of a "I want  
21 to make sure you stay healthy" type of doctor.

22 **Q.** So I think we've run through the categories now.  
23 I want you to give the court a specific example, if you can,  
24 of a way that you've used the clinical integration scorecard  
25 to provide better or lower-cost care to a particular patient

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1 or set of patients.

2 **A.** There is a bunch of examples. If we go to "better  
3 care," one I think that I just this -- just this week I've  
4 been working on, if you go to "diabetes antiplatelet  
5 therapy," you can see that 93 percent of my diabetics that  
6 are high risk are on the proper antiplatelet therapy. And  
7 what that means is that's -- their medicine is -- aspirin is  
8 the primary one, but there are several others, clopidogrel  
9 and others that we use that reduce the risk of stroke and  
10 heart attack in diabetic patients.

11 So if I hit that tab -- and this is where I --  
12 this tool is so powerful it's amazing to me, but -- okay,  
13 sorry, you hit that tab. Hit the -- sorry, Alyson. Oops,  
14 you hit the detailed list.

15 And what this does is this calls up my patients  
16 that are not on aspirin. So if I were to hit that button,  
17 these -- these three people here, these four people, their  
18 names would come up, and I could tell you the names but I  
19 think it's against the law because it's protected health  
20 information. But in any case, those four people -- and so  
21 yesterday in my clinic I had Jessica, my nurse, call them  
22 and say, "Hey, how come you're not on aspirin?"

23 So if you think about how this works, in the past,  
24 if they were in front of me in my office, we would -- I  
25 would ask, "Are you on aspirin?" But if they have a lot of

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1 illnesses and a lot of problems, that may not be something  
2 that's on the front burner, so it gets neglected.  
3 Negligence isn't something I would admit to in front of  
4 lawyers, but the point is it gets put on the back burner,  
5 and so I don't necessarily recognize that they're not on  
6 aspirin.

7 So they may show up -- say they show up in the  
8 emergency room with a stroke. My first thought is, "Oh, my  
9 word, I hope that they're on aspirin, because if they're  
10 not, you know, it's really not very good. But what this  
11 tool allows me to do -- and in two of these instances they  
12 were on a separate antiplatelet medicine that worked as well  
13 as aspirin but it didn't get captured in the tool, but two  
14 of the patients were not on aspirin. So my nurse yesterday  
15 called both of them and said, you know, "Why aren't you on  
16 aspirin?"

17 And the one had said he had had nosebleeds and had  
18 some problems with it --

19 THE COURT REPORTER: Would you slow down, please?

20 THE WITNESS: I'm sorry. I'll try. Are you  
21 ready?

22 So one of the patient's said he had nosebleeds, and so  
23 that's why he stopped the aspirin on his own. But after a  
24 conversation about the risks and benefits and why stroke  
25 reduction and the reduction in risk of heart attack was more

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1 important than -- than -- you know, accepting the risk of  
2 the nosebleeds was worth it because of the benefit.

3 So to me, rather than waiting until this patient may  
4 have had a stroke or heart attack, we can intervene before  
5 that to be sure they're on all the right treatments. Does  
6 that make a little bit of sense?

7 THE COURT: All right. Thank you. Go ahead.  
8 BY MR. KEITH:

9 **Q.** Can you give the court an example of the way  
10 you've used the "better health" category of the tool --

11 **A.** Yes. Sorry.

12 **Q.** -- to improve the care and health of your  
13 patients?

14 **A.** So if we open the "better health" tab, and we  
15 go -- I'll take mammograms because it was -- it was a hard  
16 lesson for me to learn. If you look over here, you can see  
17 that in October and January of last year, about half of the  
18 time it was about 50 percent, half of the time my patients  
19 had a mammogram that were supposed to get their mammogram.

20 And when I first got this, I had a lot of  
21 reactions. But my final reaction was I needed to do  
22 something different because if the women in my practice are  
23 not getting proper mammograms, then they're not getting  
24 screened for, you know, a fatal illness, and I'm not doing  
25 as well as I could. So if I were to hit these, I could

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1 see -- if you look at the -- look at the sheet -- I can see  
2 that other doctors in my same practice are having 90, 91, 93  
3 percent of the time their patients are screened for a  
4 mammogram, and so somehow I'm way below. So if I go down  
5 here, that blue circle represents me, and the triangle is  
6 everybody else, and this is where I am now, but I was down  
7 here with this guy, whoever that is, and I was having a very  
8 low mammography rate.

9 So what we did is Jessica, who is my nurse, and I,  
10 if you remember that list I had, we populated the list of  
11 patients that had not had their mammogram that should. And  
12 we went about calling them, and some of the patients had had  
13 a mammogram but we hadn't collected the data right, so we  
14 put that in. Other patients had just not gotten their  
15 mammogram, so we went about ordering mammograms.

16 At the same time I called Lucy, who is one of the  
17 other doctors, and asked her why is it that she has a 100  
18 percent, 95 percent mammography rate, and I only have 50.  
19 "What do you do differently?"

20 And she explained that in her workflow with her  
21 patients, every patient she went through a risk factors tool  
22 that was in the electronic record, which since that time  
23 I've started to do.

24 And if you press the "done" here, Alyson.

25 You can see that over -- I mean, you can see this

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1 graph goes up nicely, and right now I'm at 69 percent of my  
 2 women -- and the women in my patient -- I shouldn't say  
 3 that -- the women in my clinic are getting mammograms  
 4 appropriately.  
 5 And what's really important about this is just  
 6 about two weeks ago, a patient of mine -- I can't say her  
 7 name -- but she came in, and the nurse had called her to get  
 8 a mammogram, and it was an abnormal mammogram and it ended  
 9 up being a breast cancer. And my heart sort of sunk at  
 10 first because I thought here is this patient who now has  
 11 breast cancer, you know, and it was sort of -- in my mind, I  
 12 thought, is this -- was this somebody that we could have  
 13 helped earlier. But I can say that had we not had this  
 14 tool, we would not have called her because we wouldn't have  
 15 known she hadn't had her mammogram, and we wouldn't have got  
 16 her in to get the mammogram, she wouldn't have had the  
 17 biopsy and she wouldn't have had it removed.  
 18 And so now she has a Stage I/Stage II breast  
 19 cancer that we, luckily, diagnosed early, and I think it's  
 20 because of this tool, because without the tool she wouldn't  
 21 have gotten the mammogram. And now she has a 90 percent  
 22 chance of cure and she doesn't need chemotherapy and  
 23 radiation.  
 24 So when you think about that one case representing  
 25 such a dramatic impact on her personal life, but in general,

1 I mean, that's sort of the Triple Aim personified. She has  
 2 better health, she is getting better care, and it's a  
 3 dramatically lower cost because -- talking to oncologists,  
 4 it could be \$100,000 for a treatment of breast cancer that  
 5 requires chemo and radiation. So it's a dramatic cost  
 6 reduction to the patient and to the system.  
 7 MR. KEITH: And just for the record, Your Honor,  
 8 the pages we've been viewing just now are 9, 10, and 14 of  
 9 Exhibit 5105.  
 10 BY MR. KEITH:  
 11 Q. And I just want to clarify for later on the  
 12 record, Dr. Fortuin, that the trend line that you were  
 13 describing is that -- that's over at the right-hand side of  
 14 the screen, and it's labeled "trend" under "mammography  
 15 screening"; is that right?  
 16 A. That -- yes, the trend line.  
 17 THE COURT: Thank you, Mr. Keith.  
 18 Counsel, we're just about where we take the morning  
 19 break, and you seem to be pausing. Would this be a good  
 20 breaking point or do you want to go for a couple more  
 21 minutes?  
 22 MR. KEITH: I think so, Your Honor.  
 23 THE COURT: All right. Let's take -- try to hold  
 24 it to a 15-minute recess. We'll be in recess for 15  
 25 minutes.

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1 (Recess.)  
 2 \*\*\*\*\* COURTROOM REMAINS OPEN TO THE PUBLIC \*\*\*\*\*  
 3 THE COURT: Dr. Fortuin, I'll remind you that you  
 4 are still under oath.  
 5 Mr. Keith, you may resume your direct examination.  
 6 MR. KEITH: Thank you, Your Honor.  
 7 BY MR. KEITH:  
 8 Q. Just a few follow-up questions for you,  
 9 Dr. Fortuin. In the past, have you had occasion to receive  
 10 quality statistics or scores from sources other than  
 11 WhiteCloud?  
 12 A. Yes.  
 13 Q. And can you just generally describe for the court  
 14 what you've received?  
 15 A. Frequently, the payors, the health insurance  
 16 companies, will send information that compares my generic  
 17 prescription rate or when my diabetic patients had their  
 18 last A1c and this sort of thing.  
 19 Q. And can you describe to the court the way in -- in  
 20 your view the WhiteCloud analytical tool differs from  
 21 the -- you know -- so the information in the WhiteCloud tool  
 22 differs from the information that you received, say, from  
 23 health insurance companies?  
 24 A. So the health insurance company typically presents  
 25 claims data, meaning did a diabetic have a claim submitted

1 for a hemoglobin A1c and then they -- suppose that means  
 2 they had it drawn. But it wouldn't show the A1c value.  
 3 Or they might say did the patient submit a claim  
 4 for a certain prescription. But -- but frequently -- so in  
 5 one case I'm thinking of, that prescription data comes six  
 6 and ten months after the prescription, not very close to  
 7 when the prescription was written.  
 8 Q. And for that reason, do you find the WhiteCloud  
 9 tool more powerful as a means of modifying your practice  
 10 data?  
 11 A. Well, absolutely, because the data are far more  
 12 meaningful because I get to see the actual value of the A1c  
 13 or -- or a good example would be the aspirin example. There  
 14 is no claim submitted for aspirin. There is no prescription  
 15 written for aspirin. There is no lab value for aspirin. It  
 16 has to be put in my record in a way that I can -- I can mine  
 17 it, if you will, and determine which of my patients are on  
 18 aspirin or not. And then once I have that, as -- you  
 19 couldn't see it because I couldn't show the patient  
 20 information, but I see the exact patient names of my  
 21 patients who are not listed as taking aspirin.  
 22 Q. And the tool that you described using to input the  
 23 data on aspirin use, is that Centricity?  
 24 A. That's correct.  
 25 Q. And are there any other ways in which using

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1 Centricity along with the WhiteCloud tool improves the power  
2 of the WhiteCloud tool to modify your practice patterns?

3 **A.** Yeah. There are many -- there are many factors  
4 that are very important about making the WhiteCloud data  
5 meaningful. And the first probably is accuracy. And a lot  
6 of the time we have spent so far has been to make sure that  
7 the data that WhiteCloud is mining from our record is  
8 accurate so that the interfaces are proper so that they  
9 actually recognize when I have a patient on aspirin that  
10 they are on aspirin so that -- using this example -- so that  
11 I can see whether they're on aspirin or not.

12 **S.** So the accuracy of the interface -- the accuracy  
13 of the tool is important because the way the electronic  
14 records work is there are text panes where I can put free  
15 text in, and if I just note the patient is on aspirin in the  
16 free text pane, then it doesn't -- it's not accessible to  
17 WhiteCloud whereas if I put aspirin on the medication list,  
18 then WhiteCloud can get that information.

19 **Q.** Is the -- is the accuracy of the WhiteCloud  
20 analytical tool important in your mind in driving your  
21 practice patterns and those of others towards better health  
22 and lower cost?

23 **A.** So it's absolutely critical and here is why: When  
24 my mammogram data came back showing -- I spent a lot of my  
25 time trying to disprove that to show that I really am a

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1 great doctor and this is malarkey because there has to be  
2 some mistake. How is it possible that a highly trained  
3 physician such as myself, you know, could do that? But I  
4 did. And so if the data were inaccurate, I'll immediately  
5 discredit the tool.

6 **S.** So back to what you asked before. When the payor  
7 sends me information on my patients, I may glance at it, but  
8 I don't spend much time on it because I know it's claims  
9 data. And because it's claims data, it's nowhere near as  
10 robust as the her data that I get from WhiteCloud.

11 **Q.** I want you to imagine if you were an independent  
12 physician, your own practice in Magic Valley, do you think  
13 that you would, in that circumstance, choose to participate  
14 in the WhiteCloud analytical tool?

15 **A.** I think -- no. I don't think I would out of the  
16 gates want to do that, and there are many reasons I can  
17 think of. One is, I'm not sure how it would be paid for. I  
18 don't know who would be -- who would be footing the bill.  
19 Because now that I have seen it, I recognize the benefit.  
20 But prior to that, I don't know that I would have put my  
21 money into it.

22 **S.** The second thing is, who has the tool is a huge  
23 factor for me because there is a tremendous amount of fear  
24 that somebody is going to use that information against me.  
25 So are they going to refer patients away from me? Are they

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1 going to, you know, reduce the fees that the insurer pays  
2 me? Are they going to put that out in a public forum that's  
3 embarrassing to me? So the fear associated with being very  
4 transparent with my data to just anybody is pretty  
5 overwhelming from my perspective.

6 **MR. KEITH:** Thank you, Your Honor. No further  
7 questions.

8 **THE COURT:** Mr. Su.

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

10 **CROSS-EXAMINATION**

11 **BY MR. SU:**

12 **Q.** Good morning, Dr. Fortuin.

13 **A.** Good morning.

14 **Q.** Mr. Keith first asked you about your employment,  
15 and you said you had a contract with St. Luke's.

16 **A.** That's correct.

17 **Q.** You're paid on a wRVU basis?

18 **A.** That's correct.

19 **Q.** Correct?

20 You've talked a lot about Centricity, and that's  
21 your -- that's your EMR system; right?

22 **A.** That's correct.

23 **Q.** How many years have you used that?

24 **A.** We implemented in '06.

25 **Q.** And that was before your practice became part of

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1 St. Luke's clinic; correct?

2 **A.** That's correct.

3 **Q.** In fact, at that time your practice was called  
4 Snake River Internal Medicine?

5 **A.** Correct.

6 **Q.** And it was a member of a -- of an individual  
7 practice association or IPA called Southern Idaho Healthcare  
8 Cooperative; right?

9 **A.** That's correct.

10 **Q.** And the cooperative had as its members many of the  
11 other independent physician practices in Twin Falls?

12 **A.** Yes, sir.

13 **Q.** And the objective of the cooperative was to create  
14 a clinically integrated network for physicians?

15 **A.** Yes.

16 **Q.** Let's look at Trial Exhibit 1423 --

17 **MR. SU:** Which has been preadmitted, Your Honor.  
18 Could we pass up a notebook to the witness, please,  
19 Mr. Beilein?

20 **MR. KEITH:** If you have a spare, I'll take one.

21 **BY MR. SU:**

22 **Q.** So, Doctor, you know, we could do it one of two  
23 ways. You have the option of we can enhance something on  
24 the screen, but if it's easier for you to read the text of  
25 this exhibit in the notebook, you can do that as well, sir.

1 So Trial Exhibit 1423, do you see that in front of you,  
2 sir?

3 **A. Yes, sir.**

4 **Q.** And you saw this at your deposition; correct?

5 **A. To my recollection, yes.**

6 **Q.** And it's the Clinical Integration Plan for 2007  
7 for the Southern Idaho Healthcare Cooperative?

8 **A. Yes, sir.**

9 **Q.** If we turn to page 4 of this document.

10 MR. SU: And if you would, Mr. Oxford, highlight  
11 the text immediately under the first heading, "Clinical  
12 Integration Program Purpose."

13 BY MR. SU:

14 **Q.** So the purpose of the cooperative was to create a  
15 clinically integrated network of physicians; correct?

16 **A. Yes, sir.**

17 **Q.** And under the -- under the -- that heading, you  
18 see a number of bullet points. One of them is to "use  
19 evidence-based medicine to reduce overuse, underuse, and  
20 misuse"; correct?

21 **A. Yes, sir.**

22 **Q.** And -- and earlier today when Mr. Keith was asking  
23 you about, you know, the -- the idea that you can -- you're  
24 presented with information about how you're doing and how  
25 you're doing compared to your peers, that -- that's what

1 we're talking about, right, it's evidence-based care;

2 correct?

3 **A. So the metrics we're using, we have applied  
4 evidence-based medicine to determine what standard that we  
5 would like to hold ourselves to. The comparison to our  
6 peers is not really -- I don't know that that's evidence  
7 based, per se. That's just part of how we present the data.**

8 **Q.** Fair enough. But the metrics that you're using  
9 like the -- like the metrics that you -- that you  
10 demonstrated to the judge --

11 **A. That's correct.**

12 **Q.** -- in your scorecard tool, that's evidence-based  
13 care?

14 **A. Sorry for interrupting, yes, that's correct.**

15 **Q.** Thank you. You see there is a second bullet point  
16 that talks about one of the objectives of the cooperative  
17 being to create an integrated care delivery network?

18 **A. Yes, sir.**

19 **Q.** And also create efficiencies in the area of  
20 disease management; correct?

21 **A. Yes, sir.**

22 **Q.** Now, if we look at -- now that --

23 MR. SU: Mr. Oxford, if you could go down to the  
24 lower half of the page to the goals, I would like to  
25 highlight -- let's go ahead and highlight the last bullet

1 point, the very last bullet point of that page. The very  
2 last bullet point at the very bottom of the page, sir.  
3 Thank you.

4 BY MR. SU:

5 **Q.** One of the goals of the cooperative was to adopt  
6 an ambulatory her system that would apply to all of the  
7 physician practices that were members of the cooperative;  
8 correct?

9 **A. That's correct.**

10 **Q.** And they would be integrated with the hospital in  
11 the community?

12 **A. Yes. Each individual her would integrate with the  
13 hospital system.**

14 **Q.** And that's the Magic Valley Regional Medical  
15 Center you're talking about?

16 **A. At the time, yes.**

17 **Q.** All right. Let's now look at -- let's -- let's  
18 turn to -- let's turn to page 13 of this exhibit, please. I  
19 would like to highlight the last -- the text under the last  
20 heading, the only heading on that page, which reads,  
21 "Implementation of EMR and data integration among  
22 providers."

23 Do you see that the goal was -- was to get the -- all  
24 of the physician practices in the cooperative to adopt the  
25 common EMR? Correct?

1 **A. I was just reading it. Yes, that's correct.**

2 **Q.** And that -- and it was -- the cooperative  
3 recognized that "it's a critical enabler of data collection  
4 capabilities to facilitate further quality improvement  
5 initiatives." Have I read that right?

6 **A. That's correct.**

7 **Q.** And then if you look at the second paragraph  
8 there, the first sentence reads -- well, the only sentence  
9 reads, "SLMVRMC will provide support of EMR implementation  
10 in order to speed adoption and provide necessary clinical  
11 and IT expertise to assist in implementation, thus reducing  
12 common barriers to adoption by physician practices."

13 Have I read that right?

14 **A. Yes, sir.**

15 **Q.** And SLMVRMC, what was that?

16 **A. That's St. Luke's Magic Valley Regional Medical  
17 Center.**

18 **Q.** So this effort, this -- this effort on the part of  
19 the cooperative to adopt a common ambulatory EMR had the  
20 support of the St. Luke's Magic Valley Regional Medical  
21 Center?

22 **A. Yes, sir.**

23 **Q.** All right. Now, if we turn to -- I would like to  
24 direct your attention to the appendix, sir, which is at the  
25 back. It would be the 20th page of this document. Do you

1 see that, sir?  
2 The pages that follow the appendix were the set of  
3 clinical integration program initiatives that the  
4 cooperative had outlined -- set forth in writing to pursue;  
5 correct?

6 **A. Yes.**

7 **Q.** And if you look at the first initiative, which  
8 is --

9 MR. SU: Let's turn the page, yeah, and highlight  
10 that, please.

11 BY MR. SU:

12 **Q.** The first initiative is entitled "Electronic  
13 Medical Record EMR Initiative"; correct?

14 **A. Yes, sir.**

15 **Q.** And so it says here under Project 1 what the  
16 cooperative was pursuing was the adoption of the GE  
17 Centricity EMR; correct?

18 **A. Correct.**

19 **Q.** And that's -- Centricity is the -- is the EMR  
20 system that you're using now at the clinic?

21 **A. Also correct.**

22 **Q.** All right. And do you see that under Project 2,  
23 sir?

24 **A. Yes, sir.**

25 **Q.** The cooperative recognized that the EMR system

1 would be able to develop alerts and prompts based on  
2 evidence-based medicine protocols appropriate to each  
3 medical or surgical specialty. Do you see that?

4 **A. Yes, sir.**

5 **Q.** Have I read that correctly?

6 **A. That's correct.**

7 **Q.** All right. Now, it's correct, too, that the  
8 cooperative was successful in getting some of the  
9 member-physician practices to adopt Centricity, right?

10 **A. Yes. Although I don't know that the cooperative**  
11 **adopted -- you know, was responsible for that. If I could**  
12 **clarify?**

13 **Q.** Yes, sir. Go ahead.

14 **A. The practices were all managed by what's -- by an**  
15 **MSO, a management services organization, that was a**  
16 **department, if you will, or a company within the hospital,**  
17 **initially Magic Valley Regional Medical Center and then it**  
18 **was taken over by St. Luke's Magic Valley Regional Medical**  
19 **Center after the merger.**

20 **And each of those individual practices in a**  
21 **sequential fashion had Centricity implemented, partly**  
22 **because St. Luke's Magic Valley Regional Medical Center and**  
23 **the cooperative both had the same goal of implementing**  
24 **Centricity. But the -- one of the problems we found is that**  
25 **the Centricity did not communicate from one practice to the**

1 **other unless the practices themselves were integrated. So**  
2 **the clinical integration itself did not allow for the record**  
3 **to be integrated to the degree that we had hoped.**

4 **Q.** But -- but the -- but it's correct -- it's your  
5 testimony that these managed practices had adopted  
6 Centricity during the time that the cooperative was in  
7 existence; correct?

8 **A. Yes. Many of them had -- although I don't know**  
9 **which ones and I think some of them had not.**

10 **Q.** And just so the record is clear, when you -- when  
11 you talk about something being a managed practice, these  
12 were physician practices that were managed by this  
13 management services organization or MSO?

14 **A. Yeah. I guess to clarify for my life, I had a**  
15 **practice -- there were four of us and we contracted with the**  
16 **MSO to provide management and administrative services for**  
17 **our practice.**

18 **Q.** Right. So the MSO would provide management or  
19 administrative services like billing and coding and then  
20 they would take a percentage off the top of the receipts as  
21 the payment for those services; correct?

