

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**THE COMMUNITY HOSPITALS' MOTION TO EXCLUDE
LEAPFROG'S EXPERT WITNESSES**

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INTRODUCTION

Plaintiffs, five community hospitals—Delray Medical Center, Good Samaritan Medical Center, Palm Beach Gardens Medical Center, St. Mary’s Medical Center, and West Boca Medical Center (the “Community Hospitals”)—challenge Defendant The Leapfrog Group’s (“Leapfrog”) consumer-facing “Hospital Safety Grades,” including Leapfrog’s undisputed practice of arbitrarily assigning the lowest possible scores on certain measures to hospitals that don’t participate in its 350+ page Hospital Survey and its public representations about that methodology. In this motion, the Community Hospitals respectfully move *in limine* to exclude the testimony of each of Leapfrog’s proposed experts: (1) Michael Vredenburgh; (2) Dr. Farrokh Farrokhi; (3) Mark Rule; and (4) Dr. Anthony Harris. Their testimony fails to meet well established standards for use at trial.¹

Federal Rule of Evidence 702 and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), require the Court to police expert testimony to maintain a reliable record, streamline the presentation of evidence, and avoid according “expert” status to witnesses that are unqualified or opinions that are irrelevant, unhelpful, or methodologically unsound. This bedrock requirement “applies whether the trier of fact is a judge or a jury.” *Berkley Ins. Co. v. Suffolk Constr. Co., Inc.*, 699 F. Supp. 3d 1341, 1353 (S.D. Fla. 2023) (citation omitted); *see also Salomon Constr. & Roofing Corp. v. James McHugh Constr. Co.*, 2019 WL 5256980, at *4 (S.D. Fla. Mar. 22, 2019) (recognizing that motions *in limine* to exclude expert testimony can “streamline” trials, including “bench trial[s]”). Here, each of Leapfrog’s experts fails Rule 702’s “rigorous” requirements of qualification, reliability, and helpfulness to the trier of fact. *United States v. Frazier*, 387 F.3d 1244, 1260 (11th Cir. 2004) (en banc). Two are also independently barred due to violations of the expert-disclosure requirements of Federal Rule of Civil Procedure 26.²

(1) Michael Vredenburgh (“human factors” engineer). Mr. Vredenburgh’s report offered opinions about how consumers perceive or respond to Leapfrog’s website—where Leapfrog makes numerous misleading representations about its Safety Grade methodology—but he failed to identify in his report a host of documents he reviewed in forming his opinions. And then at his deposition, he stated that his opinions rest largely on a *single* webpage on Leapfrog’s website: the

¹ The Community Hospitals separately moved for summary judgment on their Florida Deceptive and Unfair Trade Practices Act (“FDUTPA”) claim. Dkt. 86. This motion ensures that any remaining evidentiary issues are resolved on proper proof.

² The Appendix to this motion summarizes the grounds for excluding each of the opinions proffered by Leapfrog’s putative experts.

webpage displaying a hospital’s “Safety Grade.” He discounted the many other consumer-facing pages where Leapfrog promotes hospitals’ failing Safety Grades—including the FAQs and “Lives Lost/Lives Saved” materials, Ex. 9 (Vredenburg) at 58:7–19, 84:16–19, 175:16–25—which contain the very misstatements and omissions at issue. By confining his analysis to one isolated portion of the website, Mr. Vredenburg failed to evaluate the overall presentation consumers actually see, rendering his opinions methodologically unsound and incapable of assisting the Court in determining whether Leapfrog’s representations about the Safety Grades—when properly considered in their full online context—are deceptive.

Mr. Vredenburg offers five opinions: that the Safety Grade webpage is “transparent” for reasonable consumers (Vredenburg Opinion One); that it is “accessible” to a general audience (Opinion Two); that the failing scores Leapfrog automatically assigns to non-participating hospitals are “readily clear” (Opinion Three); that “user-experience” testing allegedly conducted a decade ago validates the website’s clarity (Opinion Four); and that Google Analytics data show users scroll far enough to see footnote disclosures on the website (Opinion Five). Under examination, he ultimately withdrew his Google Analytics analysis—the foundation for Opinions One, Two, and Three—because the actual number of scrolls was *five times less* than he had calculated.

First, Mr. Vredenburg should be excluded for **violating Rule 26(a)(2)**. He failed to disclose scores of documents he considered—enough to fill multiple binders—depriving the Community Hospitals of a fair opportunity to examine the bases for his opinions. That failure is unjustified and severely prejudicial, warranting exclusion under Rule 26 and Federal Rule of Civil Procedure 37. *Second*, he is **unqualified** under Rule 702. He has no education, training, or experience in consumer behavior, marketing, or healthcare communications. His “human-factors” engineering background involves product and equipment design, not how lay users interpret complex health information online. Nothing in his professional history qualifies him to opine on how patients or the public understand Leapfrog’s website or disclosures. *Third*, his opinions are **unreliable, unhelpful, and irrelevant** under Rule 702(a)–(d). He applied no testable or peer-reviewed methodology, based multiple opinions on a significant and admitted miscalculation, and evaluated only a fragment of the relevant materials. By discounting the other webpages through which Leapfrog communicates its Safety Grades, he failed to analyze the overall consumer message—making his opinions both methodologically unreliable and irrelevant to the issues the Court must decide.

Because Mr. Vredenburg failed to disclose a mountain of documents he considered in

forming his opinions, and because those opinions rest on unreliable calculations and assumptions and fail to consider the materials necessary to assess consumer deception, his testimony should be excluded under Rules 26, 37, and 702.

(2) Dr. Farrokhi (neurosurgeon). Dr. Farrokhi's opinions largely relate to the claimed benefits of Leapfrog's Hospital Survey, rather than the deceptive Safety Grade methodology actually at issue in this case. His written report contained a single opinion—that Leapfrog's "Grade" is "a necessary and critical part" of improving hospital quality (Farrokhi Opinion One). Ex. 1 (Farrokhi Rep.) at 13. Under examination, he abandoned that view and replaced it with a new claim that the Survey, not the Safety Grade, improves quality (Opinion Two). Then on redirect by Leapfrog's counsel, he came up with three additional opinions: that hospitals use the Survey for benchmarking (Opinion Three); that the Survey is reliable (Opinion Four); and that completing the Survey is not burdensome (Opinion Five). None of these three additional opinions appear in his report, and each was offered for the first time in the waning minutes of his seven-hour deposition. Dr. Farrokhi also conceded that he has never studied or validated the Survey, does not know whether hospitals use it for benchmarking, and has no knowledge of how burdensome it is to complete. Ex. 6 (Farrokhi) at 295:3–8, 297:3–6, 299:19–22. His testimony therefore consists entirely of undisclosed, speculative opinions on topics outside his experience.

First, Dr. Farrokhi **violated Rule 26(a)(2)** because his new opinions were never disclosed before his deposition or even during his examination by the Community Hospitals' counsel. They were elicited for the first time on redirect by Leapfrog's counsel in the final minutes of his seven-hour deposition. That tactic deprived the Community Hospitals of any fair opportunity to explore the bases for those opinions or to prepare rebuttal testimony. Rule 26's expert-disclosure requirements exist to prevent this exact type of ambush, and Rule 37(c)(1) makes exclusion the presumptive remedy. *Second*, Dr. Farrokhi is **unqualified** under Rule 702. He is a practicing neurosurgeon with no training or experience in benchmarking, survey reliability, or survey design. He admitted that his views are based solely on personal observations from his own hospital, not on any professional study, training, or field research. *Third*, his opinions are **unreliable and unhelpful** under Rule 702(a)–(d). Each rests solely on anecdotal experience and speculation and employs no scientific or analytical framework. *Fourth*, his opinions about the Survey's purported benefits (Opinions Two and Three) are **irrelevant and unhelpful** under Rule 702(a) because they have no bearing on the issues the Court must decide—namely, whether Leapfrog's Safety Grade methodology and its

public statements about the Safety Grades are deceptive or unfair.

Because Dr. Farrokhi's new opinions are untimely disclosed, outside his field of competence, unsupported by any methodology, and (for two of them) completely irrelevant, they should be excluded under Rules 26, 37, and 702.

(3) Mark Rule (damages accountant). Mr. Rule offers an opinion about damages in a case where the plaintiffs seek no damages. If allowed to testify at trial, he plans to opine that the Community Hospitals' experts did not "quantify the damages here," even though they "could have" (Rule Opinion One). Ex. 8 (Rule) at 74:22–24, 240:19–21; *see id.* at 224:23–225:1, 242:4–9. But the Community Hospitals seek only injunctive and declaratory relief, not damages. Dkt. 74 (amended complaint waiving damages). Mr. Rule's testimony as to Opinion One is **irrelevant and unhelpful** under Rule 702(a) as a matter of law.

His second opinion—a counsel-directed "re-grading" exercise in which he deleted the four measures for which Leapfrog automatically assigns failing scores (Computerized Physician Order Entry, Bar-Code Medication Administration, ICU Physician Staffing, and Hand Hygiene, collectively, the "Four Measures") from Leapfrog's Safety Grade calculator and claimed the resulting Safety Grades would be essentially unchanged (Rule Opinion Two)—is likewise inadmissible. *First*, his opinion is **irrelevant and unhelpful** under Rule 702(a). The question before the Court is whether Leapfrog's use of the Four Measures—automatically assigning failing scores with no underlying data—artificially depressed the Community Hospitals' Safety Grades. Mr. Rule's exercise tested something else entirely: a hypothetical in which the Four Measures were deleted from the model altogether. His conclusions therefore have no probative value and cannot assist the trier of fact. *Second*, he is **unqualified** under Rule 702. Mr. Rule admits only a "layman's understanding" of hospital grading, Ex. 8 (Rule) at 126:17–127:2, and he has no experience or training in healthcare quality measurement or the design or validation of hospital rating methodologies. His background in finance and damages analysis provides no expertise relevant to hospital safety scoring or imputation methodologies. *Third*, his method is **unreliable and unhelpful** under Rule 702(a)–(d). The "re-grading" exercise he performed—manually deleting variables selected by counsel—is not a testable, peer-reviewed, or generally accepted analytical technique. It measures nothing about how Leapfrog's Safety Grade methodology actually operates and was developed solely for this litigation.

Because Mr. Rule's testimony concerns irrelevant questions and his "re-grading" analysis

is offered by an unqualified witness and rests on an unreliable and unhelpful method, his testimony should be excluded under Rule 702. His analysis only obscures the real issues here.

(4) Dr. Anthony Harris (epidemiologist). All of Dr. Harris’s opinions attempt to defend Leapfrog’s Safety Grade methodology, yet under examination he admitted he did not even understand what that methodology is. The system he set out to validate is the one at the center of this case—Leapfrog’s practice of automatically assigning the lowest scores on the Four Measures to hospitals that decline to complete its 350+ page Survey. Upon examination, it became clear he had formed his opinions unaware that the assigned scores are the lowest ones Leapfrog assigns. Ex. 7 (Harris) at 83:14–84:15. That admission is fatal: a witness who misunderstands the core feature of the system he is defending cannot provide reliable or helpful testimony. Every one of Dr. Harris’s opinions proceeds from that same misunderstanding and should be excluded in full.

Dr. Harris offers four opinions: that Leapfrog’s Safety Grade methodology is “reasonable and ethical” because its Expert Panel supposedly approved it (Harris Opinion One); that “non-response bias” is “real” and should be factored into Leapfrog’s Safety Grade methodology (Opinion Two); that the Community Hospitals are “underperformers” regardless of whether they are penalized on the Four Measures (Opinion Three); and that the re-grading analysis conducted by the Community Hospitals’ methodology expert, Dr. Sean Nicholson, is “flawed” (Opinion Four). Ex. 7 (Harris) at 66:19–67:4, 72:21–73:3, 73:15–20.³

First, his opinions are **unreliable and unhelpful** under Rule 702(a)–(d). Each is grounded on false premises or untethered to the record (or both). In particular, his core assumption underlying Opinion One—that Leapfrog’s Expert Panel reviewed and approved the challenged methodology—is demonstrably incorrect and his own admissions confirm this. The Eleventh Circuit has made clear that an expert opinion is “admissible only if an expert knows of facts which enable him to express a reasonably accurate conclusion.” *United States v. City of Miami*, 115 F.3d 870, 873 (11th Cir. 1997). Dr. Harris knew no such facts, and failed to apply a testable or peer-reviewed method to any of his conclusions. He hardly even reviewed any documents in the record—just five out of the nearly one million produced by Leapfrog, Ex. 7 (Harris) at 24:5–21, 53:11–54:19, 57:8–

³ Dr. Harris suggested at his deposition that he is offering a fifth opinion: that Leapfrog’s Safety Grade methodology is “closest to the truth” of non-participating hospitals’ actual performance (Opinion Five). Ex. 7 (Harris) at 76:14–77:6. *But see, e.g.*, Ex. 2 (Harris Rep.) at 6 (not identifying this opinion in his list of opinions); Ex. 7 (Harris) at 63:3–10, 66:19–67:4, 73:1–74:3 (agreeing that his “four” opinions—Opinions One through Four above—are “all of [his] opinions related to this matter”).

60:10—and performed no independent analysis of Leapfrog’s data or the Community Hospitals’ actual safety records. His testimony therefore lacks the methodological rigor required by *Daubert* and Rule 702. *Second*, his Opinion Three—that the Community Hospitals are supposedly poor performers—is **irrelevant and unhelpful** under Rule 702(a) insofar as it rests on the very different star ratings assigned by the Centers for Medicare & Medicaid Services (“CMS”). Nothing about those ratings addresses whether Leapfrog’s Safety Grade methodology—assigning automatic failing scores on the Four Measures—or Leapfrog’s public representations about the Safety Grades are deceptive or unfair under FDUTPA.

Because Dr. Harris misunderstood the methodology he purports to defend, reviewed virtually no evidence, applied no reliable or helpful method, and relied on the irrelevant CMS star ratings, his testimony should be excluded under Rule 702. Allowing him to testify would not clarify the facts; it would obscure them.

* * *

Leapfrog’s proffered experts should be excluded. As a group, they lack relevant qualifications, relied on undisclosed documents and unreliable methodologies, and failed to adequately prepare or process the underlying facts of this case. Exclusion will materially simplify any evidentiary proceedings and prevent these witnesses from injecting improper speculation or undisclosed material into the case, preserving a fair and efficient trial process for the Court and the parties. Although this Court has the ability to consider these putative experts’ opinions for whatever value they hold, which is negligible, they should not be credited with the legitimacy and precedential status that admission of their testimony would confer. The Court should grant this motion *in limine* in full.

LEGAL STANDARDS

“A motion in limine allows the trial court to rule in advance of trial on the admissibility and relevance of certain forecasted evidence.” *Salomon Constr. & Roofing Corp.*, 2019 WL 5256980, at *1. “[T]he admissibility of expert testimony” is “govern[ed]” by “[t]he framework set forth in Federal Rule of Evidence 702 and *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579 (1993).” *Wright v. Blackman*, 2022 WL 18584336, at *1 (S.D. Fla. Feb. 24, 2022) (Middlebrooks, J.). In addition, “[a] motion in limine” is an appropriate vehicle to address whether expert witnesses should be excluded from trial as a sanction under Federal Rule of Civil Procedure 37 for violations of the expert-disclosure requirements of Federal Rule of Civil Procedure 26. *Jegpak Enter., LLC*

v. Great Lakes Ins. SE, 2024 WL 5264399, at *1 (S.D. Fla. June 12, 2024) (Middlebrooks, J.); *see also, e.g., Brown v. NCL (Bahamas) Ltd.*, 190 F. Supp. 3d 1136, 1140–44 (S.D. Fla. 2016) (adjudicating pre-trial motion that raised arguments under both Rule 702/*Daubert* and Rules 26 and 37).

A. Federal Rule Of Evidence 702 And *Daubert*

“The proponent of expert testimony” bears a “rigorous” burden in establishing its admissibility. *Frazier*, 387 F.3d at 1260. Under Rule 702, the witness must be “qualified as an expert”; have “specialized knowledge” that “will help the trier of fact to understand the evidence or to determine a fact in issue”; and provide testimony that “is based on sufficient facts or data,” “is the product of reliable principles and methods,” and “reflects a reliable application of the principles and methods to the facts of the case.” Fed. R. Evid. 702.

Although *Daubert* arose in a jury context, these same standards govern a bench trial. *See, e.g., Berkley Ins. Co.*, 699 F. Supp. 3d at 1353 (“Rule 702 applies whether the trier of fact is a judge or a jury.” (quoting *UGI Sunbury LLC v. A Permanent Easement for 1.7575 Acres*, 949 F.3d 825, 832 (3d Cir. 2020))). In a bench trial, exclusion serves to maintain a reliable and efficient record and to avoid devoting trial time to immaterial or unreliable opinions. *See Salomon Constr.*, 2019 WL 5256980, at *4 (acknowledging that pre-trial exclusion “streamline[s]” a “bench trial”). Thus, the Court should exclude any expert testimony that fails to satisfy all of Rule 702’s three “distinct” “requirements” for “admissibility”: “qualification, reliability, and helpfulness.” *Frazier*, 387 F.3d at 1260.

Qualifications. The witness must have the expertise to “testify competently regarding the matters he intends to address,” *Frazier*, 387 F.3d at 1260 (citation omitted), which demands an examination of “the credentials of the proposed expert in light of the subject matter of the proposed testimony,” *Davis ex rel. J.D.D. v. Carroll*, 329 F.R.D. 435, 440 (M.D. Fla. 2018). Importantly, “[e]xpertise in one field does not qualify a witness to testify about others.” *Lebron v. Sec’y of Fla. Dep’t of Child. & Fams.*, 772 F.3d 1352, 1368 (11th Cir. 2014).

Reliability. Even if qualified, the witness must “emplo[y] ... the same level of intellectual rigor that characterizes the practice of an expert in the relevant field.” *McClain v. Metabolife Int’l, Inc.*, 401 F.3d 1233, 1237 (11th Cir. 2005) (citation omitted). In particular, the witness must use a “reliable methodology.” *Hughes v. Kia Motors Corp.*, 766 F.3d 1317, 1329 (11th Cir. 2014). The main indicia of reliability are whether a methodology “can be and has been tested,” whether it “has been subjected to peer review,” whether it “is generally accepted,” and its “known or potential rate

of error.” *Id.*; see *Daubert*, 509 U.S. at 593–94. In addition, the witness must “reliably appl[y]” his methodology “to the facts of the case.” *Hughes*, 766 F.3d at 1328 (emphasis added; citation omitted). Unreliable testimony is thus marked by, for example, “unsupported assumption[s],” *Buland v. NCL (Bahamas) Ltd.*, 992 F.3d 1143, 1151 (11th Cir. 2021), “causal ... ‘leaps,’” *Rider v. Sandoz Pharms. Corp.*, 295 F.3d 1194, 1202 (11th Cir. 2002), “limited data,” *McClain*, 401 F.3d at 1248, “anecdotal information,” *id.* at 1250, or “speculation that masquerades as scientific knowledge,” *id.* at 1245 (citation omitted). “[A]ny step that renders the analysis unreliable” is “fatal” because admissibility requires “good grounds for each step.” *Id.* (citation omitted).

Helpfulness. To be “helpful,” expert testimony must at minimum be “relevant”—*i.e.*, it must “relate to [an] issue in the case,” *Daubert*, 509 U.S. at 591 (citation omitted)—and it must have a “valid scientific connection to the pertinent inquiry,” *id.* at 592; see also *Frazier*, 387 F.3d at 1266 (“the trier of fact would not be *assisted* by” an opinion whose “methodological foundation or reliability” is “sufficiently slender”). In addition, testimony is unhelpful if it does not illuminate “matters that are beyond the understanding of the average lay person.” *Frazier*, 387 F.3d at 1262. In a bench trial, this requirement has particular force: because the Court, as factfinder, is capable of drawing common-sense inferences without expert assistance, opinions that merely summarize the record or rest on ordinary reasoning are unnecessary and unhelpful. *Cf. Harris v. Hixon*, 102 F.4th 1120, 1132 (11th Cir. 2024) (even “[j]urors don’t need expert testimony to help them understand” “what they c[an] plainly see for themselves” (emphasis added; citation omitted)).

B. Expert-Disclosure Requirements

Parties must make expert disclosures “at the times and in the sequence that the court orders.” Fed. R. Civ. P. 26(a)(2)(D). Those disclosures include, for each proffered expert, “a written report” that “contain[s] ... a complete statement of all opinions the witness will express,” “the basis and reasons for” those opinions, and “the facts or data considered in forming” them. Fed. R. Civ. P. 26(a)(2)(B)(i)–(ii). If an expert witness fails to comply with any of these obligations, excluding that witness from “trial” is an appropriate sanction, unless the violation is “substantially justified” or “harmless.” Fed. R. Civ. P. 37(c)(1). “The burden of establishing that a failure to disclose was substantially justified or harmless rests on the nondisclosing party.” *Mitchell v. Ford Motor Co.*, 318 F. App’x 821, 824 (11th Cir. 2009). In a bench trial, timely and complete disclosure is just as critical—it prevents surprise, permits efficient management of the evidence, and preserves a reliable record for appeal. See, e.g., *Serendipity at Sea, LLC v. Underwriters at Lloyd’s of*

London, 2024 WL 2830627, at *1, *3–5 (11th Cir. June 4, 2024) (per curiam) (affirming exclusion of untimely disclosed witness in a bench trial).

ARGUMENT

I. Michael Vredenburgh: The Human-Factors Engineer Who Failed To Disclose Five Binders Of Documents He Considered In Forming His Opinions And Whose Mathematical Miscalculations Led Him To Withdraw His Foundational Opinion

Mr. Vredenburgh’s opinions should be excluded under Rules 26, 37, and 702. Wholesale exclusion is warranted because Mr. Vredenburgh failed to disclose scores of documents he considered when forming his opinions. He is also unqualified to offer his opinions—all of which address consumer behavior—because he is simply not a consumer-behavior expert. Opinions One, Two, and Three—as narrowed at his deposition—are unreliable, unhelpful, and irrelevant, and they rest in significant part on Opinion Five, which Mr. Vredenburgh withdrew after conceding it was based on calculations that were not even close to being correct. Opinion Four is unreliable and unhelpful as well because it is based on assumptions lacking any factual support in the record. All of Mr. Vredenburgh’s opinions are inadmissible.

A. Mr. Vredenburgh Should Be Excluded Because He Failed To Disclose Scores Of Documents That He Considered In Forming His Opinions

The requirement that experts disclose in their reports *all* “the facts or data considered” in forming their opinions, Fed. R. Civ. P. 26(a)(2)(B)(ii), is “interpreted broadly to require disclosure of *any* material considered by the expert, from whatever source,” not merely what he ultimately “relied upon.” *Republic of Ecuador v. Hinchee*, 741 F.3d 1185, 1195 (11th Cir. 2013) (emphasis added). “[C]ompliance with th[is] requiremen[t] ... is not merely aspirational”; it is “designed to allow both sides ... to prepare their cases adequately and to prevent surprise.” *Reese v. Herbert*, 527 F.3d 1253, 1266 (11th Cir. 2008) (citation omitted). A violation warrants exclusion if the violation is neither “substantially justified” nor “harmless.” Fed. R. Civ. P. 37(c)(1).

1. Failure to Disclose All Materials Considered (Rule 26(a)(2)). Mr. Vredenburgh squarely violated the expert-disclosure requirements by failing to identify all the “materials he had relied upon for his opinion,” which left the Community Hospitals “unable to depose” him “fully.” *Mitchell*, 318 F. App’x at 823–25. He conceded that his expert report does not cite a wide range of documents he reviewed in forming his opinions, including a large file provided by defense counsel. Ex. 9 (Vredenburgh) at 45:6–55:7, 59:25–65:12. Indeed, Mr. Vredenburgh’s report cited only 12 documents in an appendix and 2 additional documents in footnotes, *see* Ex. 4

(Vredenburgh Rep.) at nn. 7–8 & app. C, *even though he reviewed enough additional documents to fill five binders*, Ex. 9 (Vredenburgh) at 45:12–23, 50:3–51:12. This egregious violation of Rule 26(a)(2) is not Mr. Vredenburgh’s alone—Rule 26 imposes obligations on the “part[ies]” (and their lawyers). Fed. R. Civ. P. 26(a)(2). But Leapfrog’s counsel did not advise Mr. Vredenburgh of his obligations, and instead left it to Mr. Vredenburgh—who has never before been retained as an expert in a federal case and is not an attorney—to “self-chec[k]” his compliance with the Federal Rules. Ex. 9 (Vredenburgh) at 72:19–73:19. The Federal Rules demand more of Mr. Vredenburgh, his client, and its counsel.

2. No Substantial Justification (Rule 37(c)(1)). Leapfrog cannot bear its burden to identify an excuse—much less a “substantia[l]” one—for this blatant Rule 26 violation. Fed. R. Civ. P. 37(c)(1). Mr. Vredenburgh’s decision not to cite all the materials he reviewed was deliberate: He “wanted to make sure it was easy to follow along for the reader,” and he believed the Federal Rules permitted this based on his own “research.” Ex. 9 (Vredenburgh) at 51:2–12, 73:4–19. But keeping a reader—let alone the Court or an opposing party—in the dark about what materials he considered makes it substantially more difficult, not easier, to understand, assess, and challenge his opinions. Because “reasonable people” would not “differ as to the appropriateness” of Mr. Vredenburgh’s pervasive and deliberate omissions—nor counsel’s failure to correct the error—the violation is not “substantially justified.” *Devaney v. Cont’l Am. Ins. Co.*, 989 F.2d 1154, 1163 (11th Cir. 1993).

3. Severe Prejudice to the Community Hospitals (Rule 37(c)(1)). Mr. Vredenburgh’s pervasive nondisclosure requires remediation because it is severely prejudicial. “[N]othing causes greater prejudice than to have to guess how and why an adversarial expert reached his or her conclusion[s].” *Mars v. Macy’s Fla. Stores, LLC*, 2019 WL 9078707, at *2 (S.D. Fla. Oct. 2, 2019) (citation omitted). Yet Mr. Vredenburgh withheld entire categories of information and documents that he considered. He admitted that the undisclosed materials he received from counsel would fill “five ... binders.” Ex. 9 (Vredenburgh) at 45:12–23, 50:24–51:12. He also conceded that, in several instances, he could not recall which specific documents he considered. *E.g., id.* at 48:6–18, 49:19–50:2, 262:23–263:1.

