**Adventist Health Systems/West and St. Joseph Health System**
**Additional Responses to California Attorney General Letters of August 24, 2018, August 30, 2018 and September 28, 2018**

Additional Responses to August 24, 2018 Letter

**Request # 1**

Adventist's Notice at Section 999.5(d)(5)(G) expressly states that there will be no impact on reproductive health care services provided by any of its health care facilities. The Notice further states at Section 999.5(d)(5)(K) that the "proposed transaction does not effect a change in the scope or type of any medical services currently provided in the JOC's service area." (Emphasis in original.) Our Office, however, has been informed that reproductive services will be consolidated in the County of Napa. Please provide information for all proposed consolidations and changes in medical and health care services for all counties affected by this transaction, including but not limited to, reproductive services in the County of Napa.

**Response to Request # 1**

The Master Formation Agreement ("MFA") between SJHS and AHW does **not** make any changes in the scope or type of any medical services currently provided in the ST Network, LLC's (i.e., the joint operating company, or "JOC") service area. However, separate and independent from the MFA, and pre-dating such, AHW has been evaluating its mid-to-long term planning for Adventist St. Helena Hospital in response to numerous factors, including: (a) the 2030 seismic requirements under the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital facilities Seismic Safety Act; (b) the clinical strengths of the various service lines provided at the hospital and the overall future needs of the community with regard to those clinical service lines; and (c) the continuing reduction in patient volumes and demand for OB/GYN (and other) services in St. Helena.

In this regard, Adventist Health St. Helena ("AHSH") is not compliant with the 2030 seismic requirements, and AHW management is currently exploring a number of options with respect to the future of the hospital – none of which has been finally determined (or approved by the AHW Board) to date. However, and as previously discussed with both the FTC and with your office, the AHW Board has authorized management to engage in further planning with respect to a "right-sizing" of the hospital to reflect a realistic regional role for the hospital in light of the continuing reductions in patient volumes, the associated physician recruitment challenges, and the desire to maintain and improve the core clinical service lines in a manner that best serves the community. Management expects to report back to the AHW Board in July and is hopeful that the Board will then be in a position to make a final decision in this regard. Given the seismic compliance and physician capacity issues, there is a "hard" five-year time limit for the adoption and completion of the restructuring of AHSH. In this regard, and assuming the MFA is finalized, the hospital is expected to remain in its current location and with its current capacity for five years.

While AHW and SJHS intend to explore their ability to coordinate physician and support services in order to improve volume and scale for some service lines that are currently not

clinically and/or economically viable over the mid-to-long term, AHW nonetheless expects that a number of the clinical service lines that are currently provided at St. Helena will remain clinically and/or economically non-viable and, as such, will, of necessity, be discontinued at the time of the operation of the restructured hospital in five years.[1] It is for these reasons that, while AHW is able to commit to maintaining existing services for five years at AHSH, it simply cannot guarantee to operate any such services for a longer period of time.

As was also discussed in AHW's conversations with the FTC and your office, the restructured hospital will require substantially less capacity than is provided at the existing facility. The current planning—which remains subject to further analysis, review, and AHW Board approval—indicates that the most advantageous option will likely involve a renovation or replacement of the existing facility with a 30-bed hospital that is primarily focused on AHSH's core strengths in the areas of cardiology, cardiac surgery, and orthopedics. These are the areas in which the hospital excels and can provide the highest quality and most needed services to its community.

If this plan is able to be implemented (both clinically and financially), AHW hopes to be able to expand cardio-thoracic surgery and cardiology services, including expected growth in the hospital's valve surgery program; expand orthopedic services, including growth of total joint care services and potential to develop a complex spine program; and expand its oncological surgery program, including adding technology like the Da Vinci (robotic surgery services) and the potential development of new service lines to support genetic cancer screenings and a center of excellence for multiple oncological services. All of which will maximize the hospital's value to its community.

We should, however, emphasize that this planning is premised on the ability to successfully complete the MFA; to receive all requisite government approvals; and to be able to economically afford the substantial investment required to operate either a renovated or rebuilt hospital in compliance with the seismic requirements. Absent an ability to effectively coordinate physician and support services as provided in the MFA—and to develop an effective funding mechanism for the capital investments involved—the future of AHSH will be at risk.