22 **A. That's correct.**

23 **Q.** And the -- and the balance would go to your  
24 practice and be distributed among your partners under your  
25 partnership agreement?

1 **A. That's exactly right.**

2 **Q.** Now, you're happy with Centricity; right?

3 **A. Yes, sir.**

4 **Q.** In fact, you talked about -- you gave the judge an  
5 example of the situation where you were able to ask a  
6 urologist for a consult on a patient that came by with blood  
7 in his urine; correct?

8 **A. That's correct.**

9 **Q.** And the -- you also mentioned when Mr. Keith asked  
10 you about that, this is an up-to-date program?

11 **A. Yes, sir.**

12 **Q.** Is that an off-the-shelf program?

13 **A. That's just a online medical textbook that we**  
14 **access through our computer system.**

15 **Q.** And -- and for Centricity to work with the  
16 clinical integration scorecard tool that you've demonstrated  
17 today, it -- it -- what it means is that the scorecard tool  
18 is able to extract the discrete data -- data elements that  
19 it needs to provide the -- the metrics; right?

20 **A. That's -- well, Centricity has to house discrete**  
21 **data elements that the scorecard tool has to extract; that's**  
22 **correct.**

23 **Q.** And the same thing is being done, as you  
24 understand it, with the extraction of data elements from the  
25 Epic system in the Treasure Valley; correct?

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1 **A.** That's what I'm told, but I don't currently work  
2 on Epic.

3 **Q.** Do you have an understanding that the scorecard  
4 tool has been made to -- it's been -- it's been worked on  
5 such that it can extract data elements from eClinicalWorks  
6 used by Saltzer?

7 **A.** I have been told that, but I have been told that  
8 they're working on extracting those -- those data.

9 **Q.** Okay.

10 MR. SU: If we could, Mr. Oxford, turn back to  
11 Trial Exhibit 1423. I would like to go to page 15 of that  
12 document now, please. And if we would -- could, highlight  
13 the text under "Performance, Measurement and Incentive  
14 Program" in the middle of the page.

15 BY MR. SU:

16 **Q.** So one of the initiatives that the cooperative was  
17 working on was a way to provide the member-physicians with a  
18 performance report; right?

19 **A.** Yes, sir.

20 **Q.** And if you see under the -- in the text there, the  
21 last sentence of that first -- that paragraph, it reads,  
22 "Reporting performance measures across peers is a strong  
23 motivator for physicians to improve their scores, or in the  
24 case of underperforming physicians, to self-select out of  
25 programs."

1 Do you see that?

2 **A.** Yes, sir.

3 **Q.** And that's really -- that's what you were  
4 describing to the judge earlier, right, when you said that,  
5 you know, if the guy down the hall, you know, has a better  
6 score than you, that that's going to force you to figure out  
7 what you're doing wrong; right?

8 **A.** No. I think that is exactly -- I mean, my whole  
9 description this morning is the fruition of this  
10 conceptualization from 2007.

11 MR. SU: And if we could, let's just look down,  
12 Mr. Oxford, at the 35th page of the exhibit. It's not  
13 really -- this is where it doesn't -- the numbering doesn't  
14 work out so well, I think. Do we have that? No. I'm  
15 sorry. That's not it. I don't know where that one is.  
16 We'll go past that.

17 BY MR. SU:

18 **Q.** You were talking to the judge about the -- the  
19 categories under better health, and you testified about, for  
20 instance, "fall screening"?

21 **A.** Yes, sir.

22 **Q.** And if I recall correctly, the peer group was at,  
23 like, 21 percent?

24 **A.** Yes, sir. I -- I don't remember. I -- I believe  
25 you.

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1 MR. SU: Is it possible to pull that back up? I'm  
2 not trying to mislead, Dr. Fortuin, but that was my  
3 recollection. All right.

4 So let's look -- go under "better care" is what I  
5 recall. And then -- I'm sorry. Not "better care."  
6 "Population health." That's right. In the "fall  
7 screening."

8 BY MR. SU:

9 **Q.** And you told the court that the triangle is where  
10 the peer is -- the peer group is; right?

11 **A.** That's -- yes. That's correct.

12 **Q.** Okay. So you may be at 92 percent or 91 percent,  
13 but what explains the fact that the triangle is right there  
14 where it is?

15 **A.** I would say there is probably a lot of reasons why  
16 the triangle isn't farther to the right. Perhaps other  
17 physicians haven't adopted the fall screening tool that I  
18 use. I know -- I can't speak to the doctors who work within  
19 the Epic environment, but in the Centricity environment, we  
20 have rolled out the tool electronically, and I have also  
21 implemented in my practice a sort of team-based approach  
22 where my nurse does the fall screening before me, before I  
23 even get into the room and when the fall screening comes out  
24 as high, then I address it.

25 **Q.** So that -- so before you had the tool, were you

1 doing fall screening?

2 THE WITNESS: Well, Alyson, if you hit that  
3 button.

4 So, yes, I was screening roughly for falls but not to  
5 the same degree and not in a more -- not in a -- not using  
6 an evidence-based tool that -- that we have now implemented.  
7 It was more my clinical judgment, my guess as to whether  
8 they would fall or not or they were -- you know, whether  
9 they look like they're at risk for falling, so it was not  
10 very evidence based. It was not robust.

11 BY MR. SU:

12 **Q.** Are you saying you weren't doing it for all  
13 patients? Is that what you're saying?

14 **A.** I was not doing it -- well, this -- this, by the  
15 way, is not all patients. This -- these are patients  
16 greater than the age of 65.

17 **Q.** Yes, sir.

18 **A.** So I was doing it selectively on patients that  
19 clinically would seem to be at high risk for falls. If they  
20 were on high-risk medications, if they were using a walker  
21 or wheelchair or had a gait abnormality or the more glaring  
22 things that put a person at increased risk of falling.

23 **Q.** And when you were doing that, did that -- that  
24 make you a bad doctor, that you were focusing on those kinds  
25 of characteristics?

1 **A.** I think I was as good a doctor as I could be with  
 2 the tools I had at my disposal. But having this tool at my  
 3 disposal helps me be a better doctor.  
 4 **Q.** But it all adds -- it all starts with your own  
 5 mindset, right, you want to do the best for your patients?  
 6 **A.** Well, I think every physician does.  
 7 **Q.** Right. And in fact, since every physician does,  
 8 it would be great, right, in your -- in your opinion, if  
 9 this tool were made to all -- available to all the doctors  
 10 in the Twin Falls community; right?  
 11 **A.** You're -- you're -- you're right. The tool is  
 12 available. You can Google it and download the tool and you  
 13 can implement it and you can use it. That's absolutely  
 14 true.  
 15 The difference is how do you get that information  
 16 displayed in such a way that I can sort of get a report card  
 17 of how I'm actually doing. So -- so, for me, it's nice to  
 18 look at this and say, well, I'm doing pretty well with fall  
 19 screening so I can focus my efforts on other -- other things  
 20 that maybe I need more work on, you know, like the aspirin  
 21 example or what have you.  
 22 **Q.** But I guess what I'm saying is -- what I'm asking  
 23 you is, based on your testimony -- testimony today, I gather  
 24 that you're a convert to this -- to this clinical  
 25 integration scorecard tool; correct?

1 mission, the same Triple Aim type of mission, the better  
 2 it's going to be for those patients and the network provides  
 3 an opportunity to have a relationship with physicians who  
 4 may be philosophically, you know, in line with kind of the  
 5 Triple Aim, say, but don't necessarily want to have a  
 6 contractual relationship with St. Luke's.  
 7 The -- the -- one of the barriers to this is that  
 8 these physicians that you've -- you've alluded to, these  
 9 friends of mine in Twin Falls, they either do not have a  
 10 medical record or their medical record, you know, has not  
 11 built an interface with, you know, the WhiteCloud tool and  
 12 so the time and effort and money associated with that hasn't  
 13 been spent. And the physicians who don't have an electronic  
 14 record necessarily don't want to pay for that. It's not  
 15 worth it for them to buy that. So there is no way to  
 16 interface the WhiteCloud tool with a paper chart.  
 17 **Q.** Right. But when we talk about St. Luke's Triple  
 18 Aim and one of the -- you know, one of the aims is  
 19 population health; right?  
 20 **A.** Yes, sir.  
 21 **Q.** It would be great -- I mean, it would help fulfill  
 22 St. Luke's mission if everybody in the community, all the  
 23 physicians in the community could have access to the same  
 24 tool; right?  
 25 **A.** I mean, I think anything we can do to improve the

1 **A.** A convert, you said?  
 2 **Q.** Yes, sir.  
 3 **A.** Yeah. Oh, absolutely, I mean I'm very fond of it.  
 4 **Q.** You would tell your friends and colleagues in the  
 5 community about what a great tool this is; right?  
 6 **A.** Yes. I demonstrate it to them frequently.  
 7 **Q.** And -- and I believe you have friends and  
 8 colleagues who are not part of St. Luke's clinic who are  
 9 also similarly culturally aligned; right?  
 10 **A.** That's correct.  
 11 **Q.** And these are people that, you know, if they had  
 12 the access to the tool and could share their data, they --  
 13 they want to be on it, too, right?  
 14 **A.** They do.  
 15 **Q.** And it's also your view that, in fact, that it  
 16 would be great if, you know, a network like the Select  
 17 Medical Network had independent physicians; right?  
 18 **A.** Yeah. Yes, I do. I do believe that. I mean, you  
 19 know, you're asking me a lot of questions. I guess what I  
 20 would say is, that St. Luke's clinic patients, my -- my  
 21 patients get cared for by many different doctors, some of  
 22 whom are outside of the St. Luke's clinic.  
 23 So the better relationship I have with them and  
 24 the more I can make sure that patients are seeing physicians  
 25 who are, you know, trying to -- they're seeking the same

1 care delivered to patients is good for the population.  
 2 That's -- I mean, I -- maybe what you're getting at is how  
 3 do you define the population? Is the population all of  
 4 Idaho? All of Southern Idaho? All of America? You know,  
 5 it depends on how far you want to cast that net. So, yeah,  
 6 I think the more we can work together to provide better care  
 7 for patients, the better the world is going to be.  
 8 **Q.** Certainly, the population in the areas where the  
 9 St. Luke's Health System provides services; correct?  
 10 **A.** Yeah. I -- I think what's nice about St. Luke's  
 11 mission is it doesn't confine itself to our patients or the  
 12 people that come to us. It's the people in our region.  
 13 It's a pretty broad scope.  
 14 MR. SU: Thank you, sir. No more questions,  
 15 Your Honor.  
 16 THE COURT: Redirect, Mr. Keith.  
 17 REDIRECT EXAMINATION  
 18 BY MR. KEITH:  
 19 **Q.** Dr. Fortuin, just a few questions. Counsel for  
 20 the government asked you a number of questions about the  
 21 plans and goals of an organization called the Southern Idaho  
 22 Health Cooperative. And I noticed the conspicuous absence  
 23 of a question I'm going to ask you now. How successful was  
 24 that organization?  
 25 **A.** Not.

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1 Q. And why not?

2 A. I think there were a variety of factors. I think  
3 the obstacles I described where this -- the independent  
4 physicians who were part of the cooperative but not part of  
5 the MSO had fear of the -- of Magic Valley Regional Medical  
6 Center. And that goes back to the history in Twin Falls.  
7 There was a lot of division and a lot of distrust among  
8 physicians with each other, physicians within  
9 administration. So there was a lot of fear.

10 There were a lot of physicians that were not  
11 philosophically in agreement with the whole cooperative  
12 idea, the idea of being integrated and working together.  
13 Many of the physicians simply didn't -- didn't want to share  
14 their data, didn't want to be on the same record. They  
15 wanted to do their own thing.

16 And then also a part of that is that there -- at  
17 the time where, you know, just culturally, there was -- it  
18 was very hard to fund it and a lot of the payors were not  
19 particularly interested in pursuing a robust cooperative  
20 relationship with -- with the Southern Idaho Healthcare  
21 Cooperative.

22 Q. And why is that important? Why is it important  
23 that the payors cooperate with an entity like Southern Idaho  
24 Health Cooperative to make it successful?

25 A. So this will seem a little awkward, but take the

1 patient I described who had the mammogram with the earlier  
2 diagnosed breast cancer, right? So suppose,  
3 hypothetically -- and we don't know the outcome of her case  
4 yet because she is still having her surgery -- but suppose  
5 by implementing this tool I diagnosed breast cancer earlier  
6 such that she needs very limited treatment, a surgery and  
7 that's it. And if I were to diagnosis it later, then she  
8 would need a surgery, maybe chemotherapy and maybe  
9 radiation. Maybe it's a hundred thousand -- I'm going to  
10 guess just a number, a hundred thousand dollars in  
11 treatment. Well, by reducing the need for that treatment,  
12 it -- it's saving the patient a bunch of money. It's saving  
13 the insurance company a huge bucket of money, but it's  
14 actually -- I am not making as much money because I'm not  
15 giving chemo, I'm not giving radiation, I'm not seeing the  
16 patient back.

17 And it's this very, if you will, perverted  
18 incentives that the current healthcare system has where we  
19 get paid more for people who are sicker. So there is really  
20 very little incentive for me financially, that is, there is  
21 no financial incentive for me to try to keep people healthy  
22 before they get sick.

23 So -- so there was sort of this disconnect  
24 between, you know, the fee-for-service type of payment model  
25 and what we are trying to accomplish. And if the payors

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1 were not -- didn't want to partner, then we, basically -- we  
2 use the phrase "gored our own ox," we would -- we would  
3 damage our own business model by trying to do, you know, the  
4 right thing, the Triple Aim.

5 Q. Did the participants or the -- the folks who  
6 anticipated -- are participating in the Southern Idaho  
7 Healthcare Cooperative ultimately choose to take a different  
8 tact towards achieving the Triple Aim?

9 A. Yeah. I think what -- what happened is that more  
10 and more physician practices became more tightly aligned  
11 with the Medical Center, and, in fact, the relationship sort  
12 of changed where instead of me contracting -- me having a  
13 contract with them to provide administrative services, they  
14 basically owned the practice, Magic Valley Regional Medical  
15 Center and eventually St. Luke's Regional Medical Center,  
16 St. Luke's Magic Valley Regional Medical Center, sorry, they  
17 own the practice and they contracted with me to provide  
18 physician services to them. So most all the physicians in  
19 Twin Falls -- in fact, all the St. Luke's clinic physicians  
20 in Twin Falls are now in that model.

21 Q. In speaking for your own decision or your practice  
22 group's own decision, why did you -- why did you decide to  
23 more fully financially integrate with the Regional Medical  
24 Center rather than pursue the option of trying to develop  
25 the Southern Idaho Health Cooperative?

1 A. So there were several drivers of that. One was  
2 the cost of the care we were delivering became increasingly  
3 expensive, so things like paying for the electronic medical  
4 record and those sorts of expenses were getting higher and  
5 the reimbursement wasn't going up, you know, along with  
6 that, whereas being an owned practice, the hospital could  
7 absorb that expense and could -- could pay for those sorts  
8 of things.

9 The second driver was this integration. Because  
10 my electronic record couldn't communicate with other  
11 practices that were not integrated, there was -- we were  
12 still in our own silo, if you will, and we couldn't have  
13 that cross-communication when a patient went from my office  
14 to the gastroenterologist's office or the cardiologist's  
15 office. When we fully integrated, the record became the  
16 patient's record and it went with them wherever they went.

17 Q. Counsel for the plaintiffs asked you some  
18 questions about the ability of WhiteCloud to interface with  
19 different types of electronic health records. I wanted to  
20 ask you some details about that process. So you are  
21 familiar with the work that goes into extracting -- the work  
22 that goes into making sure that WhiteCloud can extract data  
23 from Centricity; is that right?

24 A. Yes. I'm not a computer programmer, but I  
25 understand from the clinician's point of view how data has

1 to be entered in and that there are often snafus, if you  
2 will, in that process, and so that's when we reach out to  
3 WhiteCloud and they help fix it and help to understand it,  
4 so, yeah, that's how I understand it.

5 Q. And so there is work involved in insuring in the  
6 first instance that their -- that WhiteCloud has the ability  
7 to extract data from Centricity?

8 A. Correct.

9 Q. And going -- on a -- so going-forward basis, are  
10 there costs associated with maintaining WhiteCloud's ability  
11 to extract data from Centricity?

12 A. Absolutely.

13 MR. SU: Foundation.

14 THE COURT: I'm sorry?

15 MR. SU: Foundation.

16 MR. KEITH: Your Honor, I think the --

17 THE COURT: Let's lay a foundation as to how the  
18 witness knows. I'm assuming that he is involved in some of  
19 those decision-making, but we need a foundation.

20 BY MR. KEITH:

21 Q. And, Dr. Fortuin, I believe you testified that you  
22 were involved at least not necessarily on a programming  
23 level but on a programmatic level with IT work in the Magic  
24 Valley; is that correct?

25 A. That's correct.

1 Q. And so part of your work is, in fact, ensuring  
2 that the Centricity tool is used in such a way that it can  
3 interface with WhiteCloud?

4 A. So there is two answers to that question. One is  
5 trying to educate the clinicians on how to enter the data  
6 into Centricity so that it can be extracted from WhiteCloud,  
7 and then the second piece of work is, the clinician -- the  
8 clinicians -- we all provide feedback to WhiteCloud when the  
9 extraction isn't exactly right so it improves the accuracy.

10 MR. KEITH: Your Honor, I think that lays a  
11 foundation for his testimony about the work that is required  
12 to maintain the -- the interface between these two  
13 electronic systems.

14 THE COURT: I'll allow it.

15 BY MR. KEITH:

16 Q. Dr. Fortuin, can you explain to us the work that's  
17 involved on a continuous basis in making sure that their --  
18 that WhiteCloud can interface with Centricity and back and  
19 forth?

20 A. So there is a large body of work that goes around  
21 that. Certainly, there is -- it's obvious that WhiteCloud  
22 is doing a tremendous amount of work to do this, but on my  
23 end, we have a one-hour meeting every week where we sit down  
24 and talk about the interfaces, talk about Centricity, talk  
25 about the tool. In fairness, we also talk about the patient

1 portal and other aspects of the electronic health record,  
2 but there is a lot of human time, work time dedicated to the  
3 processes you just described.

4 Q. And is WhiteCloud a static tool? And by that I  
5 mean you sort of establish the metrics you're going to look  
6 at, and the way it's going to look, you're done, wash your  
7 hands of it, and the work is sort of over for now?

8 A. No. In fact, it's sometimes frustrating because a  
9 month ago they added a couple of metrics that I wasn't doing  
10 as well on, so now I had to figure those out and it was a  
11 little bit frustrating.

12 And so -- so it continues to evolve in several  
13 ways: One, the points attributed to each metric evolve as  
14 we determine which metrics may or may not be more important,  
15 the -- where the standard is, is moving based on new  
16 evidence and new findings that we have, and then which  
17 metrics. We are adding metrics all the time to accommodate  
18 requests of different physician groups that have different  
19 focus within their practice.

20 Q. And I take it that as the WhiteCloud tool changes  
21 over time, adds elements, changes the way certain metrics  
22 are acquired or displayed, that that requires work on the  
23 back end in the electronic health record to make sure that  
24 the two systems interface properly?

25 A. Yes. There is that work but there is also work --

1 so take the fall -- we have talked about fall prevention,  
2 and we had to develop the tool in Centricity in order to do  
3 the fall screening so that it could be done electronically  
4 and then captured by WhiteCloud because previously we had  
5 used paper forms of the fall risk assessment. So that takes  
6 time to -- to build that into the electronic record.

7 Q. And Mr. -- counsel for the plaintiffs asked you  
8 about whether you had colleagues in the -- independent  
9 colleagues in Twin Falls who were philosophically aligned  
10 although not financially aligned, and whether they wouldn't  
11 be eager to join in using the WhiteCloud tool. And I wonder  
12 if you can speak to the -- I wonder what -- he was sort of  
13 putting you in the mind of your independent colleagues and  
14 whether they wouldn't want to join in and use WhiteCloud.

15 And I guess now that we have discussed the costs  
16 associated with maintaining the interoperability, I wondered  
17 if you could speak to that question; that is, do you believe  
18 that the independent colleagues that you are philosophically  
19 aligned are likely to participate in the WhiteCloud tool?

20 A. So the best answer I could give for that is, I  
21 think the independent colleagues want access to their own  
22 data. I think they want control over which data and what  
23 metrics and what standards. I think they want to do it  
24 their way. I mean, their -- their name sort of says it.  
25 They're independent. They have their idea about doing

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1 things.

2 So if I were to go to them and say, Here is the  
3 WhiteCloud tool, you can participate with it, but everyone  
4 else in St. Luke's is going to be able to see your  
5 performance and how you're doing. And by the way, we have  
6 already established what the measurements are and what the  
7 standards are and what gives you a green, yellow, or red  
8 mark, what gives you these many points. I would say that  
9 most -- most independents would just ask you to kindly  
10 leave, especially when you said, And you've got to pay for  
11 it.

12 Q. And when you say we developed the metrics and what  
13 counts as good or appropriate care, who is the "we"?

14 A. Well, I -- I think that's been a collective effort  
15 to some degree. Many of the metrics are well established  
16 and well accepted, you know, nationally among national  
17 forums and groups. Several of them were -- were adjudicated  
18 by a what's called a measurement subcommittee that looked at  
19 what measurements we're doing. And quite honestly, the  
20 chief of quality of the system and other thoughtful  
21 clinicians sat down and sort of just put it together as a,  
22 you know -- and it's -- it's sort of a work in progress, as  
23 you alluded to earlier.

24 So the amazing thing is that the physicians have  
25 accepted it within St. Luke's and are using it and they

1 understand the -- the -- some of the conflicts within it. I  
2 mean, a brief example, the standard for mammography is not  
3 the same. Some expert groups say from 40 to 60 you should  
4 have a mammogram every two years. Others say from 50 to 75  
5 you should have a mammogram every two years. So there is  
6 some discord in the professional communities as to -- or  
7 expert communities as to what is the standard. But in  
8 St. Luke's, the physicians I have talked to have all  
9 accepted the standards with minimal push back in that  
10 regard. I don't know if that answers your question at all  
11 but --

12 Q. If -- if your practice group decided to leave the  
13 St. Luke's clinic and operate independently but you remained  
14 philosophically aligned and interested in working together,  
15 do you think that St. Luke's could achieve the Triple Aim as  
16 efficiently and as effectively as having you closely  
17 financially aligned with the system?