These systemic failures deprived the Community Hospitals of a full and fair opportunity to examine the bases for Mr. Vredenburgh’s opinions during his deposition—their only opportunity to do so before trial. That is precisely the type of prejudice Rule 26 is designed to avoid. *See, e.g., Bowe v. Pub. Storage*, 106 F. Supp. 3d 1252, 1260 (S.D. Fla. 2015) (“Prejudice generally occurs

when late disclosure deprives the opposing party of a meaningful opportunity to perform discovery and depositions related to the documents or witnesses in question.”).

* * *

Because Mr. Vredenburg—and Leapfrog’s counsel—failed to identify the materials he considered and can offer no valid justification for those prejudicial omissions, his testimony should be excluded under Rules 26 and 37.

B. Mr. Vredenburg Lacks Expertise To Offer His Opinions

Because “[e]xpertise in one field does not qualify a witness to testify about others,” *Lebron*, 772 F.3d at 1368, a proffered expert must possess expertise “*specific to the topic at issue*” to be qualified under Rule 702, *Wilson v. Flack*, 2022 WL 4477025, at *5 (11th Cir. Sept. 27, 2022) (emphasis added). The topic of Mr. Vredenburg’s opinions is how consumers perceive an isolated portion of Leapfrog’s Hospital Safety Grade website. Ex. 9 (Vredenburg) at 30:16–21. But he has no “knowledge, skill, experience, training, or education” in consumer behavior, consumer psychology, or any related field. Fed. R. Evid. 702. Instead, he claims expertise in “human factors” engineering (an entirely separate discipline), Ex. 9 (Vredenburg) at 87:16–23, as well as “user experience” and “low literacy” (subjects in which he has no qualifications), *id.* at 308:18–21.

1. Human-Factors Engineering Is A Separate Field. Human-factors engineering is not about consumer behavior or psychology. In Mr. Vredenburg’s words, it is about “trying to make products or systems that we live in for humans”—for example, asking “How do I make a car safe?” Ex. 9 (Vredenburg) at 88:1–23; *see Padula v. Carnival Corp.*, 2017 WL 7792714, at *5 (S.D. Fla. Oct. 13, 2017) (“[h]uman factors engineering” is a discipline about “the design of tools, machines, systems, tasks, jobs, and environments” for “safe, comfortable, and effective human use”). Accordingly, Mr. Vredenburg’s professional focus as a human-factors engineer is on “building several different engineering products,” including a large-scale 3D printer the size of his garage. Ex. 9 (Vredenburg) at 12:19–13:1, 22:19–23:4. *All* his prior expert opinions involved slip-and-fall or products liability cases. *Id.* at 123:4–124:18. Mr. Vredenburg’s opinions here—which address consumer perception of webpages—thus “extend well beyond his [claimed] expertise.” *Quashen v. Carnival Corp.*, 2022 WL 1271982, at *8 (S.D. Fla. Jan. 6, 2022) (excluding human-factors expert as unqualified).

2. He Is Not a “User Experience” or “Low Literacy” Expert. Mr. Vredenburg’s other claimed disciplines do not cure this defect. His purported “user experience” expertise is based on

a single article he authored about an airplane pilot program and a “User Experience and Design Thinking” certificate he received from Wright State University for nine credit hours of engineering courses covering topics like mobile app design, not consumer behavior. Ex. 9 (Vredenburgh) at 92:5–94:20, 96:4–6, 100:2–101:15; *see* Ex. 12 (Vredenburgh Dep. Ex. 6); *United States v. Paul*, 175 F.3d 906, 912 (11th Cir. 1999) (an “article” about handwriting and a “degree” from a law school does “not make” a witness “qualified to testify as an expert on handwriting analysis”). And his supposed “low-literacy” expertise—a claim he did not make in his report but instead first mentioned when questioned on redirect by Leapfrog’s counsel in the last 30 minutes of his nearly six-hour deposition, Ex. 9 (Vredenburgh) at 308:20–21—derives solely from an article he wrote for a high-school science competition and a follow-up paper he authored in graduate school. *Id.* at 114:12–116:14, 310:9–23, 311:2–17. Such “limited and dated” credentials cannot possibly qualify him to offer expert opinions on how consumers perceive disclosures on a website. *Payne v. C.R. Bard, Inc.*, 606 F. App’x 940, 943 (11th Cir. 2015).

C. Mr. Vredenburgh’s Opinions Are Unreliable, Unhelpful, And Irrelevant

Mr. Vredenburgh offered five opinions in his report. But at his deposition, he substantially narrowed Opinions One, Two, and Three; acknowledged that Opinion Five was a central basis for those three opinions, then withdrew that opinion due to his egregious mathematical miscalculations; and conceded that Opinion Four rests on speculation. What remains are opinions that are unreliable, unhelpful, and irrelevant. They should all be excluded.

1. Opinions One, Two, And Three: Mr. Vredenburgh’s Opinions About The Supposed Clarity And Transparency Of One Slice Of Leapfrog’s Website Are Based On A Conceded Mathematical Error And Sidestep The Relevant FDUTPA Inquiry

In his report, Mr. Vredenburgh purported to offer three “overlapping” opinions about the Leapfrog website’s presentation of Safety Grades and the Safety Grade methodology. Ex. 9 (Vredenburgh) at 215:11–16. Opinion One asserted that the website’s “design ensures high clarity and transparency for reasonable consumers” such that they can “understand that [G]rades reflect non-participation rather than direct performance data.” Ex. 4 (Vredenburgh Rep.) ¶ 24. Opinion Two relied on readability formulas—the Flesch-Kincaid Grade Level and Gunning Fog Index—to claim that the website’s content is “accessible” to a general audience. *Id.* ¶ 25. And Opinion Three contended that the website’s use of “progressive disclosure” ensures that “non-experts and experts alike” can understand “how non-participation [in Leapfrog’s Survey] results in” hospitals

receiving the “minimum scores” on the Four Measures. *Id.* ¶ 26. The common denominator for each of these opinions was Opinion Five—an evaluation of Google Analytics data, which supposedly proved that users of Leapfrog’s website frequently see the disclosures about Leapfrog’s Safety Grade methodology. *Id.* ¶¶ 29–34. Taken together, these opinions purported to show that Leapfrog’s website as a whole communicates *accurate* information to consumers about Leapfrog’s Safety Grade methodology. *Cf.* Ex. 9 (Vredenburg) at 144:20–25 (“[A]ccuracy is definitely a component of transparency.”).

But at his deposition, Mr. Vredenburg significantly walked back each of these opinions, acknowledging that the Google Analytics analysis was egregiously flawed (and withdrawing Opinion Five on that basis); stating that he isn’t actually opining on the whole of Leapfrog’s website—www.hospitalsafetygrade.org—but rather only a sliver of that site; and ultimately conceding that he is *not* offering the opinion that the website accurately discloses Leapfrog’s Safety Grade methodology. So narrowed, Opinions One, Two, and Three should be excluded as unreliable under Rule 702(b)–(d) and irrelevant and unhelpful under Rule 702(a).

a. *Unreliable and Unhelpful (Rule 702(a)–(d)).* Opinions One, Two, and Three are unreliable and provide no assistance to the Court because they rest upon Mr. Vredenburg’s unreliable and *now-withdrawn* Google Analytics analysis (Opinion Five). *See, e.g., Rink v. Cheminova, Inc.*, 400 F.3d 1286, 1294 (11th Cir. 2005) (expert opinions that relied on an “unreliable” expert opinion were properly excluded). Relying on Google Analytics data, Mr. Vredenburg originally concluded that users, on average, scroll to the bottom of the webpages containing hospitals’ Leapfrog Safety Grades—where the (inaccurate) footnote disclosures about the Safety Grade methodology are located—“more than once per visit.” Ex. 5 (Amendment to Vredenburg Rep.) at 3, fig.5. This data, he claimed, shows “high user engagement” on the Safety Grade webpages, “ensuring” that the footnote disclosures are “visibl[e].” Ex. 4 (Vredenburg Rep.) ¶¶ 22, 29–34.

But this analysis was wrong and based on a substantial error, as Mr. Vredenburg now concedes. His calculation of the number of average scrolls per user relied on the wrong denominator—counting users who *scrolled* to the bottom of the Safety Grade webpages, rather than all users who *visited* the webpages—thereby inflating scroll counts several times over. Ex. 9 (Vredenburg) at 299:14–300:8. When analyzed correctly, the data shows that only about one in five users scrolled far enough to reach the bottom of the Safety Grade webpages, where the footnote is located. *Id.* at 297:24–298:5. When confronted with this error, Mr. Vredenburg admitted that his

analysis was untenable, and he expressly withdrew Opinion Five. *Id.* at 302:18–303:7 (“Q[:] ... “[Y]ou are withdrawing Opinion 5, correct? A[:] Yes.”).⁴

The unreliability of Opinion Five—and its withdrawal—render Opinions One, Two, and Three inadmissible as well. For the first five hours of his deposition—before he recognized his error—Mr. Vredenburg repeatedly stated that his Google Analytics analysis was “an important factor” for those other opinions because each assumed that typical users scrolled far enough to see the footnote. Ex. 9 (Vredenburg) at 163:23–165:6; *see also id.* at 269:12–14 (confirming that “the fact of people scrolling down and reading [the footnote] is important to [his] analysis”). He admitted, for example, that if consumers did not scroll to the footnote, they would “not necessarily know about the imputation” and “would think that [the Community Hospitals] do the opposite of what best hospitals do.” *Id.* at 171:18–172:1. And he confirmed that his opinion on “the clarity” of the Hospital Safety Grade webpage “depend[s] on users actually scrolling down to [the] footnote.” *Id.* at 195:22–25. With his scroll analysis discredited and withdrawn, the factual and methodological basis for Opinions One, Two, and Three disappeared. That requires their exclusion. *See City of Miami*, 115 F.3d at 873–74 (expert opinion “premised” on “in correc[t] assum[ptions]” should have been “excluded”); *Bodner v. Thunderbird Prods. Corp.*, 2023 WL 1860968, at *3 (11th Cir. Feb. 9, 2023) (excluding expert opinions that “reflected no methodology at all”).

Opinions One, Two, and Three are unreliable and unhelpful for an additional reason: the scope of Mr. Vredenburg’s analysis was irrationally selective. *Cf. Payne v. C.R. Bard, Inc.*, 2014 WL 988754, at *6 (M.D. Fla. Mar. 13, 2014) (excluding expert’s “litigation-driven opinions” as “unreliable” because they were based on only “a small fraction” of the relevant materials), *aff’d*, 606 F. App’x 940 (11th Cir. 2015). In his report, Mr. Vredenburg repeatedly claimed that Leapfrog’s *entire* website is “clear,” “transparen[t],” and “accessible.” Ex. 4 (Vredenburg Rep.) ¶¶ 24–26. But at his deposition, he conceded that these claims are based almost exclusively on one webpage—the page that displays a given hospital’s Safety Grade—and that he did not account for any of the many other consumer-facing sections of Leapfrog’s website that discuss its Safety Grade methodology. Ex. 9 (Vredenburg) at 79:20–81:1, 81:18–82:1, 83:1–9. When pressed, Mr. Vredenburg admitted that those other webpages (such as the FAQs) contain

⁴ Because Mr. Vredenburg expressly withdrew Opinion Five, it is inadmissible. *See Hodges v. United States*, 2020 WL 12933849, at *4 (S.D. Fla. Nov. 13, 2020) (expert witness “may not testify regarding [an] opinion ... which has been withdrawn”).

“inconsistent” statements regarding Leapfrog’s methodology, *id.* at 193:24–195:15, 201:18–205:25, thus effectively conceding that his sweeping conclusions about “the website” rest on a cherry-picked foundation. As a result, those conclusions cannot be reliable or help this Court understand the evidence. *See, e.g., Knepfle v. J-Tech Corp.*, 48 F.4th 1282, 1296 (11th Cir. 2022) (methodology was “unreliable” because it was “only” concerned with “obtaining evidence that confirm[ed] a predetermined theory”).

2. Irrelevant and Unhelpful (Rule 702(a)). Mr. Vredenburgh’s myopic focus on one isolated part of the website also renders Opinions One, Two, and Three irrelevant and unhelpful to the pertinent issue under FDUTPA: whether the “*net* impression” of Leapfrog’s disclosures would mislead consumers. *FTC v. Life Mgmt. Servs. of Orange Cnty., LLC*, 350 F. Supp. 3d 1246, 1264 (M.D. Fla. 2018) (emphasis added; citation omitted). Indeed, he ultimately claimed that whether *any* of Leapfrog’s statements or disclosures are “true or not” is “beyond the scope of [his] analysis.” Ex. 9 (Vredenburgh) at 190:17–24, 217:7–14. Given his concessions, the record is clear: Mr. Vredenburgh is *not* opining that the footnote, visuals, or any other disclosures on Leapfrog’s website truthfully or clearly explain how or why Leapfrog assigned failing scores to non-participating hospitals. *Id.* at 152:13–16, 172:16–19, 185:13–22.⁵

2. Opinion Four: Mr. Vredenburgh’s Opinion That Leapfrog’s Supposed “User Experience” Testing Validates The Website’s Clarity Is Unreliable And Unhelpful Because He Has No Idea Whether Any Testing Occurred

Mr. Vredenburgh’s Opinion Four is that “Leapfrog’s UX [user-experience] testing validates the website’s clarity in contrast to [Dr.] Berger’s untested methodology.” Ex. 4 (Vredenburgh Rep.) ¶ 27. According to Mr. Vredenburgh, UX testing typically “involves creating a mockup of websites” and conducting “a comprehension test” on “a large number of users ... to try to ascertain how to improve [on] comprehension.” Ex. 9 (Vredenburgh) at 220:6–12. He described the UX

⁵ If anything, Mr. Vredenburgh’s testimony is powerful evidence that Leapfrog’s disclosures about its Safety Grade methodology *are* deceptive and misleading. He conceded at his deposition that a “typical user” reading the footnote disclosures on Leapfrog’s website would have “no idea” how or why a failing score was assigned—*i.e.*, whether it was based on historical data, actual performance, or something else—and that the “gas gauges” on the Safety Grade webpages could lead consumers to believe that low scores reflect poor performance, rather than the decision not to participate in Leapfrog’s Survey. Ex. 9 (Vredenburgh) at 161:19–162:3, 169:5–10, 171:5–172:3, 182:17–183:14, 193:24–194:14. And when confronted with other disclosures (*e.g.*, the FAQs), he admitted that Leapfrog’s website contains “inconsistent” statements about the Safety Grade methodology and does not follow “best practices.” *Id.* at 205:23–25, 248:8–249:15.

testing that Leapfrog supposedly conducted as adhering to an industry “gold standard,” and based this conclusion on two documents: (1) an October 2013 contract between Leapfrog and a UX consultant, which Mr. Vredenburgh disclosed for the first time *during* his deposition; and (2) a December 2014 grant report authored by Leapfrog’s CEO. *Id.* at 164:9–14, 221:23–225:17, 233:14–234:1, 248:12–13. According to Mr. Vredenburgh, these documents demonstrate that Leapfrog rigorously tested the design and usability of its website. *Id.* at 227:13–17, 236:8–21, 238:4–10, 241:1–17, 248:9–13. This opinion is unreliable and unhelpful under Rule 702(a)–(d) for two straightforward reasons: (1) Mr. Vredenburgh has no support for his assumption that Leapfrog conducted UX testing (or what any such testing entailed); and (2) even if there was UX testing, he has zero basis to conclude that the testing evaluated Leapfrog’s disclosures about its current Safety Grade methodology.

First, Opinion Four is a textbook example of “unreliable” and unhelpful expert testimony because it rests on “unsupported assumption[s].” *Buland*, 992 F.3d at 1151. Mr. Vredenburgh “assum[ed]” that Leapfrog conducted UX testing, Ex. 9 (Vredenburgh) at 233:10–21, 239:10–16, 242:12–15, 249:7–8, 272:15–17, and admitted he has *no knowledge whatsoever* of what UX testing, if any, Leapfrog conducted, *id.* at 236:22–24, 239:17–19, 242:9–243:1, 269:25–270:4, 272:13–273:1. He also acknowledged he has “no idea” whether Leapfrog followed the recommendations that the alleged UX testers provided (if any existed). *Id.* at 239:9–19, 250:6–20. Ultimately, based on “the documents” he considered, he “c[ouldn’t] say with certainty one way or another” whether UX testing occurred—only that it “*could* have been done.” *Id.* at 247:2–8, 272:21–273:1 (emphasis added). “The courtroom is not the place for” this unhelpful “speculation” and “conjecture.” *Rider*, 295 F.3d at 1202 (citation omitted).⁶

Second, Opinion Four is unreliable and will not assist the Court because it is not based on “existing data.” *McDowell v. Brown*, 392 F.3d 1283, 1301–02 (11th Cir. 2004). Even if Leapfrog did conduct UX testing at some point, Mr. Vredenburgh has no evidence of any *recent* testing of

⁶ Notably, this is not the first case in which Mr. Vredenburgh has offered an expert opinion that is based on an unsupported assumption. In a state-court personal-injury case, Mr. Vredenburgh served as a safety and human-factors expert. On summary judgment, the court disregarded Mr. Vredenburgh’s declaration because it was “based on an assumption of fact without evidentiary support.” *Bermudez v. Crunch, LLC*, No. 19-STCV-35283, at *10 (Cal. Sup. Ct. July 28, 2021); *see* Ex. 10 (Vredenburgh Dep. Ex. 10). The appeals court affirmed that decision, holding that no “evidence supported [the] assertion” Mr. Vredenburgh had made in his declaration. *Bermudez v. Crunch, LLC*, 2022 WL 16918189, at *4 (Cal. Ct. App. Nov. 14, 2022). His UX-testing opinion suffers from precisely the same flaw and should likewise be excluded.

the website that Leapfrog adopted *after* it changed its Safety Grade methodology in Fall 2024. Indeed, the only two documents on which Mr. Vredenburg relied to form his opinion—the undisclosed 2013 contract and the 2014 grant document—predate Leapfrog’s Fall 2024 Safety Grade methodology and current website *by a whole decade*. Ex. 9 (Vredenburg) at 264:16–17, 269:15–24. Any UX testing that was done more than 10 years ago could not have measured whether users understand the current disclosures for a methodology adopted in Fall 2024. Because Opinion Four rests (at best) on stale data, it is not “based on sufficient facts or data,” Fed. R. Evid. 702(b), and will not help the Court “understand” the *actual* “evidence” in this case, Fed. R. Evid. 702(a); *see, e.g., Varner v. Dometic Corp.*, 2022 WL 2307025, at *5 (S.D. Fla. Feb. 2, 2022) (excluding expert witness who “used outdated data from a ten-year old study” to opine on “current” conditions), *objections overruled sub nom. Papasan v. Dometic Corp.*, 2022 WL 1222817 (S.D. Fla. Apr. 26, 2022); *cf. Winn-Dixie Stores, Inc. v. Dolgencorp, LLC*, 862 F. Supp. 2d 1322, 1333 (S.D. Fla. 2012) (Middlebrooks, J.) (excluding expert witness who relied on data from 2009 and 2010 to calculate damages from 2005 through 2008), *aff’d*, 746 F.3d 1008 (11th Cir. 2014).

II. Dr. Farrokhi Farrokhi: The Seattle Neurosurgeon Who Materially Revised His Sole Disclosed Opinion During His Deposition And Disclosed Three Entirely New Opinions On Redirect

Dr. Farrokhi’s opinions should be excluded under Rules 26, 37, and 702. Opinions Three, Four, and Five were not disclosed in his report, but instead were elicited in the final minutes of his deposition. They are plainly untimely. Opinion Two is also untimely because it is materially different than the opinion that Dr. Farrokhi disclosed in his report (Opinion One, which he has withdrawn). In any event, Dr. Farrokhi is not qualified to offer any of his opinions, and they are all unreliable and unhelpful. Opinions Two and Three—which relate to the impact of Leapfrog’s Survey—are also unhelpful because they are irrelevant. Dr. Farrokhi should be excluded.

A. Dr. Farrokhi’s Opinions Should Be Excluded Because They Were Not Timely Disclosed (Or Were Withdrawn)

An expert’s report must contain “a complete statement of all opinions the witness will express.” Fed. R. Civ. P. 26(a)(2)(B)(i). This requirement aims “to provide opposing parties ‘reasonable opportunity for effective cross-examination and [to] perhaps arrange for expert testimony from other witnesses.’” *Reese*, 527 F.3d at 1265 (citation omitted). A violation warrants exclusion unless the violation is “substantially justified” or “harmless.” Fed. R. Civ. P. 37(c)(1).

1. Untimely Disclosure of Opinions (Rule 26(a)(2)). Dr. Farrokhi’s Opinions Three, Four,

and Five should be excluded because Leapfrog elicited them for the first time on redirect at his October 3 deposition—and then failed to afford the Community Hospitals sufficient time to cross-examine Dr. Farrokhi about them. *See, e.g., Brown*, 190 F. Supp. 3d at 1141–43 (excluding expert opinion that was not disclosed “until the deposition,” “almost one month after” the deadline for expert reports). Leapfrog’s deadline for expert reports was September 4, 2025, Dkt. 36 at 5, and Leapfrog served Dr. Farrokhi’s report on that date, Ex. 1 (Farrokhi Rep.) at 13. But the report contained a *single* opinion: that Leapfrog’s “Grade” improves hospital quality. *Id.* at 6, 12–13. It did not contend that hospitals use the results of Leapfrog’s Survey as a benchmark for their safety performance (Opinion Three); that the Survey is reliable (Opinion Four); or that the Survey is not burdensome (Opinion Five). In fact, Dr. Farrokhi’s report did not mention the Survey *at all*. Ex. 6 (Farrokhi) at 306:15–21 (“I don’t think I use[d] those words, ‘the Leapfrog [H]ospital [S]urvey.’”).

Dr. Farrokhi admitted that Opinions Three, Four, and Five appear nowhere in his report, and that the redirect questioning at his deposition was the first time Leapfrog’s counsel had asked him to opine on Survey benchmarking, reliability, and burden. *See* Ex. 6 (Farrokhi) at 296:22–297:6 (acknowledging that he “did not include” an opinion on “benchmark[ing]” “in [his] report,” and that the redirect examination by Leapfrog’s counsel was “the first time counsel ever asked [him] if you can use the hospital [S]urvey to benchmark a hospital’s performance on hospital safety”); *id.* at 295:3–296:21 (admitting that an “opinion regarding the reliability of the Leapfrog [H]ospital [S]urvey” is “no[t] ... reflect[ed] [in his] report” and that Leapfrog’s redirect was “the first time counsel ever asked [him] ... for [his] view on whether the [S]urvey is reliable”); *id.* at 300:23–301:7 (agreeing that Leapfrog’s redirect was “the first time counsel ever asked ... [his] opinion on” “the burden of completing the Leapfrog [S]urvey”). Dr. Farrokhi’s deposition was on October 3; it is therefore indisputable that Dr. Farrokhi and Leapfrog untimely disclosed these three new opinions a full month after Leapfrog’s September 4 expert-disclosure deadline.

Dr. Farrokhi’s Opinion Two—that Leapfrog’s “[S]urvey” “improve[s] quality at hospitals,” Ex. 6 (Farrokhi) at 96:1–7—was also untimely. As noted, his report contained an opinion solely about Leapfrog’s “Grade” (Opinion One), Ex. 1 (Farrokhi Rep.) at 13, and did not mention the Survey at all, Ex. 6 (Farrokhi) at 306:15–21. That is a material change because Dr. Farrokhi himself repeatedly acknowledged that Leapfrog’s Safety Grades are distinct from its Survey—indeed, he disclaimed any expertise in Leapfrog’s Safety Grades. *E.g., id.* at 32:1–21. That shift warrants exclusion of Opinion Two. *See, e.g., Brown*, 190 F. Supp. 3d at 1142–43 (excluding

expert opinion where the version offered at the deposition reflected a “change” from the version in the report).⁷

2. No Substantial Justification (Rule 37(c)(1)). There is no conceivable justification for this flagrant disregard of Rule 26 and this Court’s deadlines. If anything, Leapfrog took the *least* defensible approach: failing to apprise the Community Hospitals that Dr. Farrokhi would be materially revising the only opinion in his report and then ambushing the Community Hospitals with three completely new opinions after the Community Hospitals had already questioned Dr. Farrokhi for very nearly the full seven hours allotted to them. *See* Fed. R. Civ. P. 30(d)(1) (limiting depositions to “one day of 7 hours”). Because “reasonable people” would not “differ as to the appropriateness” of this ploy, Leapfrog’s violations are not “substantially justified.” *Devaney*, 989 F.2d at 1163 (citation omitted).

3. Severe Prejudice to the Community Hospitals (Rule 37(c)(1)). The inexcusably late disclosure of Opinions Three, Four, and Five is severely prejudicial because it has “deprived” the Community Hospitals “of the ability to prepare for effective cross-examination and rebuttal with respect to” those opinions. *Brown*, 190 F. Supp. 3d at 1143. Leapfrog’s counsel waited until the waning moments of Dr. Farrokhi’s seven-hour deposition to elicit these new opinions and then declared that counsel for the Community Hospitals was “going far beyond time” when questioning Dr. Farrokhi about them. Ex. 6 (Farrokhi) at 307:12–13. These maneuvers necessarily prevented the Community Hospitals from fully cross-examining Dr. Farrokhi about those opinions. To be sure, the Community Hospitals managed to ask Dr. Farrokhi a handful of questions before being cut off, and it is clear even from his answers to those questions that his new opinions are all inadmissible. *See infra* at 20–21, 23–26. But a few minutes of questioning is not a meaningful opportunity to elicit the complete set of reasons why an expert opinion is inadmissible and entitled to no weight.