On a more immediate basis, the management of AHSH has been faced with a specific challenge regarding the ongoing provision of OB/GYN services at AHSH. There are currently three physicians that staff that service line: Drs. [ ],[ ], and [ ]. However, Dr. [ ], now 72-years old, expects to wind down his practice and retire to an administrative position, and Dr. [ ] is refocusing her practice on genetic counseling, screening and related surgery, and will be substantially less available to provide OB/GYN services on a going-forward basis. Dr. [ ] will be continuing his Napa-based OB

[1] In this regard, OB services will not be provided at Adventist St. Helena in its restructured form and other services which are currently under consideration for discontinuation include behavioral health and ENT. With respect to behavioral health, consideration is being given to relocating such services to Adventist Health-Vallejo, but no final determination has been made in that regard.

practice, but will need to join or collaborate with other physicians in the geographic area in order to continue to provide OB/GYN services to the St. Helena community.

**[Redacted- Confidential]**

In order to effectively continue to provide such OB/GYN services at AHSH for the five years that the current hospital will continue to operate, AHW and SJHS have discussed a cooperative arrangement among the AHW and SJHS medical staffs to augment OB/GYN physician services at AHSH. Such an arrangement would allow Adventist St. Helena to continue to provide existing levels of OB/GYN services at current levels for the five-year period in which it will continue to operate in its current facility. Absent such an arrangement, continuation of such services does not appear to be practically viable due to the low volume and physician recruitment challenges, and it is most likely that AHSH would need to close such services before the end of five-year period discussed above.

We should reiterate that AHW is prepared to maintain all existing services at St. Helena for the five-year period that AHSH will continue to operate in its current structure. However, continued services after that five-year period is dependent upon the renovation or construction of a seismically compliant hospital (as well as the hospital's continued ability to recruit and retain physicians) – and on the more limited core services that likely will be provided at the newly structured facility.

**Request # 10**

Adventist's Notice at Section 999.5(d)(1)(C) provides a statement of reasons for the transaction.

a. What is Adventist going to do that is not doing now to create the healthiest communities at a cost that is affordable, assure access and provide the highest value to the people who live and work in the communities?

b. What parts of the healthcare delivery network will be integrated to ensure the most effective and efficient delivery of population health services?

c. Explain the differences between fee-for-service payment and fee-for-value payment models and how this benefits the community.

d. Explain the importance of a move from acute-care focused model to a value-based model and how this benefits the community;

e. How is Adventist's ability to standardize care around evidence-based best practices be enhanced and operational efficiencies be created by the transaction?

f. How will integration of physician models increase access to primary care and specialty physicians in the communities?

g. How will Adventist develop an information system for managing the health the parties' combined populations, designed to provide easily-accessible data in realtime?

h. What will Adventist do to facilitate better inclusion of its behavioral health inpatient services to further increase access to these services?

i. What new services are being developed?

j. What evidence is there to show that there is a substantial outmigration occurring in the communities?

k. What does it mean that the ST Network stabilize volumes, and strengthen quality?

1. How will the ST Network reduce costs in in Napa County and other counties?

m. How will Adventist further provide opportunities to expand the provision of managed Medi-Cal services to those who rely on Medi-Cal for their health care?

**Response to Request # 10**

Request 10(a):

Combining the Northern California operations of both AHW and SJHS offers a platform to help create healthier communities at an affordable cost, and to improve access and value to the people who live and work in the communities. The parties plan to achieve this by serving as a more integrated population health manager over a larger population; by linking currently disparate electronic health records across both organizations for the entire geography; by achieving the scale necessary to better recruit and retain physicians; by better aligning patient needs with physicians that can provide these services locally; and by enhancing outpatient offerings while reducing readmissions.

AHW needs additional access points and a broader footprint to achieve meaningful progress in addressing regional issues related to high-utilization mentally ill and chronically homeless populations. The parties will better achieve this because SJHS's geographic presence in the Northern California region complements AHW's. Given that more patients will be served by the parties across a broader geography, they expect they will be able together to better control the cost of care for these patients for the entire system, while providing high value to these populations. The parties anticipate they will better control costs for the system by focusing care on regional needs and reducing inpatient admissions and readmissions through better care management.