18 A. No.

19 Q. Why not?

20 A. Well, efficiency is one thing. Using the Southern  
21 Idaho Healthcare Cooperative, we -- we have been -- in '07  
22 we tried to do what St. Luke's has been doing for the last  
23 couple years, and in that couple years, St. Luke's has  
24 gotten us to a point where we have the data that Mr. Su, you  
25 know, referred to or the -- the goals that we had set forth

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1 to do. So it was very inefficient.

2 In trying to get physicians to philosophically  
3 change their practice like I described my philosophical  
4 change from being "I'll fix you when you get ill; if you get  
5 sick come see me," to a more comprehensive, "I want to keep  
6 you healthy," you know, type of physician, that  
7 philosophical change is very difficult and without the tight  
8 alignment with St. Luke's, I don't think I would have  
9 necessarily gone there. I'm not sure I would have come to  
10 that recognition.

11 And I think the other thing is there is a lot of  
12 fear out there with -- with disparate groups that have sort  
13 of loose interact -- or loose ties, these clinical  
14 integration ties being a part of St. Luke's, and that's why  
15 I think you corrected me when I said "we," I sort of think  
16 of me, we, us as St. Luke's. We're all part of the -- we're  
17 all part of the process. We're all part of the mission that  
18 we're trying to accomplish.

19 MR. KEITH: Thank you, Your Honor. No further  
20 questions.

21 THE COURT: Recross.

22 MR. SU: May I have recross, Your Honor?

23 THE COURT: Briefly.

24 MR. SU: Thank you.

25 RE-CROSS-EXAMINATION

1 BY MR. SU:

2 Q. Dr. Fortuin, Mr. Keith asked you about the mindset  
3 of the independent physicians in Twin Falls. Isn't it true  
4 that you have felt that it would be important to have an  
5 independent physician member on the clinical integration  
6 committee of your -- under your Physician Leadership Council  
7 of Magic Valley?

8 A. I think we have gone back and forth on that. I  
9 think -- I think it's -- in the interest of collegiality  
10 because we're friends with these -- these other physicians  
11 that we have been open and inclusive with them as much as we  
12 can, there are certain -- I think there are certain business  
13 and financial things we can't really be as transparent  
14 about. But in as much as we can, yeah, I've been -- I've  
15 felt that way.

16 Q. Mr. Keith also asked you about the importance of  
17 financial alignment. Isn't it true that in your view this  
18 whole -- the role of compensation isn't as important as  
19 changing the culture, the way that physicians practice and  
20 deliver care?

21 A. Well, I think compensation plays a very high role  
22 in -- in motivating people. We can't base -- I don't --  
23 we -- I don't think that we could base what we're doing on  
24 altruism or -- or just the good of the order alone. I think  
25 that having a sustainable clinical and business model is

1 **critical and a lot of -- I mean, everybody is motivated by**  
 2 **different things, and I think certainly if we -- if we make**  
 3 **our mission something that is damaging to a physician's**  
 4 **business model, that's going to be very counterproductive.**  
 5 **Q.** But isn't it true that you have expressed a view  
 6 that change in compensation is a very complicated thing to  
 7 do because a physician is going to be -- is not going to be  
 8 clear about what the cause-and-effect relationship is  
 9 between pay and performance. The example you gave me was do  
 10 I get paid more money if more of my diabetics are controlled  
 11 or do I get paid less money if my blood pressure patients  
 12 have high blood pressure; right?  
 13 **A.** So I agree that culture and philosophical  
 14 perspective and my commitment to my patients is far and away  
 15 a much greater motivator than money ever could be. So I  
 16 agree with you.  
 17 **Q.** Isn't it also true that you've -- you've expressed  
 18 a view that this can't be a top-down approach. I mean, your  
 19 rank and file within the St. Luke's clinic have to buy in to  
 20 what the leadership is doing. If that doesn't happen, then  
 21 this -- this effort to pursue the Triple Aim is a failure,  
 22 right?  
 23 **A.** Absolutely.  
 24 **Q.** Now, Mr. Keith asked you about what happened to  
 25 the Southern Idaho Healthcare Cooperative. Isn't it true

1 that the financial alignment between individual practice  
 2 groups and the Medical Center was happening independently of  
 3 what the cooperative was trying to do at the time?  
 4 **A.** Yeah. I don't know how independent -- I mean,  
 5 those were happening -- happening contemporaneously. I  
 6 don't know that they -- one was causing the other.  
 7 MR. SU: Thank you. That's all the questions,  
 8 Your Honor.  
 9 THE COURT: Anything else?  
 10 FURTHER REDIRECT EXAMINATION  
 11 BY MR. KEITH:  
 12 **Q.** Dr. Fortuin, do you regard St. Luke's as a  
 13 top-down organization in terms of the way it's attempting to  
 14 achieve a Triple Aim?  
 15 **A.** No, I don't.  
 16 MR. KEITH: Thank you. No further questions.  
 17 THE COURT: You may step down. Thank you,  
 18 Dr. Fortuin.  
 19 THE WITNESS: Thank you.  
 20 THE COURT: Call your next witness.  
 21 MR. BIERIG: Call Dr. Adebayo Crownson,  
 22 Your Honor.  
 23 THE COURT: Sir, please step before the clerk and  
 24 be sworn.  
 25 ADEBAYO CROWNSON,

1 having been first duly sworn to tell the whole truth,  
 2 testified as follows:  
 3 THE CLERK: Please state your complete name and  
 4 spell your name for the record.  
 5 THE WITNESS: Adebayo, A-D-E-B-A-Y-O; Crownson,  
 6 C-R-O-W-N-S-O-N.  
 7 THE COURT: You may inquire of the witness,  
 8 Mr. Stein.  
 9 MR. STEIN: Thank you.  
 10 DIRECT EXAMINATION  
 11 BY MR. STEIN:  
 12 **Q.** Good morning, Dr. Crownson.  
 13 **A.** Good morning.  
 14 **Q.** What is your area of medical specialty?  
 15 **A.** Family medicine.  
 16 **Q.** And are you board certified in family medicine?  
 17 **A.** Yes, I am.  
 18 **Q.** In what city do you practice?  
 19 **A.** Nampa, Idaho.  
 20 **Q.** How long have you been practicing medicine in  
 21 Nampa?  
 22 **A.** Eleven years.  
 23 **Q.** And currently you're employed by St. Luke's?  
 24 **A.** Yes.  
 25 **Q.** And is the -- is the name of the practice in

1 Nampa, St. Luke's Nampa?  
 2 **A.** It's St. Luke's Family Medicine Nampa.  
 3 **Q.** Could you summarize for the court your educational  
 4 background starting with college?  
 5 **A.** Yes. I went to undergraduate in New Jersey at  
 6 Rutgers University, where I received a bachelor's of science  
 7 in nursing BSN and a minor in premedical degree. I  
 8 subsequently then went to UMDNJ, that's the University of  
 9 Medicine and Dentistry of New Jersey in Newark, New Jersey,  
 10 where I received my M.D. degree.  
 11 And then did my internship and residency training  
 12 in family medicine at Oregon Health Sciences University in  
 13 Portland, Oregon.  
 14 **Q.** And what year was that that you finished your  
 15 internship and residency?  
 16 **A.** I finished that in '96. I take that back, sorry.  
 17 '99.  
 18 **Q.** And what did you do next?  
 19 **A.** I then went to -- I joined the United States Air  
 20 Force and was a flight surgeon for the 391st Fighter  
 21 Squadron at Mountain Home, Idaho.  
 22 **Q.** And what was your rank?  
 23 **A.** I was a major.  
 24 **Q.** So how did it come to be that you began practicing  
 25 medicine in Nampa?

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1 **A.** I was sent on a deployment after 9/11 to Kuwait  
2 and Afghanistan and when I came back decided to separate  
3 after I got married, and after I separated, my wife and I  
4 both enjoyed Idaho, so we decided to stay in Idaho and work.  
5 So I sought employment with a few organizations and wind up  
6 with Saint Alphonsus Medical Group in Nampa.

7 **Q.** And when you say you -- when you talked about  
8 separating, you talked about separating from the Air Force?

9 **A.** That's correct.

10 **Q.** So what year did you join Saint Alphonsus Medical  
11 Group?

12 **A.** I joined Saint Alphonsus Medical Group in 2002.

13 **Q.** And Saint Alphonsus Medical Group, you also know,  
14 is referred to sometimes as SAMG?

15 **A.** That is correct.

16 **Q.** And at the time that you joined Saint Alphonsus  
17 Medical Group in 2002, was the hospital in Nampa owned by  
18 Saint Alphonsus?

19 **A.** No. It was owned by Catholic Health Initiative,  
20 and it was at that time called Mercy Medical Center.

21 **Q.** And Mercy Medical Center is the hospital that's  
22 also known today as Saint Alphonsus Nampa?

23 **A.** That's correct.

24 **Q.** So when you first started working for SAMG in  
25 Nampa in 2002, did you hold any leadership positions?

1 **A.** Yes. They had two clinics, and I was the medical  
2 director for the two Saint Alphonsus Medical Group clinics.

3 **Q.** And those were both family medicine clinics?

4 **A.** That is correct, yes.

5 **Q.** So how long did you work for SAMG after you  
6 started in 2002?

7 **A.** I worked for SAMG until 2007 and left SAMG at that  
8 time.

9 **Q.** And can you describe the circumstances in which  
10 you left SAMG the first time?

11 **A.** I -- well, I was obviously not very happy with my  
12 employment at that time because I didn't feel that physician  
13 engagement was there. And when you practice medicine, it's  
14 important to have physicians as a partner with the  
15 administration, and I didn't think that was there. So  
16 that's why I left.

17 **Q.** And that was -- when you say "partner with the  
18 administration," this would have been the administration of  
19 Mercy Medical Center before it was acquired by Saint  
20 Alphonsus?

21 **A.** No, no. The Saint Alphonsus Medical Group.

22 **Q.** I'm sorry. Saint Alphonsus Medical Group.

23 **A.** Right.

24 **Q.** So -- so 2007 you left Saint Alphonsus Medical  
25 Group and did what?

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1 **A.** The Mercy Physician Group -- sorry -- Mercy  
2 Medical Center was interested in developing their own  
3 medical group, and so I decided to start that effort by  
4 being one of the physicians.

5 **Q.** So this would have been -- you would have been,  
6 then, on the staff of Mercy Medical Center?

7 **A.** Yes. So I was -- I became a -- an employed -- an  
8 employed physician with Mercy Physician Group, and, yes, I  
9 was on staff at the hospital at -- at Mercy Medical Center.

10 **Q.** And were there other primary care doctors who were  
11 members of Mercy Physicians Group?

12 **A.** Yes. When I left SAMG, two other physicians from  
13 SAMG joined me and we subsequently employed other physicians  
14 to a total of about seven family physicians.

15 **Q.** So Saint Alphonsus then purchased the Mercy  
16 Medical Center around 2009; is that right?

17 **A.** That is correct.

18 **Q.** And so how did that then affect your employment  
19 status?

20 **A.** So I essentially became -- because Mercy Medical  
21 Center was -- was purchased by Trinity Saint Alphonsus, I  
22 essentially became employed by SAMG again for the second  
23 time.

24 **Q.** And how did you view the prospect of working for  
25 SAMG a second time?

1 **A.** I was not very happy about doing that, but the  
2 leadership at Saint Alphonsus told my group to give them a  
3 trial period of about a year to see -- for us to see that  
4 the SAMG we left in the first place has changed and that  
5 it's a better place to work now. So we did that. We gave a  
6 trial period of about a year. And after that year, decided  
7 to leave and join St. Luke's.

8 **Q.** So you made the -- you made a decision to leave  
9 SAMG in -- in what time period?

10 **A.** It was about 2011 is when we decided. I decided  
11 to leave SAMG.

12 **Q.** And what did you do next in order to pursue -- you  
13 know, pursue additional work?

14 **A.** I start -- I started looking around to see what my  
15 options were and so I looked at Saltzer Medical Group. I  
16 looked at Primary Health and decided that St. Luke's would  
17 be a better option for me.

18 I enjoyed -- well, I -- I have always worked for  
19 hospital-employed physician groups, and I thought that would  
20 be a better option for me, so I decided to join St. Luke's.

21 **Q.** So did St. Luke's approach you and say, Hey, we  
22 would like you to leave Saint Alphonsus and come work for us  
23 in Nampa?

24 **A.** No, they didn't. I actually called the  
25 administration center at Shoreline and found out that the

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1 director for family medicine is Sandy Stevenson. So I  
2 called her and engaged her and -- and she also told me to  
3 get a letter of intent from my lawyer. So I talked to my  
4 lawyer, got a letter of intent to St. Luke's that I wanted  
5 to seek employment with them.

6 **Q.** And over what period of time did you then have  
7 discussions with people from St. Luke's about becoming an  
8 employed physician?

9 **A.** It was probably about three months. I engaged  
10 with Sandy Stevenson, Joni Stright, and much later on with  
11 Chris Roth.

12 **Q.** So when you were practicing with SAMG before  
13 coming over to St. Luke's, as a primary care doctor, would  
14 you sometimes have occasion to have patients that would need  
15 to be admitted to a hospital?

16 **A.** Yes.

17 **Q.** And can you tell the court generally where you  
18 would send patients that you would see in your practice in  
19 Nampa if they needed to be hospitalized?

20 **A.** As a SAMG employee?

21 **Q.** Yes.

22 **A.** They would typically go to -- since that's the  
23 only local hospital, they would typically go to Saint  
24 Alphonsus Nampa.

25 **Q.** And so did you have any concerns when you were

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1 considering about whether to affiliate with St. Luke's as to  
2 whether that -- there might be some pressure on you to start  
3 sending your patients to a St. Luke's facility, Meridian  
4 or -- or Boise?

5 **A.** Yes, I did. And I -- you know, I actually  
6 represented my group and had a meeting with some of  
7 St. Luke's leadership, including Chris Roth, John Kee, and  
8 some others, and I asked the question that you just asked,  
9 well, so what -- what does this mean? I am employed by  
10 St. Luke's, but here I am in Nampa. St. Luke's does not  
11 have any facilities in Nampa, so is the expectation that I  
12 will be sending my patients to Meridian because that's not  
13 going to work very well. And I was told emphatically  
14 that -- by Chris Roth that, They are your patients, you are  
15 the physicians, you take care of them the way you see best.

16 And if the local hospital -- they believed  
17 strongly that care should be close to the patient. And so  
18 if the local hospital is where the patient is to go, that's  
19 where they go. And, therefore, there was absolutely no  
20 pressure on me at all to send patients anywhere besides  
21 keeping them close to home.

22 **Q.** So when you were practicing as a primary care  
23 doctor at SAMG, you were practicing primarily in an  
24 office-based setting in Nampa; is that right?

25 **A.** Primarily, yes, but I did do some hospitalist work

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1 for SAMG.

2 **Q.** And can -- can you just tell the court briefly  
3 what a hospitalist is?

4 **A.** Well, a hospitalist is a physician that  
5 essentially takes care of patients when they come in the  
6 hospital because they are not able to get their care on an  
7 outpatient basis any longer. And so the hospitalist admits  
8 the patient, follows the patient throughout the hospital  
9 stay, and discharges the patient to the outpatient  
10 physician.

11 **Q.** So when you were working as a  
12 hospitalist -- and -- and by the way, when you're talking  
13 about working as a hospitalist, you were working as a  
14 hospitalist at Saint Alphonsus Nampa or Mercy Medical  
15 Center?

16 **A.** Yes.

17 **Q.** So when you would work as a hospitalist and see  
18 patients, would these be your patients? In other words, are  
19 these -- would you only be admitting people who you  
20 personally saw in your clinic practice?

21 **A.** No. The situation was that they were having  
22 difficulty getting enough hospitalists to cover shifts and  
23 so I -- one of my partners and I, Dr. Cothorn and I,  
24 essentially agreed to help out. So we will help out and  
25 work as a hospitalist, which meant that we admitted any

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1 patient that came into the hospital that requires inpatient  
2 hospitalization.

3 **Q.** So can you describe briefly how the population of  
4 patients that you would tend to see when you were working as  
5 a hospitalist was different in -- if they were different  
6 from the population of patients you would tend to see in  
7 your office in terms of how sick they were?

8 **A.** Well, patients in the office tend to have a  
9 fairly -- I wouldn't say benign, they are sick but they're  
10 not sick enough to be in the hospital, so they tend to have  
11 a short-term, short course of disease process. And, you  
12 know, you manage a lot of chronic diseases, hypertension,  
13 diabetes, so you do that and in an outpatient setting.

14 In an inpatient setting, however, patients that  
15 you admit are generally much sicker, they have a high acuity  
16 of care. And what that meant is that you are ordering a lot  
17 more tests, a lot more labs, a lot more care for those  
18 patients.

19 **Q.** Now, you started working for St. Luke's in 2012;  
20 is that correct?

21 **A.** Yes.

22 **Q.** I'm sorry. 2011 or 2012?

23 **A.** 2011.

24 **Q.** 2011. So when you moved from Saint Alphonsus to  
25 St. Luke's within Nampa, did all of your patients come with

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1 you?

2 **A.** No. The process for me leaving was that  
3 the -- there was a letter sent out by Saint Alphonsus  
4 Medical Group to my patients. It -- it did tell them that I  
5 was leaving but didn't tell them where I was going. So I  
6 only -- by word of mouth, I only had about maybe 60 percent  
7 of patients that figured out where I was and followed me.

8 **Q.** So the -- the court has already heard,  
9 Dr. Crownson, from Saint Alphonsus's economic expert  
10 regarding some data she put together concerning the use of  
11 diagnostic imaging services and laboratory services by your  
12 group at Saint Alphonsus Nampa before and after the --  
13 before and after you affiliated with St. Luke's. And so I  
14 would just like to talk briefly about those two specific  
15 services.

16 So with respect to laboratory services that you would  
17 order, could you describe generally what your practice was  
18 in terms of use of laboratory services when you were at  
19 Mercy Physicians Group then Saint Al's then St. Luke's?

20 **A.** So for laboratory services -- I -- I do have to  
21 maybe give you a bit of a background, and that is the fact  
22 that we were in two locations. So one location was at South  
23 Nampa and the other location was close to the freeway at --  
24 north of Nampa.

25 **And the South Nampa, before when Saint Alphonsus**

1 bought Mercy and they took over, before then, we had a lab  
2 technician. And so most of our blood -- most of our  
3 laboratory work was done in house, meaning that if the  
4 patient requires any type of laboratory order done, it would  
5 be done in house by a phlebotomist. And then --

6 **Q.** I'm sorry, when you say "in house," does that mean  
7 in the -- in the clinic?

8 **A.** In the clinic, right.

9 **And then it would be sent somewhere for**  
10 **processing. When Saint Alphonsus took over, we didn't --**  
11 **they wanted to cut costs, so we lost that, that phlebotomy**  
12 **service, and we were sending most of those patients to the**  
13 **hospital to get their blood drawn.**

14 **We were located only about two miles from the**  
15 **hospital, so the argument is, it makes sense to send most of**  
16 **those patients to the hospital. So we sent most of our**  
17 **laboratory needs for patients to the hospital.**

18 **On the -- in the other location, they were on the**  
19 **third floor. And at the -- at the first floor was radiology**  
20 **and laboratory services that was sort of part of the**  
21 **hospital, and so they sent all their patients down to the**  
22 **first floor for their lab work.**

23 **Q.** And when Mercy Physicians Group left Saint Al's,  
24 did those physicians in that -- in that northernmost  
25 location that used to have the laboratory on the first

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1 floor, did they move to a different building?

2 **A.** Yes.

3 **Q.** And did that other building have a hospital-based  
4 laboratory in that -- in the new building?

5 **A.** So the -- the new building had a -- they had  
6 **phlebotomy services, so somebody that actually drew the**  
7 **blood and sent it -- and sent it for processing.**

8 **Q.** And with regard to the -- the phlebotomist that  
9 you used to have in the southernmost office that you had in  
10 Nampa, was the decision that was made to get rid of the  
11 phlebotomist, was that a decision that was made by your  
12 practice?

13 **A.** No, it was not.

14 **Q.** So when you came to work for St. Luke's, did that  
15 change?

16 **A.** Yes, it did.

17 **Q.** How did it change?

18 **A.** We hired a laboratory technician who did all our  
19 lab -- lab work, once again, in the clinic, and this was for  
20 patient convenience, so did all the lab work in house again,  
21 in the clinic, and that was then sent by courier to -- for  
22 processing.

23 **Q.** And so does -- does that mean that when you  
24 started working for St. Luke's, laboratory services that you  
25 used to send to the hospital to be done can now be done in

1 your office?

2 **A.** That's correct.

3 **Q.** So now I want to talk a little bit about  
4 diagnostic imaging services.

5 **A.** Okay.

6 **Q.** Can you describe for the court generally what the  
7 practice of the Mercy Physicians Group and later when you  
8 were with SAMG was with respect to diagnostic imaging  
9 services.

10 **A.** So we have advanced imaging and there are plain  
11 films that can be done in the office. The plain films, we  
12 had plain films in our offices, actually, the South Nampa  
13 office. And so those were done in the clinic.

14 **Q.** I'm sorry. What is a plain film?

15 **A.** Plain film -- films that is not CT scan, MRI, so  
16 it was not advanced imaging. And so it was done in our  
17 clinic. At the northern clinic, it was done downstairs on  
18 the first floor because they had radiology services there as  
19 well.

20 **Q.** And what about for advanced imaging?

21 **A.** Advanced imaging, they were almost always sent to  
22 Saint Alphonsus Nampa.

23 **Q.** And has the -- has your practice for ordering  
24 advanced imaging changed at all since the time you became  
25 employed by St. Luke's?

1 **A.** For the first year, it did not change very much  
2 and the reason being that there were no other options. The  
3 only option was Saint Alphonsus Nampa, so we sent most of  
4 our patients there for advanced imaging.

5 About a year after we started with St. Luke's,  
6 St. Luke's built an imaging center in North Nampa and we  
7 give patients the option. Most of the time, patients prefer  
8 to go to St. Luke's because of the interface between the  
9 imaging and the -- and our electronic medical record.

10 **Q.** Dr. Crownson, when you were most recently employed  
11 at SAMG, what medical record system did you use?

12 **A.** EClinicalWorks.