The Community Hospitals are also prejudiced by the belated disclosure of Opinion Two. The stark “change” between the version offered at Dr. Farrokhi’s deposition and the version written down in his report hindered the Community Hospitals’ ability to “prepare for effective cross-examination.” *Brown*, 190 F. Supp. 3d at 1142. Counsel came to the deposition prepared to

⁷ Dr. Farrokhi expressly withdrew Opinion One about the “Grade,” and therefore it is inadmissible. *See, e.g.*, Ex. 6 (Farrokhi) at 220:18–221:7 (“strick[ing] the word ‘[G]rade’ from” his report); *Hodges*, 2020 WL 12933849, at *4 (expert witness “may not testify regarding [an] opinion ... which has been withdrawn”).

question Dr. Farrokhi about his knowledge of Leapfrog’s “Safety Grade[s],” Ex. 1 (Farrokhi Rep.) at 13, only to be informed by Leapfrog’s counsel and Dr. Farrokhi in the midst of the deposition that he was “not [t]here” to opine on the “[G]rade[s],” Ex. 6 (Farrokhi) at 31:4–32:8. That is a prejudicial bait-and-switch.

If “compliance with the requirements of Rule 26” is to remain “not merely aspirational,” Leapfrog’s utter disregard of those requirements cannot stand. *Reese*, 527 F.3d at 1266 (citation omitted). Dr. Farrokhi should be prohibited from offering any of his opinions.

B. Dr. Farrokhi Is Not Qualified To Offer His Opinions

To be qualified under Rule 702, an expert must have “expertise specific to the topic at issue.” *Wilson*, 2022 WL 4477025, at *5. Dr. Farrokhi is completely unqualified to offer Opinions Three, Four, and Five—which likely explains why he didn’t write those opinions in his report. Nor is Dr. Farrokhi qualified to offer Opinion Two—his anecdotes do not give him the requisite experience to make a sweeping causal claim about the impact of Leapfrog’s Survey on hospital quality.

1. *Opinions Three, Four, and Five.* Dr. Farrokhi’s own admissions demonstrate that he is not qualified to offer his end-of-deposition opinions. He claimed to be qualified as an expert solely because of his “experience” as the “medical director of quality” for his hospital and the “chairman” of his hospital’s “quality council.” *E.g.*, Ex. 6 (Farrokhi) at 288:5–17. But his testimony confirmed that he has no experience—whether in those positions or otherwise—regarding the reliability of Leapfrog’s Survey (Opinion Four), the burden imposed by the Survey (Opinion Five), or benchmarking (Opinion Three).

Dr. Farrokhi cannot possibly be qualified to opine on the reliability of Leapfrog’s Survey (Opinion Four)—a component of Leapfrog’s Safety Grade methodology, *see supra* at 1—because he repeatedly stressed that he is “not a methodology expert,” Ex. 6 (Farrokhi) at 28:22, 32:8, 151:19, much less an expert on Leapfrog’s specific methodology, *id.* at 198:2–16. Nor did he claim to be a general expert on “external surveys” for hospitals. *Id.* at 96:11–16. He has never “been involved in developing a grading methodology for hospitals,” *id.* at 54:7–9, has never published in that area, *id.* at 61:18–20; Ex. 11 (Farrokhi Dep. Ex. 1) at 3–5, and would not “consider [himself] to be an expert in developing those types of rating systems,” Ex. 6 (Farrokhi) at 54:7–55:2. He is, instead, a practicing neurosurgeon. *Id.* at 45:11–46:17, 60:3. Given this total lack of qualifications, Opinion Four should be excluded.

Similarly, Dr. Farrokhi has zero experience relevant to Opinions Five and Three. He has

never “personally been involved in” completing Leapfrog’s Survey, and therefore does not—and cannot—have experience with how burdensome it is (Opinion Five). Ex. 6 (Farrokhi) at 200:20–201:3, 204:6–21. He doesn’t even know if his *own* hospital uses the Survey as a “benchmark,” *id.* at 298:17–299:4, and thus has no experience with hospitals using it as such (Opinion Three). He should not be permitted to testify as an “expert” on subjects he admits he knows nothing about.

2. Opinion Two. Dr. Farrokhi also is not qualified to offer his opinion that Leapfrog’s Survey improves hospital quality, which purports to make a causal claim about the systemic impact of the Survey on *all* hospitals. *See, e.g.*, Ex. 6 (Farrokhi) at 96:4–5 (“I think [Leapfrog’s Survey] is one of the best surveys out there to improve quality at hospitals[.]”). He *himself* was “not willing to say” that he is a general “expert in improving quality systems at hospitals.” *Id.* at 61:2–11. Any familiarity Dr. Farrokhi has regarding the effect of the Survey is at best confined to anecdotal experiences at his Seattle hospital. *See, e.g., id.* at 102:3–107:2. He admitted he does not “know anything specific about the internal functions of an environment in which [he has] not worked,” *id.* at 117:21–119:25, and therefore has no “opinion about the [Community] [H]ospitals,” *id.* at 287:7–8. Dr. Farrokhi is not qualified to make a broad causal claim about the impact of the Survey based on experiences limited to a single hospital. *See, e.g., Doe v. Rollins Coll.*, 77 F.4th 1340, 1348–50 (11th Cir. 2023) (affirming exclusion of expert as “not qualified” because of “mismatch” between expert’s qualifications and testimony (citations omitted)).

C. All Of Dr. Farrokhi’s Opinions Are Unreliable And Unhelpful

Even assuming Dr. Farrokhi is “qualified by experience,” that “does not mean” his experience “standing alone ... is a sufficient foundation rendering reliable *any* conceivable opinion [he] may express.” *Frazier*, 387 F.3d at 1261. He must still “explain *how* that experience leads to the conclusion reached, why that experience is a sufficient basis for the opinion, and how that experience is *reliably applied to the facts*.” *Id.* (second emphasis added; citation omitted). Dr. Farrokhi flunks these requirements for each of his opinions.

1. Opinion Two: Dr. Farrokhi’s Opinion That Leapfrog’s Survey Improves Hospital Quality Is Not Based On Any Reliable Methodology And Is Grounded In Inaccurate Assumptions

Dr. Farrokhi’s Opinion Two is a causal claim—namely, that participation in Leapfrog’s Survey compels improvements in hospital quality. *E.g.*, Ex. 6 (Farrokhi) at 22:19–24:6. For “expert opinions that relate to causation,” “*Daubert* ... require[s] a valid methodology.” *Rapoport v. Classic Cruise Holdings, S. de R.I.*, 2009 WL 10700258, at *2 (S.D. Fla. Sept. 10, 2009).

“[A]necdotal” experiences do “not” amount to a “methodology,” *Rider*, 295 F.3d at 1199, and therefore are “universally regarded as an insufficient scientific basis for a conclusion regarding causation,” *Allison v. McGhan Med. Corp.*, 184 F.3d 1300, 1316 (11th Cir. 1999) (citation omitted).

These principles render Opinion Two inadmissible. Dr. Farrokhi conceded that this opinion is based solely on his “experience as it relates to working in an environment”—his hospital—“that is subject to the Leapfrog [S]urvey,” Ex. 6 (Farrokhi) at 162:10–13, and his testimony consisted almost entirely of anecdotes from working at that hospital, *see, e.g., id.* at 102:3–107:2. He also claimed in conclusory fashion that “it’s common knowledge that quality metrics drive improvement in quality care.” *Id.* at 26:13–15. He did not, however, identify or even try to locate any empirical evidence demonstrating that participation in Leapfrog’s Survey specifically causes an improvement in outcomes, or any peer-reviewed study establishing that unsupported causal link. *Id.* at 25:23–26:22, 76:24–80:21, 97:18–98:14; Ex. 1 (Farrokhi Rep.) at 14. Because Opinion Two is based on anecdotes and supposed common knowledge rather than rigorous analysis, it easily flunks the basic reliability requirements for causation testimony under *Daubert* and will not illuminate any of the evidence or issues before the Court. *See, e.g., Rider*, 295 F.3d at 1199; *cf. Kneppfle*, 48 F.4th at 1296 (affirming exclusion of expert who was “only” concerned with “obtaining evidence that *confirm[ed]* [his] predetermined theory”). And at minimum, Dr. Farrokhi cannot reliably make a sweeping causal claim about the impact of the Survey on hospital quality based merely on experience at one hospital. *See, e.g., Hughes*, 766 F.3d at 1331 (affirming exclusion of expert where “the leap from data to opinion was too great”); *cf. Rider*, 295 F.3d at 1199 (observations concerning a “single patient” did not “provide reliable proof of causation”).

Insofar as Dr. Farrokhi is suggesting that *non*-participation in Leapfrog’s Survey causes *poor* safety performance, *cf.* Ex. 6 (Farrokhi) at 93:24–94:2, that claim is even less reliable or helpful because it has *zero* basis (not even anecdote) and contradicts the facts of this case, *see, e.g., Guinn v. AstraZeneca Pharms. LP*, 602 F.3d 1245, 1255 (11th Cir. 2010) (expert opinion is “unreliable” and therefore inadmissible where it is “not logically supported by the facts of th[e] case”). The “experience” on which Dr. Farrokhi is “relying” for Opinion Two comes entirely “from working at a hospital *that participates in the Leapfrog [S]urvey.*” Ex. 6 (Farrokhi) at 282:25–283:24 (emphasis added). Thus, as he admitted, he has no experience that would allow him to assess “how quality is impacted between a hospital that participates and a hospital that does not participate” in

the Survey. *Id.* at 283:25–284:6. And he did not try to make up for that gap by collecting data or reviewing evidence about the safety records or practices of non-participating hospitals, let alone the Community Hospitals. *Id.* at 89:20–25, 117:21–23, 120:3–121:3, 122:5–8, 194:5–8, 261:20–262:12. Had he done so, he would have found that the Community Hospitals *do* engage in the safety practices measured by Leapfrog and that they perform well on those measures, notwithstanding their decision to opt out of Leapfrog’s coercive Survey. *See, e.g.*, Dkt. 88-95 (McCauley) 166:2–170:11. Opinion Two is far afield from this case and should be excluded.

2. Opinions Three, Four, And Five: Dr. Farrokhi’s Opinions Regarding “Benchmarking” And The Supposed Reliability And Ease Of Leapfrog’s Survey Are Pure Speculation

Because Dr. Farrokhi revealed Opinions Three, Four, and Five for the first time in the final minutes of his deposition, the Community Hospitals had almost no time to explore the bases for those opinions. Even so, it quickly became evident that these opinions are “unsubstantiated by any proffered facts, explanation, or analysis,” rendering them unreliable and unhelpful under Rule 702(a)–(d). *Cook ex rel. Est. of Tessier v. Sheriff of Monroe Cnty.*, 402 F.3d 1092, 1112 (11th Cir. 2005).

1. Opinion Three Is Pure Guesswork. Dr. Farrokhi opined that Leapfrog’s Survey enables hospitals to “benchmark” their safety performance against peers. Ex. 6 (Farrokhi) at 293:9–14. This opinion is inadmissible because it is “speculation ... masquerad[ing] as scientific knowledge.” *McClain*, 401 F.3d at 1245 (citation omitted). Dr. Farrokhi acknowledged he does not know if *any* hospital uses Leapfrog’s Survey for benchmarking—indeed, he does not know if his *own* hospital uses the Survey for this purpose. Ex. 6 (Farrokhi) at 152:7–153:25, 154:15–20, 298:5–299:4. He also could not describe how the asserted benchmarking occurs, what metrics are supposedly compared, or whether Leapfrog provides hospitals with data or Survey responses from other hospitals—an obvious prerequisite to any benchmarking. *Id.* at 152:1–153:25. Based on these admissions alone, Opinion Three is pure conjecture and should be excluded.

2. Opinion Four Rests on False Assumptions and Analytic Leaps. Dr. Farrokhi opined that Leapfrog’s Survey is “reliable” and does not “generat[e] inaccurate and misleading results.” Ex. 6 (Farrokhi) at 289:19–290:3. But—no doubt because he lacks any qualifications to offer that opinion, *e.g.*, *id.* at 28:22—he did not and could not offer his *own* analysis of whether the Survey is a reliable or accurate way of measuring hospital performance, *id.* at 297:25–298:4. Instead, the sole basis for this opinion is his “trust” in the “experts” who supposedly developed and approved

the Survey, *id.* at 130:6–15; *see id.* at 292:18–22 (“we have to trust those expert panels to pull all the data and the expertise together to come up with the questions on the [S]urvey”). That blind deference is unreliable and provides no assistance to the Court for at least two reasons.

First, it rests on the “unsupported assumption” that Leapfrog’s experts *actually approved* the content of the Survey. *Buland*, 992 F.3d at 1151. Leapfrog’s Senior Vice President of Health Care Ratings Missy Danforth, testified that the Survey is “under [her] authority”—she “own[s]” it, and although Leapfrog’s experts “help out with various aspects of the ... Survey,” “at the end of the day” *she* is the one who “review[s] every word ... before it goes out.” Dkt. 88-91 (Danforth) at 192:16–193:17. Yet Dr. Farrokhi never mentioned Ms. Danforth in his report or deposition, let alone articulated any reason why her approval of the Survey would necessarily make it reliable. That glaring omission renders Opinion Four unreliable and the opposite of helpful. *See, e.g., Cook*, 402 F.3d at 1112 (affirming exclusion of expert opinion that was “presented without any supporting factual foundation, analysis, or explanation”).

Second, even if Leapfrog’s experts had some involvement in developing the Survey, Dr. Farrokhi’s reflexive deference is still unreliable and unable to assist the Court because he offers no peer-reviewed or generally accepted criteria that would allow someone to *test* their supposed expertise. In other words, Dr. Farrokhi has given the Court no way to know whether his trust is warranted, so Opinion Four is precisely the sort of “unsupported ‘leap of faith’ ... condemned by *Daubert*.” *Rink*, 400 F.3d at 1292 (citation omitted). If Dr. Farrokhi and Leapfrog believe there are actual methodology experts who endorse the Survey’s reliability, Leapfrog should have proffered one of *those* individuals as an expert. What Leapfrog cannot do is use the final minutes of Dr. Farrokhi’s deposition to position him as an “expert” about the purported expert opinions of others, especially when he could offer no details about who those experts are, why they are experts, or what their role was (if any) with respect to the Survey. *See United States v. Batchelor-Robjohns*, 2005 WL 1761429, at *5 (S.D. Fla. June 3, 2005) (“[A]n expert may not blindly rely on the conclusions of another and still meet the reliability requirements of Rule 702 and *Daubert*.” (citations omitted)). Dr. Farrokhi’s opinion about the purported reliability and accuracy of Leapfrog’s Survey—Opinion Four—should be excluded.

3. Dr. Farrokhi Has No Basis to Support Opinion Five. Dr. Farrokhi opined that “gathering data for the Leapfrog [S]urvey is of no consequence to a hospital that has fully integrated patient safety into its culture.” Ex. 6 (Farrokhi) at 293:20–294:6. This opinion is inadmissible

because Dr. Farrokhi offered *no* “foundation, analysis, or explanation” for it. *Cook*, 402 F.3d at 1112. Before Leapfrog’s counsel elicited this opinion, Dr. Farrokhi stated unequivocally that he “ha[s] no basis to judge” “whether responding to the ... [S]urvey is burdensome or not.” Ex. 6 (Farrokhi) at 204:18–21. Even after Leapfrog solicited Opinion Five, Dr. Farrokhi still was unable to articulate any basis for it. In particular, he has performed no “analysis of the incremental burden to [his] hospital of completing” the Survey, *id.* at 299:19–22, and he has never “asked anyone from [his] hospital whether there is a burden,” *id.* at 300:5–12. Moreover, although he claimed that Opinion Five rests on “experience,” *id.* at 293:20–294:6, he admitted he has none: He has never “personally been involved in providing data to respond to a Leapfrog [S]urvey,” has never “been involved in ... actually filling it out,” and does not know “how many individuals,” *id.* at 200:9–201:3, “how many hours,” or “how much money” it takes to respond, *id.* at 204:11–17. Dr. Farrokhi thus has no reliable basis to conclude that the Survey is not burdensome, and his completely unfounded, “bald assertion” is unhelpful and “cannot carry the *Daubert* burden.” *United States v. Pon*, 963 F.3d 1207, 1221 (11th Cir. 2020).

Opinion Five is also “unreliable” because—like Dr. Farrokhi’s other opinions—it is “not logically supported by the facts of this case.” *Guinn*, 602 F.3d at 1255. The un rebutted evidence is that Leapfrog’s 350+ page Survey is burdensome, Dkt. 87 ¶ 6, which confirms beyond doubt that Dr. Farrokhi has no reliable basis for Opinion Five. It should be excluded.

D. Dr. Farrokhi’s Opinions Two And Three Are Irrelevant And Unhelpful

Dr. Farrokhi’s opinions about the effects of Leapfrog’s Survey on hospital quality (Opinions Two and Three) are also “irrelevant” to the Community Hospitals’ FDUTPA claim and therefore “not ‘helpful’” under Rule 702(a). *A.A. Profiles, Inc. v. City of Fort Lauderdale*, 253 F.3d 576, 581, 585 (11th Cir. 2001). This case does not concern whether participation in Leapfrog’s Survey improves hospital quality (Opinion Two) or whether hospitals use the Survey results as a benchmark for safety performance (Opinion Three). Instead, this case is about whether Leapfrog’s methodology of automatically assigning failing scores to non-participating hospitals on the Four Measures is deceptive or unfair. Dkt. 41 at 2–3, 6. Whatever impact the Survey might have, that does nothing to excuse Leapfrog’s choice to deceive consumers into thinking that the Safety Grades for non-participating hospitals reflect actual performance. The issues are completely separate.

Indeed, Dr. Farrokhi conceded multiple times that he is “not a methodology expert,” *e.g.*,

Ex. 6 (Farrokhi) at 32:8—meaning he necessarily cannot offer any admissible opinion on whether Leapfrog’s Safety Grade methodology is deceptive or unfair. Given that acknowledged lack of expertise, Dr. Farrokhi affirmatively disclaimed that “any of the opinions [he’s] offering in this case [are] relevant to the question of whether Leapfrog is deceptive to consumers.” *Id.* at 273:18–22; *see also id.* at 32:9–13 (“couldn’t delve into the details of” “whether Leapfrog is transparent with patients about how it calculates the ... [G]rade”). Opinions Two and Three thus should be excluded. *Bowe v. Pub. Storage*, 2015 WL 10858370, at *4–5 (S.D. Fla. June 2, 2015) (excluding expert in FDUTPA case who “d[id] not test the relevant inquiry, which is whether an objective reasonable consumer would have been deceived by [the defendant’s] alleged misrepresentations”).

III. Mark Rule: The Damages Accountant In A Case With No Damages Claim

Mr. Rule’s opinions fail under Rule 702. Opinion One, which addresses damages, is irrelevant and unhelpful because the Community Hospitals seek no damages. Opinion Two, a counsel-devised “re-grading” exercise, is likewise inadmissible because it tests a hypothetical irrelevant to Leapfrog’s actual Safety Grade methodology, was performed by a witness unqualified in hospital grading, and applies no reliable or helpful method. Both opinions should be excluded.

A. Opinion One: Mr. Rule’s Damages Opinion Is Irrelevant And Unhelpful

Mr. Rule’s Opinion One observes that the Community Hospitals’ experts did not quantify the damages incurred by the Community Hospitals. Ex. 8 (Rule) at 74:16–24, 224:15–225:10. The Community Hospitals agree, rendering expert testimony on this self-evident point unhelpful under Rule 702(a). Opinion One should be excluded for this reason alone.

Opinion One is also unhelpful because it is irrelevant. The Community Hospitals seek only injunctive and declaratory relief under FDUTPA, which “*does not require a showing of actual damages.*” *Colonial Van Lines, Inc. v. Colonial Moving & Storage, LLC*, 2020 WL 6700449, at *4 n.1 (S.D. Fla. Oct. 20, 2020) (emphasis added); *accord Ahearn v. Mayo Clinic*, 180 So. 3d 165, 172 (Fla. 1st DCA 2015). To obtain that relief, a plaintiff need only show that it was “aggrieved” by the defendant’s FDUTPA violation. *SMS Audio, LLC v. Belson*, 2017 WL 1533941, at *4 n.6 (S.D. Fla. Mar. 9, 2017) (Middlebrooks, J.) (citing *Caribbean Cruise Line, Inc. v. Better Bus. Bureau of Palm Beach Cnty., Inc.*, 169 So. 3d 164, 166–67 (Fla. 4th DCA 2015)). There is no requirement that such aggrievement be quantified. *See, e.g., Bluegreen Vacations Unlimited, Inc. v. Timeshare Termination Team, LLC*, 2023 WL 4105529, at *8 (S.D. Fla. June 21, 2023) (allegation of “loss of contractual payments” sufficed for “aggrieve[ment]” under FDUTPA).

The Community Hospitals withdrew their damages claim with prejudice in mid-August 2025, Dkt. 54 at 2—more than three weeks before Mr. Rule served his September 4 report, Ex. 8 (Rule) at 288:4–10. “Given th[at] narrow[ing]” of the case, a damages opinion is irrelevant and provides no assistance to the Court. *Bowe*, 2015 WL 10858370, at *4–5 (excluding expert opinion that did not address “the relevant inquiry” for a FDUTPA claim).

Mr. Rule admitted that his opinion was based on the incorrect assumption that the Community Hospitals seek monetary damages. He testified he was unaware that the Community Hospitals had withdrawn their request for damages (by then, more than a month prior), Ex. 8 (Rule) at 228:10–229:11, and that he had not reviewed the Community Hospitals’ August 12 notice withdrawing their damages claim (Dkt. 54) or their August 28 amended complaint (Dkt. 74), Ex. 8 (Rule) at 255:5–256:11, 259:4–260:2, 262:18–263:15, 275:5–14, 287:3–21. His Opinion One therefore rests on a “faulty premis[e]” “at odds” with the current state of the pleadings, *Marmol v. Kalonymus Dev. Partners, LLC*, 2023 WL 6534410, at *3 (S.D. Fla. Sept. 5, 2023), and it should be excluded as irrelevant and unhelpful under Rule 702(a), *see, e.g., City of Miami*, 115 F.3d at 873–74 (excluding expert opinion “premised” on an “in correc[t] assum[ption]”).

B. Opinion Two: Mr. Rule’s “Re-Grading” Exercise—For Which He Lacks Any Qualifications—Is Irrelevant, Unhelpful, And Unreliable

Mr. Rule’s Opinion Two concerns Leapfrog’s Safety Grade methodology for hospitals that don’t participate in Leapfrog’s Survey. The methodology “impute[s]” the lowest possible scores on the Four Measures—which together account for nearly 25 percent of a hospital’s Safety Grade. Dkt. 88-97 (Romano) at 251:14–252:1. At counsel’s instruction, Mr. Rule tested “what would happen” to the Community Hospitals’ Safety Grades “if the imputed [scores] were given no weight.” Ex. 8 (Rule) at 162:21–163:5. Using Leapfrog’s Excel “Safety Grade Calculator,” *id.* at 194:2–3, he simply replaced each of the Community Hospitals’ scores for the Four Measures with “N/A,” reasoning that this would give them zero weight. *See id.* at 151:12–20; Ex. 3 (Rule Rep.) at Exs. 6–10.⁸ From that spreadsheet edit, he concluded that imposing the lowest scores on the Four Measures is not a “significant driver” of the Community Hospitals’ “D” and “F” Safety Grades (even though they received those Safety Grades for the first time *after* Leapfrog adopted

⁸ As explained in the declaration accompanying this motion, although Mr. Rule’s report is marked as “Confidential,” Leapfrog’s counsel agreed in writing on November 10, 2025—prior to this filing—to de-designate all of Leapfrog’s expert witness reports.

this deceptive methodology). Ex. 8 (Rule) at 330:2–331:15; Dkt. 86 at 5.

This re-grading exercise is irrelevant and therefore unhelpful under Rule 702(a); Mr. Rule is unqualified to engage in that exercise under Rule 702; and his counsel-chosen method is unreliable and unhelpful under Rule 702(a)–(d).

1. Irrelevant and Unhelpful (Rule 702(a)). “Expert testimony which does not relate to any issue in the case is not relevant and, ergo, non-helpful.” *Prosper v. Martin*, 989 F.3d 1242, 1249 (11th Cir. 2021) (citation omitted). The issue before the Court is whether Leapfrog’s use of the Four Measures—the only measures for which Leapfrog imputes scores—artificially depressed the Community Hospitals’ Safety Grades by assigning failing scores despite having no underlying data. Mr. Rule’s exercise tested a different hypothetical: a world in which those Four Measures were deleted entirely from the model. That scenario bears no resemblance to any real-world grading methodology used by Leapfrog and therefore “the trier of fact would not be assisted by the opinion.” *Frazier*, 387 F.3d at 1266 (emphasis omitted); *see also* *Bowe*, 2015 WL 10858370, at *4–5 (excluding expert whose opinions “d[id] not test the relevant inquiry” for FDUTPA claim). Particularly in a bench trial, the Court does not need speculation about a hypothetical model untethered to the record; the only question is whether Leapfrog’s actual Safety Grade methodology—its use of imputation for the Four Measures—deceptively distorted the Community Hospitals’ Safety Grades.

2. Unqualified (Rule 702). An expert must have “expertise specific to the topic at issue to satisfy Rule 702.” *Wilson*, 2022 WL 4477025, at *5. By this standard, Mr. Rule is not qualified to re-grade hospitals or to opine on the causal impact of Leapfrog’s methodology. His self-described “are[a] of expertise” is “economic damages analysis,” Ex. 8 (Rule) at 122:14–23, and his associated “core competencies” are “economic damages, valuation, solvency, forensic accounting, and alter-ego-type analyses,” *id.* at 58:14–59:2. He admitted he has no experience in “building” or “evaluating” a “hospital grading methodology,” *id.* at 121:19–122:23, or any other types of “health care quality measures,” *id.* at 118:18–119:6; has not published any articles on or studied those subjects, *id.* at 15:1–7, 86:12–15, 119:11–22; and has never testified in a case “that was specifically focused on hospital ratings,” *id.* at 69:19–70:12; *see also* *id.* at 368:12–369:3. He described his understanding of Leapfrog’s methodology as only that of a “layma[n],” *id.* at 126:17–127:2, and he admitted he has no “specialized knowledge” about how it works, *id.* at 154:13–23. Because Opinion Two concerns “an area that he d[oes] not ... specialize in,” Mr. Rule is not qualified to

offer Opinion Two. *Lebron*, 772 F.3d at 1369; *see, e.g., Palma v. Safeco Ins. Co. of Ill.*, 2021 WL 1405507, at *5–6 (M.D. Fla. Apr. 14, 2021) (“expert in forensic economics” was “not qualified” to opine on plaintiff’s “future medical costs and life care plan”); *Johnston v. Borders*, 2018 WL 8244335, at *4–5 (M.D. Fla. May 2, 2018) (“economist” was “not qualified” to offer an opinion regarding “vocational rehabilitation”).