The parties expect to work together to attract physicians and better align patient needs with physicians that can provide these needed services locally. Coordination of physician services will permit the parties to better meet minimum volume thresholds required to retain physicians. The parties expect that the eventual formation of a clinically integrated network ("CIN") in conjunction with enhanced and collaborative physician alignment will help the parties more effectively retain care within the network. Through the CIN, the parties are considering implementing new mechanisms to monitor, standardize, and control utilization of healthcare services in a manner that is designed to control costs and assure quality of care.

In addition, the parties are jointly developing a comprehensive care continuum strategy to enhance outpatient and ambulatory offerings. Concurrently, the parties are considering undertaking special projects and initiatives they believe will achieve improved outcomes for members such as potential collaboration on discharge planning and post-discharge care with the objective of reducing hospital readmissions.

Request 10(b):

AHW and SJHS expect to create an integrated delivery network throughout the counties of Humboldt, Lake, Mendocino, Napa, Solano and Sonoma, in hopes of providing more effective and efficient delivery of population health services. The network will consist of five hospitals currently operated by AHW and four hospitals by SJHS:

From AHW:

(1) Adventist Health Clearlake Hospital, Inc. dba Adventist Health Clear Lake;

(2) Willits Hospital, Inc. dba Adventist Health Howard Memorial;

(3) St. Helena Hospital dba Adventist Health St. Helena;

(4) St. Helena Hospital dba Adventist Health Vallejo; and

(5) Ukiah Adventist Hospital dba Adventist Health Ukiah Valley.

From SJHS:

(1) Queen of the Valley Medical Center;

(2) Santa Rosa Memorial Hospital;

(3) St. Joseph Hospital of Eureka; and

(4) Redwood Memorial Hospital of Fortuna.

The affiliation will also include both parties' home health care entities—AHW's Western Health Resources and SJHS's St. Joseph Home Care Network—and the parties' rural health clinics and hospital based outpatient clinics within the JOC's service area.

In addition, upon the closing of this transaction, the parties currently intend to jointly enter into an agreement regarding the formation of a clinically integrated network ("CIN"). The parties intend to explore various clinical integration activities, including but not limited to, implementing mechanisms to monitor and control utilization of healthcare services in a manner that is designed to control costs and assure quality of care; jointly developing population health management strategies with the expectation of improving coordination of care for patients; and implementing performance metrics and routine evaluations of CIN physicians in order to measure performance, assess practice patterns and potentially identify areas for improvement.

Request 10(c):

Healthcare providers in the United States historically have been paid on a fee-for-service basis, through which healthcare providers are paid based on rates for services provided to patients. The healthcare system is in the midst of a shift from fee-for-service payment models to fee-for-value (also called value-based) reimbursement models that reward providers for improving patient outcomes and controlling the total cost of care provided. The shift to value-based care stands to benefit the community because it focuses on improving outcomes and reducing total cost: two weaknesses of the old fee-for-service models, which economically incentivized more care, without regard to total cost of care or quality of outcomes.

More services do not always lead to better outcomes. *See, e.g.*, J. Michael McWilliams, M.D., et al., *Performance Differences in Year 1 of Pioneer Accountable Care Organizations*, New Engl. J. Med. 2015; 372:1927-36 (May 14, 2015)[2]; Alliance of Community Health Plans, *Rewarding High Quality: Practical Models for Value-Based Physician Payment*, 2014 Report (Apr. 20, 2016).[3] Increasingly, hospitals, physicians, and payers, have recognized that to ensure the right care is provided to a patient in the right setting at the right time, payment systems should reward health care providers for achieving the best patient outcomes in the most cost-effective manner. A payment system that rewards good outcomes, obtained through cost-effective delivery of appropriate health care tailored for an individual patient, aligns the interests of patients, providers, and payers alike.