13 **Q.** And what medical record system do you use now that  
14 you're at St. Luke's?

15 **A.** The first year I was still on eClinicalWorks. The  
16 second year we started on Epic.

17 **Q.** And so now -- so you now have experience using  
18 both eClinicalWorks and Epic; is that right?

19 **A.** Yes, I have.

20 **Q.** Can you describe for the court the comparative  
21 benefits of Epic versus eClinicalWorks from the perspective  
22 of somebody who has used both systems?

23 THE COURT: Mr. Ettinger?

24 MR. ETTINGER: Your Honor, this is way beyond the  
25 scope of any witness description for this witness. I can

1 provide the court with a copy of it.

2 THE COURT: Mr. Stein?

3 MR. STEIN: I would need to -- I would need to  
4 take another look at the description.

5 THE COURT: Well, was there anything listed  
6 concerning a comparison of the electronic medical record  
7 systems?

8 MR. STEIN: Not specifically relating to the  
9 electronic medical record system, but about his experiences  
10 working for the two systems.

11 THE COURT: The two healthcare systems?

12 MR. STEIN: Yes. I'm sorry, the two healthcare  
13 systems.

14 THE COURT: Well, the witness can only in a very  
15 broad sense describe it; otherwise, I think it would be  
16 unfair to raise that issue.

17 MR. ETTINGER: Your Honor, by the way, it doesn't  
18 even say his experience in working for St. Luke's. It only  
19 says his experiences working for Saint Al's in this  
20 description.

21 MR. STEIN: Well, it also talks about how  
22 his -- he talked about his use of laboratory and imaging and  
23 the relationship of having Epic available and the images  
24 available in Epic in terms of --

25 THE COURT: That's in the disclosure?

1 MR. STEIN: Yes. That -- well, that the referrals  
2 of services are within the scope of the disclosure.

3 THE COURT: Well, I'm just going to -- I am going  
4 to confine counsel to what's disclosed. So if we have to,  
5 we'll take it up again.

6 MR. STEIN: Okay.

7 THE COURT: And I'll sustain the objection to this  
8 in the sense that I'll direct counsel to stay within the  
9 four corners of the witness disclosure.

10 BY MR. STEIN:

11 **Q.** Dr. Crownson, you previously testified when we  
12 were just talking about why it is that some patients prefer  
13 to have imaging done at St. Luke's. You mentioned something  
14 about the integration of the image with the record. Can you  
15 elaborate on what it is you're referring to specifically?

16 **A.** From my perspective as a physician?

17 **Q.** Yes.

18 **A.** So the -- what -- what I was referring to is the  
19 fact that when a patient is sitting in my office and I need  
20 an advanced imaging result, if that image was done at a  
21 facility where it's not interfaced with the electronic  
22 medical record, I have to have my staff call to have that  
23 image sent to me. That obviously takes time and sometimes I  
24 don't even get the result while the patient is still there  
25 in the office for me to interact with the patient based on

1 the result.

2 **When the imaging center is interfaced with my  
3 electronic medical record, all I have to do is just pull it  
4 up and I can then use that information to treat the patient.  
5 So obviously it did help a great deal in quality of care for  
6 the patient.**

7 THE COURT: Just let me inquire. I think, Doctor,  
8 earlier you said that the patient preferred. How does the  
9 patient know or how does that impact the patient, himself,  
10 or herself as opposed to just making it more convenient for  
11 the doctor?

12 THE WITNESS: The patient a lot of times will  
13 inquire from us, well, so if I go to this particular imaging  
14 center, do you get the results much easier because it is  
15 St. Luke's? They would inquire that, they would ask that  
16 question when I give them the option.

17 And then I will tell them, yes, because I get the  
18 result right away.

19 BY MR. STEIN:

20 **Q.** Dr. Crownson, there -- there has also been a  
21 suggestion by the -- the plaintiffs' expert that it is  
22 your -- just the fact of your affiliation with St. Luke's  
23 has led you to preferentially -- or led Mercy Physicians  
24 Group to preferentially change referral patterns for Mercy  
25 Physicians Group and so I just want to explore, if I can,

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1 the -- the issue of your interaction with other St. Luke's  
2 physicians since you have been employed by St. Luke's.  
3 And -- and as a St. Luke's physician now, do you  
4 have -- is your level of interaction with other St. Luke's  
5 doctors different than it was when you were employed by  
6 Saint Alphonsus?

7 **A. Can you clarify that question?**

8 **Q.** Yeah. Do you have more -- for example, do you  
9 have more frequent interactions with other St. Luke's  
10 doctors now that you're an employee of St. Luke's than you  
11 did when you were affiliated with Saint Alphonsus?

12 **A. Yes.**

13 **Q.** And in what context do those interactions occur?

14 **A. In terms of referral?**

15 **Q.** In -- in terms of interactions with St. Luke's  
16 physicians.

17 MR. ETTINGER: Your Honor, except in the referral  
18 context, it's beyond the scope of this notice, which I can  
19 provide the court if you'd like to see it.

20 THE COURT: Well, I think, counsel did clarify  
21 that it is in terms of referral, so I'm -- with that  
22 limitation, I'll allow the witness to answer the question.

23 THE WITNESS: Well, in terms of referral, what I  
24 would say is the first -- well, since we have joined  
25 St. Luke's, one, there has not been any pressure on us to

1 change our referral patterns. So my group has, for the most  
2 part, kept our referral patterns intact.

3 What -- what has been frustrating to some -- some  
4 of -- to me and some of my other group members is that  
5 sometimes when we refer patients -- because really our  
6 philosophy is that I would like to keep care close to home,  
7 which is Nampa for us, and so if there is a specialist in  
8 Nampa, that is what our first preference is for the patient.  
9 And what has been frustrating at times is that when we have  
10 referred these patients to some of the specialists that are  
11 based locally in Nampa, those patients then are taken to  
12 Treasure Valley to -- for their surgeries. And so that has  
13 been a frustration.

14 And in terms of other St. Luke's physicians,  
15 specialists, if -- first of all, if the care can be provided  
16 close to home, we use the services. If it cannot, we will  
17 send them to Meridian or Boise.

18 Epic makes it easy to use a physician who is in Epic  
19 because the referral process is seamless and also the  
20 getting the note back to the primary care provider is also  
21 seamless because it's all in the same record. And so from  
22 that standpoint, if care has to be done in -- in Meridian or  
23 Boise, it's -- it's been much easier for us to use  
24 St. Luke's providers.

25 BY MR. STEIN:

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1 **Q.** So you mentioned something about patients being  
2 taken to Treasure Valley. What -- what were you referring  
3 to specifically?

4 **A. Specifically, I was referring to the -- some  
5 surgeons in Nampa that we will -- so a patient will ask me,  
6 No, Doc, keep my care here, I don't want to travel, my  
7 family is here. And so we will do that, refer the patients  
8 to a local surgeon in Nampa. And then the patient comes  
9 back and complain to us that, Well, our case was done in  
10 Treasure Valley and how is that? And so that became a  
11 pattern for a while that became bothersome to my group.**

12 **Q.** And when you say it was done in Treasure Valley,  
13 are you referring to Treasure Valley Hospital or something  
14 else?

15 **A. No. Treasure Valley Hospital.**

16 **Q.** And so have you had discussions with others  
17 at -- with St. Luke's administration about trying to bring  
18 more specialists to Nampa?

19 **A. Yes, I did.**

20 **Q.** And the -- the court has heard a little bit about  
21 the physician leadership structure within St. Luke's and the  
22 family medicine division. And with regard to St. Luke's  
23 Family Medicine in Nampa, are you the site leader for -- for  
24 that division?

25 **A. I'm the site manager, yes. Site medical director.**

1 **Q.** And so do you participate in meetings of the  
2 family medicine division that are led by Dr. Johnson?

3 **A. Yes, I do.**

4 MR. STEIN: Your Honor, I don't have any further  
5 questions at this time.

6 THE COURT: Mr. Ettinger.

7 MR. ETTINGER: Thank you, Your Honor.

8 CROSS-EXAMINATION

9 BY MR. ETTINGER:

10 **Q.** Dr. Crownson, isn't it, in fact, the case that  
11 your group's approach is to first attempt to make a referral  
12 to St. Luke's providers when you have a patient?

13 **A. That is not true.**

14 MR. ETTINGER: Keely, could you put up  
15 Exhibit 1445, please.

16 BY MR. ETTINGER:

17 **Q.** Dr. Crownson, do you remember seeing this document  
18 in your deposition?

19 **A. Yes, I do.**

20 **Q.** And do you remember this is a report on a meeting  
21 with you by other St. Luke's personnel, including Sandy  
22 Stevenson, who you mentioned, and Linda House?

23 **A. Yes, I do.**

24 **Q.** And do you see under "notes" under "referrals"  
25 that says -- that says, "Dr. Crownson voiced concern

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1 regarding their ability to refer to St. Luke's physicians  
 2 without people having to travel to Boise or Meridian. The  
 3 physician's first attempt to make a referral to St. Luke's  
 4 providers, close quote.  
 5 Did I read that correctly?  
 6 **A. Yes, you did.**  
 7 **Q.** Thank you.  
 8 Now, you testified here today that --  
 9 THE COURT: Counsel, could I -- could you blow up  
 10 that up again? I -- I think the way you read it changed the  
 11 punctuation of that second sentence.  
 12 Okay. Go ahead and proceed.  
 13 MR. ETTINGER: Thank you, Your Honor.  
 14 BY MR. ETTINGER:  
 15 **Q.** Today you said that -- if I understood you  
 16 correctly, that patients choose St. Luke's because of -- for  
 17 imaging because of the better interface with the medical  
 18 record. Is that -- is that your testimony?  
 19 **A. Well --**  
 20 **Q.** Could you just answer yes or no; is that your  
 21 testimony?  
 22 **A. Well, can you repeat that, then?**  
 23 **Q.** Is it your testimony that patients have been  
 24 choosing St. Luke's for imaging because there is a better  
 25 interface with the electronic medical record. Is that your

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1 testimony?  
 2 **A. That is not entirely true. I said that patients**  
 3 **were given the option for where they want to go for the**  
 4 **advanced imaging, and when patient ask us, would it be**  
 5 **easier for me as their physician to see their records if**  
 6 **they go to a facility that is interfaced with my medical**  
 7 **record, and the answer is yes. And so sometimes patients**  
 8 **will still go to Saint Alphonsus Nampa for their imaging**  
 9 **because it's close to their house and sometimes they will**  
 10 **choose to go to St. Luke's over by North Nampa.**  
 11 **Q.** Is it -- are there patients who out of the clear  
 12 blue sky say to you unprompted, Gee, if I go to one place or  
 13 another, will that -- how will that interface with your  
 14 medical record?  
 15 **A. Absolutely.**  
 16 **Q.** How many patients have done that, Dr. Crownson?  
 17 **A. A lot of patients.**  
 18 **Q.** Hundreds? Dozens? How many?  
 19 **A. I -- I don't count. But it's a lot -- a lot of my**  
 20 **patients that require advanced imaging ask that question.**  
 21 **Q.** And is it your testimony to the court that you  
 22 don't tell the patients affirmatively, You know, if you go  
 23 to a St. Luke's facility, you're going to interface with  
 24 the -- with my medical record better?  
 25 **A. Absolutely not.**

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1 **Q.** You never say that?  
 2 **A. No.**  
 3 **Q.** Now, Doctor, you remember you -- you submitted a  
 4 declaration sworn under oath in this case. Do you recall  
 5 that?  
 6 **A. Yes.**  
 7 **Q.** And in the declaration you never mention medical  
 8 records as a reason why patients are using St. Luke's, did  
 9 you?  
 10 MR. STEIN: I'm sorry --  
 11 MR. ETTINGER: I'm going to.  
 12 MR. STEIN: I just would object if he is going to  
 13 ask a question about the declaration, if we could at least  
 14 offer the witness an opportunity to see the declaration.  
 15 MR. ETTINGER: I'm perfectly happy -- I was about  
 16 to anyhow, Your Honor --  
 17 THE COURT: Thank you --  
 18 MR. ETTINGER: -- but we'll just give it to him  
 19 right now.  
 20 THE COURT: -- Mr. Ettinger.  
 21 BY MR. ETTINGER:  
 22 **Q.** Dr. Crownson, you have been handed a declaration.  
 23 You signed that under oath; is that right?  
 24 **A. Yes.**  
 25 **Q.** And you read it carefully before you signed it?

2215

1 **A. Yes.**  
 2 **Q.** And you believed it to be as accurate as possible?  
 3 **A. Yes.**  
 4 **Q.** Why don't you turn to paragraph 8 of the  
 5 declaration. And in paragraph 8, you said you let patients  
 6 choose where their imaging is conducted; correct?  
 7 **A. Can I read it?**  
 8 **Q.** Sure, go ahead.  
 9 **A. Okay.**  
 10 **Q.** You said you let patients choose, and you find  
 11 their choice often coincides with geographic preference, is  
 12 what you said in your declaration; correct?  
 13 **A. That's correct.**  
 14 **Q.** Is that true or not?  
 15 **A. It is true.**  
 16 **Q.** Is there a reason you didn't mention electronic  
 17 medical records in your declaration?  
 18 **A. Because that is part of the preferences that**  
 19 **patients make based on the interface with my electronic**  
 20 **medical record. But -- but I have to say that when this**  
 21 **came through when I did this declaration, it was fairly**  
 22 **early in the process when the facility was built. So I can**  
 23 **now represent that patients have a preference based upon my**  
 24 **electronic medical record but back then I couldn't. It was**  
 25 **fairly new at that time.**

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1 Q. So in the fall of 2011, your group switched over  
2 to St. Luke's; correct?

3 A. That's correct.

4 Q. And in the fall of 2011, the imaging cases that  
5 your group sent to Saint Al's plummeted at that time. Isn't  
6 that right?

7 A. That's not -- I have to see what you mean. I  
8 don't -- that's not the case. I can speak to my practice,  
9 and my practice is that most patients that still required  
10 advanced imaging were sent to Saint Alphonsus Nampa.

11 Q. Can you speak for the seven doctors in your group  
12 or just yourself personally?

13 A. I -- I can speak for them because we talk amongst  
14 ourselves.

15 Q. Have you seen the data that shows that those cases  
16 went down in the fall of 2011, a year before the St. Luke's  
17 facility opened?

18 MR. STEIN: Objection, Your Honor. I -- I believe  
19 that assumes facts not in evidence.

20 THE COURT: I -- subject to it being tied in, I'll  
21 allow it but then strike the testimony unless it is, in  
22 fact --

23 MR. ETTINGER: And, Your Honor --

24 BY MR. ETTINGER:

25 Q. Well, let me put this way, have you seen data one

1 way or the other that describes the number of imaging cases  
2 sent to Saint Alphonsus during the period after your group  
3 was acquired and before the St. Luke's facility opened?

4 A. Who collected the data?

5 Q. I'm asking you, have you seen such data?

6 A. I have not seen the data.

7 Q. Thank you. Now, is it your testimony today that  
8 geography plays a role in where your patients go for imaging  
9 or not?

10 A. Right now, after seeing the -- given a time with  
11 patients since the imaging center was built, I would say,  
12 sure, geography plays a role because if a patient that lives  
13 in South Nampa, most of -- most of the time they will  
14 probably prefer to go to Saint Alphonsus Nampa. If they  
15 live in North Nampa, they will probably prefer to go to  
16 North Nampa. However, there is still a preference for the  
17 record being interfaced with my medical record where  
18 patients in South Nampa might still prefer to go to the  
19 St. Luke's facility because it interfaces with my medical  
20 record.

21 Q. Now, your group of seven physicians, it gets about  
22 half their patients from South Nampa; correct?

23 A. Repeat that.

24 Q. Your group of seven physicians gets about half  
25 their patients from South Nampa; isn't that right?

2218

2219

1 A. I haven't done the data analysis, so I cannot  
2 answer that for sure.

3 Q. Okay. And your offices are in South Nampa, aren't  
4 they, even today?

5 A. That is correct.

6 Q. So Saint Alphonsus is closer to your facilities  
7 than is the St. Luke's facility; correct?

8 A. Yes.

9 Q. And for patients who live in North Nampa, there is  
10 a St. Luke's North Nampa imaging facility and there is also  
11 a Saint Al's North Nampa imaging facility; isn't that right?

12 A. Yes.

13 Q. And so for your patients who live in North Nampa,  
14 about half of them are likely to find Saint Al's more  
15 geographically convenient than St. Luke's; correct?

16 A. It depends on where they live.

17 Q. Does it sound like about half and half of the  
18 North Nampa people?

19 A. I don't know for sure.

20 Q. Okay. And is it your testimony that neither you  
21 nor any other member of your group makes any effort to  
22 influence your patients as to where they get ancillary  
23 services or imaging services performed?

24 A. That is my testimony.

25 Q. The St. Luke's imaging facility opened in June of

1 2012; is that right?

2 A. I believe so.

3 Q. Okay. So your comment about medical records  
4 wouldn't apply to any data prior to June of 2012; correct?

5 A. Yes.

6 Q. Now, you mentioned you worked as a hospitalist.  
7 Hospitalists don't do outpatient work in their role as  
8 hospitalists; correct?

9 A. In my case, I did outpatient work. I was just  
10 helping the hospital by volunteering to be a hospitalist  
11 sometimes.

12 Q. Let me -- let me be clear. When you had your  
13 hospitalist hat on, figuratively speaking, you were doing  
14 inpatient work not outpatient work; correct?

15 A. That is correct.

16 Q. And you and Dr. Cothorn acted as hospitalists for  
17 approximately one week out of every six; is that right?

18 A. That's approximately about right.

19 Q. And during those seven days, typically you would  
20 admit six to ten patients a day; is that right?

21 A. Yeah. I think that's about -- that's reasonable.

22 Q. And you admitted those patients -- you were listed  
23 as the admitting physician for those patients, your  
24 testimony; correct?

25 A. Yes.

2220

1 **Q.** How many patients have complained to you about  
2 being sent to Treasure Valley Hospital for surgery?

3 **A.** I don't have the number, but I know that there  
4 were quite a few patients that complained to me about that.

5 **Q.** More than ten?

6 **A.** Absolutely more than ten, yes.

7 **Q.** Did you inquire -- did they have any complaints  
8 about the quality of the care they received?

9 **A.** The complaint wasn't about Treasure Valley. It  
10 was about the fact that their care wasn't provided locally  
11 as was intended.

12 **Q.** And you believe that it's very important to have  
13 your office very close to your patients; correct?

14 **A.** I believe that it's important to keep care close  
15 to home, yes.

16 **Q.** Yeah. And you have an office in Nampa to be as  
17 close as you can to your Nampa primary care patients;  
18 correct?

19 **A.** Yes.

20 MR. ETTINGER: Nothing further. Thank you.

21 THE COURT: Mr. Stein, any recross -- redirect,  
22 excuse me.

23 MR. STEIN: Briefly.

24 If we could, could I -- could I indulge on plaintiffs'  
25 counsel just to put Exhibit 1445 back up on the screen.

2221

1 MR. ETTINGER: Sure.

2 REDIRECT EXAMINATION

3 BY MR. STEIN:

4 **Q.** Dr. Crownson, we're showing you again Plaintiffs'  
5 Exhibit 1445. Did you write this document?

6 **A.** No, I didn't.

7 **Q.** Did you ever see this document before your  
8 deposition?

9 **A.** No. I saw it first time at my deposition.

10 **Q.** Okay. And Mr. -- I'm sorry, plaintiffs' counsel  
11 read you the second sentence there that says, "The  
12 physician's first attempt to make a referral to SL  
13 providers."

14 Is that something you said?

15 **A.** No, I didn't say that.

16 **Q.** And is that -- is it -- even if you didn't say it,  
17 is it a true statement?

18 **A.** No, it's not.

19 **Q.** And what was -- what was the purpose of this  
20 meeting that you had with Dr. Johnson and Sandy Stevenson  
21 and Linda House?

22 **A.** The -- the purpose was to look at specialty needs  
23 in Nampa. And I have always told them, told St. Luke's  
24 leadership, that I really prefer to keep care close to home,  
25 and so that was the -- that was what generated this meeting.

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1 So they -- we met and talked about what are the specialty  
2 needs that are in Nampa.

3 The surgery, the reference to surgery was the fact  
4 that was to demonstrate to them why my group is frustrated  
5 because patients that are sent to local surgeons are having  
6 their cases done in Treasure Valley Hospital, and they are  
7 not happy about it. And so that was to demonstrate that.  
8 But the purpose of this meeting was to work with St. Luke's,  
9 St. Luke's leadership in trying to get more specialists'  
10 care in Nampa.

11 **Q.** And when you talk about local surgeons, do you  
12 mean local as in Nampa?

13 **A.** That's correct.

14 **Q.** And were those surgeons -- the surgeons that  
15 you're talking about, were they formerly affiliated with a  
16 medical group in Nampa?

17 **A.** They were formerly affiliated with Saltzer Medical  
18 Group.

19 MR. STEIN: No further questions.

20 THE COURT: Mr. Ettinger, anything else?

21 MR. ETTINGER: No, Your Honor.

22 THE COURT: All right. You may step down,  
23 Dr. Crownson. Thank you very much.

24 Call your next witness.

25 MR. BIERIG: We are calling Mr. Chris Roth,

2223

1 Your Honor. We'll get him.

2 THE COURT: Mr. Roth, would you step forward  
3 before the clerk, Ms. Gearhart, be sworn as a witness, and  
4 then follow her directions from there.

5 CHRISTOPHER WILLIAM ROTH,  
6 having been first duly sworn to tell the whole truth,  
7 testified as follows:

8 THE CLERK: Please state your complete name and  
9 spell your name for the record.

10 THE WITNESS: My full name is Christopher William  
11 Roth, C-R-I-S-T-O-P-H-E-R; William, W-I-L-L-I-A-M; last name  
12 Roth, R-O-T-H.

13 THE COURT: Mr. Schafer, you may inquire.

14 MR. STEIN: Thank you, Your Honor.

15 DIRECT EXAMINATION

16 BY MR. SCHAFER:

17 **Q.** Good afternoon, Mr. Roth.

18 **A.** Good afternoon.

19 **Q.** You currently work for St. Luke's; is that  
20 correct?

21 **A.** That is correct.

22 **Q.** What is your position?

23 **A.** I'm currently the chief executive officer of  
24 St. Luke's Treasure Valley.