3. Unreliable and Unhelpful (Rule 702(a)–(d)). Mr. Rule’s method—handed to him by Leapfrog’s counsel—is unreliable and unhelpfully misdirects from the issues in this case. “The hearsay statement of counsel, absent independent investigation or verification, is not the type of evidence on which an expert ... [can] reasonably rely to form an opinion.” *Carrizosa v. Chiquita Brands Int’l, Inc.*, 47 F.4th 1278, 1323 (11th Cir. 2022). Mr. Rule offered nothing to suggest that his counsel-selected procedure—removing the Four Measures and substituting “N/A”—has ever been “tested,” “subjected to peer review and publication,” or achieved “general acceptance.” *Daubert*, 509 U.S. at 593–94. Nor did he show that it is “based upon reliable sources and data,” *McClain*, 401 F.3d at 1251—indeed, he identified no “literature” supporting the method, Ex. 8 (Rule) at 353:19–354:15.

Mr. Rule’s approach also tests the wrong question and thus lacks a “valid scientific connection to the pertinent inquiry.” *Daubert*, 509 U.S. at 592. He acknowledged that the proper “but-for” world is one where non-participating hospitals participate in Leapfrog’s Survey and receive actual scores for all measures that factor into the Safety Grade. Ex. 8 (Rule) at 363:5–367:10, 373:3–378:18; *see also* Ex. 7 (Harris) at 258:4–262:1 (also admitting this). Instead of calculating that scenario, he simply removed the Four Measures altogether. That faulty assumption alone warrants exclusion. *See City of Miami*, 115 F.3d at 873–74 (expert opinion “premised” on “in correc[t] assum[ption]” should have been “excluded”).

Even on its own terms, the N/A method rests on “unsupported assumption[s]” that render it “unreliable.” *Buland*, 992 F.3d at 1151. Mr. Rule admitted that each of Leapfrog’s 22 measures do not carry equal weight, and did not dispute that the Four Measures “might relate more closely to some of the remaining [measures] than others,” Ex. 8 (Rule) at 349:19–350:7, yet he “redistributed” the weights “evenly” without analysis, *id.* at 348:19–25 (emphasis added); *see also id.* at 351:4–13. He performed no testing and admitted he just trusted “Leapfrog and their advisors that put [the Excel workbook] together.” *Id.* at 353:13–18. That “blin[d] rel[iance]” on the conclusions of others and a method hand-picked by Leapfrog’s counsel cannot substitute for a scientifically

grounded, independently verified approach. *Batchelor-Robjohns*, 2005 WL 1761429, at *5; *see also, e.g., Sumner v. Biomet, Inc.*, 434 F. App'x 834, 842–43 (11th Cir. 2011) (affirming exclusion of expert opinion “arrived at for the purposes of th[e] litigation” and not “developed ... during research conducted independent of th[e] litigation”); *Berkley Ins. Co.*, 699 F. Supp. 3d at 1354–56 (expert opinion could not “satisfy even a barebones showing of reliability” where it was “generated to advocate for the specific legal arguments of counsel ... without any objectively verifiable basis”). Opinion Two should therefore be excluded.

IV. Dr. Anthony Harris: The Epidemiologist Who Bases His Unreliable And Unhelpful Opinions On Inaccurate Assumptions That Conflict With The Record

Dr. Harris's opinions are inadmissible under Rule 702. They are all unreliable and unhelpful because they pertain to Leapfrog's Safety Grade methodology and Dr. Harris did not understand that methodology. Each opinion is inadmissible for other reasons as well. It is undisputed that Dr. Harris's Opinion One is based on a false premise. Opinion Two does not rest on any methodology. Opinion Three is built on irrelevant and unreliable comparisons. And Opinion Four, like all of Dr. Harris's opinions, is based on incorrect assumptions. Dr. Harris should be excluded.

A. All Of Dr. Harris's Opinions Are Unreliable And Unhelpful Because They Pertain To Leapfrog's Safety Grade Methodology, Which Dr. Harris Fundamentally Misunderstood

Dr. Harris is Leapfrog's putative methodology expert, and all his opinions purport to evaluate the merits of Leapfrog's Safety Grade methodology, yet he deeply misapprehended that methodology when forming his opinions. His “incorrec[t] assum[ptions]” render all his opinions unreliable and unhelpful under Rule 702(a)–(d) as a matter of law. *City of Miami*, 115 F.3d at 873–74.

It is undisputed that Leapfrog automatically assigns “Limited Achievement” scores on the Four Measures for hospitals that don't participate in its Survey, and that those scores (15, 25, 5, and 15, respectively) are the *lowest scores* assigned for those measures. Dkt. 87 ¶ 15; *see* Dkt. 88-28 at 058; Dkt. 88-44 at 527; Dkt. 88-84 (Austin) at 290:10–13. Yet Dr. Harris “th[ought] that” non-participating hospitals “could have gotten a lower score, being a zero.” Ex. 7 (Harris) at 83:14–84:15; *see also id.* at 320:13–18.

That false assumption cuts through each of Dr. Harris's opinions. His opinion that Leapfrog's Safety Grade methodology is “reasonable” (Opinion One) and his opinion that the methodology appropriately accounts for nonresponse bias (Opinion Two) cannot be reliable if he didn't fully understand how the methodology works—much less if he was assuming that the methodology

was *more generous* for non-participating hospitals than it actually is. Similarly, his opinion that the Four Measures don't matter to the Community Hospitals' "D" and "F" Safety Grades (Opinion Three) cannot be reliable if he thought they were receiving a benefit from the imputed scores. And his critique of Dr. Nicholson's analysis of Leapfrog's Safety Grade methodology (Opinion Four) cannot be reliable if he didn't fully understand the methodology that Dr. Nicholson was analyzing. The Court simply cannot have any confidence in—or any use of—Dr. Harris's opinions given his misunderstanding of such a key fact. *See City of Miami*, 115 F.3d at 873 (expert opinion is “admissible only if an expert knows of facts which enable him to express a reasonably accurate conclusion”); *Bodner*, 2023 WL 1860968, at *3 (affirming exclusion of expert who “didn't ‘understand the underlying facts’”). They should all be excluded on this basis alone.

B. Opinion One: Dr. Harris's Opinion That Leapfrog's Safety Grade Methodology Is “Reasonable And Ethical” Because Its Expert Panel Approved It Is Based Only On Leapfrog's Undisputed Falsehoods

In Opinion One, Dr. Harris contends that Leapfrog's methodology of imputing scores on the Four Measures for hospitals that choose not to participate in Leapfrog's Survey is “reasonable and ethical.” Ex. 7 (Harris) at 66:19–67:4, 90:14–91:1, 105:3–106:4. Setting aside that Dr. Harris didn't understand how this imputation Safety Grade methodology works, *see supra* at 30, this ringing endorsement of Leapfrog's arbitrary and manipulative methodology is otherwise based entirely on the assumption that Leapfrog's Expert Panel discussed and approved the Safety Grade methodology—an assumption Dr. Harris *admitted during his deposition was false*. Ex. 7 (Harris) at 106:5–10. That alone requires exclusion of Opinion One. It should also be excluded because it is not based on any reliable or helpful method.

1. Opinion One Rests On False Assumptions

Dr. Harris's opinion about the supposed reasonableness of Leapfrog's Safety Grade methodology is both unreliable and unhelpful under Rule 702(a)–(d) because it is “premised” on demonstrably “incorec[t] assum[ptions].” *City of Miami*, 115 F.3d at 873–74; *see also, e.g., Buland*, 992 F.3d at 1151 (“unsupported assumption” renders expert testimony “unreliable”). Dr. Harris claimed to have developed this opinion based on a review of the transcript of an April 12, 2024 Expert Panel Zoom meeting where the Expert Panel supposedly discussed the Safety Grade methodology that Leapfrog ultimately adopted for Fall 2024. Ex. 2 (Harris Rep.) at 11–13; Ex. 7 (Harris) at 99:11–100:3, 101:20–102:14. But at his deposition, when confronted with the transcript, the slide deck from the meeting, and fact witnesses' account of what occurred at the meeting, he was

unable to identify any discussion of the Fall 2024 Safety Grade methodology. Ex. 7 (Harris) at 135:21–138:14; *see also id.* at 120:1–121:2 (“[I]t’s impossible for me to tell you with any confidence and understanding of what went on at that meeting.”). That’s because the unrebutted evidence—including the sworn admissions of Leapfrog’s own fact witnesses—confirms beyond dispute that the Fall 2024 Safety Grade methodology was *not* proposed, considered, or approved at the April 12 meeting. Dkt. 87 ¶ 28; *see, e.g.*, Dkt. 88-97 (Romano) at 156:17–21 (“Q. Is it fair to say that the approach that Leapfrog ultimately adopted is not the approach that was put forward to you or the expert safety panel on April 12th, 2024? A. Yes. That’s correct.”).

Dr. Harris ultimately conceded at his deposition that, although he initially assumed the Expert Panel “chose” the Safety Grade methodology, this assumption is factually “incorrect.” Ex. 7 (Harris) at 106:5–10. He then admitted that he *does not know* who chose the Safety Grade methodology *or why*, and that the “why” could affect his assessment of it. *Id.* at 106:5–107:3, 116:1–9. Because Dr. Harris’s opinion is based on demonstrably false “assumption[s]” about critical facts that he admitted would “affect” his analysis, it should be excluded. *City of Miami*, 115 F.3d at 873; *see also Bodner*, 2023 WL 1860968, at *3 (exclusion appropriate where expert “admitted” that he “didn’t understand the underlying facts of how” the relevant action “occurred”).

Similarly, Dr. Harris acknowledged that it “would change [his] opinion” about Leapfrog’s Safety Grade methodology if there were evidence that Leapfrog selected it “to penalize” non-participating hospitals. Ex. 7 (Harris) at 145:20–14; *see id.* at 145:16–18. That evidence indisputably exists in spades—for example, Dr. Patrick Romano, one of the members of Leapfrog’s Expert Panel, testified that Leapfrog’s methodology “penal[izes]” non-participants and that its “purpose” “is not accuracy.” Dkt. 88-97 (Romano) at 142:12–22. Yet Dr. Harris eyeballed Dr. Romano’s deposition transcript for just “three to four minutes.” Ex. 7 (Harris) at 214:5–13.

Dr. Harris thus utterly fails at the core project of an expert witness: reliably applying any relevant expertise to the facts of this particular case. Instead, he ignored the record and adopted assumptions that flatly conflict with it. Leapfrog produced more than 1 million documents, Ex. 7 (Harris) at 128:4–7, yet Leapfrog’s counsel cherry-picked just five for Dr. Harris to review, and he spent only 10.5 hours *total* developing his opinions and written report, *id.* at 24:5–8, 53:11–54:19, 57:16–21, 359:8–19. Dr. Harris’s paltry review of the record falls far short of the rigor that *even he* concedes would have been necessary to understand the Expert Panel’s discussions on which he purports to opine. *See, e.g., id.* at 120:1–121:2 (“my opinion could have changed” if “I

was able to go back and see exactly what they [(i.e., the Expert Panel)] had and I had time to literally have been a member there, which would have been like two hours probably”). In short, Dr. Harris’s endorsement of Leapfrog’s methodology is impermissibly based on false assumptions and “speculatio[n]” rather than “the facts of [the] case.” *Cendan v. Trujillo*, 2020 WL 6149800, at *4 (S.D. Fla. Oct. 20, 2020). It should be excluded.

2. Opinion One Is Not Based On Any Reliable Or Helpful Method

Dr. Harris also conceded that his assessment of Leapfrog’s methodology is “[n]ot” based on any “scientific method”—much less a testable, peer-reviewed, or generally accepted one with a known or potential error rate. Ex. 7 (Harris) at 100:4–101:18; *see Bodner*, 2023 WL 1860968, at *3 (excluding expert opinions that “reflected no methodology at all”). Instead, his opinion rests on “two” considerations: (1) the publicly available “credentials” of the members of Leapfrog’s Expert Panel; and (2) the “transcript” of the single meeting where he claimed (incorrectly) that the Expert Panel discussed the Safety Grade methodology Leapfrog adopted in Fall 2024. Ex. 7 (Harris) at 99:6–100:3, 101:20–102:14. This process of looking at online biographies and referencing nonexistent discussions is not a methodology; it is “unreliable *ipse dixit*” and unhelpful. *Knepfle*, 48 F.4th at 1296.

a. Expert Panel Member Credentials. In assessing the credentials of the Expert Panel members, Dr. Harris “just looked at their bios” available online. Ex. 7 (Harris) at 93:6–9, 94:10–18. He formulated no criteria that would allow someone to test his claim that the credentials are “outstanding,” nor whether those credentials qualify someone to serve on this particular Expert Panel. *Id.* at 30:1–8. And he failed to explain why empaneling a group of supposedly “A plus plus plus” members (*id.*) would inherently translate to a reasonable and ethical methodology. *Rider*, 295 F.3d at 1202 (“*Daubert* ... requires more” than “unsupported ‘leaps of faith’ in the causal chain”). And, of course, the Court is “fully capable” of assessing the biographies of the Expert Panel members for itself should the Court wish, *Hixon*, 102 F.4th at 1132 (citation omitted), so purported expert testimony on this point is “simply not helpful,” *Prosper*, 989 F.3d at 1249–50.

b. Expert Panel Meeting Transcript. Dr. Harris also applied no scientific method to assess the Expert Panel’s alleged discussions of Leapfrog’s Safety Grade methodology, Ex. 7 (Harris) at 100:4–101:18—perhaps because, as explained above, the transcript of the only meeting Dr. Harris claimed to have evaluated confirms unambiguously that no such discussions occurred, *see supra* at 31–32. Dr. Harris also admitted not knowing anything about the Expert Panel’s “process”

more broadly, such as how frequently it meets or its voting rules. Ex. 7 (Harris) at 65:9–20. And he offered no basis to conclude that Leapfrog’s Safety Grade methodology could be reliable simply because (as he mistakenly believed) the Expert Panel discussed it at one meeting. His opinion thus “require[s] the kind of scientifically unsupported ‘leap of faith’ which is condemned by *Daubert*.” *Rink*, 400 F.3d at 1292. And the Court does not need an expert (or any) witness to read a transcript of a meeting, much less to report inaccurate facts about it. *See, e.g., In re Trasylol Prods. Liab. Litig.*, 709 F. Supp. 2d 1323, 1346 (S.D. Fla. 2010) (Middlebrooks, J.) (an expert witness is “neither able nor allowed” to provide a “factual narrative” based on “documents” that can “be presented to the [factfinder] directly”). Opinion One is inadmissible.

C. Opinion Two: Even If Nonresponse Bias Is “Real,” Dr. Harris Does Not Reliably Apply Any Such Principle To The Facts Of This Case

Dr. Harris’s Opinion Two is that “nonresponse bias is real and should be accounted for in a methodology evaluating hospital safety grades.” Ex. 7 (Harris) at 73:1–7. He defined nonresponse bias as a phenomenon in which “[t]he people who do not respond are different and not representative of the total population.” Ex. 2 (Harris Rep.) at 13; *see* Ex. 7 (Harris) at 28:15–20 (“[T]here’s a difference between those that report, complete a survey and those that do not.”). He opined that nonresponse bias should factor into the calculation of Leapfrog’s Safety Grades because “hospitals know their data” and “if the data is going to help you, you’d report the data.” Ex. 7 (Harris) at 301:3–13. The basis for Opinion Two is thus driving at a “causal” claim, Ex. 2 (Harris Rep.) at 13: In Dr. Harris’s view, hospitals decline to participate in the Survey supposedly *because* they know they perform poorly on the Four Measures, Ex. 7 (Harris) at 79:17–80:15. Assuming for sake of argument that nonresponse bias is a valid principle in the abstract, Dr. Harris’s opinion that it is relevant *here* is unreliable and unhelpful under Rule 702(a)–(d) for at least two reasons.

First, his opinion—premised on a causal assertion about why hospitals choose not to participate in Leapfrog’s Survey—is not based on any methodology, even though “*Daubert* ... require[s] a valid methodology for any expert opinions that relate to causation.” *Rapoport*, 2009 WL 10700258, at *2. Dr. Harris did not develop *any* methodology to evaluate why hospitals—let alone the Community Hospitals—choose not to participate in Leapfrog’s Survey. Ex. 7 (Harris) at 241:5–9, 262:19–263:20. Indeed, he conceded he did not conduct “any analysis” of whether it was “appropriate” for Leapfrog to “appl[y] ... nonresponse bias principles” in selecting the Fall 2024 Safety Grade methodology. *Id.* at 216:11–19. That concession alone shows that Opinion Two is

pure speculation. *See Frazier*, 387 F.3d at 1266 (trier of fact will “not be *assisted* by” an opinion that lacks a “methodological foundation or reliability”).

Second, Opinion Two is “unreliable” and unhelpful because it is “not logically supported by the facts of this case.” *Guinn*, 602 F.3d at 1255. Again, his opinion is that nonresponse bias is relevant here because non-participating hospitals supposedly know they would perform poorly on the Four Measures if they participated in the Survey. But he conceded that he failed to consider the record evidence showing that the Community Hospitals would have scored *above* the arbitrary failing scores they were assigned on the Four Measures, despite acknowledging that such evidence “would affect” (and entirely belie) his opinion. Ex. 7 (Harris) at 241:11–247:14. An expert opinion cannot be reliable or helpful to the Court when the expert concedes that a “fact” he failed to consider “would affect the relevant ... analysis.” *City of Miami*, 115 F.3d at 874.

D. Opinion Three: Dr. Harris’s Opinion That The Community Hospitals Are Underperformers Is Irrelevant, Unhelpful, And Unreliable

Dr. Harris’s Opinion Three asserts that the Community Hospitals “are underperformers regardless of [their] assigned score[s] for the [F]our [M]easures.” Ex. 7 (Harris) at 73:8–14. He bases this conclusion on two premises: (1) a set of copy-and-paste charts consisting of publicly available information, including the Community Hospitals’ CMS “star ratings”; and (2) the fact that the Four Measures account for “24 percent” of each Hospital’s Safety Grade, which he believes to be “an incredibly small percentage of the overall [G]rade,” such that, “[e]ven if the assignment method for th[e] four measures was not optimal,” “that would not really affect the overall [G]rades.” *Id.* at 160:11–161:2, 314:14–315:3. Neither premise offers a relevant, helpful, or reliable basis for Dr. Harris’s (incorrect) opinion that the Community Hospitals have poor safety records.

1. Dr. Harris’s Testimony About CMS Is Irrelevant, Unhelpful, And Unreliable

Dr. Harris’s opinion that the Community Hospitals are poor performers is irrelevant and unhelpful insofar as it is based on the CMS star ratings. And although Dr. Harris also analyzed how the Community Hospitals perform on certain measures that factor into both the CMS star ratings and Leapfrog’s Safety Grades, his analysis is unreliable and unhelpful.

a. CMS Star Ratings. Testimony regarding the CMS star ratings is irrelevant and thus unhelpful under Rule 702(a). The Community Hospitals are challenging Leapfrog’s methodology for calculating its Safety Grades, and those Safety Grades are “solely focused on patient safety.”

Dkt. 88-94 (Jupiter) at 284:2–4. The CMS star ratings, by contrast, seek to evaluate hospitals’ overall clinical performance and therefore account for several “other factors.” *Id.* at 283:10–11, 283:23–284:4. Leapfrog’s own witnesses have acknowledged that the CMS star ratings are not based on data that is “one-to-one” with what Leapfrog measures. Dkt. 88-91 (Danforth) at 155:22–157:4; *see also, e.g.*, Dkt. 88-88 (Campione) at 127:19–128:2 (“the ... [G]rades and th[e] [CMS] star ratings” are “not apples-to-apples comparison”). Dr. Harris himself conceded that the CMS star ratings are “different” from Leapfrog’s Safety Grades, Ex. 7 (Harris) at 309:1–8, yet he offered no explanation for how the star ratings could meaningfully inform his opinion about the Safety Grades.

Nor do the CMS star ratings bear on either of the two elements the Community Hospitals must establish to obtain injunctive or declaratory relief under FDUTPA: “that (1) the defendant engaged in a deceptive act or practice in trade, and (2) [the] plaintiff is a person ‘aggrieved’ by the deceptive act or practice.” *SMS Audio, LLC*, 2017 WL 1533941, at *4 n.6. The first element concerns *Leapfrog’s* own acts, not CMS’s separate star-rating program. The second element focuses on whether the Community Hospitals have been “aggrieved” by Leapfrog’s conduct. To be “aggrieved,” a party must simply “demonstrate some specific past, present, or future grievance” that is not “merely speculative,” *Ahearn*, 180 So. 3d at 173, such as reputational harm, *Wyndham Vacation Resorts, Inc. v. Timeshares Direct, Inc.*, 123 So. 3d 1149, 1152 (Fla. 5th DCA 2012). The record is replete with evidence that Leapfrog inflicted real reputational and competitive injuries on the Community Hospitals—in particular, the CEOs of all the Community Hospitals have offered unrebutted testimony that their failing Safety Grades cause patients to cancel procedures, drive physicians away, and erode community confidence. Dkt. 87 ¶¶ 56–61. And Leapfrog’s own executives have admitted that failing Safety Grades can damage hospitals’ reputations. *Id.* ¶ 55. Dr. Harris’s opinion on the Community Hospitals’ CMS star ratings has no bearing on these undisputed facts. It is irrelevant and unhelpful.

b. Performance on CMS Measures. To be sure, some of the measures that factor into the CMS star ratings also factor into Leapfrog’s Safety Grades. But Dr. Harris’s analysis of those measures is unreliable and unhelpful under Rule 702(a)–(d). The centerpiece of his analysis—two color-coded charts that purport to compare certain CMS measures for the Community Hospitals with those of five other Florida hospitals—underscores his methodological shortcomings. Ex. 7 (Harris) at 278:18–279:4, 279:20–281:8; *see* Ex. 2 (Harris Rep.) at 18 (Exs. 4 & 6). Dr. Harris

admitted that his sole contribution to this copy-and-paste job was adding green, yellow, or red color-coding. Ex. 7 (Harris) at 278:18–279:4. But at his deposition, he could not be sure of what the different colors represent. *Id.* at 281:3–14 (“I would -- I need to double-check that and clarify that.”). And he acknowledged that his report did not provide any explanation either. *Id.* at 281:15–19. He likewise could not recall how he selected the five comparator Florida hospitals. *Id.* at 295:5–296:5 (“I would need to double-check that.”). Dr. Harris’s inability to “adequately explain” even basic facts about the methodology underlying his charts renders his Opinion Three “unreliable.” *MidAmerica C2L Inc. v. Siemens Energy Inc.*, 2023 WL 2733512, at *9 (11th Cir. Mar. 31, 2023); *see also, e.g., In re Zantac (Ranitidine) Prods. Liab. Litig.*, 644 F. Supp. 3d 1075, 1234–35 (S.D. Fla. 2022) (an “expert’s duty to adequately explain his or her opinion and methodology” goes to the “core” of “*Daubert* reliability”).

Without any reliable methodology, Dr. Harris has no support for his claims regarding the likely performance of the Community Hospitals on the four Leapfrog-specific imputed measures. For example, he claimed that the Community Hospitals’ “hand hygiene data [i]s probably going to be poor” based *solely* on their performance on the CMS measures he reviewed. Ex. 7 (Harris) at 267:9–269:14. But it is undisputed that the hand-hygiene measure is a *Leapfrog-specific* measure—CMS doesn’t measure hand hygiene in any respect. Dkt. 88-91 (Danforth) at 363:17–20. And Dr. Harris admitted he did *not* “perform a causal analysis” that sought to draw a connection between the Community Hospitals’ “CMS scores ... for the infection control measures” and their “decision not to participate in the hand hygiene survey.” Ex. 7 (Harris) at 390:20–391:5; *see id.* at 268:13–269:14. Nor did he collect or analyze any data about the Community Hospitals. *Id.* at 79:10–11, 227:8–15. Had he reviewed the record on this point, he would have found un rebutted evidence that the Community Hospitals *do* engage in the safety practices measured by Leapfrog and perform well on those measures. *See supra* at 23. His opinion that the Community Hospitals have poor safety records is a textbook example of “speculation that masquerades as scientific knowledge.” *McClain*, 295 F.3d at 1245 (citation omitted).

2. Dr. Harris’s Imprecise Claim That The Four Measures Do Not “Really” Affect Safety Grades Is Unreliable And Unhelpful

Dr. Harris’s opinion about the Community Hospitals’ performance is also based on his claim that the Four Measures do “not *really* affect” their overall Safety Grades because those measures account for 24% of a given hospital’s Safety Grade. Ex. 7 (Harris) at 314:14–315:3 (emphasis added); *see id.* at 160:11–161:2. This “rough approximation” of the Four Measures’ impact

is inherently unreliable and unhelpful, *Rink*, 400 F.3d at 1292, and Dr. Harris offered no data or analysis to back it up. And, of course, common sense supports the exact opposite conclusion. For example, as Dr. Harris acknowledged, if “there’s [100] points possible” in a schoolroom setting and there is “a zero on 24” of those points, then “the highest” possible score “is 76,” Ex. 7 (Harris) at 165:20–166:4—a significant limitation.