Request 10(d):

See response to Request 10(c). As part of the transition from fee-for-service to value-based care models, healthcare providers—including AHW and SJHS—are focusing on ways to minimize or avoid treating patients in an acute-care hospital setting. Treating patients at acute-care hospitals can be costly and can lead to additional medical issues like infections. Through

[2] http://www.nejm.org/doi/full/10.1056/NEJMsa1414929#t=article.
[3] https://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf.

the ST Network affiliation, the parties will use their combined resources to help avoid or minimize acute-care episodes, and whenever possible deliver care in lower-acuity settings. As the ST Network focuses on value-based care models, the parties expect to be able to reduce the need for expensive acute-care hospital admissions and readmissions (through care coordination, population health), and treat patients in lower-acuity settings when possible.

Request 10(e):

Through the ST Network affiliation, the parties will draw upon their joint expertise concerning evidence-based best practices and will collaborate with one another to attain further advancements. The parties each currently have respective strengths in different service lines and believe they will be able to extend these best practices to each other's hospitals and a larger patient population. For example, SJHS has a strong evidence-based best practice concerning sepsis early detection and treatment, with clear steps to be taken in the first 3 hours, and a second set of steps to be completed within 6 hours, all focused on patient data collection and analysis. In fact, SJHS's Northern California hospitals have been the leading region for reduction in sepsis mortality for the last two years out of 51 hospitals within Providence St. Joseph Health. Similarly, AHW has championed clostridium difficile infection prevention strategies that are implemented using evidence-based tools and resources, and which resulted in a 31% reduction in cases between 2015 and 2017.[4] The parties can share these learnings and apply them across a broader population and all of the hospitals. In addition, the parties expect their ability to enhance standardization of care through evidence-based best practices will improve as a result of bringing together a larger and more diverse patient population than either has on its own, which means a bigger pool from which to develop these evidence-based practices.

The affiliation will also provide the opportunity to achieve operational efficiencies. This will occur through the standardization and use of evidence-based practices as described above, which should help lower costs and improve the quality of the services provided. As described in the response to Request 10(a), the parties anticipate that operational efficiencies will also result from the shared population health strategies and best practices that will be applied to the broader population, which the parties expect will lower the cost of care for the whole system. In addition, the parties anticipate that operational efficiencies can result from providing the scale needed to fill physician needs, splitting physician staffing to better align with volumes, and more appropriately staffing call teams to reduce physician turnover. The parties expect that the CIN the parties currently plan on creating after the close of this transaction will augment these efficiencies by helping to fill current and future physician gaps experienced in all five counties. Finally, the affiliation will help facilitate the parties' ability to meet minimum volume thresholds to hopefully optimize and efficiently provide clinical services.

[4] Adventist Health, 2016-2017 Nursing Report, *available at* https://www.adventisthealth.org/assets/2016-2017-Nursing-Annual-Report.pdf.

Request 10(f):

The parties expect to work together to attract physicians and better align patient needs with physicians that can provide these needed services locally. Coordination of physician services will permit the parties to better meet minimum volume thresholds required to retain physicians. The parties expect that the eventual formation of a clinically integrated network ("CIN") in conjunction with enhanced and collaborative physician alignment will help the parties more effectively retain care within the network. Through the CIN, the parties are considering implementing new mechanisms to monitor, standardize, and control utilization of healthcare services in a manner that is designed to control costs and assure quality of care. In addition, AHW has strong experience and expertise in the Rural Health Clinic model and expects to work with SJHS to utilize that physician model in appropriate locations to increase access to primary and specialty physicians, with a focus on access for those enrolled in Medi-Cal.

Request 10(g):

Currently, both AHW and SJHS have electronic medical record ("EMR") systems in place. AHW primarily uses Cerner while SJHS primarily uses MEDITECH.[5] SJHS has its own Private HIE which is utilized by many providers integrating and viewing shared patient data. AHW and SJHS will work via both systems' available HIE technology to ensure the access of shared patient data.