25 **Q.** How long have you held that position?

2224

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1 **A.** I have held that position since August of 2011.  
 2 **Q.** And prior to that, how long had you worked at  
 3 St. Luke's?  
 4 **A.** I joined St. Luke's in March of 2007.  
 5 **Q.** What was your position at St. Luke's from 2007  
 6 through 2011?  
 7 **A.** I was the chief operating officer of St. Luke's  
 8 Regional Medical Center.  
 9 **Q.** Can you describe your responsibilities as CEO of  
 10 St. Luke's Treasure Valley?  
 11 **A.** As the CEO, I'm responsible for implementation of  
 12 our strategic plan and fulfillment of our mission.  
 13 **Q.** And in your roles as COO and now CEO, do you have  
 14 occasion to interact with individual physicians?  
 15 **A.** Yes.  
 16 **Q.** And why do you do that as an executive of  
 17 St. Luke's?  
 18 **A.** Well, healthcare is a team sport, if you will, and  
 19 any successful administrator is going to need to partner  
 20 closely with physicians to work together, develop  
 21 relationships. So it's -- it's essential to interact and  
 22 engage and work with physicians.  
 23 **Q.** Can you briefly describe for the court your  
 24 educational background.  
 25 **A.** I have a bachelor's degree in biology and a

1 master's degree in healthcare administration.  
 2 **Q.** And, Mr. Roth, I assume you are familiar with the  
 3 Saltzer Medical Group?  
 4 **A.** Yes.  
 5 **Q.** When was the first time that you interacted with  
 6 anyone from Saltzer?  
 7 **A.** I believe the first interaction was in 2007, the  
 8 year I joined St. Luke's.  
 9 **Q.** And at the time that you first interacted with  
 10 Saltzer, what was the nature of the relationship between  
 11 Saltzer and St. Luke's?  
 12 **A.** Well, a number of the physicians at Saltzer were  
 13 on the medical staff at St. Luke's, so physicians across the  
 14 community were practicing with one another. There were  
 15 individuals at St. Luke's that have had professional  
 16 relationships with those at Saltzer over the years predating  
 17 my tenure, so a number of interactions over the years.  
 18 **Q.** And after 2007, how, if at all, did the St. Luke's  
 19 relationship change with Saltzer?  
 20 **A.** Well, after 2007, we began to -- as I got to know  
 21 Saltzer a little bit better and we began to work together  
 22 further, we ended up formalizing a partnership actually in  
 23 2008 whereby we agreed, St. Luke's and Saltzer, to begin a  
 24 more deliberative focused effort around a series of --  
 25 series of initiatives.

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1 MR. SCHAFER: And, Mr. Chase, could you pull up  
 2 Exhibit 2196?  
 3 BY MR. SCHAFER:  
 4 **Q.** And, Mr. Roth, do you recognize this document?  
 5 **A.** I do.  
 6 **Q.** And what is this document?  
 7 **A.** This is a memorandum of understanding between  
 8 St. Luke's Regional Medical Center and Saltzer Medical Group  
 9 that -- it's a nonbinding agreement but outlines the  
 10 parties' intent to focus on specific areas to where we would  
 11 begin to work together.  
 12 **Q.** And what's the date of this agreement?  
 13 **A.** December 19th, 2008.  
 14 **Q.** And did you play any specific role with respect to  
 15 this document?  
 16 **A.** I did.  
 17 **Q.** And what was that role?  
 18 **A.** I don't believe I signed it, but I was involved  
 19 in -- I certainly read it and involved in helping and  
 20 working with Saltzer to create the five areas that we would  
 21 focus on that are outlined in this document.  
 22 **Q.** And if you look at the third and fourth whereas  
 23 clauses on this page, could you read those for the court?  
 24 **A.** "Whereas Saltzer and St. Luke's have a mutual  
 25 interest in improving health care for the residents of Ada

1 and Canyon Counties; and whereas Saltzer and St. Luke's  
 2 believe that together they can improve access to high  
 3 quality medical care, enhance coordination of medical  
 4 services, and streamline the healthcare service delivery  
 5 model."  
 6 **Q.** And did those statements accurately set forth  
 7 St. Luke's goals with respect to entering this MOU with  
 8 Saltzer?  
 9 **A.** Yes.  
 10 **Q.** And did they accurately set forth discussions that  
 11 you had with Saltzer regarding the purpose of entering into  
 12 this MOU?  
 13 **A.** Yes.  
 14 **Q.** If you could turn to the second page and look at  
 15 the second paragraph. You see a discussion there regarding  
 16 a planning group?  
 17 **A.** Yes.  
 18 **Q.** What -- what was that planning group?  
 19 **A.** Well, the planning group was created where each  
 20 party, as it says here, would appoint four members -- four  
 21 from Saltzer, four from St. Luke's -- that would really  
 22 oversee, make recommendations related to the five areas  
 23 outlined in the MOU.  
 24 **Q.** And in working together, Saltzer and St. Luke's,  
 25 were -- were the entities able to meet the goals of this

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1 memorandum of understanding?

2 **A.** We made some progress in the areas, the five areas  
3 that are outlined. I recall we had some immediate success  
4 in the area of cardiovascular services. Saltzer for years  
5 had a difficult time recruiting cardiologists into the  
6 practice, and St. Luke's was able to provide that service  
7 and work with Saltzer in that regard. So some immediate  
8 success in that area.

9 In the area of urology, despite a lot of effort  
10 over the years, we weren't successful helping that group  
11 recruit a urologist to that community.

12 And in the other areas, we were able to have some  
13 meaningful outcomes relative to our relationships and  
14 program integration, but it took a number of years to do  
15 that.

16 **Q.** At a certain point, did there come to be a  
17 discussion between Saltzer and St. Luke's about potentially  
18 forming a more closer relationship?

19 **A.** Yes.

20 **Q.** And how did those discussions come about?

21 **A.** Well, at first they -- they came about as a  
22 natural evolution of the memorandum of understanding that we  
23 just read. We had developed planning groups. We were  
24 meeting to talk about these programs and these areas. We  
25 started to have success and things grew from there.

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1 I recall a meeting that I attended with Nancy  
2 Powell and Bill Savage, and Ed Castledine, I know was there,  
3 as well, at the Saltzer Medical Group where Bill and Nancy  
4 indicated that the physicians at Saltzer were interested in  
5 pursuing discussions beyond those areas outlined in the MOU  
6 and wanted to sit down with St. Luke's to talk about what a  
7 future relationship might look like. During that meeting,  
8 we essentially planned what that -- what the next meeting  
9 would be where we would begin to explore those options.

10 **Q.** So was that something that St. Luke's was  
11 interested in exploring that closer relationship with  
12 Saltzer?

13 **A.** Yes.

14 **Q.** And, Mr. Roth, can you tell the court why that  
15 was, why St. Luke's was interested in pursuing a closer  
16 relationship with Saltzer?

17 **A.** Well, there are a number of reasons. First, we  
18 have had a relationship with Saltzer for many years. As I  
19 referenced earlier, physicians at Saltzer were on the  
20 medical staff of St. Luke's. Physicians throughout the area  
21 are talking with one another, caring for the same patients.

22 In the MOU, we decided early on that we had some  
23 shared goals to improve the health of people in our  
24 community and streamline care, coordinate care. Saltzer  
25 wanted to work with us. They were clear that they wanted to

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1 sit down with St. Luke's and only St. Luke's to discuss a  
2 relationship. They had decided they wanted to partner with  
3 somebody. They didn't know what it would look like in the  
4 end, but willing to do that.

5 We, St. Luke's, were seeing 30 percent, if I  
6 recall, the -- of inpatients in our Meridian facility were  
7 residents of Canyon County, 20 percent of all of our  
8 patients are inpatients from Boise and Meridian collectively  
9 were from Canyon County. We have wanted and had at the time  
10 to establish a greater presence in Canyon County to care for  
11 those patients.

12 Saltzer was and is an incredibly well-respected  
13 group. They are the preeminent group, if you will, in the  
14 state of Idaho relative to multispecialty group practice.

15 They know Nampa. They know Canyon County. They have the  
16 relationships. They have the trust of the community. They  
17 had geographic dispersement in terms of their clinics, they  
18 had locations in Meridian, Nampa, throughout Ada and  
19 Canyon County. So when a group like that says we're  
20 interested in pursuing an additional further relationship,  
21 absolutely we were interested.

22 **Q.** And today, Mr. Roth, is Saltzer important to  
23 St. Luke's plans in Canyon County?

24 **A.** Yes.

25 **Q.** And why is that?

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1 **A.** I think for all the reasons I mentioned.

2 **Q.** After that initial discussion that you had with  
3 Bill Savage and Nancy Powell, what steps did St. Luke's take  
4 in moving towards a closer affiliation with Saltzer?

5 **A.** Well, that -- after that meeting, we -- we had, I  
6 guess, our first integration meeting. It was a group of  
7 physician leaders from Saltzer and a group of administrators  
8 from St. Luke's where we met at the Meridian hospital and  
9 talked about shared visions and our interests, St. Luke's,  
10 and Saltzer's interests and the discussions really began at  
11 that point.

12 **Q.** Do you know how many meetings you participated in  
13 with Saltzer representatives with respect to the -- what  
14 eventually became the PSA between the parties?

15 **A.** No. A lot.

16 **Q.** And in one of the clips, I believe, that was  
17 played from your deposition, you talked about three  
18 different types of alignment. Can you talk about, if that's  
19 your opinion, what -- what -- what the three different types  
20 of alignment are, in your view?

21 **A.** Sure. We have a vision to transform healthcare,  
22 which implies a fundamentally different way to deliver  
23 healthcare than exists today. Our vision states that we  
24 will align with providers by delivering integrated, seamless  
25 quality care across all of our settings. And when we talk

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1 about aligning with providers, talk about strategic clinical  
 2 and financial alignment.  
 3 **Q.** Can you describe, just in a nutshell, what each of  
 4 those types of alignment entails?  
 5 **A.** So strategic alignment would be St. Luke's and  
 6 physicians working toward the same purpose, the same end  
 7 goal and pursuing the same types of strategies to effect our  
 8 vision. Clinical alignment would be having the same type of  
 9 clinical information, being able to use that in a way to  
 10 provide seamless, integrated patient care, to get the  
 11 physicians and the other caregivers the information they  
 12 need to effectively care for patients. And financial  
 13 alignment so that we are -- our financial interests are  
 14 aligned and we're not -- we're not competing against one  
 15 another in that regard.  
 16 **Q.** And can St. Luke's align with independent  
 17 physicians?  
 18 **A.** If I talk about clinical strategic financial  
 19 alignment, there are areas of those that, yes, we can have  
 20 some success in alignment in each of those categories or  
 21 progress in each of those categories.  
 22 **Q.** Do you believe you can achieve the same level of  
 23 alignment with independent physicians as you can with a  
 24 group like Saltzer under a PSA?  
 25 **A.** Not as I defined it, no.

1 **Q.** And you mentioned that under the MOU between  
 2 Saltzer and St. Luke's, the two entities were working  
 3 together. Was there anything from your involvement with the  
 4 planning committee that you thought or Saltzer thought could  
 5 be enhanced by a closer relationship?  
 6 **A.** Could you -- could you repeat that question?  
 7 **Q.** Sure. In connection with working with Saltzer  
 8 under the MOU that was signed that we looked at in -- from  
 9 2008, you referenced a -- a planning committee that you  
 10 played some role in. Was there anything in your experience  
 11 in working with that planning committee that you thought the  
 12 relationship between the parties could benefit from closer  
 13 affiliation than was permitted under that MOU?  
 14 **A.** Yeah. I -- I don't recall how long the planning  
 15 committee as envisioned in the MOU lasted. It -- it, over  
 16 the course of -- or a period of time we began discussions of  
 17 integration. So we -- we didn't have a separate planning  
 18 committee meeting to talk about those five things and a  
 19 separate committee meeting to talk about broader  
 20 integration. That kind of came together.  
 21 **Q.** And during your discussions with Saltzer, did the  
 22 subject of St. Luke's putting a hospital in Canyon County  
 23 ever come up?  
 24 **A.** Yes.  
 25 **Q.** And can you describe those conversations.

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1 **A.** Well, it was, I think, public knowledge that some  
 2 years ago before I joined St. Luke's, St. Luke's purchased a  
 3 large piece of property in Caldwell, over a hundred acres,  
 4 for the purpose of putting healthcare facilities in the area  
 5 in the future at some undetermined point of time.  
 6 Saltzer Medical Group was very interested in the  
 7 St. Luke's plans because they told us of when and where we  
 8 would put a hospital in Canyon County. They were  
 9 particularly concerned because during that period of time,  
 10 CHI -- it's a parent company of the -- of the hospital in  
 11 Nampa -- was selling that facility. Saltzer told us --  
 12 **MR. ETTINGER:** Your Honor, I think this is  
 13 hearsay.  
 14 **THE COURT:** Well, is it -- Mr. Schafer?  
 15 **MR. SCHAFER:** Your Honor, this is background as to  
 16 the -- the discussions in St. Luke's intent and motivation  
 17 with respect to the eventual decision that the facility  
 18 would be opened in Nampa.  
 19 **THE COURT:** All right. I'll allow it as not being  
 20 offered for the truth of the matter asserted but only as  
 21 providing a basis for some of the decisions that were  
 22 subsequently made by St. Luke's.  
 23 Proceed. Counsel, we're probably at the breaking  
 24 point. But I'll let you go. You can just kind of pick a  
 25 spot in the next few minutes --

1 **MR. SCHAFER:** Okay. Thank you, Your Honor.  
 2 **THE COURT:** -- for a natural breaking point.  
 3 **BY MR. SCHAFER:**  
 4 **Q.** So if you could continue your answer, Mr. Roth.  
 5 **A.** Saltzer told us -- told me they were extremely  
 6 interested in having a St. Luke's hospital in that  
 7 community. They were concerned that Saint Alphonsus may end  
 8 up acquiring the hospital in Nampa. We indicated to  
 9 Saltzer -- I indicated to Saltzer that we did not have  
 10 immediate plans to put a hospital in Nampa or Canyon County.  
 11 They expressed to me that they felt the location  
 12 we selected in Canyon County, that land we purchased, was in  
 13 the wrong location, it needed to be in the Nampa city limits  
 14 and they wanted to know our specific plans to put inpatient  
 15 facilities in that market. It was a topic of continued  
 16 conversation throughout our discussions.  
 17 **Q.** And where do those plans stand today, Mr. Roth?  
 18 **A.** Saltzer entered into a lease with a private  
 19 developer to establish a presence in a new location in  
 20 Nampa. St. Luke's subsequently followed and established a  
 21 presence in that location. Today, we have emergency  
 22 services and outpatient services and others in that  
 23 location. We have acquired the property and we intend to  
 24 put additional facilities on that location as the demand is  
 25 there and the population supports.

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1 MR. SCHAFER: Your Honor, this is probably a good  
 2 breaking point for the lunch break.  
 3 THE COURT: All right. Counsel, we'll take then a  
 4 15-minute recess. We'll be in recess.  
 5 (Recess.)  
 6 \*\*\*\*\* COURTROOM REMAINS OPEN TO THE PUBLIC \*\*\*\*\*  
 7 THE COURT: Mr. Schafer, you may resume your  
 8 examination of Mr. Roth.  
 9 I'll remind you, sir, you are still under oath.  
 10 MR. SCHAFER: Thank you, Your Honor.  
 11 BY MR. SCHAFER:  
 12 **Q.** Mr. Roth, before we took a break, we talked a  
 13 little bit about the memorandum of understanding between  
 14 Saltzer and St. Luke's. And you also talked about your  
 15 views of the three types of alignment with physicians.  
 16 I wanted to ask you: Do you believe that working with  
 17 Saltzer under just the memorandum of understanding St.  
 18 Luke's would have been able to achieve the three types of  
 19 alignment you referenced?  
 20 **A.** No.  
 21 **Q.** And why not?  
 22 **A.** Well, I -- I think we began to dabble in some of  
 23 those areas. So if we talk about strategic alignment, at  
 24 the time, we're still separate organizations competing  
 25 against one another, trying to find areas that we can work

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1 together on and make sense.  
 2 Relative to financial alignment, there was no  
 3 financial relationship involved in those, outside of lease  
 4 agreements and things like that, so we -- we were completely  
 5 separate in that regard.  
 6 In the area of clinical alignment -- I'll take the  
 7 cardiology practice, for example -- that's an area where we  
 8 successfully partnered with Saltzer to provide cardiac  
 9 services in that clinic. So that's a good start, but we're  
 10 still using separate medical records, we've got separate  
 11 registration processes, we've got separate billing  
 12 processes. So it -- we began to dabble in those areas, but  
 13 certainly not full alignment in each of those three  
 14 categories.  
 15 **Q.** After the -- you mentioned that after the  
 16 memorandum of understanding was entered, the relationship  
 17 sort of evolved in starting to talk more about a closer  
 18 affiliation. How long did those discussions take place  
 19 before Saltzer and St. Luke's actually finalized the PSA?  
 20 **A.** We finalized the PSA at the beginning of this  
 21 year, 2013, and we began the discussions that MOU started in  
 22 December of 2008, so the better part of three years.  
 23 **Q.** And why did it take so long to reach an agreement?  
 24 **A.** Well, they were complex. St. Luke's and Saltzer  
 25 are large, complex organizations in their own right. And

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1 this is a huge decision for both organizations to agree to  
 2 partner with -- with one another in -- in that regard.  
 3 The physicians at Saltzer had other -- there were  
 4 other complicating issues in that some of the physicians  
 5 owned real estate; some didn't; some had investments in  
 6 other businesses, surgery centers like Treasure Valley  
 7 Hospital; some didn't.  
 8 During the course of the discussions, Saltzer  
 9 engaged an independent consultant to help propose some ideas  
 10 towards integration and effectively represent Saltzer, and  
 11 it took us some time to process and discuss some of the new  
 12 ideas that he was proposing.  
 13 Near the end of our discussions in late 2011-2012,  
 14 Saltzer indicated that they wanted to engage with Saint  
 15 Alphonsus to entertain a potential relationship with Saint  
 16 Alphonsus, so that took some time to work out.  
 17 And then, you know, Saltzer being a 40-plus  
 18 physician, multispecialty group practice, just working out  
 19 compensation agreements with each of those physicians and  
 20 multiple specialties is incredibly complex. So it took a  
 21 while.  
 22 **Q.** Before St. Luke's and Saltzer entered into the  
 23 PSA, did they enter into a preliminary agreement or a letter  
 24 of intent?  
 25 **A.** Yes, we had a letter of intent.

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1 **Q.** And what was the purpose of that letter of intent?  
 2 **A.** The purpose of that letter of intent is to outline  
 3 the parameters of the relationship that we were looking to  
 4 have. It's a roadmap, high-level, that says this is what we  
 5 intend to do, Saltzer and St. Luke's, and once we complete  
 6 the relationship.  
 7 **Q.** And in that letter of intent, was there a  
 8 provision that pertained to confidentiality or exclusivity  
 9 regarding negotiations?  
 10 **A.** Yes.  
 11 **Q.** And what, more specifically, did it provide?  
 12 **A.** Well, we typically enter into these types of  
 13 agreements where both parties agree to keep the information,  
 14 sensitive information, confidential. The exclusivity  
 15 provision would have said that during the course, we're  
 16 going to talk with one another and not others; that was a  
 17 discussion very early on.  
 18 We indicated to Saltzer that if -- if they were  
 19 looking to engage with St. Luke's and somebody else and have  
 20 integration discussions with more than one party at the same  
 21 time, we weren't interested, and they assured us that they  
 22 wanted to see this through with St. Luke's. We memorialized  
 23 that in that agreement.  
 24 **Q.** In one of your previous answers, you referenced  
 25 that there came a point in time when Saltzer came to

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1 St. Luke's regarding potential -- a potential affiliation  
 2 that had been offered by Saint Al's.  
 3 Was that something that the Saltzer physicians asked  
 4 St. Luke's if they could do?  
 5 **A.** Yes.  
 6 **Q.** And did St. Luke's give its blessing?  
 7 **A.** Yes. It was in the latter part of 2011, early  
 8 2012, where the physician leaders at Saltzer indicated that  
 9 there was a desire by some in the group to engage with Saint  
 10 Alphonsus in exploring what a relationship with Saint  
 11 Alphonsus might look like.  
 12 It was frustrating in that we had been in these  
 13 discussions for a number of years, but clearly remember the  
 14 meeting where we, myself and others, attended with the  
 15 Saltzer physicians, and Gary Fletcher stood up and said,  
 16 "We're not here to twist arms. What's important is that we  
 17 have a shared vision. If you don't have that shared vision  
 18 and you want to explore that with Saint Alphonsus, then, by  
 19 all means, go ahead. But let's not take forever to do it."  
 20 And I think we agreed on a 90-day time period by which  
 21 Saltzer would engage with Saint Alphonsus and determine  
 22 their course.  
 23 **Q.** And what was the result of those discussions, the  
 24 discussions between Saltzer and Saint Alphonsus?  
 25 **A.** Saltzer concluded after that that they wanted to

1 pursue an integrated relationship with St. Luke's. They  
 2 proceeded to hold a vote with the partners. The vote was  
 3 overwhelmingly in support of integrating with St. Luke's,  
 4 and then we completed the agreement.  
 5 **Q.** Mr. Roth, was any purpose of St. Luke's  
 6 affiliation with Saltzer to affect the referral patterns of  
 7 Saltzer physicians?  
 8 **A.** No.  
 9 **Q.** Was the subject of autonomy of referrals ever  
 10 discussed in your meetings with Saltzer physicians?  
 11 **A.** Yes.  
 12 **Q.** And did anything in the PSA that was eventually  
 13 entered between the parties address that issue?  
 14 **A.** Yes.  
 15 **Q.** And how did it address that issue?  
 16 **A.** Well, very early on in the discussions with  
 17 Saltzer, as it became apparent that we were -- both parties  
 18 were looking toward a more financially, clinically,  
 19 strategically integrated relationship, the concern was  
 20 raised that, well, is St. Luke's going to require us to send  
 21 our patients to St. Luke's facilities.  
 22 And we were consistently adamant, no, we don't do  
 23 that with any of our physicians. They wanted -- Saltzer  
 24 wanted that memorialized, and we were happy to do that. So  
 25 in the agreement, it clearly says and states that physicians

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1 at Saltzer can refer patients to wherever they would like.  
 2 **Q.** Mr. Roth, I have put up on the screen Joint  
 3 Exhibit 24. And can you identify this document?  
 4 **A.** This is the Professional Services Agreement, yes.  
 5 **Q.** And if you could look on page 5 of the exhibit,  
 6 Section 2.2(a), what's the title of that section?  
 7 **A.** "Exclusivity."  
 8 **Q.** If you could turn to the next page, the last  
 9 sentence of that provision, can you read that last sentence  
 10 that's highlighted there.  
 11 **A.** "All Saltzer physicians may have privileges at any  
 12 hospital and may refer patients to any practitioner or  
 13 facility regardless of its affiliation with St. Luke's."  
 14 **Q.** So how is that statement consistent with the  
 15 heading "Exclusivity"?  
 16 **A.** Well, in regard to exclusivity, we want physicians  
 17 and partners who are engaged with us to effect our mission  
 18 of transforming healthcare. We need a -- we need partners  
 19 who are dedicated administratively, dedicated relative to  
 20 medical direction, not conflicted to those ends. So the  
 21 exclusivity really references having dedication towards the  
 22 group and St. Luke's to effect our mission.  
 23 That being said, physicians need to be able to  
 24 have the, in our opinion, the flexibility to send patients  
 25 where they deem appropriate based on whatever determinations

1 they make. If we wanted to, we could require physicians in  
 2 these types of agreements to send patients to St. Luke's,  
 3 and we don't.  
 4 **Q.** And beyond being written in the contract itself,  
 5 do you have any expectation regarding whether Saltzer  
 6 physicians will actually exercise the right to refer  
 7 patients to non-St. Luke's facilities or keep their  
 8 privileges at other facilities?  
 9 **A.** Yes, I have that expectation.  
 10 **Q.** And why is that?  
 11 **A.** Because they do today.  
 12 **Q.** And is there any reason why you feel that Saltzer  
 13 physicians are any more likely to do that than any other  
 14 groups with which St. Luke's is affiliated?  
 15 **A.** Can you repeat that?  
 16 **Q.** Is there anything regarding the contractual  
 17 process that leads you to believe that Saltzer might be more  
 18 likely to exercise those rights than other groups with which  
 19 St. Luke's is affiliated?  
 20 **A.** No.  
 21 **Q.** Mr. Roth, you referenced one of the impediments to  
 22 moving more quickly towards an agreement with the Saltzer  
 23 group being that some of the Saltzer physicians had an  
 24 ownership interest in Treasure Valley Hospital. Do you  
 25 remember that?