Worse, the only “analysis” Dr. Harris *did* conduct directly contradicts his claim. As part of his attempted rebuttal of the opinions of Dr. Nicholson, Dr. Harris performed a re-grading calculation in which he arbitrarily assigned each Community Hospital a “[S]ome [A]chievement” score—a higher score than the “Limited Achievement” score actually assigned under Leapfrog’s current Safety Grade methodology—on each of the Four Measures. Ex. 7 (Harris) at 310:20–313:12. Although that method is unreliable in its own right, *see infra* Part IV.E, it resulted in three of the five Community Hospitals receiving a Safety Grade that is a *whole letter higher* than the one they received under Leapfrog’s methodology, Ex. 7 (Harris) at 301:19–313:12. Dr. Harris was thus forced to admit that Leapfrog’s arbitrary “assignment” of scores for the Four Measures “can affect” non-participating hospitals’ Safety Grades “by a letter change.” *Id.* at 319:4–16. His very different initial claim—that imputation does not “really” affect the overall Safety Grade—is thus unreliable and unhelpful.

E. Opinion Four: Dr. Harris’s Attempted Rebuttal Of Dr. Nicholson’s Re-Grading Analysis Is Not Based On Any Reliable Or Helpful Method

Dr. Harris’s Opinion Four is that the analysis performed by one of the Community Hospitals’ experts, Dr. Nicholson, is “flawed.” Ex. 7 (Harris) at 28:21–29:13; *see id.* at 73:15–20. Dr. Nicholson is a tenured professor at Cornell University who has spent decades researching and assessing healthcare quality. In his report, Dr. Nicholson measured what Safety Grades the Community Hospitals would have received had they participated in the Leapfrog Survey. Dr. Harris attempted to rebut this analysis with his own re-grading calculation in which he arbitrarily assigned each of the Community Hospitals a “Some Achievement” score on the Four Measures. *Id.* at 324:7–325:9. But Dr. Harris’s method is not reliable. In particular—and unlike Dr. Nicholson—he offered nothing to suggest that the re-grading method he invented is a generally accepted or peer-reviewed way to evaluate what hospitals’ Safety Grades would have been had they participated in Leapfrog’s Survey.

The undisputed facts also make clear that Dr. Harris’s method *cannot be* a valid—much less reliable or helpful—means of measuring what the Community Hospitals’ Safety Grades would

have been had they participated in the Survey. For non-participating hospitals, Leapfrog imputes scores for the Four Measures and removes three measures from the mix entirely. Dkt. 75 ¶¶ 21–22. By contrast, as Dr. Harris acknowledged, participating hospitals receive scores (based on reported data) not only for the Four Measures *but also* those other three measures. Ex. 7 (Harris) at 258:4–262:1. Yet his re-grading method, unlike Dr. Nicholson’s, failed to assign *any* scores for those other three measures. *Id.* at 255:8–256:12. His method therefore cannot reliably measure what the Community Hospitals’ Safety Grades would have been had they participated in Leapfrog’s Survey. *See City of Miami*, 115 F.3d at 873–74 (expert opinion “premised” on “incorec[t] assum[ptions]” should have been “excluded”). Opinion Four should be excluded.⁹

CONCLUSION

The Court should exclude each of Leapfrog’s proffered expert witnesses from testifying at trial.

⁹ In the section of his report that attempted to rebut Dr. Nicholson’s analysis, Dr. Harris slipped in a claim (Opinion Five) that Leapfrog’s Safety Grade methodology is the “closest to the truth,” Ex. 2 (Harris Rep.) at 22, of what non-participating hospitals’ Safety Grades would have been had they participated in the Survey, Ex. 7 (Harris) at 19:21–20:8, 324:7–11. If Dr. Harris intended for this to be one of his opinions, there is no justification for failing to disclose it in the section of his report listing his opinions, *see* Ex. 2 (Harris Rep.) at 6, and this failure (and continued equivocation at the deposition itself) hindered the Community Hospitals’ ability to cross-examine him, *see id.* at 63:3–11, 66:19–67:4, 73:1–74:3 (confirming that his “four” opinions—Opinions One through Four above—are “all of [his] opinions related to this matter”); *Bandsuch v. Werner Enters., Inc.*, 2009 WL 10669780, at *2 (M.D. Fla. Feb. 24, 2009) (limiting “expert witness’s trial testimony” to the specific “opinions” articulated in his “deposition and expert report” (citing Fed. R. Civ. P. 26(a)(2)(B))), *aff’d*, 368 F. App’x 88 (11th Cir. 2010); *see also supra* at 8–11, 17–20 (discussing Rule 26 expert-disclosure requirements and Rule 37(c)(1) exclusion sanction). In any event, Dr. Harris cited each of the four opinions discussed above as a basis for his “closest to the truth” claim. *See, e.g.*, Ex. 7 (Harris) at 324:4–325:9 (Opinion One); *id.* at 80:4–8 (Opinion Two); *id.* at 78:12–79:16 (Opinion Three); *id.* at 324:4–325:9 (Opinion Four). Accordingly, if any one of those opinions is excluded, Dr. Harris’s claim about the purported accuracy of Leapfrog’s methodology should also be excluded. *Cf., e.g., Rink*, 400 F.3d at 1294 (expert opinions that relied on another expert’s “unreliable” opinion were properly excluded). This claim is also unreliable and unhelpful under Rule 702(a)–(d) because Dr. Harris admitted it is not based on any data, Ex. 7 (Harris) at 77:12–17 (“I don’t have data.”), and when confronted with actual data of how the Community Hospitals perform on the Four Measures, he conceded that Leapfrog’s arbitrary assignment of “Limited Achievement” scores on those measures “may have been an underestimate of the truth,” *id.* at 244:13–247:4; *see Knepfle*, 48 F.4th at 1295–96 (affirming exclusion where expert “implicitly conceded needing to collect” data to support an opinion but failed to do so).

CERTIFICATE OF GOOD FAITH CONFERENCE

Pursuant to Local Rule 7.1(a)(2), I hereby certify that the undersigned has conferred both orally and in writing with Leapfrog's counsel, Kimberly E. Blair, Courtney L. Wood, and Kavi Modi, in a good-faith effort to resolve the issues raised in this motion, but has been unable to resolve those issues.

Dated: November 10, 2025

Respectfully submitted,

By: /s/ Jeffrey Marcus

By: /s/ Mary Beth Maloney

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APPENDIX**BASES FOR EXCLUSION OF LEAPFROG'S
PUTATIVE EXPERT WITNESS TESTIMONY**

<u>Leapfrog's Putative Expert & Purported Field of Expertise</u>	<u>Opinions</u>	<u>Grounds for Exclusion</u>	<u>Governing Law</u>
Michael Vredenburg ("Human Factors" Engineer)	Opinion One: Leapfrog's website design ensures clarity and transparency for reasonable consumers.	Failed to timely disclose the facts or data considered in forming this opinion	Federal Rules of Civil Procedure 26(a)(2)(B)(ii) and 37(c)(1)
		Witness not qualified	Federal Rule of Evidence 702; <i>Daubert v. Merrell Dow Pharmaceuticals, Inc.</i> , 509 U.S. 579 (1993)
		Irrelevant	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Two: Leapfrog's website is accessible to a general audience.	Failed to timely disclose the facts or data considered in forming this opinion	Fed. R. Civ. P. 26(a)(2)(B)(ii) and 37(c)(1)
		Witness not qualified	Fed. R. Evid. 702; <i>Daubert</i>
		Irrelevant	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Three: Hospitals' scores on the Four Measures for which Leapfrog's Safety Grade methodology imputes scores are readily clear on Leapfrog's website to users with basic reading comprehension.	Failed to timely disclose the facts or data considered in forming this opinion	Fed. R. Civ. P. 26(a)(2)(B)(ii) and 37(c)(1)
		Witness not qualified	Fed. R. Evid. 702; <i>Daubert</i>
		Irrelevant	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Four: Leapfrog's user-experience testing validates the clarity of Leapfrog's website.	Failed to timely disclose the facts or data considered in forming this opinion	Fed. R. Civ. P. 26(a)(2)(B)(ii) and 37(c)(1)
		Witness not qualified	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Five: Google Analytics data demonstrates high user engagement with full page content on Leapfrog's website, ensuring visibility of key disclosures.	Failed to timely disclose the facts or data considered in forming this opinion	Fed. R. Civ. P. 26(a)(2)(B)(ii) and 37(c)(1)
		Withdrawn	<i>Hodges v. United States</i> , 2020 WL 12933849, at *4 (S.D. Fla. Nov. 13, 2020) (expert witness "may not testify regarding [an] opinion ... which has been withdrawn")

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<u>Leapfrog's Putative Expert & Purported Field of Expertise</u>	<u>Opinions</u>	<u>Grounds for Exclusion</u>	<u>Governing Law</u>
Dr. Farrokh Farrokhi (Neurosurgeon)	Opinion One: Leapfrog's Safety Grades improve hospital quality.	Failed to timely disclose this opinion and the basis and reasons for it	Fed. R. Civ. P. 26(a)(2)(B)(i) and 37(c)(1)
		Withdrawn	<i>Hodges</i> , 2020 WL 12933849, at *4 (expert witness "may not testify regarding [an] opinion ... which has been withdrawn")
	Opinion Two: Leapfrog's Hospital Survey improves hospital quality.	Failed to timely disclose this opinion and the basis and reasons for it	Fed. R. Civ. P. 26(a)(2)(B)(i) and 37(c)(1)
		Witness not qualified	Fed. R. Evid. 702; <i>Daubert</i>
		Irrelevant	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Three: Hospitals can use Leapfrog's Hospital Survey to benchmark themselves against peer hospitals.	Failed to timely disclose this opinion and the basis and reasons for it	Fed. R. Civ. P. 26(a)(2)(B)(i) and 37(c)(1)
		Witness not qualified	Fed. R. Evid. 702; <i>Daubert</i>
		Irrelevant	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Four: Leapfrog's Hospital Survey is a reliable methodology.	Failed to timely disclose this opinion and the basis and reasons for it	Fed. R. Civ. P. 26(a)(2)(B)(i) and 37(c)(1)
		Witness not qualified	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Five: Leapfrog's Hospital Survey is not burdensome.	Failed to timely disclose this opinion and the basis and reasons for it	Fed. R. Civ. P. 26(a)(2)(B)(i) and 37(c)(1)
		Witness not qualified	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>

APPENDIX**BASES FOR EXCLUSION OF LEAPFROG'S
PUTATIVE EXPERT WITNESS TESTIMONY**

<u>Leapfrog's Putative Expert & Purported Field of Expertise</u>	<u>Opinions</u>	<u>Grounds for Exclusion</u>	<u>Governing Law</u>
Mark Rule (Damages Accountant)	Opinion One: The Community Hospitals' experts did not quantify the damages incurred by the Community Hospitals.	Irrelevant	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Two: Leapfrog's Safety Grade methodology is not a significant driver of the Community Hospitals' resulting "D" and "F" Safety Grades.	Witness not qualified	Fed. R. Evid. 702; <i>Daubert</i>
		Irrelevant	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>

APPENDIX**BASES FOR EXCLUSION OF LEAPFROG'S
PUTATIVE EXPERT WITNESS TESTIMONY**

<u>Leapfrog's Putative Expert & Purported Field of Expertise</u>	<u>Opinions</u>	<u>Grounds For Exclusion</u>	<u>Governing Law</u>
Dr. Anthony Harris (Epidemiologist)	Opinion One: Leapfrog's Safety Grade methodology is reasonable and ethical.	Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Two: Nonresponse bias is real and should be accounted for in a hospital grading methodology.	Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Three: The Community Hospitals are underperformers regardless of the scores they receive on the Four Measures for which Leapfrog's Safety Grade methodology imputes scores.	Irrelevant	Fed. R. Evid. 702; <i>Daubert</i>
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Four: The methodology used by one of the Community Hospitals' experts, Dr. Sean Nicholson, to determine what the Community Hospitals' Safety Grades would have been had they participated in Leapfrog's Hospital Survey, is flawed.	Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>
	Opinion Five: Leapfrog's Safety Grade methodology is the closest to the truth of what non-participating hospitals' Safety Grades would have been had they participated in Leapfrog's Hospital Survey.	Failed to timely disclose this opinion and the basis and reasons for it	Fed. R. Civ. P. 26(a)(2)(B)(i) and 37(c)(1)
		Unhelpful	Fed. R. Evid. 702; <i>Daubert</i>
		Unreliable	Fed. R. Evid. 702; <i>Daubert</i>

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**DECLARATION OF LEE R. CRAIN IN SUPPORT OF
THE COMMUNITY HOSPITALS'
MOTION TO EXCLUDE LEAPFROG'S EXPERT WITNESSES**

I, Lee R. Crain, declare and state as follows:

1. I am a partner at the law firm of Gibson, Dunn & Crutcher LLP. I am an attorney and admitted to practice law in the State of New York. I have been granted permission by the Court to participate *pro hac vice* in this case. Dkt. 14. I represent the Community Hospitals in this matter and submit this declaration in support of the Community Hospitals' Motion to Exclude Leapfrog's Expert Witnesses (the "Motion") filed contemporaneously herewith.

2. I am over the age of eighteen and make this declaration from personal knowledge based on the information and documents referenced in this declaration.

3. Below I address the various exhibits identified in the Motion. The exhibits are organized as follows: expert reports submitted in this action by Defendant The Leapfrog Group, as set forth at, **I. Expert Reports** (Exs. 1-5); transcripts of depositions taken in this case, as set forth at, **II. Deposition Transcripts** (Exs. 6-9); and documents used as deposition exhibits in this case, as set forth at, **III. Deposition Exhibits** (Exs. 10-12).

I. Expert Reports

4. Attached as **Exhibit 1** is a true and correct copy of the report of Dr. Farrokh Farrokhi, one of Leapfrog's putative expert witnesses, dated September 4, 2025.

5. Attached as **Exhibit 2** is a true and correct copy of the report of Dr. Anthony Harris, one of Leapfrog's putative expert witnesses, dated September 4, 2025.

6. Attached as **Exhibit 3** is a true and correct copy of the report of Mark Rule, one of Leapfrog's putative expert witnesses, dated September 4, 2025. Although Exhibit 3 is marked "CONFIDENTIAL," on November 10, 2025, prior to the filing of the Motion, Leapfrog's counsel agreed to de-designate all of its expert witness reports.

7. Attached as **Exhibit 4** is a true and correct copy of the report of Michael Vredenburg, one of Leapfrog's putative expert witnesses, dated September 4, 2025.

8. Attached as **Exhibit 5** is a true and correct copy of the amendment to the report of Michael Vredenburg, dated September 19, 2025.

II. Deposition Transcripts

9. Attached as **Exhibit 6** is a true and correct copy of the transcript of the deposition of Dr. Farrokh Farrokhi, one of Leapfrog's putative expert witnesses, taken in the above-captioned action on October 3, 2025.

10. Attached as **Exhibit 7** is a true and correct copy of the transcript of the deposition of Dr. Anthony Harris, one of Leapfrog's putative expert witnesses, taken in the above-captioned action on September 29, 2025.

11. Attached as **Exhibit 8** is a true and correct copy of the transcript of the deposition of Mark Rule, one of Leapfrog's putative expert witnesses, taken in the above-captioned action on September 29, 2025.

12. Attached as **Exhibit 9** is a true and correct copy of the transcript of the deposition of Michael Vredenburg, one of Leapfrog's putative expert witnesses, taken in the above-captioned action on September 30, 2025.

III. Deposition Exhibits

13. Attached as **Exhibit 10** is a true and correct copy of an opinion in *Bermudez v. Crunch, LLC*, No. 19-STCV-35283 (Cal. Sup. Ct. July 28, 2021), which was marked as Exhibit 10 in the deposition of Michael Vredenburg, one of Leapfrog's putative expert witnesses.

14. Attached as **Exhibit 11** is a true and correct copy of the curriculum vitae of Dr. Farrokh Farrokhi, one of Leapfrog's putative expert witnesses, dated January 21, 2024, which was marked as Exhibit 1 in the deposition of Dr. Farrokh Farrokhi.

15. Attached as **Exhibit 12** is a true and correct copy of Wright State University's "User Experience (UX) and Design Thinking Graduate Certificate (UEDT-CERTD)" webpage, which was downloaded from https://catalog.wright.edu/preview_program.php?poid=23019&catid=25, and which was marked as Exhibit 6 in the deposition of Michael Vredenburgh, one of Leapfrog's putative expert witnesses.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on November 10, 2025, in New York, New York.



Lee R. Crain

EXHIBIT 1

**IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

GOOD SAMARITAN MEDICAL CENTER,
INC., DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. D/B/A PALM BEACH
GARDENS MEDICAL CENTER, ST.
MARY'S MEDICAL CENTER, INC., AND
WEST BOCA MEDICAL CENTER, INC.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

CASE NO. 9:25-cv-80526

**Expert Report of Dr. Farrokh Farrokhi
September 4, 2025**

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I, Dr. Farrokh Farrokhi, hereby declare under penalty of perjury that the following is true and correct:

I. Introduction & Scope

I have been retained by Wilson Elser Moskowitz Edelman & Dicker LLP, counsel for The Leapfrog Group (TLG), in the matter of Plaintiffs: Good Samaritan Medical Center, Inc. (“Good Samaritan”), Delray Medical Center, Inc. (“Delray Medical Center”), Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center (“Palm Beach Gardens Medical Center”), St. Mary’s Medical Center, Inc. (“St. Mary’s”), and West Boca Medical Center, Inc. (“West Boca Medical Center”) (collectively, “Plaintiffs” or “the Plaintiff Hospitals”), by and through their attorneys for their Complaint against The Leapfrog Group (“TLG”).

I have been asked to provide my opinions and experience as a practicing physician and leader in hospital quality systems. In particular, I have been asked to comment on how participation in externally reported quality metrics impacts the daily work and ultimate quality of care for patients at hospitals with a cultural emphasis on transparent quality improvement.

I submit the following report as an opinion based solely on my personal and professional knowledge, research and experience. This does not represent the opinions of my current or former employers, co-workers or partners.

II. Relevant Professional Background

My educational and career focus has been continuously directed at using science and culture for improving systems that care for patients. After completing my undergraduate studies in Biophysics at Johns Hopkins University and medical training at Baylor College of Medicine in

Houston, I finalized my clinical education through neurosurgical residency training at the University of Texas and University of Washington. For the subsequent two decades, I have continued to learn and apply that clinical background toward quality improvement in health care systems.

Deliberately choosing to practice neurosurgery in a quality-focused and patient-centered environment, I have grown to understand the details of quality and care delivery. During this time, I have held multiple leadership roles, including Chief of Neurosurgery, Chair of Functional Neurosurgery, member of the Medical Executive Committee, and for the last decade, Chair of the Quality Council and Medical Director of Quality. Over my tenure as chief, the neurosurgery program more than doubled the number of faculty and volume of patients served, advocating primarily for safer surgical interventions. During these years, I also helped our system establish a nationally certified Center of Excellence for Spine care, accreditation as a Comprehensive Stroke Center, and founded a robust and ever-growing research institute focused on quality improvement, patient safety, risk reduction, and appropriate care delivery.

In the last two decades, my research has focused on improvement of neurosurgery and healthcare at the policy, systems and patient levels. I have led teams in the application of artificial intelligence to risk reduction, system efficiency through lean methodology, and complication avoidance through standard work in neurosurgery. Merging research and clinical interests, I was able to align the broader neurosurgical community on quality and innovation as President of the Washington Association of Neurological Surgeons and subsequently on the board of directors. Through these collaborations and subsequent publications focused on patient safety, I have seen measurable improvement in patient care at local, regional, and national levels.

I have also contributed to healthcare policy through authorship of the Bree Accountable Care Policy for lumbar fusion surgery and Washington State Labor and Industries Guidelines for Cervical Spine Surgery. These efforts, linked with frontline operational research and publication in health care improvement, serve as long-lasting impacts to improve the neurosurgical field and ensure patients receive the highest caliber care. In recent years, I have combined clinical neurosurgery, quality improvement, and healthcare policy to contribute to global health efforts, advancing neurosurgery education in Nepal and other low- and middle-income countries.

The daily work at Medical Director or Quality and Chair or the Quality Council is particularly applicable to this case. Our hospital quality team directly manages Key Performance Indicators (KPIs) applicable to TLG reporting as well as multiple other external and internal regulatory quality organizations. Nearly 300 KPIs are continuously monitored as automated and manually compiled data streams. A monitoring committee meets on a weekly basis to review KPIs not at target, signaling the accountable expert teams, triggering improvement work. Each or 28 standing committees and multiple ad hoc teams present to the monthly meeting of our Hospital Quality Council on a bi-annual basis. The expert team's work is to refine KPI targets, maintain them at goal, and share with the larger quality group their methodology and results in a transparent way. I have been overseeing the details of this work for over a decade.

A full list of my research, leadership, professional and community experience is provided in my attached CV.

III. Summary of Review

From my perspective as a physician-customer of a quality focused healthcare system, nothing in the delivery of healthcare today happens in isolation. This is significantly amplified in

complex care settings such as neurosurgery. Recognizing that the outcome of my patient's surgery is not solely dependent on my personal knowledge and skill, I have come to understand the critical contribution of other doctors, nurses, pharmacists, surgical technicians, sterile processing staff, infection preventionists, quality managers, administrative leaders and even patient families. To bring together so many people with such critical input on the outcome of every surgery I perform, takes culture and structure.

The decision by our healthcare system to participate in multiple transparent external reporting systems on quality (such as TLG, CMS, and Healthgrades), and to share the results with all members of our team and our community, has been critical to developing the safest space for practicing medicine. When everyone is aware of the unifying goal of safe and effective care for every patient, and there is input from all team members on how that may be achieved, we then create a learning healthcare system that will continue to improve despite constant change.

As a physician who cares about the wellbeing of my patients, I want to work in a system that places significant cultural, financial and strategic emphasis on measuring and improving the product they deliver. I want the help of everyone in my system and the community in this work. Safe care for patients only happens if we participate in every **opportunity** to thoughtfully measure and improve our work.

Taking the perspective of a quality leader tasked with implementing positive change requires focused efforts. We all want the best medical care for ourselves and our loved ones. Those of us who attend the monthly hospital quality meetings have the same desire, and are constantly reminded of how we can do better. The members of the quality team are keenly focused on building a system that can deliver this level of care for every patient, every time. To do this, we

need to process an overwhelming amount of information and decide how best to direct resources toward improving certain key performance indicators. This is only the first step.

Much of the work of a hospital quality system is to question the why and how of how we measure success. Does washing your hands 10% more often reduce 10% of infections? Should we expect to hold this standard at 100%? These simple questions have complex answers that can only be addressed by local experts working with the national data and applying those learning to their particular environments. This only happens in a healthcare system when that work is a priority and we partner with large national organizations like the TLG, that measure and share learnings about quality and safety.

The reporting of an A or F grade is only the beginning of the quality improvement work. To get the grade, you have to participate in the process, study the subject matter, question the targets and contribute to the best next step. From a health system perspective, this requires leadership to invest human and financial resources in the effort as a primary priority. Leadership must make it clear that every action, by every member of the healthcare team, should be filtered through the lens of what is best for the patient.

Although I do not agree with the details of every metric used to measure our performance by governmental, for profit, and non-profit organizations that work in this space, I am grateful that my leadership and my team engage in the work of measuring and improving care every day.

IV. Materials Reviewed

A. Provided by Counsel

1. Complaint Case No. 9:25-cv-80526
2. Amended Complaint Case No. 9:25-cv-80526
3. Expert Report of Thomas Chakurda with Exhibits
4. Chakurda Exhibit B Materials
5. Leapfrog Materials Cited by Chakurda

6. Leapfrog Hospital Survey
7. Leapfrog Ambulatory Surgery Center Survey

B. Publicly available resources

1. <https://www.leapfroggroup.org/>
2. <https://www.hospitalsafetygrade.org/>
3. <https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-group-qsog>
4. <https://www.medicare.gov/care-compare/?providerType=Hospital>
5. <https://www.healthgrades.com/>
6. <https://health.usnews.com/best-hospitals>
7. <https://www.who.int/docs/default-source/patient-safety/9789241598590-eng-checklist.pdf>
8. <https://pmc.ncbi.nlm.nih.gov/articles/PMC3489074/>
9. <https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapifiveelements.pdf>
10. <https://psnet.ahrq.gov/primer/reporting-patient-safety-events>

V. Physician Consumer Perspective on Quality Culture

Engaging in the complex work of caring for critically ill patients is a team effort. The outcomes of treatments are no longer the work of a single physician or a single nurse. This is particularly true in the field of neurosurgery where the margin for error is slim and the risks of catastrophic consequence is high for every patient. Knowing these truths, choosing a system that holds safety and quality care as a public and constant priority, is basic and necessary.

The contribution of multiple doctors, nurses, pharmacists, surgical technicians, sterile processing staff, infection preventionists, quality managers, administrative leaders and even patient families, to the care of every patient in every episode of care is critical. To bring together so many people of varied training and experience, with such critical input on the outcome of every treatment in a hospital, takes dedication to a culture of safety and robust quality structure.

Many healthcare systems participate in multiple transparent external reporting systems on quality. These include government-based organizations such the Centers for Medicare and

Medicaid Services (CMS) (“Quality, Safety & Oversight Group (QSOG)”). Others are non-profit organizations such as TLG (“TLG Website”). While many others are for profit companies in the public information space for healthcare, such as Healthgrades (“Healthgrades Website”) and U.S. News and World Report (“Best Hospitals | U.S. News Hospital Rankings and Ratings”). Systems that treat medicare and medicaid insured patients are obligated to participate in CMS safety and quality reporting and standards. This is a financial necessity for payment for services. The degree of participation in for profit and non-profit quality reporting systems is a choice for and by leaders of healthcare systems. And as no system can participate in all quality of these initiatives, how they choose to define participation is critical.

As a physician, I am a customer of the environment of care created by my hospital and health care system. I know that I cannot achieve the safe goals of care for my patients without the help of a large team in a system focused on quality care. I rely on the culture and structure of the system to keep me and all members of the team performing at their best for every patient. Examples of how this culture is created can be found in patient safety reporting systems (“Reporting Patient Safety Events | PSNet”). These are simple, transparent and rapid response systems available to every doctor, nurse and employee who notices a defect in care. The individuals then report this event for evaluation, correction and collation across multiple units. If a new IV pump is malfunctioning on three different units, this reporting system allows for rapid correction of the defect. If nurses have the wrong order sets for immediate post-surgery x-rays in the orthopedic and neurosurgical wards, then a standard correction can rapidly improve care in all spaces.