Request 10(h):

The parties expect their affiliation to increase the availability of and access to behavioral health services, as the SJHS hospitals in the 5-county region have no inpatient psychiatric or behavioral health beds and only limited outpatient psychiatric services. AHW is also considering long-term plans to expand its behavioral health capabilities at its Vallejo facility, which may include increased bed capacity, and direct referral capabilities with SJHS's Queen of the Valley Medical Center. Because a goal of the affiliation is to increase clinical collaboration between the parties, SJHS expects it will be able to build off of AHW's expertise and integrate behavioral health within its primary medical clinics. This, the parties presume, will allow earlier interventions for more patients with mental health issues and hopefully ensure better outcomes. AHW currently delivers approximately 12,000 annual behavioral health-focused Rural Health Clinic visits and will look to expand this expertise across the geography.

Request 10(i):

The transaction will benefit local communities by extending the breadth and depth of existing services. The parties are currently in discussion about what new services will be provided but no final determinations have been made. The parties expect that they will expand their Rural Health Clinic network in applicable areas and coordinate and expand the cancer

[5] SJHS's Northern California hospitals expect that MEDITECH will be phased out at those facilities during 2021.

service line in Mendocino County. As discussed in the responses to Request 10(e) and Request 3 of the Attorney General's September 28, 2018 letter (provided under separate cover), the parties expect that the ST Network transaction will help support sustainable clinical operations at AHSH that would otherwise be diminished or compromised due to the challenges facing the hospital. In addition, as discussed in the response to Requests 10(a) and 10(h), as well as Request 5 of the September 28, 2018 letter, additional behavioral health and other population health services will be extended to local underserved communities.

Request 10(j):

See the response to Request 5 to the Attorney General's September 28, 2018 letter (provided under separate cover).

Request 10(k):

AHW and SJHS have experienced difficulty recruiting and retaining specialists—such as gastroenterologists, urologists, and otolaryngologists—in certain communities because low volumes at their separate facilities are unable to sustain the number of physicians within those specialties that are needed to support hospital/ER coverage needs and to maintain high quality practices. The ST Network will be able to deploy specialists to multiple locations across the AHW and SJHS systems in the region to ensure high enough volumes to support these specialists. The relationship between volumes and quality is widely documented. *See, e.g.*, H. Bauer, et al., *Minimum Volume Standards in Surgery - Are We There Yet*, Visc. Med 2017;33:106 ("The quality of surgery is directly dependent on the quantity, more specifically, on the number of operations performed at a given hospital as well as on the designated surgeon.").

Request 10(l):

See the response to Requests 10(a), (b), and (e). In addition, the parties' expected ability to deploy specialists across the ST Network as described in response to Request 10(k), should help reduce underutilization of physicians and high turnover among physicians in specialties with insufficient volumes at the parties' respective facilities. The parties anticipate that better utilization of specialists will significantly reduce locum tenens staffing costs, particularly at AHSH, and reduce the costs associated with recruiting and retaining physicians.

Request 10(m):

See the response to Request 4 of the Attorney General's September 28, 2018 letter (provided under separate cover).

**Adventist Health Systems/West and St. Joseph Health System**
**Additional Responses to California Attorney General Letters of August 24, 2018, August 30, 2018 and September 28, 2018**

Additional Responses to August 30, 2018 Letter

**Request # 3**

If there is an impact on medical and health care services, provide information for all proposed consolidations and changes in these services, including reproductive health services, for all counties affected by this transaction, including but not limited to, reproductive services in the County of Napa.

**Response to Request # 3**

Apart from the anticipated changes that will occur at Adventist Health St. Helena at least five years after the closing date of the transaction, and that are described in the response to Request #1 to the Attorney General's August 24, 2018 letter, SJHS and AHW anticipate there will be no consolidation or changes in services at the AHW and SJHS hospitals that are the subject of the proposed transaction.

Responses to September 28, 2018 Letter

**Request # 1:**

For both Adventist and St. Joseph, provide all documents submitted to the Federal Trade Commission in response to any Civil Investigation Demands;

a. Please produce all Electronically Stored Information ("ESI") in electronic format, with file suitable for loading into a Relativity compatible litigation support review database.

**Response to Request #1**

AHW and SJHS have been producing and will continue to provide to the California Attorney General's office all documents submitted to the Federal Trade Commission in response to any Civil Investigation Demands. These materials are produced in an electronic format suitable for loading into a Relativity compatible litigation support review database.