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1 **A.** Yes.

2 **Q.** And was St. Luke's concerned with the fact that

3 some Saltzer surgeons had an ownership in that facility?

4 **A.** Yes.

5 **Q.** And why was that a concern?

6 **A.** Well, it really goes back to the concept of

7 alignment, clinical strategic financial alignment. And

8 physicians that are part of Saltzer and still invested in

9 Treasure Valley Hospital, it prevents alignment in those

10 areas.

11 **Q.** Were you aware of any prior relationship that any

12 of the Saltzer surgeons had with an ambulatory surgery

13 center in Nampa?

14 **A.** Yes.

15 **Q.** And what was your understanding of what happened

16 with respect to that facility?

17 **A.** My understanding is that the surgeons at Saltzer

18 did their outpatient surgery at a surgery center in Nampa.

19 They subsequently invested in Treasure Valley Hospital,

20 moved their cases to Treasure Valley Hospital, and that

21 surgery center in Nampa closed.

22 **Q.** And did that history add at all to your concern

23 with respect to the Saltzer surgeons' ownership in Treasure

24 Valley Hospital?

25 **A.** Yes.

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1 **Q.** Did St. Luke's require that the Treasure Valley

2 Hospital owners sell their interests in Treasure Valley

3 Hospital in order to become part of the St. Luke's clinic?

4 **A.** No.

5 **Q.** Why not?

6 **A.** They didn't want to.

7 **Q.** Were there any conditions placed on the offers to

8 the Treasure Valley Hospital owners if they decided to

9 maintain their interest in Treasure Valley Hospital?

10 **A.** Yes.

11 **Q.** What conditions were those?

12 **A.** Their salaries, their compensation agreements were

13 lower, and there were prohibitions in terms of leadership

14 positions they could hold in Saltzer.

15 **Q.** And why were those two conditions put in place for

16 the surgeons if they decided to maintain their Treasure

17 Valley Hospital ownership?

18 **A.** Well, it really goes back to -- to the alignment

19 question. If we have surgeons who are personally invested

20 in a competing surgery center and we're asking them to

21 dedicate their time, their talents, their energies to

22 improving systems and care to -- in Saltzer and St. Luke's

23 essentially competing facilities, it's very difficult. And

24 that was put in place to recognize that.

25 **Q.** Did you or did anyone else from St. Luke's tell

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1 the Treasure Valley Hospital owners that in order to be part

2 of the exclusive agreement with St. Luke's, that they would

3 not only have to sell their interests in Treasure Valley

4 Hospital, but they could no longer take cases there?

5 **A.** No.

6 **Q.** Take patients there?

7 **A.** No.

8 **Q.** Did you ever meet individually with any of the

9 Saltzer surgeons to discuss issues regarding the PSA or the

10 Treasure Valley Hospital ownership?

11 **A.** Yes.

12 **Q.** And who did you meet with?

13 **A.** Dr. Steve Williams.

14 **Q.** And can you tell me what you discussed with

15 Dr. Williams?

16 **A.** Yes. I remember very well the meeting. We met at

17 the Meridian Hospital late afternoon, early evening for

18 nearly two hours. And we talked about the visions of our

19 respective organizations, and we talked about Treasure

20 Valley Hospital as it relates to that.

21 **Q.** And what specifically did you discuss regarding

22 Treasure Valley Hospital?

23 **A.** Well, Dr. Williams was at the time an investor in

24 Treasure Valley Hospital. He was concerned about our

25 position that -- relative to exclusivity. And what I mean

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1 by that is, as part of our relationship with Saltzer, we

2 agreed, both parties, that we would come together and design

3 the healthcare delivery system that the community needs.

4 And one of the elements of that would be what types of

5 physicians over the course of time and providers need to be

6 recruited into the area and that we would jointly make those

7 decisions and do that together.

8 We -- because the surgeons, Dr. Williams wanted to

9 retain that investment in Treasure Valley Hospital, we, St.

10 Luke's, indicated that we are not going to agree to sit down

11 at the table with the surgeons and plan when physicians need

12 to be recruited into that -- into the community.

13 In other words, we wanted the ability to recruit

14 physicians into the community at such time that we determine

15 that needed to happen.

16 **Q.** And did you tell Dr. Williams that -- or any of

17 the Saltzer surgeons -- that St. Luke's would recruit more

18 surgeons into Nampa or Canyon County regardless of need?

19 **A.** No. I told them we wanted the option to recruit

20 if we needed to.

21 **Q.** And what was Dr. Williams' response to that?

22 **A.** We disagreed on -- on that point. He felt

23 that -- and at the time, he was practicing primarily at the

24 Meridian Hospital and Treasure Valley Hospital. Today it's

25 Treasure Valley Hospital and Saint Alphonsus. But he felt

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1 that -- that he and other surgeons could support Treasure  
 2 Valley Hospital, the Meridian Hospital, and a future Nampa  
 3 hospital.

4 And while I conceded that's possible, that we, St.  
 5 Luke's, needed the flexibility. In the event that they  
 6 couldn't cover it, we needed to be able to have the option  
 7 to recruit physicians that could cover it.

8 Q. Did Dr. Williams tell you anything at that meeting  
 9 about what he thought the surgeons would do?

10 A. He indicated that he thought a couple of surgeons  
 11 from Saltzer may end up leaving the group as a result of  
 12 this and -- position. So that's -- he made me aware of  
 13 that.

14 Q. And were you upset to hear that?

15 A. No.

16 Q. Why not?

17 A. It really goes back to my reference Gary Fletcher  
 18 earlier talking about our vision. To the extent that  
 19 physicians don't want to work with St. Luke's in that  
 20 regard, have no ill will, but we don't want to work with  
 21 them in this regard relative to the alignment we're talking  
 22 about. So the sooner that decision is made, the better.

23 Q. Mr. Roth, are you generally aware of the  
 24 compensation offers that St. Luke's made to the Saltzer  
 25 physicians?

1 A. I am, generally.

2 Q. Do you know whether the compensation offered to  
 3 the primary care physicians would have increased by a larger  
 4 percentage than the compensation offered to the surgeons?

5 A. I believe it did.

6 Q. And why was that?

7 A. Well, a couple of factors. As we looked at  
 8 primary care compensation within the Saltzer Medical Group  
 9 before we integrated, it was certainly lower than the  
 10 specialists, which is typical, primary care physicians being  
 11 paid lower than specialists. When we compared their  
 12 compensation to other primary care physicians in St. Luke's,  
 13 it was lower, so we wanted to increase that.

14 From a percentage basis, it's going to increase  
 15 more as a percentage basis because there -- the base for a  
 16 primary care physician is lower than that of a specialist.  
 17 So that would be why it increases at a larger percentage  
 18 rate.

19 Q. And why -- why is having equitable salaries across  
 20 the physicians within St. Luke's a goal of St. Luke's?

21 A. Having equity in compensation in any organization,  
 22 whether physicians or nurses or others, is important. It's  
 23 important for the culture. It is a representation of value,  
 24 how -- how is the organization valuing the services  
 25 that -- that I'm providing.

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1 One of the areas I'm very proud of is that  
 2 we -- we take away any -- our payment methodologies to  
 3 physicians are blind to the payors, if you will. So a  
 4 physician, if they see a patient with no insurance or some  
 5 insurance, Medicare, Medicaid, Blue Cross, they get paid the  
 6 same regardless. So the equity in our compensation systems  
 7 is -- is really important.

8 Q. Did St. Luke's take any steps to ensure that the  
 9 compensation offers it was making to the Saltzer physicians  
 10 were within fair market value?

11 A. Yes.

12 Q. What steps did it take?

13 A. We will always seek a third party, independent  
 14 third party group, to evaluate the compensation arrangements  
 15 we have with physicians to determine if they fall within the  
 16 limits of fair market compensation.

17 Q. And, Mr. Roth, if one simply looks at the  
 18 compensation increase from what a Saltzer physician may have  
 19 made in 2012 at Saltzer to what he might have made, or might  
 20 make, in 2013 as part of St. Luke's, do you think that that  
 21 gives an accurate sense or a full sense of the compensation  
 22 structure of that agreement?

23 A. I don't believe it does.

24 Q. And why not?

25 A. Well, the agreement that we entered in with

1 Saltzer is a five-year agreement that sets the compensation  
 2 for a five-year period, so comparing one year to five is  
 3 kind of apples and oranges.

4 Q. And how was the payment structure of those  
 5 agreements established?

6 A. The way Saltzer physicians are reimbursed is a  
 7 traditional fee-for-service compensation system.

8 Q. And, Mr. Roth, there has been discussion in this  
 9 case about a goal St. Luke's has about moving from volume to  
 10 value. Are you familiar with that goal?

11 A. Yes.

12 Q. So why didn't St. Luke's immediately put Saltzer  
 13 on a quality- or value-based payment model?

14 A. Moving from volume to value sounds easy. But what  
 15 we're talking about is putting in a system that is  
 16 fundamentally different from how healthcare, the business of  
 17 healthcare, works. Healthcare providers are paid based on  
 18 how much we do and how many patients we see, and it's been  
 19 like that for a long, long time. And we're trying to change  
 20 that.

21 We're -- we, St. Luke's Health System hospitals,  
 22 providers, are a -- one cog in the system, if you will,  
 23 related to reimbursement. So changes like this don't happen  
 24 overnight. It requires a level of integration to start  
 25 moving reimbursement from volume to value that hasn't

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1 existed in our community, which is why I keep talking about  
2 integration and alignment.

3 For Saltzer, day 1, a group that had not had  
4 quality targets, to my knowledge, relative to compensation  
5 prior to joining St. Luke's, frankly, I'm not aware of any  
6 other independent groups that have joined St. Luke's that  
7 had meaningful quality and value targets as part of their  
8 clinic compensation. To change that on day 1 would be an  
9 incredible challenge. We're not integrated. We're not  
10 sharing information. We're not on the same medical record.  
11 We don't have measurable outcomes, day 1, and it takes time  
12 to do that.

13 So that being said, St. Luke's and Saltzer agreed  
14 that that's the direction that we want to go, and both  
15 organizations are prepared to go in that direction to move  
16 physician compensation more towards the value side.

17 Q. And has St. Luke's begun transitioning any of the  
18 groups that have been part of the St. Luke's clinic for  
19 longer than Saltzer in that direction?

20 A. Yes.

21 Q. And what groups?

22 A. We have the Idaho Pulmonary group, the  
23 cardiologists, St. Luke's Internal Medicine. We have a  
24 pediatric gastroenterology group that's moved in that  
25 direction, endocrinology group, and we've got another large

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1 group we're getting ready for at this time.

2 Q. Mr. Roth, you would admit that those groups and  
3 the move from volume to value, that's still a relatively  
4 small percentage of those physicians' compensation, isn't  
5 it?

6 A. Yes.

7 Q. And why is that? Why not more?

8 A. We just -- St. Luke's Internal Medicine just went  
9 through this transition. And the way it occurred is the  
10 physicians established a compensation committee within that  
11 group and determined their compensation going forward and  
12 said: We're willing to put our compensation at risk for  
13 meaningful quality and value measures.

14 Certainly a step in the right direction. Does it  
15 represent the majority of their compensation? No, it  
16 doesn't. But it's a start. And it's a start to change a  
17 system that the rest of the region and the rest of the  
18 country operates from.

19 Q. Mr. Roth, what role, if any, did a desire to gain  
20 market power play in the decision of St. Luke's to affiliate  
21 with Saltzer?

22 A. None.

23 Q. And what role, if any, did a desire to increase  
24 prices to commercial payors play in the decision to  
25 affiliate with Saltzer?

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1 A. None.

2 Q. I want to switch gears and ask you a couple of  
3 questions about the West Valley Medical Center. Are you  
4 familiar with West Valley?

5 A. Yes.

6 Q. Where is that located?

7 A. Caldwell.

8 Q. Is West Valley a competitor of St. Luke's?

9 A. Yeah. And they're -- they're part of, I believe,  
10 the nation's largest for-profit hospital system.

11 Q. In what ways does St. Luke's compete against West  
12 Valley?

13 A. We compete against West Valley like we would  
14 compete against Saint Alphonsus or anybody else providing  
15 services in the community.

16 Q. Despite that --

17 A. All the --

18 Q. I'm sorry. Go ahead.

19 A. All the services that we provide and they provide,  
20 we are competing against one another in some regard.

21 Q. Despite that competition, does St. Luke's work  
22 together with West Valley on any programs or initiatives?

23 A. Yes.

24 Q. And what are those?

25 A. We have an agreement in place where St. Luke's is

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1 -- and West Valley Medical Center are working together to  
2 improve certain aspects of cardiac services. St. Luke's has  
3 employed physicians in Caldwell, West Valley Medical Center,  
4 cardiologists, urologists that practice at West Valley  
5 Medical Center, and are involved in programs in that regard.  
6 We do compete, but we also work together in areas that make  
7 sense, and we agree to do so.

8 Q. And why did St. Luke's decide to work with West  
9 Valley on the cardiac program, for example?

10 A. Well, West Valley was struggling with their echo  
11 service. They were very interested in establishing a  
12 certified chest pain clinic in their hospital, something  
13 that St. Luke's had already established.

14 Two physicians -- namely, Dr. Bathina and  
15 Dr. Fields, St. Luke's Clinic physicians, practiced  
16 primarily in Caldwell and have for years -- were also  
17 interested in helping that hospital achieve better results.  
18 So we were willing to enter into an agreement with West  
19 Valley to -- to make improvements in that regard.

20 Q. With respect to those physicians you mentioned who  
21 admit patients at West Valley Medical Center, why doesn't  
22 St. Luke's just tell them to take all of those patients to a  
23 St. Luke's facility?

24 A. Well, for all the reasons I repeated earlier; we  
25 don't do that. We -- we could, but we don't.

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1 MR. SCHAFER: No further questions.  
 2 THE COURT: Cross-examination.  
 3 MR. BIERIG: Your Honor, excuse me for  
 4 interrupting.  
 5 THE COURT: Oh, yes, Mr. Bierig.  
 6 MR. BIERIG: We have a bit of a dilemma here. As  
 7 the court knows, we have subpoenaed Dr. -- excuse me,  
 8 Director Armstrong of the Department of Health and Welfare  
 9 of the State of Idaho. The only time that he could do it  
 10 this entire week was this afternoon, and I don't know how  
 11 long a cross-examination is going to take.  
 12 I can say that my direct examination of Mr. Armstrong  
 13 will be fairly substantial, so I think there is two or three  
 14 possible solutions. One would be to delay the  
 15 cross-examination of Mr. Roth; the other is if the court is  
 16 willing to stay longer than 2:30 today.  
 17 But I'm concerned. I'm told by Mr. DeLange that  
 18 Director Armstrong is not available tomorrow, and his  
 19 testimony really --  
 20 THE COURT: Well, let me just -- Mr. Ettinger, are  
 21 you willing to defer your cross-examination?  
 22 MR. ETTINGER: How much time, Your Honor? I would  
 23 say 40 minutes, maybe.  
 24 THE COURT: Well, I don't think that would give us  
 25 enough time. Are you willing to delay it until tomorrow

1 morning?  
 2 MR. ETTINGER: Yes, Your Honor.  
 3 THE COURT: All right. I think that solves the  
 4 problem. Let's have Mr. Roth step down and then call out of  
 5 your order your next witness.  
 6 Thank you, Mr. Ettinger. That's very much appreciated.  
 7 You will be allowed to step down, Mr. Roth, but subject  
 8 to recall probably tomorrow morning.  
 9 THE WITNESS: Okay.  
 10 THE COURT: All right. Thank you.  
 11 MR. BIERIG: We call Dr. Richard Armstrong.  
 12 THE COURT: All right.  
 13 MR. BIERIG: Director Richard Armstrong, sorry.  
 14 THE COURT: While Mr. Armstrong is taking the  
 15 stand, I think there was an issue raised -- well, I don't  
 16 see Mr. Wilson.  
 17 Mr. Wilson, a question was raised about counsel using  
 18 leading questions in examining the witness. The Rule  
 19 611(b), I believe it is, provides that it is proper to use  
 20 cross -- to use leading questions in cross-examination and  
 21 while examining a hostile witness, a party, or someone  
 22 identified with a party.  
 23 I think that's broad enough, and I'm quite lenient on  
 24 leading questions as long as counsel is not putting words in  
 25 the witness's mouth. So while you'll have a continuing

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1 objection, I am going to give counsel some leeway.  
 2 MR. WILSON: Understood. Thank you.  
 3 THE COURT: All right. Director, is it Director  
 4 Armstrong? Would you step before the clerk and be sworn.  
 5 RICHARD MERLE ARMSTRONG,  
 6 having been first duly sworn to tell the whole truth,  
 7 testified as follows:  
 8 THE CLERK: Please state your complete name and  
 9 spell your name for the record.  
 10 THE WITNESS: It's Richard Merle Armstrong,  
 11 R-I-C-H-A-R-D M-E-R-L-E A-R-M-S-T-R-O-N-G.  
 12 THE COURT: You may inquire of the witness.  
 13 MR. BIERIG: Thank you Your Honor.  
 14 DIRECT EXAMINATION  
 15 BY MR. BIERIG:  
 16 Q. Good afternoon, Mr. Armstrong. It's nice to see  
 17 you again.  
 18 A. Hello, sir.  
 19 Q. You are currently the director of the Department  
 20 of Health and Welfare of the State of Idaho; is that  
 21 correct?  
 22 A. Yes.  
 23 Q. For how long have you held that position?  
 24 A. Since June of 2006.  
 25 Q. Is the department divided -- does the department

1 divide the state of Idaho into different geographic regions?  
 2 A. Yes. We have a number of different designations,  
 3 depending on the kind of work that we're doing. So where  
 4 there is a connection to the criminal justice system, we use  
 5 seven divisions. But for other functions, we have three  
 6 divisions. It depends on the kind of work that we do.  
 7 Q. But there are basically seven different geographic  
 8 regions in the -- for the Department of Health and Welfare?  
 9 A. Yes.  
 10 Q. In what region is Nampa located?  
 11 A. That would be Region 3.  
 12 Q. And what does Region 3 cover?  
 13 A. It covers a grouping of counties that's  
 14 predominantly along the Oregon border. So it would go from  
 15 approximately Riggins down through Owyhee County.  
 16 THE COURT: Counsel, let me just -- you mentioned  
 17 seven divisions. I assume those coincide with the judicial  
 18 districts prescribed, or are they different?  
 19 THE WITNESS: No. They coincide with the judicial  
 20 districts.  
 21 THE COURT: All right. So that would be the same  
 22 as the Third Judicial District --  
 23 THE WITNESS: Yes.  
 24 THE COURT: -- which would be Canyon County,  
 25 Owyhee, and --

1 THE WITNESS: Payette --  
 2 THE COURT: Payette.  
 3 THE WITNESS: -- and Washington and those  
 4 counties.  
 5 BY MR. BIERIG:  
 6 **Q.** So have you referred to this region as the "Boise  
 7 Valley region"?  
 8 **A.** No, sir. I would -- I would -- I would not. The  
 9 Boise Valley region would include parts of 4 as well.  
 10 **Q.** So would the region that Nampa -- that  
 11 the -- excuse me, that Nampa is located in include Boise,  
 12 Meridian, and Caldwell, as well?  
 13 **A.** If we're referring to it as the "Boise region,"  
 14 yes. It would be the metro population center.  
 15 **Q.** And have you characterized that region as pretty  
 16 much a single medical region?  
 17 **A.** I don't know whether I have in the past, but if  
 18 you ask me today, I would say, yes, it's pretty much the  
 19 same medical region.  
 20 **Q.** So that would be Meridian, Nampa, Caldwell, and  
 21 Boise would be a single medical region?  
 22 **A.** Yes.  
 23 **Q.** Would you regard Nampa as a single medical region?  
 24 **A.** I don't see it as a -- as an isolated medical  
 25 region.