Cultural expectations set as a standard by leaders are the path to this rapidly improving environment. When leaders choose to participate in a transparent reporting system, contribute to

improving defects noted, and do not resist bad reports as a negative reflection of individuals or the system, the work of improvement takes pole position. It has been shown that early and public disclosure of medical errors has reduced liability for physicians and health systems. Applying this ethos to quality reporting is no different. If we know when we are not at our best, we can take steps at improving our work.

Over the last 20 years, I have seen much resistance by individuals to this cultural shift from individual performance to team success. “Expert” surgeons for many years resisted the simple incorporation of the Surgical Safety Checklist (“Surgical Safety Checklist”). This is a simple task of getting the attention of all members of a surgical team, introducing yourself and your role, and then reviewing a short list of safety items such as the correct patient name and correct surgical side. This two minute pause by the entire team before every surgery has proven to reduce wrong side surgery surgical error. It has improved communication and efficiency in the operating theater. Since the 2009 World Health Organization recommendation of the incorporation of the Surgical Safety Checklist, some estimate greater than a 50% reduction in loss of life and complications in surgery. The items on the checklist have also been substantially modified since 2009 and now are adapted to each individual surgical setting (“WHO SSC Risk Reduction”).

TLG and other reporting agencies serve to deliver this type of check list for hospitals at scale. The specifics of what and how will undoubtedly evolve over the years, but the culture of transparent reporting of performance and systematic focus on improvement is foundational and cannot be abandoned or ignored.

VI. Operational Quality Leadership Experience and Impact

Many hospitals have dedicated resources and personnel for quality and safety. CMS has certain requirements for this work and describes QAPI as “the coordinated application of two

mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality...while involving caregivers in practical and creative problem solving.” There is much nuance in the interpretation and implementation of this mandate.

For members of the quality leadership team at a hospital, this is their focus. For all employees at a quality-oriented healthcare system, this is integral to the daily work of caring for patients. The better our doctors and nurses understand the how and why of quality, the more they can contribute to the results.

As Chair of the Quality Council of our system, I am charged with gathering a committee of people from all corners of our hospital to evaluate how we accomplish these tasks. We have to review the performance and improvement work of our colleagues on over 280 different Key Performance Indicators on a continuous basis. This requires members to be educated on how quality measurement works, how improvement science can be applied, and how to interpret the results of this work. No easy task!

As an example, let's review the simple task and ask of hand washing by healthcare workers. Since the 1847 teachings of a Hungarian physician, Ignaz Semmelweis, we have known that clean hands reduce risk of disease transmission. Today, alcohol-based gels can achieve results similar to hand washing. To measure how many members of a healthcare team wash their hands at every opportunity is a herculean task. TLG recommends “Collecting hand hygiene compliance data on at least 200 hand hygiene opportunities (or a minimum threshold number of hand hygiene opportunities based on unit throughput), each month, in each patient care unit).” Although surrogates, such as volume of gel used per employee and patient, are options in measuring this

target, ultimate success is based on global attention to the subject of hand washing from all possible approaches.

None of these are perfect measures. None of these measurements have any impact if the education and culture change or impact behavior are not in place. As such, this single metric must be part of a system of ever improving measurement techniques and quality improvement strategies. We must participate and give feedback to the evaluating organizations so that they too can improve their process.

As a leader in the quality department, I have had the pleasure of working with members of a team that are keenly focused on building a system that can deliver this level of care for every patient, every time. To do this, we need to process an overwhelming amount of information and decide how best to direct resources toward improving certain key performance indicators. This is only the first step. To get the grade, you have to participate in the process, study the subject matter, question the targets and contribute to the best next step. From a health system perspective, leadership must make it clear that every action of the healthcare team should be filtered through the lens of what is best for the patient with the available knowledge and resources at hand.

VII. Why Participation Matters

The world of healthcare delivery is changing rapidly, much like the rest of our world. New techniques and technologies are infiltrating the pace. This is often a great addition, such as minimally invasive surgical robots and AI medical assistants. But each of these additions introduces another point of possible error.

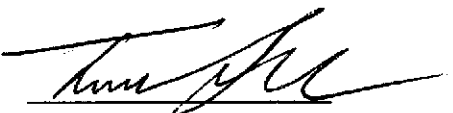
Industries focused on measuring and improving the outcomes of healthcare delivery are required, now more than ever, to keep patients safe. TLG and others must continue their work of

bringing the healthcare industry together around a focus on how we are truly performing, how we best can help our sick patients, and how we can avoid causing inadvertent harm in the process.

The Leapfrog Group Grade offers an easily visible and transparent representation of the complex quality and safety evaluation system that exists in US healthcare today. It is a necessary and critical part of an array of public and private reporting systems that are needed for continuous improvement of the care we deliver to our patients. Patients, providers, payors and need visibility into the healthcare system.

When an airline crashes and lives are lost, it is instantly visible news around the world. The entire airline industry then quickly rallies to improve. When a patient dies of a preventable medical error or lack of best practice, that loss is generally silent. We have an ethical and professional obligation to our patients to make this visible so our industry can rally to improve.

Executed September 4th, 2025



Dr. Farrokh Farrokhi

VIII. Works Cited

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EXHIBIT 2

**UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

GOOD SAMARITAN MEDICAL CENTER,	)	
INC., et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	No. 9:25-CV-80526-DMM
THE LEAPFROG GROUP,	)	
	)	
Defendant.	)	

EXPERT REPORT OF DR. ANTHONY HARRIS

September 4, 2025

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I, Dr. Anthony Harris, hereby declare under penalty of perjury that the following is true and correct:

I. RELEVANT PROFESSIONAL BACKGROUND

I have experience in process measures, outcome measures and hospital rankings in different capacities over my career. As a hospital epidemiologist and associate hospital epidemiologist for over twenty-five years, I had to deal with front-line data collection to assess our hospital's performance for different CDC, Leapfrog and Vizient metrics. I also had to critically assess these metrics and the meaning of these metrics. I had to spearhead and launch quality improvement in our hospital for both measured metrics and non-measured metrics. I had to allocate hospital epidemiology resources for interventions to improve process measures and outcome measures that would most importantly improve patient outcomes. I also had to assess how these measures would affect the workload of healthcare workers and assess potential benefits and costs of these interventions for the hospital.

In addition, as a researcher I have published for over 20 years on some of these topics. Most of my work has been on risk adjustment for healthcare-associated infections. I have publications that have evaluated the impact of comorbidity risk adjustment and its effect on hospital rankings. I have over 15 publications in this area.¹

In addition, in 2015, I served as President of The Society for Healthcare Epidemiology of America. In this role, I represented over 1,500 members. One area that members were concerned about was hospital pay for performance metrics. I responded to the members' concerns and

¹ PMID: 31918439; PMID: 29397800; PMID: 28481976; PMID: 31432440; PMID: 28625170; PMID: 28669363; PMID: 27418295; PMID: 33327970; PMID: 32756970; PMID: 33337474; PMID: 17098569; PMID: 18643745; PMID: 15718484

questions about pay for performance metrics. I also worked with the Director of Policy and Practice to respond to public comments for measure metrics similar to what Leapfrog did in 2024.

To summarize, I have extensive experience relative to hospital outcome metrics, publications in this area and national leadership experience. A full list of my experience and qualifications is provided in my CV which is attached as Exhibit A to this expert report.

II. SCOPE OF OPINIONS

I have been retained by Wilson Elser, LLP counsel for The Leapfrog Group in connection with the lawsuit captioned *Good Samaritan Medical Center, Inc. v. The Leapfrog Group*, Case No. 9:25-CV-80526-DMM filed in the US District Court for the Southern District of Florida, West Palm Beach Division (the “Litigation”). I understand from a review of the Complaint filed in the Litigation on April 30, 2025² and the subsequent Amended Complaint³ filed on August 28, 2025.

In the litigation, five South Florida hospitals, Good Samaritan Medical Center, Inc. (“Good Samaritan”), Delray Medical Center, Inc. (“Delray Medical Center”), Palm Beach Gardens Community, Inc. (“Palm Beach Gardens Medical Center”), St. Mary’s Medical Center, Inc. (“St. Mary’s”) and West Boca Medical Center, Inc. (“West Boca Medical Center”) (collectively “Plaintiff Hospitals”) all operating under Palm Beach Health Network, and all owned by Tenet Healthcare Corporation are the plaintiffs. The Plaintiff Hospitals assert, *inter alia*, that four years ago they made a voluntary decision to stop participating in the voluntary, free-of-charge survey Leapfrog makes available to all hospitals. During that time, the five Plaintiff Hospitals benefited

² Complaint and Demand for Jury Trial (“Complaint”), *Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary’s Medical Center, Inc., and West Boca Medical Center, Inc. v. The Leapfrog Group*, Case No. 9:25-cv-80526 (April 30, 2025).

³ Amended Complaint (“Amended Complaint”), *Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary’s Medical Center, Inc., and West Boca Medical Center, Inc. v. The Leapfrog Group*, Case No. 9:25-cv-80526 (August 28, 2025).

from the fact that for 4 of the 32 safety measures that make up the Leapfrog Hospital Safety Grade the Plaintiff Hospitals were given grades equal to the mean of similarly situated participating hospitals performed on those four metrics. The five Plaintiff Hospitals note that while benefiting from the mean established by participating hospitals the five Plaintiff Hospitals never earned an “F” under that system. The Leapfrog methodology for those 4 measures changed for the Fall 2024 Hospital Safety Grades. For the November 2024 Hospital Safety Grades, hospitals not participating in the Leapfrog Hospital Survey were assigned a score equivalent to “Low Achievement” for each of those 4 metrics. Under these new metrics, the five Plaintiff Hospitals earned D and F grades under the new Leapfrog Hospital Grading methodology for Fall 2024. The five Plaintiff Hospitals allege that The Leapfrog Hospital grading methodology is unfair and Leapfrog’s website display of the Hospital Safety Grades is deceptive to consumers of the information. The five Plaintiff Hospitals claim injury to revenue, reputation and goodwill as a result of the allegedly unfair grading methodology and deceptive display of those grades.

I have been asked to provide my opinions as a rebuttal expert to opine on certain opinions raised in Dr. Sean Nicholson’s report in this litigation, including but not limited to: (1) Assigning data based on nonresponse bias in a methodology is reasonable; (2) the ever evolving nature of these types of methodologies due to the nature of the healthcare industry standards, publicly available data, and evolving technology; (3) the reasonableness and ethical nature of Leapfrog’s methodology with respect to assigning a score for non-participating hospitals for the 4 metrics; (4) the public good of Leapfrog’s transparent methodology heavily outweighs any potential externalities in connection with the ever-evolving healthcare industry standards, data, and

technology; and (5) the flaws in the methodology(ies) relied on by Dr. Nicholson and his recalculation of grades as inaccurate.⁴

III. SUMMARY OF OPINIONS

- a. While no methodology is perfect, Leapfrog takes great pains to consult with the leading experts in the country to create a methodology that is reasonable and ethical in light of the ever-changing landscape of the healthcare industry standards and available data.
- b. Nonresponse-Bias is Real and Should Be Accounted For in a Methodology Evaluating Hospital Safety Grades
- c. These 5 Hospitals are Underperformers Regardless of the Assigned Score for the 4 Measures at Issue
- d. Dr. Nicholson's Methodology Wrongly Recalculates the 5 Hospitals Grades by Inserting Mean Scores for 7 of the Survey Measures When Only 4 of Those Measures are Assigned Low Achievement Scores

IV. MATERIALS RELIED UPON

See materials listed in Exhibit B.

V. INDEPENDENCE OF OPINIONS AND COMPENSATION

I am being compensated at a billing rate of \$600 per hour, \$800 per hour for deposition testimony and \$1000 per hour for trial testimony. The opinions expressed in this report are my own opinions. None of my compensation in this matter is contingent on my opinions or the outcome of this matter.

VI. HISTORICAL BACKGROUND OF LEAPFROG'S HOSPITAL SAFETY GRADES AND THE EXPERT PANEL

According to its website, The Leapfrog Group was founded in 2000. It is an independent national nonprofit organization who lauds its mission as "To trigger giant leaps forward in the

⁴ Expert Report of Dr. Sean Nicholson ("Nicholson Report") (Aug. 7, 2025), at 34-43.

safety, quality and affordability of U.S. health care by using transparency to support informed health care decisions and promote high-value care.”⁵ Among its initiatives, the Leapfrog Hospital Safety Grade was launched in 2012 and assigns letter grades to hospitals based on their record of patient safety, helping consumers protect themselves and their families from errors, injuries, accidents and infections.⁶

In putting together its methodology for its Hospital Safety Grades, Leapfrog states that it utilizes the guidance of “the nation’s leading quality and patient safety experts.”⁷ Currently on the Leapfrog expert panel for the Safety Grade are the veritable “Who’s Who” of experts in the field of patient safety and quality. These experts include:

David Bates, M.D., Harvard University
Kathy McDonald, PhD, Johns Hopkins University School of Nursing
Matthew D McHugh, Ph.D., J.D., M.P.H., R.N., C.R.N.P., F.A.A.N., University of Pennsylvania School of Nursing
Arnold Milstein, M.D., M.P.H., Stanford University
Doris Peter, PhD, Consultant
Peter Pronovost, M.D., Ph.D., F.C.C.M., University Hospitals
Patrick Romano, M.D., M.P.H., University of California, Davis
Sara Singer, Ph.D., Stanford University
Arjun Srinivasan, M.D., CAPT U.S. Public Health Service, Centers for Disease Control and Prevention
Tim Vogus, Ph.D., Vanderbilt University

The talent and expertise of the individuals compiling Leapfrog’s Safety Grade Expert Panel cannot and should not be questioned when it comes to the area of patient safety and quality.

According to its website, the mission of the Safety Grade Expert Panel is governed by the *Expert Panel’s Guiding Principles on the Development of the Composite Leapfrog Hospital Safety*

⁵ Mission and Vision, Leapfrog, available at <https://www.leapfroggroup.org/about/mission-and-vision>.

⁶ Leapfrog’s Spring 2025 Safety Grades Are in, available at <https://www.leapfroggroup.org/news-events/leapfrog%E2%80%99s-spring-2025-safety-grades-are-%E2%80%94new-trend-data-shows-one-eight-hospitals#:~:text=About%20The%20Leapfrog%20Group&text=Among%20its%20initiatives%2C%20the%20Leapfrog,%2C%20injuries%2C%20accidents%20and%20infections>.

⁷ <https://www.leapfroggroup.org/about/expert-panelists>

Grade for U.S. Hospitals, which Leapfrog publishes on its Hospital Safety Grade website.⁸ The Expert Panel’s Guiding Principles are the following:

Purpose of Composite Score

The purpose of the composite score is to create a simple metric that will improve consumer and purchaser engagement around patient safety in U.S. hospitals. Ideally, this increased engagement will create additional market forces for hospitals to improve the safety of care delivery. In the dissemination of the grades, hospitals will be engaged to help them understand, prepare, and communicate about this score in a manner that promotes both respect and improvement.

Construct

The focus of this composite score is patient safety, which is being defined as “freedom from harm.” We recognize that patient safety is a different, and a narrower, construct than hospital quality. The composite score should recognize both a hospital’s efforts toward patient safety and the hospital’s patient safety outcomes.

Inclusion of Measures

The performance measures that are used in creating the composite grade should have the following characteristics:

- Ideally can be obtained from a data source that publicly releases hospital-level data at the national level.
 - o If no such data source exists, preference will be given to data sources with the following characteristics: provide consistent data across geographic locations, are transparent with their data, do not represent a financial burden for hospitals to report data or for Leapfrog to access the data, and have a mechanism in place to ensure the integrity of the data reported (e.g., attestation, audit, verification process).
- The measure is clearly related to patient safety.
- Measures that focus on outcomes are generally preferred to measures that focus on processes of care or structural factors. When outcome measures are unavailable, or are insufficiently robust (i.e., case-mix adjustment methods have not been fully worked out), proven process or structural measures will be utilized.
- If the measure focuses on processes of care or structural factors, it should have strong evidence of being correlated with safer patient outcomes.
- Measures should not be limited to those that are collected and publicly reported through the Leapfrog Hospital Survey.

Scientific Soundness of Measures

Measures that have been shown to be scientifically sound (e.g., valid, reliable) are preferred; however, lack of existing research on the scientific soundness of a measure

⁸ https://www.hospitalsafetygrade.org/media/file/Expert_Panel_Guiding_Principles_Nov12_updated.pdf

does not preclude the inclusion of the measure in the composite. The scientific soundness of a measure is one consideration, amongst many, in deciding whether to include the measure in the composite. In addition, techniques such as reliability-adjustment should be used, when possible, to compensate for differences in the reliability of a measure.

Imputing missing data

When a hospital is missing data for a particular performance measure, we recommend ignoring the measure and re-calibrating the weights within the domain so that hospitals are scored only on the measures for which their performance data are available. In situations where a hospital does not have data available from the primary data source for a particular performance measure, but an alternative data source is available, data from the alternative or secondary data source can be used in the composite. If data are used from a secondary data source, attempts should be made to provide a grade that is equitable to what the hospital would have earned had the data been available from the primary data source.

If a hospital is missing data for a large number of performance measures, then a grade cannot be reliably calculated. In this situation, no grade should be issued for the hospital.

Evolution of the Composite Grade

The composite grade will evolve as the science of performance measurement improves. On a regular basis, the methods used to calculate the composite grade will be revisited; possible methodology modifications will be generated from analyses, expert panel input, and stakeholder comments. In addition, the individual performance measures that make-up the composite grade will be revisited on an regular basis, with structured processes to reassess the current measures and to identify new measures that could be added to and/or replace the current measures. The composite grade will also ideally serve as a ‘living laboratory’ to help push forward the science of patient safety performance measurement.

Transparency

The process of developing this composite score will be transparent to all parties that are interested. The weighting and calculation process will be transparent to hospitals, consumers, and others. Hospitals will have the opportunity to review their composite grades prior to public release.

VII. BACKGROUND OF LEAPFROG’S METHODOLOGY RELEVANT TO THE DISPUTE

I am aware from documents provided that in Summer 2024, Leapfrog put out a *Request for Public Comments: Planned Updates to the Leapfrog Hospital Safety Grade Methodology for Fall*

2024, which requested public comment for its planned updates to the Leapfrog Hospital Safety Grade methodology that was to be used to calculate the fall 2024 Hospital Safety Grades.⁹ In that Request Leapfrog explained that beginning in fall 2024 “Leapfrog will update the Imputation Methodology for CPOE, BCMA, IPS, and Hand Hygiene measures for hospitals that do not submit a 2024 Leapfrog Hospital Survey by August 31, 2024.”¹⁰ The changes come under the guidance of Leapfrog’s national expert panel, the research team at Johns Hopkins Medicine, and in response to stakeholder feedback.”

Specifically, I am aware that concerns were raised that the imputation of the cohort mean score for non-reporting hospitals for the CPOE, BCMA, IPS and Hand Hygiene measures was unfairly over-inflating grades for non-reporting hospitals. In other words, non-reporting hospitals were benefiting from the scores of participating hospitals without any basis to assign the non-participating hospitals the cohort mean for these four measures.

After a review of the imputation method being utilized in Spring 2024 by the Expert Panel, Leapfrog implemented the following new imputation method was put into place for the Fall 2024 Hospital Safety Grades:

1) New Step 1 Imputation (Does not apply to BCMA)

If the hospital had a score assigned by Leapfrog in the previous two rounds of grades (i.e., spring 2024, fall 2023), the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., fall 2024). This is a reduction from the previous methodology, which imputed scores from up to four previous rounds of grades. This will help ensure any historical data used in calculating the Safety Grade is reflective of hospital protocols within the past 2 years (e.g., the reporting periods for CPOE IPS, and Hand Hygiene on the 2023 Leapfrog Hospital Survey was 2023).

⁹ Request for Public Comments on Changes to Leapfrog Fall 2024 Safety Grade Methodology, available at https://www.hospitalsafetygrade.org/media/file/Fall2024HospitalSafetyGrade_ProposedMethodologyChanges.pdf.

¹⁰ Request for Public Comments on Changes to Leapfrog Fall 2024 Safety Grade Methodology.

Note that Step 1 imputation will be temporarily paused for the BCMA measure. In 2024, Leapfrog expanded the BCMA Standard to include pre-operative and post-anesthesia care units in addition to med-surg units, critical care units, and labor and delivery units. Due to these changes, scores from the 2023 Leapfrog Hospital Survey are not an accurate representation of performance on the current measure and thus not suitable for Step 1 imputation.

2) New Step 2 Imputation

For hospitals that do not have historical data from the last two rounds of the Safety Grade (Step 2 imputation then applies), instead of imputing a score based on the cohort mean, hospitals will be assigned a point value that is equivalent to receiving “Limited Achievement” for that measure on the Leapfrog Hospital Survey (Table 1). This category assignment would reflect Leapfrog’s lack of current information about a hospital’s status in implementing these important patient safety structures.

VIII. THE LEAPFROG METHODOLOGY ACCURATELY REFLECTS THE NONPERFORMANCE OF PLAINTIFFS

I have reviewed the members of the Safety Grade Expert Panel.¹¹ I am previously familiar with Dr. David Classen, Dr. Arjun Srinivasan and Dr. David Bates, having heard them speak at national meetings and interacted with them in various academic capacities. They are world experts in the field. In my opinion, they are in the top 1% of potential advisory board members on issues of patient safety and safety metrics. I have reviewed via the internet the other members of the Safety Grade Expert Panel and hold similarly high opinions of them.¹² I have also reviewed transcripts of the Expert Panel meetings wherein the subject of the 4 imputed measures at issue in the Litigation were discussed.

¹¹ Safety Grade Expert Panel, Leapfrog, available at <https://www.leapfroggroup.org/about/expert-panelists>.

¹² <https://blogs.cdc.gov/safehealthcare/bios/arjun-srinivasan-md/>; <https://medicine.utah.edu/faculty/david-c-classen>; <https://hsph.harvard.edu/profile/david-westfall-bates>; <https://nursing.jhu.edu/faculty-research/faculty/directory/kathryn-mcdonald/>; <https://www.nursing.upenn.edu/live/profiles/92-matthew-mchugh>; <https://med.stanford.edu/profiles/arnold-milstein>; <https://med.uth.edu/imm/2023/07/07/peter-doris-phd>; <https://www.uhhospitals.org/about-uh/leadership/uh-system-leadership/peter-pronovost>; <http://health.ucdavis.edu/pediatrics/team/122/patrick-romano---internal-medicine---pediatrics-general---health-policy-sacramento/>; https://healthpolicy.fsi.stanford.edu/people/sara_j_singer; <https://business.vanderbilt.edu/bio/tim-vogus/>.

Based on my review of the credentials of the Safety Grade Expert Panel, the thorough discussions surrounding the imputation methods which were implemented for the Leapfrog Fall 2024 Hospital Safety Grades, it is my opinion to a reasonable degree of scientific certainty that process of reconfiguring the Leapfrog methodology to be implemented in the Fall 2024 Hospital Safety Grades was carefully and thoughtfully done resulting in a reasonable and ethical methodology.

All hospital evaluation groups including Leapfrog, CMS and Vizient are continually re-assessing strengths and weaknesses of their methodologies. The goal of these groups is to improve hospital safety ranking systems to be fair, accurate and ultimately help drive hospitals to improve patient outcomes. Based on available data and the everchanging landscape, Leapfrog (as well as other ranking groups) seek to revise their metrics at various times to ensure the best possible (not perfect) grading methodology available based on the current landscape of the healthcare industry and available data.

In my career, I have worked most closely in day-to-day hospital epidemiology with the hospital-associated infection outcomes such as central-line associated bacteremia (CLABSI), central-line associated urinary tract infection (CAUTI), surgical site infection rates (SSI), MRSA bacteremia rates and hand hygiene. And thus, I am most familiar with CDC advisory boards that have led to measurement adjustment and risk adjustment of these metrics that are part of both CMS hospital evaluations and Leapfrog evaluations.

In my experience, all of these groups methodically and ethically strive to improve these rankings and metrics. In short, Leapfrog's Safety Grade Expert Panel are the leaders in the country in these areas and were improving the process by their assignment method of the 4 process measures at issue in the Litigation. Thus, it is my opinion that the assignment method the Safety

Grade Expert Panel chose is reasonable and ethical. While no methodology is perfect, Leapfrog takes great pains to consult with the leading experts in the country to create a methodology that is reasonable and ethical in light of the ever-changing landscape of healthcare industry standards and available data.

IX. NON-RESPONSE BIAS IS APPROPRIATELY CONSIDERED IN ASSIGNING A SCORE LOWER THAN THE MEDIAN SCORE TO NON-PARTICIPATING HOSPITALS

Nonresponse bias is a very important component of this case. It is taught throughout the MPH, MS and PhD curriculums.¹³ Nonresponse bias arises when people who complete surveys differ in their responses to people who do not complete surveys. The people who do not respond are different and not representative of the total population.

Relative to this case, prior to the Fall 2024 Leapfrog Hospital Grading period, values assigned to hospitals that did not participate in the survey were the cohort median values for the 4 structural measures at issue in the Litigation. In my opinion, in the case of these four structural measures, nonresponse bias is likely to follow the following causal logic: hospitals that choose not to report their results are hospitals that know that they are poor performing on the process/structural measures being collected. If these non-participating hospitals believed they were median or high performers they would have spent the required time to complete the survey.¹⁴ Thus, prior to the fall of 2024, it was advantageous for the poor performing hospitals to decline reporting so that they would be assigned the cohort median values that are higher than their likely actual values.¹⁵ This would falsely favorably bias their scores on these structural measures.

¹³ Rothman, K.J., Greenland, S., & Lash, T.L. (2008). *Modern epidemiology* (3rd ed.). Published by Lippincott Williams & Wilkins; Celetano, D.D., Szklo, M. & Farag, Y. (7th ed). (2024). *Gordis epidemiology*. Published Elsevier.

¹⁴ See e.g., PBHN000002103.

¹⁵ LEAPFROG00178624.

In 2024, the Leapfrog Group, based on the recommendation of the Safety Grade Expert Panel, decided that a solution to this nonresponse bias and likely falsely favorable scores on these four process measures would be to assign lower scores than the cohort median. Based on their methodology, the Safety Grade Expert Panel took the 3 process measures that came from the Leapfrog Hospital Survey and for which no secondary source information was available (1. Staff work together to prevent errors, 2. Effective leadership to prevent errors, 3. Nursing and Bedside Care for Patients) and assigned them as unmeasured, a.k.a “Declined to Report” with no value assigned.¹⁶ The Expert Panel took 4 structural process measures (CPOE, BCMA, IPS and Hand Hygiene) and assigned them values corresponding to the category of “Limited Achievement.”¹⁷

The five Plaintiff Hospitals had numerous opportunities to complete the voluntary survey and submit their actual numbers and avoid the imputation of “Limited Achievement” for these 4 measures if the survey data called for a higher score. They also had numerous opportunities during the widely publicized Public Comment Period to comment on the proposed revisions to the Leapfrog Safety Grade methodology for Fall 2024.¹⁸ I reviewed the public comments on the proposed changes and many were favorable.¹⁹ Comments also led to the assigned scores being clearly labeled as assigned and not the actual hospital data, which allowed transparency for the public with respect to the display of the methodology for these 4 measures. This leads me to conclude that nonresponse bias led to poorer performing hospitals on the process measures not reporting their results, tactically figuring that they were better off with 3 outcomes as not reported and 4 measures as limited achievement. In fact, the five Plaintiff Hospitals acknowledged in their

¹⁶ Safety Grade Scoring Methodology, at 11, available at <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024.pdf>.

¹⁷ Safety Grade Scoring Methodology, at 15.

¹⁸ Request for Public Comment on Changes to Leapfrog Fall 2024 Safety Grade Methodology, available at https://www.hospitalsafetygrade.org/media/file/Fall2024HospitalSafetyGrade_ProposedMethodologyChanges.pdf.

¹⁹ LEAPFROG00178624-00178627.

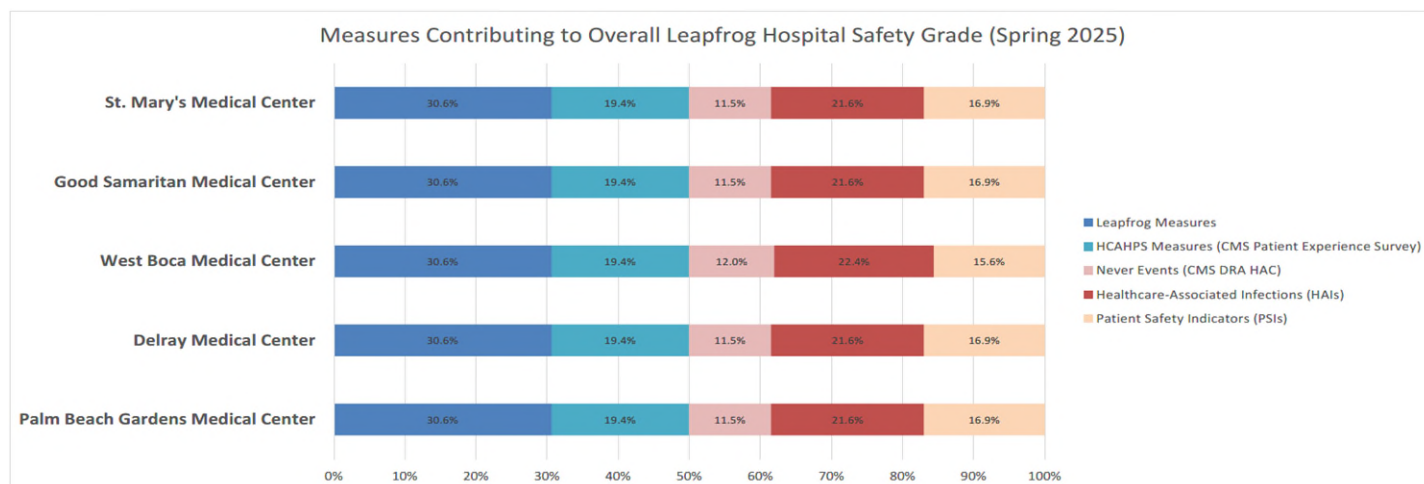
Complaint that they were previously receiving the benefit of reporting hospitals' grades on their score by being assigned the median score for participating hospitals.²⁰

In summary, nonresponse bias leads to the true values of non-participating hospitals not being at the cohort median but likely lower. It can be debated as to how low the values should be, i.e. should they have been assigned values of "Limited Achievement" or "Some Achievement." The nonresponse bias that likely exists should not have led them to being assigned the mean or the two highest performance categories of considerable achievement or achieve the standard. The method of assignment was done in a transparent fashion to try to achieve proximity to the causal truth.

X. THESE 5 HOSPITALS ARE UNDERPERFORMERS REGARDLESS OF THE ASSIGNED SCORE FOR THE 4 MEASURES AT ISSUE

The five Plaintiff Hospitals are underperforming in the areas of patient safety and quality regardless of the Leapfrog Hospital Safety Grades. The majority of the Leapfrog Hospital Safety Grade is based on CMS and HCAHPS measures.

Exhibit 1: Measures Contributing to Overall Leapfrog Safety Grade (Spring 2025)



²⁰ Complaint, at ¶¶ 50, 55.

CMS uses a star rating system with 5 stars being the highest and one star being the lowest. CMS provides an Overall Rating that is describes as “The overall star rating is based on how well a hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates, and safety of care.” CMS also provides a Patient Survey Rating which “measures patients' experiences of their hospital care. Recently discharged patients were asked about important topics like how well nurses and doctors communicated, how responsive hospital staff were to their needs, and the cleanliness and quietness of the hospital environment.”²¹

As demonstrated in Exhibit 2,²² the CMS ratings for these five hospitals average 1.2 stars.

Exhibit 2: CMS Star Ratings for the Five Plaintiff Hospitals

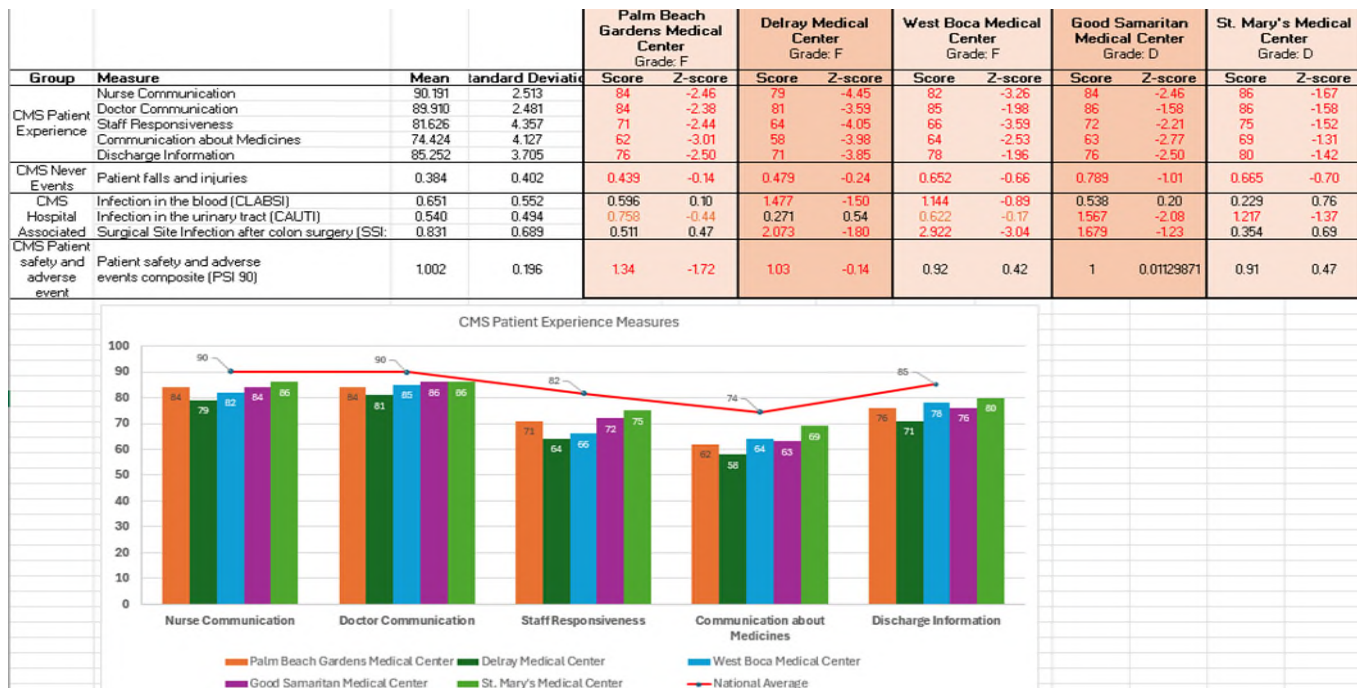
HOSPITAL	OVERAL RATING	PATIENT SURVEY RATING
West Boca Medical Center	2	1
Palm Beach Gardens	1	2
Good Samaritan	1	1
Delray Medical Center	1	1
St. Mary's Medical Center	1	1
Average Rating	1.2	1.2

This reflects poor performance. These five Plaintiff Hospitals are low on almost all of the outcome metrics, which are derived from CMS, and CMS data makes up the substantial majority of a non-reporting hospital's score. The five Plaintiff Hospitals are also underperforming on the HCAP scores and process measures, i.e. patient experience scores, which make up a significant part of non-reporting hospitals' scores.²³

²¹West Palm Beach, Florida Hospitals Comparison, CMS, <https://www.medicare.gov/care-compare/results?searchType=Hospital&page=1&city=West%20Palm%20Beach&state=FL&zipcode=&radius=25&sort=closest&tealiumEventAction=Landing%20Page%20-%20Search&tealiumSearchLocation=search%20bar>.

²² West Palm Beach, Florida Hospitals Comparison, CMS, <https://www.medicare.gov/care-compare/results?searchType=Hospital&page=1&city=West%20Palm%20Beach&state=FL&zipcode=&radius=25&sort=closest&tealiumEventAction=Landing%20Page%20-%20Search&tealiumSearchLocation=search%20bar>.

²³ Safety Grade Scoring Methodology, at 12.

Exhibit 3: Summary of CMS Data for the Five Plaintiff Hospitals

To further summarize the poor performance of the five Plaintiff Hospitals, I have created the below table. The rows list each of the hospitals. I have then placed CMS outcomes and HCAHPS outcomes in columns.²⁴ I have color coded the results for ease of interpretation. Red is defined as poor performance, yellow defined as average performance and green as above average performance. What the visualization below shows is that these hospitals were dramatically under-performing on most of the outcomes.

Exhibit 4: Plaintiff Hospitals' Performance on CMS and HCAHP Measures Contained in the Hospital Safety Grade

²⁴ Data drawn from LEAPFROG00020679.

Hospital	H-COMP-1: Nurse Communication	H-COMP-2: Doctor Communication	H-COMP-3: Staff Responsiveness	H-COMP-5: Communication about Medicines	H-COMP-6: Discharge Information	CLABSI (Infection in Blood)	CAUTI (Infection in Urinary Tract)	SSI: Colon (Surgical site infection after colon surgery)	MRSA	C. Diff	PSI 90 (Harmful Events)
Palm Beach Gardens Medical Center	84	84	71	62	76	0.596	0.758	0.511	0.278	0.395	1.34
Delray Medical Center	79	81	64	58	71	1.477	0.271	2.073	0.922	0.284	1.03
West Boca Medical Center	82	85	66	64	78	1.144	0.622	2.922	1.318	0.198	0.92
Good Samaritan Medical Center	84	86	72	63	76	0.0538	1.567	1.679	0	0.25	1
St. Mary's Medical Center	86	86	75	69	80	0.229	1.217	0.354	0.829	0.37	0.91

It is worth noting that the five Plaintiff Hospitals complain that their non-participation on the Leapfrog Hospital Survey is the reason these five hospitals are receiving their lower grades. However, the five Plaintiff Hospitals' theory is belied by the metrics of other non-reporting hospitals in Florida. Exhibit 6 below shows the significant difference in performance between those non-reporting hospitals that receive a C grade or better and the publicly available data for other non-participating hospitals; thus further demonstrating the poor performance of the five Plaintiff Hospitals regardless of participation in the Leapfrog Hospital Survey.

Exhibit 6: Comparison of Plaintiff Hospitals' Performance on CMS and HCAHP Measures to Other Non-Participating Hospitals in Florida

Hospital	H-COMP-1: Nurse Communication	H-COMP-2: Doctor Communication	H-COMP-3: Staff Responsiveness	H-COMP-5: Communication about Medicines	H-COMP-6: Discharge Information	CLABSI (Infection in Blood)	CAUTI (Infection in Urinary Tract)	(Surgical site infection after colon surgery)	MRSA	C. Diff	PSI 90 (Harmful Events)
Palm Beach Gardens Medical Center	84	84	71	62	76	0.596	0.758	0.511	0.278	0.395	1.34
Delray Medical Center	79	81	64	58	71	1.477	0.271	2.073	0.922	0.284	1.03
West Boca Medical Center	82	85	66	64	78	1.144	0.622	2.922	1.318	0.198	0.92
Good Samaritan Medical Center	84	86	72	63	76	0.0538	1.567	1.679	0	0.25	1
St. Mary's Medical Center	86	86	75	69	80	0.229	1.217	0.354	0.829	0.37	0.91
Desoto Memorial Hospital	92	91	85	72	88	n/a	n/a	n/a	n/a	1.31	0.97
Kerality Hospital Miami	90	89	82	72	72	n/a	0	n/a	n/a	0.268	0.91
Ascension St. Vincent's St. Johns County	93	92	85	75	91	n/a	n/a	n/a	n/a	0	0.95
Gulf Breeze Hospital	93	92	86	76	87	n/a	n/a	0.571	n/a	1.347	0.95
Baptist Hospital	91	90	78	76	85	0.272	0	0.322	0.446	0.443	0.94

In addition to the above table, I have reviewed the weighting of both the process and outcome metrics. I have reviewed the CMS outcome measures that are common to the Leapfrog

grade and CMS and the raw data and Z scores for the outcomes such as PS-90, CLABSI, CAUTI, MRSA.²⁵

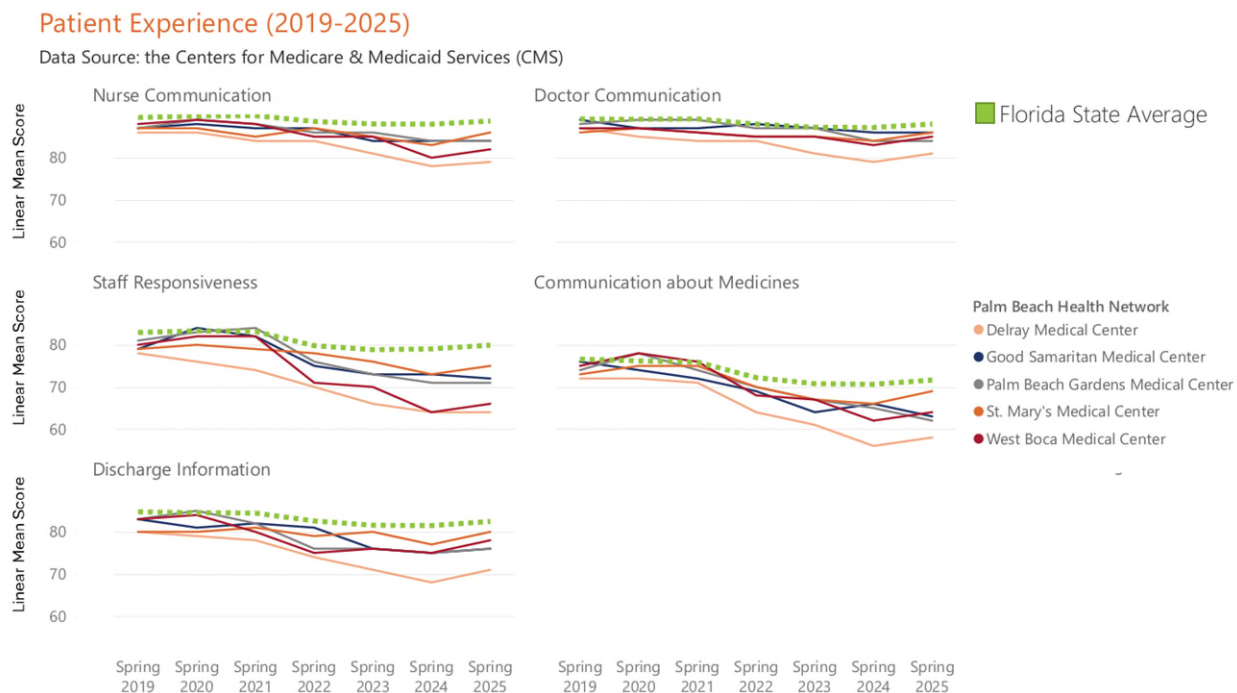
The Z scores for these five Plaintiff Hospitals are negative in the majority of cases, indicating poor performance. The SIRs (standard infection ratio)²⁶ for the hospital-associated outcomes for the five Plaintiff Hospitals are worse than the national average in the majority of cases, also showing poor performance. These metrics account for a much larger portion of the weighting of the hospital grade and thus I conclude that these hospitals were under-performing on these outcome metrics that are used by CMS and Leapfrog. For example, the four assigned structural measures at issue in the Litigation account for less than 25% of the overall rating. The other measures account for 75% of the grade. Thus, even if the assignment method for these four measures was not optimal, which I do not believe is the case, they would not really affect the overall grades and conclusions due to the weighting system used by the Leapfrog Group.

I have also reviewed the HCAHPS scores of the five Plaintiff Hospitals.²⁷ The performance of the five Plaintiff Hospitals on these outcomes was even worse than their performance on the CMS outcomes.

²⁵ The CMS PSI 90 measure summarizes patient safety across multiple indicators, monitors performance over time, and facilitates comparative reporting and quality improvement at the hospital level. CMS Quality Measures Fact Sheet, at 1, available at <https://www.cms.gov/priorities/innovation/files/fact-sheet/bpciadvanced-fs-psi90.pdf>. Additionally, CLABSI (central line-associated bloodstream infections) and CAUTI (catheter-associated urinary tract infections) are healthcare-associated infection measures. Safety Grade Scoring Methodology, at 13, available at <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024.pdf>.

²⁶ NHSN Standardized Infection Ratio (SIR), available at <https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf>.

²⁷ HCAHPS: Patients' Perspectives of Care Survey, available at <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hcahps-patients-perspectives-care-survey>. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey collects data to measure patient perceptions of their hospital experience.

Exhibit 7: The Five Plaintiff Hospitals' HCAHPS Scores

The HCAHPS scores represent what patients think of the hospital on discharge. I am familiar with the HCAHPS methods, and they have been developed and evolved since 2006. Similar to the Leapfrog methodology, the HCAHPS scores have been developed by advisory boards. The methodology is transparent and ethical and has been improved over the years. The HCAHPS score aims to represent the quality of the patient experience in hospitals. As seen in Exhibit 7, the five Plaintiff Hospitals have extremely poor performance in these metrics.

XI. NICHOLSON'S RECALCULATION INACCURATELY RELIES ON THE RECALCULATION OF PLAINTIFFS' HOSPITAL SAFETY GRADES

I have also reviewed the re-calculations performed by Dr. Nicholson in his Expert Report in support of the five Plaintiff Hospitals. Dr. Nicholson's re-calculations contain a major flaw;

namely, in order to over-inflate the Hospital Safety Grades of the five Plaintiff Hospitals, he imputed mean values for too many process measures.²⁸

As discussed above, the Leapfrog Hospital Safety Grade takes 12 measures from the Leapfrog Hospital Survey in order to calculate a hospital's safety grade. However, if a hospital chooses not to participate in the Leapfrog Hospital Survey, those twelve measures are calculated as follows:

- For seven of the measures, Leapfrog will turn to secondary data, particularly HCAHPS data
- For 3 of the measures, Leapfrog will not use those measures at all in the calculation of a non-participating hospital
- For the 4 structural measures (CPOE, BCMA, IPS and Hand Hygiene) Leapfrog will assign a non-participating hospital a "Limited Achievement" score for each measure.

Dr. Nicholson recalculated 7 of the measures, the 4 structural measures plus the 3 process measures which are **not** included in Leapfrog's Hospital Safety Grade calculation for non-participating hospitals and gave each of the five Plaintiff Hospitals an imputed median score for all 7 measures.²⁹ The only explanation appears to be that Dr. Nicholson misunderstood that the Leapfrog Group methodology took the 7 process measures that were not reported by the hospitals and only imputed values for 4 of these measures. Dr. Nicholson inaccurately imputed median values for 7 of these measures. Dr. Nicholson's re-calculation in this regarding overinflates the five Plaintiff Hospitals' recalculated grades. As described above, Dr. Nicholson is giving the five Plaintiff Hospitals too high scores on the 4 metrics due to nonresponse bias and giving them

²⁸ Nicholson Report, at 36-38.

²⁹ Nicholson Report, at 36-38.

additional points on 3 scores that were not even part of the Leapfrog calculation for these five non-participating Plaintiff Hospitals.³⁰ Dr. Nicholson's error leads to a faulty conclusion.

As outlined above, nonresponse bias is a critical component to reasonable and ethically calculating the Hospital Safety Grade on the 4 structural measures. The Leapfrog Safety Grade Expert Panel correctly concluded that assigning the median to these 4 measures would be incorrect. Thus, it is my opinion to a reasonable degree of professional certainty that the methods of assignment utilized by Leapfrog and recommended by the Safety Grade Expert Panel were correct. To demonstrate this point, I ran recalculations to assess the grade outcomes for these five Plaintiff Hospitals *if* Leapfrog assigned the five Plaintiff Hospitals a rating on the 4 measures that was between the assigned "Low Achievement" score and the incorrect median on the 7 measures that Dr. Nicholson proposed. To do this, I re-ran the calculations with the assignment of "Some Achievement" for the 4 structural measures and kept the 3 measures as uncalculated, i.e. "Decline to Respond." Exhibit X8 below is a summary of these three methods.

This below table summarizes some key elements/conclusions. It is my expert opinion, based on a reasonable degree of professional certainty, the Leapfrog Group methodology is the closest to the truth (2nd column). The last column is the Nicholson method is flawed based on assigning 7 values instead of 4 values and based on assignment to the mean.³¹ The center column "Some Achievement" is a conservative estimate of what would happen if the hospitals had a more favorable grade on the 4 measures than the truth. Even the "Some Achievement" column demonstrates poor performance of the hospitals with grades of F, D, D, D and C.

Exhibit 8: Recalculation of the Four Assigned Structural Measures

³⁰ Nicholson Report, at 39-40.

³¹ Nicholson Report, at 39.

Plaintiff Hospitals	Current grade (Spring 2025)	Grade if Hospital's Assigned Score Associated with "Some Achievement" on the Leapfrog Hospital Survey	Grade as calculated by Nicholson with 7 measures
Palm Beach Gardens Medical Center	F	D	C
Delray Medical Center	F	F	C
West Boca Medical Center	F	D	C
Good Samaritan Medical Center	D	D	C
St. Mary's Medical Center	D	C	C

I have reviewed the manuscripts by W. Hwang and S. Smith which are cited and relied heavily upon in Dr. Nicholson's expert report.³² Although these papers have scientific merit as evidenced by the publications in which they were published and peer review process that was undertaken prior to these manuscripts being accepted, they are based on a retired Leapfrog methodology that is no longer in use and is not applicable to the issues presented by this Litigation, i.e. the Fall 2024 change in methodology.³³ The field of hospital outcomes, metrics and risk adjustment has evolved tremendously since the time these publications were authored. Thus, it is my expert opinion, to a reasonable degree of academic certainty, that a detailed analysis of these manuscripts for the purposes of evaluating the current Leapfrog Hospital Safety Grade

³² Nicholson Report, at 22, 27-31, 33, 35-37, 39-42; Wenke Hwang et al., "Hospital Patient Safety Grades May Misrepresent Hospital Performance," Journal of Hospital Medicine 9(2) (2014); Shawna N. Smith et al., "Dissecting Leapfrog: How Well Do Leapfrog Safe Practices Scores Correlate with Hospital Compare Ratings and Penalties, and How Much Do They Matter?" Medical Care 55(6) (2017).

³³ Hwang et al. (2014), at ; Smith et al., at 609 (2017).

methodology is not appropriate in light of the outdated nature of the methodology reviewed in those studies. Therefore, Dr. Nicholson's reliance on this outdated methodology was inappropriate for attempting to assessing the current Leapfrog methodology.

I understand that Dr. Nicholson has reserved his right to change and/or update is expert findings as additional information becomes available. In addition, I understand that as of the issuance of this report, the five Plaintiff Hospitals have not made a significant production and continue to object to requests for information regarding the five Plaintiff Hospitals actual safety data on the four structural measures as well as information they may have provided to other survey organizations like Vizient, US News & World Report, HealthGrades and CMS. In addition, it was my understanding that I would have the benefit of reviewing the depositions taken of all 5 CEOs before my report was due to the Court. I understand that the Plaintiff Hospitals unilaterally cancelled those depositions and did not agree to reschedule them prior to the time my report was due. Based on all of the foregoing, I reserve the right to adjust and supplement my opinions based on a review of any documents produced in this litigation and the testimony of the five Plaintiff Hospitals. I also reserve the right to supplement my analysis and conclusions set forth in this report should any opinions of the Plaintiffs' experts be modified or supplemented in any way.