1 **Q.** How many Medicaid recipients are there currently  
 2 in the state of Idaho?  
 3 **A.** I believe there is around 240,000.  
 4 **Q.** How, if at all, do you expect that number to  
 5 change in the coming years?  
 6 **A.** We would expect that with the advent of the  
 7 insurance exchange that there will be an increase of about  
 8 35,000 individuals who are currently eligible but not  
 9 enrolled that will become enrolled as individuals, seek  
 10 private insurance through the insurance exchange, and,  
 11 through that process, will be aware of their Medicaid  
 12 eligibility.  
 13 **Q.** So is it your testimony that you expect an  
 14 increase of roughly 35,000 in the foreseeable future of the  
 15 Medicaid population?  
 16 **A.** Over the next couple years.  
 17 **Q.** Are physicians who practice in medical office  
 18 settings required to treat Medicaid patients?  
 19 **A.** They are not.  
 20 **Q.** And are you aware that a number of physicians in  
 21 Idaho limit the number of Medicaid patients they will  
 22 accept?  
 23 **A.** Yes. I am aware some do.  
 24 MR. BIERIG: Your Honor, I'd like to show a couple  
 25 of documents to the witness, and I would ask Ms. Timoschick

1 **Q.** Now, how many divisions are there within the  
 2 Department of Health and Welfare?  
 3 **A.** There are ten.  
 4 **Q.** And is one of those divisions the medically  
 5 indigent services division?  
 6 **A.** It is not a separate division.  
 7 **Q.** But there is a --  
 8 **A.** It is connected to the director's department,  
 9 which is my cost center.  
 10 **Q.** And one of the concerns of the Department of  
 11 Health and Welfare is dealing with the medically indigent in  
 12 the state of Idaho? Would that be accurate?  
 13 **A.** That is one of our areas of responsibility.  
 14 **Q.** Are you aware whether physicians who practice in a  
 15 medical office setting, whether they're required to treat  
 16 medically indigent patients?  
 17 **A.** I'm not aware that they are required to treat  
 18 medically indigent patients.  
 19 **Q.** In fact, as independent businesspersons, they are  
 20 not required to treat medically indigent patients; is that  
 21 correct?  
 22 **A.** That's my understanding.  
 23 **Q.** Now, another division in the department is the  
 24 Medicaid division?  
 25 **A.** Yes, sir.

1 to provide a brochure to -- through Mr. Metcalf and to  
 2 counsel.  
 3 Your Honor, this is -- I'm asking the court to put up  
 4 Defendant's Exhibit 2236.  
 5 BY MR. BIERIG:  
 6 **Q.** I'd ask Mr. Armstrong to look at this document.  
 7 **A.** Yes, sir.  
 8 **Q.** You can identify the handsome individual whose  
 9 picture appears there?  
 10 **A.** Vaguely familiar.  
 11 **Q.** I'd call your attention to the fourth paragraph  
 12 that starts "Paying for value." Would you mind just reading  
 13 that.  
 14 **A.** "Paying for value, Armstrong says, means his  
 15 agency's goal is to move away from fee-for-service medical  
 16 care. It becomes units of service that's important, as  
 17 opposed to what the outcome is. We're shifting toward a  
 18 more outcomes-oriented measure of success,' says Armstrong."  
 19 **Q.** These are -- in this article, these are statements  
 20 that are said to have been made by you to the Idaho  
 21 legislature in January of 2013. Is that accurate?  
 22 **A.** That's accurate.  
 23 **Q.** And do the statements attributed to you in that  
 24 fourth paragraph of Exhibit 2236 reflect your current view  
 25 as director of the Department of Health and Welfare?

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1 **A. Yes.**  
 2 **Q.** So is it a goal of the Department of Health and  
 3 Welfare to move from the fee-for-service model to, quote,  
 4 paying for value?  
 5 **A. Yes, it is.**  
 6 **Q.** And when you use the term "pay for value," what do  
 7 you mean?  
 8 **A. We believe that the healthcare system should focus**  
 9 **on the positive outcome of a medical event, as opposed to be**  
 10 **focusing on the number of services that can be provided**  
 11 **which are paid for independently of the outcome.**  
 12 **Q.** So why is transitioning to pay-for-value a goal of  
 13 the department?  
 14 **A. We have a budget that we have to manage, and it is**  
 15 **very difficult to manage that budget forward when -- under**  
 16 **the current environment. And so we know that we need to**  
 17 **move to a different method of payment that can slow the rate**  
 18 **of inflation, healthcare inflation; at the same time, get a**  
 19 **better result from the dollars we spend.**  
 20 **Q.** Would it be fair to say that one of the primary  
 21 reasons that the department wants to transition to  
 22 pay-for-value is that the fee-for-service system drives  
 23 utilization and frequency of services?  
 24 **A. That would be our belief.**  
 25 **Q.** And would it be fair to say that the department

1 believes that moving toward more managed care will result in  
 2 better quality and lower prices in the long run?  
 3 **A. That's our goal.**  
 4 **Q.** And that's your belief, is it not?  
 5 **A. That's my belief.**  
 6 **Q.** How does the Department of Health and Welfare  
 7 intend to effectuate the transition from fee-for-service  
 8 Medicaid payments to a pay-for-value approach?  
 9 **A. We have -- we began this process some years ago by**  
 10 **moving parts of our business to managed care concepts. And**  
 11 **each of those pieces that have been moved have been**  
 12 **successful, which encourages us to move additional pieces of**  
 13 **business to that concept.**  
 14 **The next major goal will be to move physical**  
 15 **medicine to managed care, and we'll do that through a**  
 16 **request for proposal process.**  
 17 **Q.** So does the desired transition to the  
 18 pay-for-value approach that you just articulated involve the  
 19 healthcare providers in the state of Idaho?  
 20 **A. Oh, absolutely.**  
 21 **Q.** In what way?  
 22 **A. Well, they will -- they will be involved to -- in**  
 23 **the responses that would come in to a request for proposal,**  
 24 **and that would be either through accountable care**  
 25 **organizations or through connections to insurance entities**

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1 **or other companies that would respond to our proposal.**  
 2 **Q.** So these providers have to be prepared to  
 3 undertake a pay-for-value approach to care for Medicaid  
 4 patients. Would that be a fair statement?  
 5 **A. Yeah, that would be logical.**  
 6 **Q.** How long do you anticipate that the transition to  
 7 a pay-for-value approach will take to achieve?  
 8 **A. It will take a -- it will take a period of time,**  
 9 **probably 18 to 24 months. It's a culture shift away from**  
 10 **where we have been, and it will take some time for that to**  
 11 **really take hold.**  
 12 **Q.** It doesn't happen overnight, does it?  
 13 **A. Typically not.**  
 14 **Q.** Now, would paying for value include shifting to a  
 15 more outcome-oriented measure of success?  
 16 **A. Yes, it would.**  
 17 **Q.** And a shift to a more outcomes-oriented measure of  
 18 success would require a shift by hospital systems, would it  
 19 not?  
 20 **A. By?**  
 21 **Q.** By hospital systems. Excuse me, by health  
 22 systems.  
 23 **A. Yes, I think it would. Health systems today are**  
 24 **oriented around fee-for-service medicine, so, yes, it would**  
 25 **require a shift.**

1 **Q.** And they would have to shift more towards some  
 2 kind of capitated or value-based approach to delivery of  
 3 care; is that correct?  
 4 **A. Yeah. It would be to a different payment method.**  
 5 **Q.** Would it include having a healthcare system moving  
 6 services from inpatient to outpatient settings?  
 7 **A. That would be logical. It would be a logical**  
 8 **outcome, yes.**  
 9 **Q.** And would it also involve health systems moving  
 10 toward preventive care and community outreach?  
 11 **A. That would be part of it as well.**  
 12 **Q.** Would the shift you're describing involve having  
 13 physicians who are committed to developing best practice  
 14 protocols and following those protocols?  
 15 **A. Yes, it would.**  
 16 **Q.** In your view, as director of the Idaho Department  
 17 of Health and Welfare, are physicians more likely to agree  
 18 to and follow best practice standards if they are involved  
 19 in setting the standards?  
 20 **A. That's my assumption.**  
 21 **Q.** So would it advance the goals of the Department of  
 22 Health and Welfare if St. Luke's is incentivizing the  
 23 physicians that it employs to get involved in developing  
 24 best practice protocols?  
 25 **A. Yes. I think the more health systems encourage**

1 **physicians to move this direction, it would be very helpful.**

2 **Q.** And would the Medicaid program benefit from  
3 physicians working together to develop evidence-based  
4 practice protocols?

5 **A.** Yes, it would.

6 **Q.** And would the Medicaid program benefit from  
7 physicians being incentivized to practice medicine in  
8 accordance with the best -- excuse me -- in accordance with  
9 best evidence practice protocols?

10 **A.** Yes.

11 **Q.** Does, in your judgment, shifting to a value-based  
12 payment system involve physicians and hospitals forgoing  
13 services on which they are currently making money in order  
14 to emphasize outcome?

15 **A.** I -- that's a difficult question, because  
16 "forgoing" would imply that something is being delivered  
17 that isn't appropriate or necessary.

18 **Q.** Okay. Well, let me ask you this, Mr. Armstrong:  
19 Does the term "accountable care organization" mean anything  
20 to you?

21 **A.** Yes, it does.

22 **Q.** Would it be fair to say that an accountable care  
23 organization is a vehicle for a health system to assume risk  
24 for the costs of delivering care to the patient population?

25 **A.** That is the current definition.

1 **Q.** So would assumption of risk by a health system  
2 advance the goals of the Department of Health and Welfare to  
3 transition to pay-for-value?

4 **A.** It's my assumption that that is a key ingredient.

5 **Q.** Is assumption of risk by providers part of the  
6 transition to pay-for-value that the department hopes to  
7 achieve?

8 **A.** Would you say that again, please?

9 **Q.** Yes. Is assumption of risk by providers part of  
10 the transition to pay-for-value that the department hopes to  
11 achieve, so that the providers will take on risk?

12 **A.** Yes, it is.

13 **Q.** In your judgment, would moving to an approach to  
14 payment by which a health system takes the risk of excess  
15 utilization require the healthcare system to have a viable  
16 methodology for them to control their costs?

17 **A.** Yes. They'd have to have a viable method.

18 **Q.** Would it involve having sufficient patients in the  
19 system so that the risks of patients who require  
20 significantly more services, or more intensive services than  
21 most patients, could be spread across a large number of  
22 patients?

23 **A.** When we move into the changing payment  
24 methodology, we will be stratifying our members into various  
25 risk categories because we already know that there are

1 certain Medicaid patients who use significant resources  
2 today and others who do not. So we would first be  
3 stratifying them into various risk categories where there  
4 would be a different payment attached to that category.

5 Now, within that category, we know that there will  
6 be folks at each end of that class, and there would be then  
7 a pooling within that class.

8 **Q.** So a health system that's seeking to assume risk  
9 would need to have a significant number of patients across  
10 which to spread the risk of outliers. Would that be true?

11 **A.** That would be true.

12 **Q.** Would the system toward which the department is  
13 moving, would it benefit from having health systems having a  
14 unified electronic health record across the system?

15 **A.** Today, there are -- I'm part of the Idaho Health  
16 Data Exchange; I'm a board member. And, therefore, I have  
17 observed that using that tool, that clinical data has been  
18 able to move between electronic medical records that are  
19 from different manufacturers.

20 So today there is a greater utility  
21 of -- available than used to be available to the medical  
22 community. So clinical information can move between  
23 dissimilar EMRs.

24 **Q.** But do you regard a unified electronic health  
25 record within a health system as being an advantage to the

1 health system in terms of managing patients?

2 **A.** Clearly, there needs to be clinical data in front  
3 of the physician for the best decision-making to take place.

4 **Q.** And do the plans of the department include having  
5 each Medicaid patient be part of a medical home?

6 **A.** Yes, sir.

7 **Q.** What does the term "medical home" mean to you?

8 **A.** Well, a medical home is a location that a patient  
9 is connected to for the coordination of their care.

10 **Q.** And it's -- when you say -- is that a single home,  
11 or would that be just the patient going wherever the patient  
12 feels like it for whatever the patient wants?

13 **A.** That definition hasn't been totally concluded yet.  
14 We are in the process of that evaluation. The simplest  
15 definition is that it is attached to a single physician.  
16 However, we also know that people with significant medical  
17 disability may very well be best placed in the care of a  
18 specialist until such time as their crisis has been averted.

19 **Q.** But would it be fair to say that having a medical  
20 home involves providing coordinated care for each patient?

21 **A.** Absolutely.

22 **Q.** And would the process of coordination of care  
23 benefit from having a unified health record and physicians  
24 working closely together?

25 **A.** Yes. They have to have close coordination.

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1 **Q.** You may have answered this, but let me just ask  
2 you again. How long do you anticipate that the transition  
3 from fee-for-service to more managed care for Medicaid  
4 patients in Idaho will take to accomplish?  
5 **A.** I don't know the exact answer to that. There are  
6 a lot of variables that have to play out.  
7 **Q.** Would it be fair to say a number of years?  
8 **A.** That would be fair.  
9 **Q.** And would it be fair to say that it will require  
10 lots of changes by health systems?  
11 **A.** Some health systems more than others, but change  
12 will be necessary.  
13 **Q.** Okay. I would ask you, Director, to take a look  
14 at the other document in your -- in the material I gave you,  
15 which is marked as Defendant's Exhibit 2237.  
16 THE COURT: Counsel, just a moment. Before we  
17 move on, 2236 was referenced but has not been admitted.  
18 MR. BIERIG: I was going to do that afterwards,  
19 but I would move its admission now, Your Honor.  
20 THE COURT: Is there an objection, Mr. Wilson?  
21 MR. WILSON: No objection, Your Honor.  
22 THE COURT: All right. 2236 will be admitted.  
23 (Defendants' Exhibit No. 2236 admitted.)  
24 THE COURT: And now we're moving on to which  
25 exhibit?

1 MR. BIERIG: 2237.  
2 THE COURT: All right. Thank you.  
3 BY MR. BIERIG:  
4 **Q.** Do you recognize this document?  
5 **A.** I do.  
6 **Q.** And what is it?  
7 **A.** It is the strategic plan for the Department of  
8 Health and Welfare.  
9 **Q.** For what year?  
10 **A.** 2013-2017.  
11 **Q.** If you wouldn't mind, could you take a look at  
12 page 4 of the document, which says "Goals and Objectives."  
13 And I would ask you to look at Goal No. 1, Objective No. 2,  
14 if Cort could put that up.  
15 **A.** Yes, sir.  
16 **Q.** If you look at that goal -- well, why don't you  
17 just read for the record Objective No. 2 under Goal No. 1.  
18 **A.** "Increase the use of evidence-based clinical  
19 preventive services to 70.3 percent by 2017."  
20 **Q.** Is that, in fact, one of the department's goals?  
21 **A.** Yes, it is.  
22 **Q.** Why by 2017?  
23 **A.** Well, if you're going to have a strategic plan,  
24 you -- and you want to accomplish anything, you have to  
25 measure it, and you have to test yourself against the

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1 **measurement, and you have to have a destination. And that's**  
2 **the destination that our team came to.**  
3 **Q.** So you think that taking four years to have the  
4 data to measure your success is a reasonable period?  
5 **A.** Yes. And this covers areas beyond Medicaid. This  
6 is part of public health as well.  
7 **Q.** And in order to effectuate this goal of having  
8 providers increase the use of evidence-based clinical  
9 preventive services, would it be fair to say that the  
10 department is going to have to rely on providers to make  
11 that change?  
12 **A.** Yes.  
13 **Q.** Are you aware that the Saltzer Medical Group has  
14 affiliated with St. Luke's?  
15 **A.** I am aware of that.  
16 **Q.** And are you aware that the affiliation -- that  
17 that affiliation is being challenged by the State of Idaho  
18 and the other plaintiffs in this case?  
19 **A.** I am aware of that.  
20 **Q.** Now, if the physicians from Saltzer who have  
21 become affiliated with St. Luke's are incentivized to  
22 increase the use of evidence-based clinical preventive  
23 services, would that advance the objectives of the  
24 department?  
25 **A.** So the question is if they were?

1 **Q.** Yes.  
2 **A.** Well, if they were, well, then it would advance  
3 the department's objectives.  
4 **Q.** So you're saying if they were, it would?  
5 **A.** Yes.  
6 **Q.** Yes. And if the physicians from the Saltzer  
7 Medical Group who have become affiliated with St. Luke's  
8 were incentivized to develop best medical practice  
9 protocols, would that advance the goals of the department?  
10 **A.** If they were incentivized, it would.  
11 **Q.** And if the physicians of the Saltzer Medical Group  
12 who are employed now by St. Luke's were incentivized to  
13 engage in more coordinated care, would that also advance the  
14 goals of the department?  
15 **A.** If they were, it would.  
16 **Q.** Is it fair to say that you believe that different  
17 provider groups will attempt different methods of  
18 incentivizing their physicians to meet the goals of the  
19 department?  
20 **A.** Yes. As we look around the state, we see a wide  
21 variation in the relationships between hospitals and  
22 physicians. We see a wide variation of the distribution of  
23 certain specialties within those communities. So it's  
24 logical that there will be different techniques used by  
25 various medical communities around the state of Idaho.

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1 Q. Okay. And as the director of the Department of  
2 Health and Welfare for the State of Idaho, you don't believe  
3 that care should be delivered differently to Medicaid  
4 patients than it is delivered to commercially insured  
5 patients, do you?

6 A. No. A community standard of care should be  
7 applied equally to every member of the community.

8 Q. Right. So that it would be fair to say that, in  
9 your view, the benefits of outcome-based care should accrue  
10 to all Idahoans, not just Medicaid patients.

11 A. That would be our hope.

12 Q. And you believe that high-quality care means the  
13 right care at the right time. Would that be a fair  
14 statement?

15 A. Yeah, that's a fair statement.

16 Q. And you may have answered this, but you also  
17 believe that the quality of care should be the same for all  
18 patients, Medicaid, uninsured, commercially insured,  
19 regardless of the source of payment?

20 A. Yes. A good standard of care should be applied  
21 equally.

22 Q. Are you aware that St. Luke's has a policy of  
23 treating all patients regardless of their ability to pay?

24 A. I'm not fully aware of that policy, but it is one  
25 that I believe exists, but I have never actually read it.

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1 Q. Well, assuming that St. Luke's has such a policy,  
2 would that policy promote the goals of the Department of  
3 Health and Welfare?

4 A. If we look at it from a public health perspective,  
5 yes, it would.

6 Q. And if St. Luke's has a policy of requiring all  
7 physicians whom it employs or with whom it has a  
8 professional services agreement to treat all patients  
9 regardless of their ability to pay, would that advance the  
10 goals of the department?

11 A. For public health, I would believe it would.

12 Q. Right. Are you aware, Director Armstrong, that a  
13 hospital with an emergency room is required to make its  
14 emergency department available to anyone who presents at the  
15 hospital, regardless of ability to pay?

16 A. I'm aware of that.

17 Q. And are you aware that hospitals must provide  
18 translation services for people who appear at the hospital  
19 and who do not speak English?

20 A. I believe that's true. I haven't read it  
21 specifically.

22 Q. Okay. And are you aware that hospitals are also  
23 required to meet significant requirements in order to be  
24 accredited for Medicare and Medicaid services?

25 A. Yes.

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1 Q. Do you know where the Saltzer Medical Group is  
2 located?

3 A. Yes.

4 Q. And where is that?

5 A. It's in Nampa, Idaho.

6 Q. And Nampa is in Canyon County; correct?

7 A. Yes, sir.

8 Q. Is there a significant Medicaid population in  
9 Canyon County?

10 A. Yes, there is.

11 Q. And would it be fair to say that taking care of  
12 Medicaid recipients in Canyon County is a concern of the  
13 department?

14 A. Yes. It's important.

15 Q. If Saltzer's affiliation with St. Luke's enhanced  
16 the ability of Saltzer physicians to serve Medicaid  
17 patients, would you see that as a good thing for the  
18 department?

19 A. If that affiliation resulted in treating more  
20 Medicaid patients, it would be consistent with our  
21 objectives.

22 Q. And if the affiliation of Saltzer with St. Luke's  
23 helps St. Luke's to transition to value-based rather than  
24 volume-based delivery of healthcare in the Treasure Valley,  
25 would you see that as a positive development for the goals

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1 of the department?

2 A. If that happened, it would.

3 Q. If this court were to order St. Luke's to divest  
4 Saltzer and the divestiture resulted in treatment of fewer  
5 Medicaid patients in Canyon County, would that be a negative  
6 result from a public health standpoint?

7 A. That's a difficult question to answer because it's  
8 assuming that there would be -- that the physicians would no  
9 longer treat Medicaid patients, and I don't know that to be  
10 true.

11 Q. Well, I'm not -- I'm asking not if they stopped  
12 altogether, but if they reduced the number of Medicaid  
13 patients they saw as a result of a divestiture, would that  
14 be a negative result from a public health standpoint, in  
15 your view?

16 A. Today, we do not have an access issue. If there  
17 were a decline in the number of physicians that would see  
18 Medicaid patients, it could create an access problem for us.

19 Q. I'm going to show you a statement that you made at  
20 your deposition and see whether you still agree with it. Is  
21 that okay?

22 A. Sure.

23 MR. BIERIG: Could you put on 59.

24 Your Honor, this is the deposition of Director  
25 Armstrong at page 40, line 13 to page 41, line 1. I'll just

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1 read that.

2 THE COURT: Thank you.

3 BY MR. BIERIG:

4 Q. "If the court were to order St. Luke's to

5 divest the Saltzer Medical Group --

6 A. "Um-hmm.

7 Q. " -- and if, as a result of the

8 divestiture of Saltzer Medical Group, the

9 Saltzer physicians were unable to treat as many

10 Medicaid patients as they are treating in their

11 affiliation with St. Luke's, how would that

12 action comport with the policy of the

13 department?

14 "MR. WITHROE: Same objection.

15 "THE WITNESS: If they were unable to serve the number of

16 Medicaid people as they are today, it would be negative, in

17 my view, because we would have fewer physicians to treat

18 Medicaid patients."

19 Did you state that at your deposition?

20 MR. WILSON: Objection, Your Honor. It's not

21 impeaching.

22 THE WITNESS: I --

23 MR. WILSON: He essentially gave the same answer

24 today in court.

25 MR. BIERIG: Well, in that case, if he is willing

1 to say he agrees with it, I don't --

2 THE COURT: Let's rephrase the question and let

3 the witness answer. If he agrees with the former statement,

4 then there is no reason to include that in the record here

5 today. But I'm not sure the question was precisely phrased

6 the same way, so --

7 BY MR. BIERIG:

8 Q. The question was: If --

9 MR. BIERIG: Could you just put that back on there

10 for a second?

11 THE COURT: This may make it just a little easier

12 for you to prepare your response since you will see the

13 question both in writing and orally.

14 Proceed, Mr. Bierig.

15 BY MR. BIERIG:

16 Q. So my question is: If the divestiture of the

17 Saltzer Medical Group -- if, as a result of the divestiture

18 of the Saltzer Medical Group, the Saltzer physicians were

19 unable to treat as many Medicaid patients as they are

20 treating through their affiliation with St. Luke's, would

21 that be a negative outcome from the point of view of the

22 department?

23 A. I would agree with my former statement.

24 Q. Your former -- when you say your former statement,

25 the statement in the deposition?

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1 A. Certainly.

2 Q. Okay. Thank you.

3 And if this court were to order St. Luke's to divest

4 Saltzer and that divestiture resulted in fewer physicians

5 treating medically indigent patients, would that be a

6 negative result from a public health standpoint?

7 A. I don't believe -- well, medically indigent care

8 typically is delivered through the hospital, and I think

9 they would still be obligated to deliver that care under

10 current law.

11 Q. The hospital. But what about the physicians?

12 A. Well, then the physician -- I don't know, as I'm

13 not sure how the physician gets tied to that case.

14 Q. Well, let me show you another statement that you

15 made, and let's see whether you agree with it or disagree

16 with it.

17 MR. BIERIG: So if you could put on 60.

18 Your Honor, this is page 42, lines 11 to 25.

19 Q. "If the court were to order St. Luke's to

20 divest the Saltzer Medical Group --

21 A. "Okay.

22 Q. -- "and if, as a result, the physicians at

23 the Saltzer Medical Group were unable to treat

24 the number of -- the same number of medically

25 indigent patients as they are able to treat by

1 virtue of their affiliation with St. Luke's,

2 would -- how would that comport with the policy

3 of the department?

4 "MR. WITHROE: Same objection.

5 "THE WITNESS: From a public health standpoint, that would be

6 negative. That would be -- that would have fewer folks

7 receiving care, from a public health standpoint."

8 BY MR. BIERIG:

9 Q. Would you agree with that?

10 A. I would.

11 Q. Thank you. Are you aware, Director Armstrong,

12 that part of the reason for the affiliation between Saltzer

13 and St. Luke's is to help create through that affiliation a

14 clinically integrated health system network using

15 evidence-based medical protocols?

16 A. I can't say that I'm aware that was in the

17 agreement because I wasn't party to the agreement.

18 Q. I believe that you testified that you were aware

19 of it. I'll put on your testimony, and we'll see.

20 A. I'm aware of it because I read the newspaper.

21 Q. Okay. But -- right.

22 A. So that's the exposure that I would have to

23 whatever the agreement may have been.

24 Q. Right. And through reading the newspaper, have

25 you learned that part of the reason for the affiliation

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1 between Saltzer and St. Luke's is to help create through  
 2 that affiliation a clinically integrated health system using  
 3 evidence-based medical protocols?  
 4 **A. Yes, sir, I'm aware of that.**  
 5 **Q.** And if St. Luke's is successful in doing that,  
 6 will that promote the department's goal of providing  
 7 clinically coordinated care?  
 8 **A. If they are successful, it would be.**  
 9 **Q.** And it would be fair to say, would it not, that  
 10 clinical integration advances the goals of the department?  
 11 **A. Yes, it does.**  
 12 **Q.** And would it also be fair to say that adoption of  
 13 best practice protocols also advances the goals of the  
 14 department?  
 15 **A. Yes. We believe community best practice standards**  
 16 **will advance our goals.**  
 17 **Q.** And would placing emphasis on preventive care also  
 18 advance the goals of the department?  
 19 **A. Yes, sir.**  
 20 **Q.** Is it fair to say that, as director of the  
 21 Department of Health and Welfare, you grapple with the  
 22 problem of trying to provide quality healthcare to Medicaid  
 23 patients at an affordable cost?  
 24 **A. Yes, I do.**  
 25 **Q.** And is an important element in addressing the

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1 problem of providing quality healthcare to Medicaid patients  
 2 at an affordable cost to have health delivery systems that  
 3 coordinate care among physicians, other healthcare  
 4 professionals, and using evidence-based medical practices  
 5 and electronic medical record and effective utilization  
 6 control?  
 7 **A. That's our future view. There isn't much of it**  
 8 **going on today, but it is our view of the future.**  
 9 **Q.** And that is what you hope to see in the future?  
 10 **A. That's right.**  
 11 **Q.** And to the extent that a health system is moving  
 12 to that, you would view that as a good thing, would you not?  
 13 **A. Yeah. The more communities that move towards that**  
 14 **concept, the better it will be for the department.**  
 15 **Q.** As the director of the Department of Health and  
 16 Welfare, do you have any concerns that the affiliation  
 17 between St. Luke's and Saltzer will result in the  
 18 Medicaid program -- will result in the Medicaid program  
 19 having to pay higher prices for care?  
 20 **A. I'm not aware of that.**  
 21 **Q.** Now, you are the highest-ranking government  
 22 official in the state of Idaho in the field of healthcare,  
 23 are you not?  
 24 **A. That's a bit subjective, but possibly.**  
 25 **Q.** Well, is there anyone you can think of that's a

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1 higher-ranking official?  
 2 **A. Not at this moment.**  
 3 **Q.** Okay. Does the governor consult you from time to  
 4 time on healthcare policy issues?  
 5 **A. Yes, he does.**  
 6 **Q.** As the director of the Department of Health and  
 7 Welfare, were you ever consulted by the Attorney General  
 8 about the wisdom of bringing this lawsuit?  
 9 **A. No.**  
 10 **Q.** Were you ever -- were you consulted by any other  
 11 member of the Attorney General's Office about the wisdom of  
 12 bringing this suit before this lawsuit was brought?  
 13 **A. No.**  
 14 **Q.** Have you ever been consulted by the attorney  
 15 general about the wisdom of a remedy which would seek to  
 16 unwind the Saltzer/St. Luke's affiliation?  
 17 **A. Nothing outside of what's happening in this trial.**  
 18 **Q.** So before this suit was filed, no one asked your  
 19 opinion on whether the State of Idaho should seek to divest  
 20 the Saltzer Medical Group from St. Luke's; is that correct?  
 21 **A. That's correct.**  
 22 MR. BIERIG: I have no further questions,  
 23 Your Honor.  
 24 THE COURT: Mr. Wilson.  
 25 MR. WILSON: Thank you.

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1 CROSS-EXAMINATION  
 2 BY MR. WILSON:  
 3 **Q.** Director Armstrong, does the Idaho Department of  
 4 Health and Welfare have any law enforcement responsibility  
 5 with regard to antitrust laws in the state of Idaho?  
 6 **A. No.**  
 7 **Q.** Your concern is public health; correct?  
 8 **A. Yes, sir.**  
 9 **Q.** Not antitrust; correct?  
 10 **A. That's correct.**  
 11 **Q.** Does your agency have any responsibility to  
 12 regulate competition between healthcare providers for  
 13 commercial business?  
 14 **A. No.**  
 15 **Q.** Does your agency have any responsibility to  
 16 regulate how healthcare providers interact with commercial  
 17 healthcare insurers?  
 18 **A. No.**  
 19 **Q.** Would you have expected that the Attorney  
 20 General's Office would have consulted you -- with you about  
 21 this lawsuit?  
 22 **A. No.**  
 23 **Q.** Are you upset that you weren't contacted?  
 24 **A. Not at all.**  
 25 **Q.** Does your department have any responsibility for

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1 regulating the commercial side of healthcare? In other  
2 words, you're focused on Medicaid; correct?

3 **A. We're focused on Medicaid. However, our license  
4 and certification division licenses and certifies hospitals,  
5 and that would be for all services that are delivered within  
6 the hospital. So it indirectly has a bearing on commercial  
7 insurance.**

8 **Q.** Right. But you don't have any regulatory --  
9 regulatory oversight regarding commercial insurers, for  
10 example?

11 **A.** No.

12 **Q.** So the views and assumptions you expressed in your  
13 testimony today were limited to the provision of Medicaid  
14 services; is that correct?

15 **A.** That's my focus.

16 **Q.** Do you know what the competitive impact will be of  
17 the acquisition of Saltzer by St. Luke's?

18 **A.** By "competitive impact" --

19 **Q.** Do you know how it will affect the competition for  
20 healthcare in and around Nampa?

21 **A.** I really don't know.

22 **Q.** Director Armstrong, do you know whether the  
23 acquisition of Saltzer by St. Luke's will, in fact, result  
24 in the treatment of more Medicaid patients?

25 **A.** I don't know that for a fact.

1 **Q.** Do you know anything about the incentives that may  
2 or may not be in place for Saltzer physicians to do that?

3 **A.** I've not been party to those discussions.

4 **Q.** And do you know whether a divestiture of the  
5 Saltzer physician group from St. Luke's would result in less  
6 Medicaid patients being seen in the Nampa area?

7 **A.** I don't know that.

8 **Q.** In your view as the director of the Department of  
9 Health and Welfare, can an independent physician group  
10 provide services to Medicaid patients without losing money?

11 **A.** I am aware of some physician practices that have  
12 reengineered their process, and I am told they don't lose  
13 money on Medicaid patients.

14 **Q.** So in your view, does a physician group have to  
15 get acquired by a hospital to treat Medicaid patients  
16 without losing money?

17 MR. BIERIG: Objection. There is no foundation  
18 for this question, Your Honor.

19 THE COURT: I think we need to find out does the  
20 witness know and what's the basis for knowing that.

21 MR. WILSON: He is the director of the Department  
22 of Health and Welfare. He has regular interactions with  
23 physician groups throughout the state. And, in fact, I  
24 think Mr. Bierig opened the door for this sort of  
25 questioning through all of his questions directed towards

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1 the provision of Medicaid services and how the acquisition  
2 would affect that.

3 THE COURT: Well, my concern was the reference to  
4 losing money. I wasn't sure how that tied in and how this  
5 witness would know what the financial inner workings of a  
6 medical practice are. If that's not a critical part of the  
7 question, perhaps you could rephrase.

8 MR. WILSON: Certainly, Your Honor.

9 BY MR. WILSON:

10 **Q.** In your view, Director Armstrong, does a physician  
11 group need to get acquired by a hospital to treat Medicaid  
12 patients?

13 **A.** I'm not aware of any requirement.

14 **Q.** And there are many physician groups that treat  
15 Medicaid patients in the Nampa area that aren't affiliated  
16 with a hospital; correct?

17 **A.** Correct.

18 **Q.** You mentioned, I think when Mr. Bierig was asking  
19 you questions, something about access by Medicaid patients  
20 in Nampa. At present, are there any access issues for  
21 Medicaid patients in the Nampa area?

22 **A.** We are not aware of access problems in that area.

23 **Q.** Mr. Bierig also asked you several questions about  
24 best evidence practice protocols. Do you remember that?

25 **A.** Yes.

1 **Q.** In your view, is there any one correct way to  
2 achieve best evidence practice protocols?

3 **A.** We believe the community needs to establish what  
4 those best practices are and that it would be then the  
5 community responsibility to have a high level of performance  
6 against those best practice standards.

7 **Q.** Well, is there any one way, in your view, to  
8 achieve this concept of coordinated care that you spoke  
9 about?

10 **A.** As we have traveled around the country and looked  
11 at -- there are various models, and those models evolve  
12 around the community in which they are practiced. And it  
13 seems that there are a number of different ways of  
14 being -- ways of bringing about compliance with those  
15 standards.

16 **Q.** In fact, I think you testified during your direct  
17 examination that, even here in the state of Idaho, there is  
18 a wide variation; correct?

19 **A.** Well, certainly, because every -- every community  
20 has a different set of providers, a different mix of  
21 specialties and services. So just by that variability,  
22 there would probably be different approaches used.

23 **Q.** In your view, Director, is it necessary for  
24 hospitals to employ physicians for those hospitals to  
25 coordinate care with the physicians?

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1 MR. BIERIG: Objection. There is no foundation  
2 that Director Armstrong is familiar with how hospitals work  
3 in terms of how they structure relationships with  
4 physicians.

5 MR. WILSON: In light of the questioning on direct  
6 examination, Your Honor, I find the objection a bit bold.  
7 All of Mr. Bierig's questioning was of the director  
8 regarding whether his views about evidence-based protocols  
9 were consistent with the objectives of the department and  
10 what St. Luke's was doing was consistent with the objectives  
11 of the department. I am merely asking him, in his view --

12 THE COURT: I'll overrule the objection. The  
13 question is asked in the context, even though there is a  
14 reference to coordinating care. I am assuming you're tying  
15 it back to the witness's testimony about evidence-based  
16 practices and coordinating care, perhaps, as being one part  
17 of that.

18 MR. WILSON: Let me rephrase, Your Honor, if I  
19 may.

20 THE COURT: Yes.

21 BY MR. WILSON:

22 **Q.** In your view, Director Armstrong, is it necessary  
23 for hospitals to employ physicians in order to achieve best  
24 evidence practice protocols with physicians -- with  
25 physicians?

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1 MR. BIERIG: Objection, Your Honor. I don't mean  
2 to be bold as was suggested, but there was nothing in my --  
3 in my examination about whether employment was necessary,  
4 and I don't think a foundation has been laid for whether  
5 Director Armstrong knows about how hospital physician  
6 relationships work.

7 THE COURT: Well, I'm going to overrule the  
8 objection, but obviously, Director Armstrong, you can just  
9 indicate you don't know. But I'm going to allow the  
10 question to be asked and answered, if you know.

11 Why don't you rephrase it one more time, Mr. Wilson.

12 MR. WILSON: Thank you, Your Honor.

13 BY MR. WILSON:

14 **Q.** Director Armstrong, in your view, is it necessary  
15 for hospitals to employ physicians in order to achieve best  
16 evidence practice protocols with those physicians?

17 **A.** **My experience at this point comes from our study  
18 of various healthcare systems around the country as we have  
19 tried to map our way forward around managed care and best  
20 practice delivery.**

21 **And in those studies, we have seen both employed  
22 circumstance and we have seen independent contracted  
23 relationships deal with these circumstances. I don't think  
24 I would be able to say that one over the other is superior,  
25 based on my experience, because I haven't had that**

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1 **experience yet with the Medicaid program.**

2 **Q.** And likewise, Director Armstrong, in your view, is  
3 it necessary for physicians to be on the same electronic  
4 medical record in order to achieve the goal of coordinated  
5 care?

6 **A.** **Through the data exchange, we have seen cases and  
7 we have had anecdotal evidence that coordination of  
8 care -- effective coordination of care can occur between  
9 providers using different EMRs, that the data was delivered  
10 effectively to the treating physician for a good clinical  
11 outcome.**

12 MR. WILSON: Your Honor, may I have one moment,  
13 please?

14 THE COURT: Yes.

15 BY MR. WILSON:

16 **Q.** Director Armstrong, is St. Luke's the only  
17 hospital in Idaho that provides medical care to all comers  
18 regardless of economic circumstances?

19 **A.** **I don't believe so. I believe all hospitals do.**

20 MR. WILSON: Thank you. Nothing further,  
21 Your Honor.

22 THE COURT: Mr. Bierig, redirect. And I assume  
23 you would move for the admission of Exhibit 2237?

24 MR. BIERIG: Yes, Your Honor, we would.

25 THE COURT: Is there any objection, Mr. Wilson?

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1 MR. WILSON: No, Your Honor.

2 THE COURT: All right. 2237 is admitted.  
3 (Defendants' Exhibit No. 2237 admitted.)

4 REDIRECT EXAMINATION

5 BY MR. BIERIG:

6 **Q.** Director Armstrong, I believe that counsel for the  
7 State asked you if your jurisdiction was limited to  
8 Medicaid, and you gave an answer. But I just want to make  
9 sure I understand your previous testimony that it's your  
10 belief that care should not be delivered differently to  
11 Medicaid patients than it is delivered to any other patients  
12 in the state of Idaho. Is that correct?

13 **A.** **That's my belief, yes.**

14 **Q.** Right. And counsel for the State asked you about  
15 the electronic health record. You haven't done any study of  
16 the Epic electronic health record that's utilized in -- at  
17 St. Luke's, have you?

18 **A.** **No.**

19 **Q.** And you haven't compared it in any way to the  
20 Idaho Data Exchange; is that correct?

21 **A.** **No.**

22 **Q.** So you really -- would you say that you're really  
23 in a position to make judgments about the relative benefits  
24 of the Idaho Data Exchange -- excuse me, the Idaho Health  
25 Data Exchange as compared with the functionality of the Epic

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1 system?

2 **A. No. I have done no study of it.**

3 MR. BIERIG: Thank you, Director Armstrong.  
4 No further questions.

5 THE COURT: Anything else, Mr. Wilson?

6 MR. WILSON: No, Your Honor. Thank you.

7 THE COURT: All right. Director Armstrong, you  
8 may step down.

9 We only have ten more minutes. Counsel, I can't stay  
10 much longer. I have a class coming at 3:30 that I am  
11 involved in teaching, so I really can't stay longer. I  
12 assume that we'll recall Mr. Roth and proceed with cross.

13 MR. SCHAFER: Mr. Roth left, Your Honor, thinking  
14 that this would go -- run until the end of the day. We do  
15 have a ten-minute clip that we can play of one of our video  
16 depositions.

17 THE COURT: Why don't we do that. If it's ten  
18 minutes, that would work rather well.

19 MR. STEIN: It's a ten-minute clip. It's a Saint  
20 Alphonsus employee, and about five of the ten minutes  
21 interspersed are attorneys' eyes only. And I hate to do  
22 this, but given that it's the end of the day, I'm wondering  
23 whether it makes sense to just clear the courtroom for this  
24 last bit.

25 THE COURT: We will, but then we'll make a -- the

1 non-attorneys' eyes only portions available --

2 MR. STEIN: Yes.

3 THE COURT: -- to the public by way of the  
4 transcript; correct?

5 MR. STEIN: Yes. I think this is purely just in  
6 terms of the logistics of getting the headphones on and off.

7 THE COURT: All right. Ladies and gentlemen, I  
8 will have to clear the courtroom for the reasons indicated.

9 Having you come in and out would be counterproductive, I  
10 think, at this point. And if you wish to see what was  
11 testified to that's not privileged, you can review the  
12 publicly available transcript.

13 \*\*\*\*\*COURTROOM CLOSED TO THE PUBLIC\*\*\*\*\*

14 THE COURT: All right. Counsel, will you  
15 indicate -- oh, we need to publish the deposition. Do you  
16 have the original?

17 MR. SCHAFER: We do, Your Honor. I think  
18 Ms. Timoschick has it. This is Dr. Michael Roach, for the  
19 record.

20 THE COURT: Ms. Gearhart, if you'll publish the  
21 deposition. Is there -- okay. We'll publish both the  
22 deposition of Mr. Armstrong and --

23 THE CLERK: The deposition of Richard Armstrong  
24 and the deposition of Michael Roach are published.

25 (The depositions of Richard Armstrong and

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1 Michael Roach published.)

2 THE COURT: All right. You may go ahead and  
3 proceed.

4 (Testimony of Michael Roach via video deposition.)

5 (Video deposition of Michael Roach concluded.)

6 MR. SCHAFER: Your Honor, that's the end of it,  
7 Dr. Roach.

8 THE COURT: All right. Counsel, we'll be in  
9 recess, then, until 8:30 tomorrow morning.

10 With regard to -- I think our understanding was that  
11 with regard to yesterday's testimony and the portions  
12 designated AEO, that counsel were going to submit some kind  
13 of an affidavit or proffer as to which portions were to be  
14 redacted from the public transcript and why, and then I will  
15 rule on it. I assume that you got the daily transcript this  
16 morning and that we can expect seeing something by tomorrow.

17 Is that the plan, Ms. Duke? Do you know or --

18 MS. DUKE: With respect to what we just played?

19 THE COURT: No. Yesterday.

20 MS. DUKE: Yesterday. Yes, we have a process in  
21 place that all of the parties go through, and they --

22 THE COURT: All right. When --

23 MS. DUKE: -- put in their AEO. And then,  
24 ultimately, it's filed. I'm not sure --

25 MR. DeLANGE: Your Honor, I think -- correct me if

1 I'm wrong. I think yesterday's designation was a St. Luke's  
2 AEO designation, so we have assumed St. Luke's is going to  
3 provide you the -- the AEO justification, if you will,  
4 to --

5 THE COURT: Yes. That's my -- that would be my  
6 understanding, unless there are some third parties. And I  
7 assume that's been relayed to them.

8 MR. DeLANGE: My understanding is it was just  
9 St. Luke's designated AEO yesterday.

10 THE COURT: Well, whoever is making the  
11 designation, obviously, would have to bear the burden.

12 MR. STEIN: We -- and we should be able to do that  
13 tomorrow, Your Honor.

14 THE COURT: All right.

15 MR. STEIN: There is one issue with the  
16 transcript. I think the version that we got yesterday, it  
17 actually did not include Mr. Greene's cross-examination.

18 THE COURT: I'll let you work with  
19 Ms. Hohenleitner on that and sort out what that is.

20 MR. DeLANGE: You are talking about the day  
21 before, Dr. Pate.

22 MR. STEIN: Dr. Pate. Okay. Well, we'll work it  
23 out.

24 THE COURT: All right. Very good.

25 All right. Counsel, we'll be in recess, then, until

2300

1 8:30 tomorrow morning.  
2 (Court recessed at 2:33 p.m.)

1 REPORTER'S CERTIFICATE

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I, Tamara I. Hohenleitner, Official  
Court Reporter, County of Ada, State of Idaho,  
hereby certify:

That I am the reporter who transcribed  
the proceedings had in the above-entitled action  
in machine shorthand and thereafter the same was  
reduced into typewriting under my direct  
supervision; and

That the foregoing transcript contains a  
full, true, and accurate record of the proceedings  
had in the above and foregoing cause, which was  
heard at Boise, Idaho.

IN WITNESS WHEREOF, I have hereunto set  
my hand October 11, 2013.

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-s-  
Tamara I. Hohenleitner  
Official Court Reporter  
CSR No. 619