Executed this 4th Day of September 2025

/s/ Dr. Anthony Harris_____

EXHIBIT B

List of Materials Considered

Online Sources

1. Mission and Vision, Leapfrog, available at <https://www.leapfroggroup.org/about/mission-and-vision>.
2. Leapfrog's Spring 2025 Safety Grades Are in, available at <https://www.leapfroggroup.org/news-events/leapfrog%E2%80%99s-spring-2025-safety-grades-are-%E2%80%94-new-trend-data-shows-one-eight-hospitals#:~:text=About%20The%20Leapfrog%20Group&text=Among%20its%20initiatives%2C%20the%20Leapfrog,%2C%20injuries%2C%20accidents%20and%20infections>.
3. Safety Grade Expert Panel, Leapfrog, available at <https://www.leapfroggroup.org/about/expert-panelists>.
4. Bio of Dr. Arjun Srinivasan, available at <https://blogs.cdc.gov/safehealthcare/bios/arjun-srinivasan-md/>.
5. Bio of Dr. David C. Classen, available at <https://medicine.utah.edu/faculty/david-c-classen>.
6. Bio of Dr. David W. Bates, available at <https://hsph.harvard.edu/profile/david-westfall-bates>.
7. Bio of Dr. Kathryn McDonald, available at <https://nursing.jhu.edu/faculty-research/faculty/directory/kathryn-mcdonald/>.
8. Bio of Dr. Matthew McHugh, available at <https://www.nursing.upenn.edu/live/profiles/92-matthew-mchugh>.
9. Bio of Dr. Arnold Milstein, available at <https://med.stanford.edu/profiles/arnold-milstein>.
10. Bio of Dr. Peter Doris, available at <https://med.uth.edu/imm/2023/07/07/peter-doris-phd>.
11. Bio of Dr. Peter Pronovost <https://www.uhhospitals.org/about-uh/leadership/uh-system-leadership/peter-pronovost>.

12. Bio of Dr. Patrick Romano, available at <http://health.ucdavis.edu/pediatrics/team/122/patrick-romano---internal-medicine---pediatrics-general---health-policy-sacramento/>.
13. Bio of Dr. Sara J. Singer, available at https://healthpolicy.fsi.stanford.edu/people/sara_j_singer.
14. Bio of Dr. Tim Vogus, available at <https://business.vanderbilt.edu/bio/tim-vogus/>.
15. Expert Panel Guiding Principles, The Leapfrog Group, available at https://www.hospitalsafetygrade.org/media/file/Expert_Panel_Guiding_Principles_Nov12_update_d.pdf.
16. Request for Public Comments on Changes to Leapfrog Fall 2024 Safety Grade Methodology, available at https://www.hospitalsafetygrade.org/media/file/Fall2024HospitalSafetyGrade_ProposedMethodologyChanges.pdf.
17. Safety Grade Scoring Methodology, Leapfrog, available at <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024.pdf>.
18. West Palm Beach, Florida Hospitals Comparison, CMS, <https://www.medicare.gov/care-compare/results?searchType=Hospital&page=1&city=West%20Palm%20Beach&state=FL&zipcode=&radius=25&sort=closest&tealiumEventAction=Landing%20Page%20-%20Search&tealiumSearchLocation=search%20bar>.
19. CMS Quality Measures Fact Sheet, available at <https://www.cms.gov/priorities/innovation/files/fact-sheet/bpciadvanced-fs-psi90.pdf>
20. NHSN Standardized Infection Ration (SIR), available at <https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf>.
21. HCAHPS: Patients' Perspectives of Care Survey, CMS, available at <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hcahps-patients-perspectives-care-survey>.

1. Complaint and Demand for Jury Trial (“Complaint”), *Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary’s Medical Center, Inc., and West boca Medical Center, Inc. v. The Leapfrog Group*, Case No. 9:25-cv-80526 (April 30, 2025).
2. Amended Complaint, *Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center, St. Mary’s Medical Center, Inc., and West boca Medical Center, Inc. v. The Leapfrog Group*, Case No. 9:25-cv-80526 (August 28, 2025).
3. Expert Report of Dr. Sean Nicholson (“Nicholson Report”) (Aug. 7, 2025).

Documents Produced

1. LEAPFROG00178624-00178627.
2. LEAPFROG00020679.
3. PBHN000002103

Academic Sources

1. Rothman, K. J., Greenland, S., & Lash, T. L. (2008). *Modern epidemiology* (3rd ed.). Published by Lippincott Williams & Wilkins.
2. Celentano, D. D., Szklo, M., & Farag, Y. (7th ed.). (2024). *Gordis epidemiology*. Published by Elsevier .
3. Wenke Hwang et al., “Hospital Patient Safety Grades May Misrepresent Hospital Performance,” *Journal of Hospital Medicine* 9(2) (2014).
4. Shawna N. Smith et al., “Dissecting Leapfrog: How Well Do Leapfrog Safe Practices Scores Correlate with Hospital Compare Ratings and Penalties, and How Much Do They Matter?” *Medical Care* 55(6) (2017).

EXHIBIT 3

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**IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

GOOD SAMARITAN MEDICAL CENTER,
INC., DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. D/B/A PALM BEACH
GARDENS MEDICAL CENTER, ST.
MARY'S MEDICAL CENTER, INC., AND
WEST BOCA MEDICAL CENTER, INC.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

CASE NO. 9:25-cv-80526

**Rebuttal Expert Report of Mark F. Rule, CFA, ABV
September 4, 2025**

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I, Mark Rule, hereby under penalty of perjury that the following is true and correct:

I. Introduction

1. On April 30, 2025, Plaintiffs Good Samaritan Medical Center, Inc. (“Good Samaritan”), Delray Medical Center, Inc. (“Delray Medical Center”), Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center (“Palm Beach Gardens Medical Center”), St. Mary’s Medical Center, Inc. (“St. Mary’s”), and West Boca Medical Center, Inc. (“West Boca Medical Center”) (collectively, “Plaintiffs” or “Plaintiff Hospitals”) filed a Complaint and Demand for Jury Trial (“Complaint”) against The Leapfrog Group (“TLG,” “Leapfrog,” or “Defendant”).
2. In the Complaint, Plaintiffs claim that “TLG holds itself out as an honest and credible public service organization devoted to hospital safety,” but “[i]n reality, it operates a brazen pay-to-play scheme that distorts the truth, misleads patients, and inflicts serious harm on hospitals and the communities they serve.”¹ Plaintiffs also claim that TLG’s Hospital Safety Grades “are based, in material part, on easily manipulatable, self-reported data submitted by hospitals that choose to dedicate the time and resources to respond to TLG’s sprawling 100+ page data requests.”² According to Plaintiffs, TLG changed its scoring methodology in 2024 such that “any hospital declining to provide data would automatically fail on the affected metrics, leading to inevitable Ds and Fs for Plaintiffs for the first time.”³ As a result, Plaintiffs allege that “TLG will deliberately misrepresent these trusted hospitals as dangerous facilities, undermining the doctors, nurses, and healthcare workers on whom the community depends.”⁴
3. In particular, Plaintiffs allege that, “[b]y virtue of its solicitation of information from Florida healthcare facilities, publication of information and Hospital Safety Grades for Florida hospitals, and commission of deceptive acts and unfair practices against Plaintiffs and the residents of Florida, TLG is subject to the Florida Deceptive and Unfair Trade Practices Act” (“FDUTPA”).⁵

¹ Complaint, ¶ 1.

² Complaint, ¶ 1.

³ Complaint, ¶ 3.

⁴ Complaint, ¶ 3.

⁵ Complaint, ¶ 118.

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4. I have been engaged by Wilson Elser Moskowitz Edelman & Dicker LLP (“Counsel”) on behalf of its client, TLG, to review and comment on certain aspects of the expert reports of Dr. Jonah Berger, Mr. Thomas Chakurda, and Dr. Sean Nicholson (collectively, “Plaintiffs’ Experts”).⁶ Specifically, I have been asked to opine on whether a quantitative analysis could be performed to measure the economic harm, if any, that was sustained by Plaintiffs as a result the alleged actions of Defendant. Further, I was asked to analyze whether the Plaintiffs’ Spring 2025 Hospital Safety Grades would be materially impacted by certain changes in the algorithm inputs.

II. Qualifications

5. I am a Partner and Managing Director at AlixPartners, a global financial and business consulting firm. I have over 25 years of experience providing operational, financial, valuation, litigation, bankruptcy, and management consulting to clients operating in a diverse range of industries. I have consulted with companies in many industries including, but not limited to, wealth management and investment advisory, private equity, construction, chemical, electronics, energy, entertainment, food, healthcare, insurance, manufacturing, metals and mining, mortgage, newspaper, pharmaceutical, power generation, real estate, recruiting, retail, telecommunications, and transportation. I have significant experience in the areas of damages, valuation, solvency, and forensic accounting and have been retained in numerous matters to provide analyses of these issues. I have been qualified as an expert in U.S. federal and state courts as well as American Arbitration Association, International Chamber of Commerce, and JAMS arbitrations on issues related to damages, valuation, solvency, and forensic accounting. Additionally, I have served as an independent damages and valuation arbitrator.
6. I graduated from the University of Notre Dame in 2000 with a Bachelor of Business Administration in finance and computer applications. In 2009, I graduated from the University of Chicago Graduate School of Business with a Masters of Business Administration with concentrations in economics, finance, and accounting. In addition, I am a Chartered Financial Analyst (“CFA”) charterholder and a member of the CFA Institute, CFA Society of Chicago,

⁶ Expert Report of Jonah Berger, Ph.D., dated August 7, 2025 (“Berger Report”), Expert Report of Thomas Chakurda, dated August 7, 2025 (“Chakurda Report”), and Expert Report of Professor Sean Nicholson, dated August 7, 2025 (“Nicholson Report”).

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and the Association of Insolvency & Restructuring Advisors. In addition, I hold the Accredited in Business Valuation (“**ABV**”) credential, a professional designation from the American Institute of Certified Public Accountants (“**AICPA**”).

7. **Appendix 1** contains a copy of my *curriculum vitae* and my testimony over the last four years.
8. The opinions presented in this report are based on my analysis of information available as of the date of this report and my experience, education, and expertise. The specific materials and information that I relied upon are identified within this report and in **Appendix 2**.
9. AlixPartners is compensated for my time spent on this matter at an hourly rate of \$1,275. AlixPartners is also being compensated on an hourly basis for any other AlixPartners professionals working under my direction in this matter. Neither my nor AlixPartners’ compensation is contingent on the opinions offered or the outcome of this matter.

III. Summary of Certain Plaintiff Expert Reports

A. Berger Report

10. Dr. Berger was engaged by Plaintiffs to assess: (i) “whether, and in what ways, low or failing TLG Hospital Safety Grades may impact consumers’ perceptions of Plaintiff Hospitals and consumers’ decisions to seek care at Plaintiff Hospitals,” (ii) “whether and how repeated publication of low or failing TLG Hospital Safety Grades (i.e., future grades using the same imputation methodology) could affect consumers’ perceptions of, and decisions to seek care at, Plaintiff Hospitals,” and (iii) “the extent to which TLG’s imputation disclosures would be expected to affect consumers’ understanding of TLG’s imputation methodology (i.e., TLG’s practice of assigning the minimum score on the imputed measures and not basing it on hospital performance) and consumers’ understanding of the impact of TLG’s imputation methodology on TLG’s Hospital Safety Grades for non-participating hospitals, including Plaintiff Hospitals.”⁷
11. According to Dr. Berger, “TLG’s ‘D’ or ‘F’ Hospital Safety Grades for Plaintiff Hospitals likely impact consumers perceptions of Plaintiff Hospitals and deter consumers from choosing to receive care there,” and “if TLG continues to publish low or failing grades for Plaintiff

⁷ Berger Report, ¶ 12.

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Hospitals in the future, these effects are likely to be amplified.”⁸ Additionally, he opines that “TLG’s ‘D’ or ‘F’ Hospital Safety Grades for Plaintiff Hospitals likely negatively impact consumers’ perceptions of Plaintiff Hospitals’ quality,” and “[b]eyond perceptions, TLG’s ‘D’ or ‘F’ Hospital Safety Grades for Plaintiff Hospitals also likely affect consumers’ *choices* and deter consumers from choosing Plaintiff Hospitals.”⁹

12. Dr. Berger did not quantify any harm to the Plaintiff Hospitals.

B. Chakurda Report

13. Mr. Chakurda states that he was asked to provide his “opinions on the role of hospital rating systems, including TLG’s grades, in the brand management and marketing of hospitals, as well as to provide [his] opinions on the reputational impact of receiving negative TLG grades for hospitals.”¹⁰

14. According to Mr. Chakurda, among other things, “a strong hospital brand impacts all of the hospital’s stakeholders because it drives patients and caregivers to choose that hospital, and also increases patient referrals and doctor and staff recruitment and retention.”¹¹ He opines that “[a]lthough a hospital’s brand is multi-faceted, hospital ratings are a significant part of how a hospital is perceived in the community,” and “TLG’s safety grades are among the more prominent of these hospital ratings.”¹² Mr. Chakurda further opines that “hospitals who receive low TLG grades experience reputational harm to their brand.”¹³

15. Mr. Chakurda did not quantify any harm to the Plaintiff Hospitals.

C. Nicholson Report

16. Dr. Nicholson was engaged by Plaintiffs “to assess i) the foundational principles that govern a proper methodology for evaluating hospital safety and quality, ii) whether the methodology that Defendant The Leapfrog Group (‘TLG’) uses to develop its hospital grades conforms to

⁸ Berger Report, ¶ 15.

⁹ Berger Report, ¶¶ 16, 17.

¹⁰ Chakurda Report, ¶ 2.

¹¹ Chakurda Report, ¶ 12.

¹² Chakurda Report, ¶ 13.

¹³ Chakurda Report, ¶ 13.

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these principles, and iii) the potential impact that TLG's hospital grades may have on patient decisions regarding which hospitals to use for their medical care."¹⁴

17. According to Dr. Nicholson:

- "TLG's methodology departs from guiding principles for how hospital quality or safety should be measured, resulting in hospital grades that are misleading and unreliable predictors of actual patient outcomes, posing risks to patients, hospitals, and the public."¹⁵
- "TLG's methodology generates hospital grades that are incomparable across hospitals due to non-uniform ways of capturing various measures."¹⁶
- "TLG's methodology results in unreliable and systematically biased grades that are inappropriately inflated for the hospitals that choose to participate in TLG's hospital survey and inappropriately deflated for the hundreds of hospitals that choose to not participate."¹⁷
- "TLG's hospital grades have been shown to be unreliable predictors of patient outcomes, with multiple studies showing that hospitals better graded by TLG fail to perform any better than lower graded hospitals with respect to important patient outcomes such as mortality and infection rates."¹⁸

18. Dr. Nicholson did not quantify any harm to the Plaintiff Hospitals.

IV. Understanding of Relevant Legal Issues

19. I understand based on discussions with Counsel that, under the FDUTPA, a plaintiff must prove the following in order to recover damages from the defendant: (i) defendant engaged in a deceptive or unfair act or practice in the conduct of its trade or commerce, and (ii) defendant's actions were the legal cause of actual damages sustained by plaintiff. Additionally, I understand that an act or practice is "deceptive" to the extent it is likely to mislead a person or

¹⁴ Nicholson Report, ¶ 2.

¹⁵ Nicholson Report, ¶ 3.

¹⁶ Nicholson Report, ¶ 3.

¹⁷ Nicholson Report, ¶ 3.

¹⁸ Nicholson Report, ¶ 3.

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entity, acting reasonably in the circumstances, to the person's or entity's detriment. Moreover, I understand that an act or practice is "unfair" if it offends established public policy and is immoral, unethical, oppressive, unscrupulous, or substantially injurious to consumers. Further, I understand that an "unfair" practice or act must satisfy three tests: (i) it must produce substantial injury to claimant, (ii) the injury must not be outweighed by a benefit to consumers/competition that the practice produces, and (iii) it must be an injury that claimant could not have reasonably avoided.

V. Discussion and Analysis of Opinions**A. Summary**

20. Based on my review, an analysis of the economic harm, if any, sustained by Plaintiffs as a result of the actions allegedly done by TLG could have been undertaken by Plaintiffs, including by Plaintiffs' Experts. However, Plaintiffs' Experts failed to demonstrate and quantify any such economic harm.
21. Additionally, although Dr. Nicholson opines that "TLG's methodology results in unreliable and systematically biased grades that are...inappropriately deflated for the hundreds of hospitals that choose to not participate,"¹⁹ the grades for the Plaintiff Hospitals would not materially change to the extent certain "imputed" values were excluded from the calculation methodology.

B. Lack of a "But-For" Analysis

22. The calculation of economic harm in the form of lost profits can be estimated in numerous ways, including those based on (i) the before-and-after approach or "but-for" analysis ("comparing the performance of the company before and after the alleged harmful acts"), (ii) forecast approach ("using sales forecasts of expected performance for the business or industry to evaluate the probable effect of the harmful acts"), (iii) yardstick approach ("comparing the harmed business to comparable but unharmed businesses or locations to assess but-for results"), and (iv) market share approach ("comparing the plaintiff's market share during the

¹⁹ Nicholson Report, ¶ 3.

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period prior to the harm to that of the firm afterward”).²⁰ All of the aforementioned attempt to determine, but for the alleged conduct of the defendant, how the plaintiff’s profits would compare with its actual profits.

23. The calculation of lost goodwill or reputational damages is generally based on a loss of business value sustained by a claimant as a result of alleged harmful acts.²¹ Similar to a determination of lost profits, a loss of business value can be determined by comparing the “before-and-after” values of the business based on the discounted cash flow approach, the market approach, or the comparable company transaction approach.²²
24. Plaintiffs’ Experts have not undertaken any “but-for” analyses in order to determine whether Plaintiffs sustained lost profits or lost business value as a result of the claimed TLG actions. Thus, Plaintiff Experts have not reliably demonstrated that the Plaintiff Hospitals suffered any “substantial injury” as a result of the alleged actions of TLG asserted in this matter.
25. As opposed to reliably determining any lost profits or lost business value as a result of TLG’s alleged actions, Plaintiffs’ Experts instead opine on the “possible” harm that Plaintiffs could have sustained, was “expected to” sustain, or “likely” sustained, without providing any demonstration or quantification of such harm.²³ Indeed, it appears that Plaintiffs’ Experts were not even asked to quantify the lost profits or lost business value that Plaintiffs may have sustained based on the claimed actions.²⁴ Additionally, Dr. Berger cites to various studies that are unrelated to TLG or the relevant healthcare industry.²⁵

C. Lack of Consideration of Potentially Relevant Economic Measures

26. As noted above, Plaintiffs’ Experts have not attempted to measure any economic harm allegedly suffered by Plaintiffs as a result of TLG’s claimed conduct. Information that is

²⁰ Litigation Services Handbook: The Role of the Financial Expert, Sixth edition (2017), “Damages Theories and Causation Issues,” p. 4.23.

²¹ Litigation Services Handbook: The Role of the Financial Expert, Sixth edition (2017), “Damages Theories and Causation Issues,” p. 4.24 (“A loss of goodwill will lead to reduced cash flows, which factor into the valuation.”)

²² Litigation Services Handbook: The Role of the Financial Expert, Sixth edition (2017), “Damages Theories and Causation Issues,” p. 4.23.

²³ See, e.g., Berger Report, ¶¶ 15, 17, 31, 38, 41, 48, 55, 85; Chakurda Report, ¶¶ 12-13, 31, 35, 45-46; Nicholson Report, ¶¶ 18, 34, 38.

²⁴ Berger Report, ¶ 12; Chakurda Report, ¶ 2; Nicholson Report, ¶¶ 2, 16.

²⁵ See, e.g., Berger Report, ¶¶ 21, 26, 29, 58.

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relevant to a determination of economic damages includes, but is not limited to: company forecasts and budgets; historic financial (sales, revenues, costs, profits) performance; industry/market research, including trends, key events, and comparable company financial performance; general economic trends and conditions; changes in competition; and any company-specific factors.²⁶

27. Plaintiffs' Experts have not undertaken the requisite analyses to reliably conclude that Plaintiffs have suffered economic harm (*i.e.*, substantial injury) due to the alleged actions of TLG. Moreover, although the types of information set forth above were available to Plaintiffs, I understand that they did not produce such materials. Instead, the Plaintiffs produced a one-page summary of "key indicators" that compares changes in certain hospital performance measures.²⁷ The relevance of such summary figures is unclear, as no supporting materials were provided, and there is no demonstrated linkage between any decreases in patient "encounters"²⁸ and the alleged actions of TLG.

D. Imputed Values are not a Significant Driver of Plaintiff Hospitals' Grades

28. I understand that TLG's Hospital Safety Grades, which "are assigned to nearly 3,000 general acute-care hospitals across the nation twice annually," are based on "up to 22 national patient safety measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Hospital Survey, and information from other supplemental data sources, to produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors."²⁹ TLG states that the "measure set is divided into two domains: (1) Process/Structural Measures and (2) Outcome Measures," with each domain representing 50% of the Safety Grade.³⁰

²⁶ Litigation Services Handbook: The Role of the Financial Expert, Sixth edition (2017), "Damages Theories and Causation Issues," p. 4.32-4.33.

²⁷ Declaration of Erik Cazares, May 13, 2025, Exhibit 4; Declaration of Cynthia McCauley, May 13, 2025, Exhibit 4; Declaration of Sheri Montgomery, May 14, 2025, Exhibit 4; Declaration of Jerad Hanlon, May 13, 2025, Exhibit 4; Declaration of Heather Havericak, May 14, 2025, Exhibit 4.

²⁸ Declaration of Sheri Montgomery, May 14, 2025, ¶ 26; Declaration of Erik Cazares, May 13, 2025, ¶ 25; Declaration of Jerad Hanlon, May 13, 2025, ¶ 24; Declaration of Cynthia McCauley, May 13, 2025, ¶ 36.

²⁹ Leapfrog Hospital Safety Grade Scoring Methodology, Spring 2025 Safety Grade (<https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025.pdf>) ("Leapfrog Spring 2025 Scoring Methodology"), p. 3.

³⁰ Leapfrog Spring 2025 Scoring Methodology, p. 4.

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29. I understand that in “cases where a hospital’s information is not available for a certain measure, Leapfrog uses a secondary data source,” and in other “cases where a hospital’s information is not available from any data source, Leapfrog has outlined a methodology for dealing with the missing data.”³¹ In particular, I understand that twelve of the 22 measures used in the TLG grading methodology are based on the Leapfrog Hospital Survey. However, because the survey is voluntary, TLG utilizes “secondary data when available” for hospitals that did not complete the survey.³²
30. TLG employs an “imputation method,” if necessary, for four of the Process/Structural Measures to the extent the hospital does not provide information via the Leapfrog Hospital Survey.³³ TLG states that it “has worked closely with statisticians at Mathematica, Leapfrog’s National Expert Panel, and [its] scientific partners at Johns Hopkins Medicine to develop a new two-step imputation approach for determining scores for CPOE, BCMA, IPS, and Hand Hygiene if they are missing from” the survey.³⁴ For purposes of the Spring 2025 grades, the first step in the imputation process is, “[i]f the hospital had a score assigned by Leapfrog in the previous two rounds of grades (i.e., fall 2024, spring 2024), excluding imputed scores, the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e. spring 2025).”³⁵ For the second step, “[i]f the hospital does not have historical data from the last two rounds...of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving ‘Limited Achievement’ for this measure on the Leapfrog Hospital Survey.”³⁶ These point assignments are shown below:³⁷

³¹ Leapfrog Spring 2025 Scoring Methodology, p. 4.

³² Leapfrog Spring 2025 Scoring Methodology, p. 15.

³³ Leapfrog Spring 2025 Scoring Methodology, p. 15. These imputed amounts may be applicable for the following measures: Computerized Physician Order Entry (“CPOE”), Bar Code Medication Administration (“BCMA”), ICU Physician Staffing (“IPS”), and Hand Hygiene Score (“HHS”).

³⁴ Leapfrog Spring 2025 Scoring Methodology, p. 15.

³⁵ Leapfrog Spring 2025 Scoring Methodology, p. 15. This step is only applicable to the CPOE, IPS and Hand Hygiene measures.

³⁶ Leapfrog Spring 2025 Scoring Methodology, p. 16.

³⁷ Leapfrog Spring 2025 Scoring Methodology, p. 16.

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Step 2 Imputation Point Assignments

Measure	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement	15
BCMA	Limited Achievement	25
IPS	Limited Achievement	5
Hand Hygiene	Limited Achievement	15

31. Plaintiffs allege that “TLG’s imputation model deceives consumers by inventing negative data about hospitals that TLG wishes to punish for declining to participate in its survey.”³⁸ Consequently, Plaintiffs allege that, as a result of the use of imputed data, “hospitals who elect not to participate in TLG’s survey receive only 60 out of 400 possible points in these four categories – resulting in artificially deflated overall grades with no basis in fact and no correlation to a hospital’s actual safety performance.”³⁹
32. In his report, Dr. Nicholson states that the “statistics literature recommends several methods to address missing data from survey non-participants, none of which involve TLG’s current method of arbitrarily imputing the lowest-possible value for non-participating hospitals.”⁴⁰ He also states that he “compared the grades that TLG assigned to Plaintiffs with the grades that Plaintiffs would have been assigned had they participated in TLG’s survey and self-reported data in a similar way to participating hospitals, i.e., if they had given themselves the average score that participating hospitals gave themselves on each measure.”⁴¹ According to Dr. Nicholson, based on this analysis, “had Plaintiffs chosen to participate in TLG’s survey and answered that survey in the way that participating hospitals do, Plaintiffs would have been assigned by TLG grades of ‘C’, i.e., one to two letter grades higher than the grades Plaintiffs were actually assigned when they chose not to participate in TLG’s survey.”⁴²
33. As described above, Plaintiffs dispute TLG’s use of imputed values for the CPOE, BCMA, IPS, and Hand Hygiene measures. Therefore, I have analyzed changes in the Plaintiff Hospitals’ grades assuming that the imputed factors are excluded from the determination of a

³⁸ Complaint, ¶ 52.

³⁹ Complaint, ¶ 52.

⁴⁰ Nicholson Report, ¶ 67.

⁴¹ Nicholson Report, ¶ 66.

⁴² Nicholson Report, ¶ 66.

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Hospital Safety Grade. In particular, I entered an “N/A” as each of the Plaintiff Hospitals’ scores for the CPOE, BCMA, IPS, and Hand Hygiene measures. In this way, the imputed scores were not utilized, the weights were redistributed across all entered scores, and new grades for each hospital were determined.⁴³

34. Based on my analysis eliminating consideration of the four imputed scores, the grades for the Plaintiffs would not materially change, as the letter grades for Delray Medical Center, Palm Beach Gardens Medical Center, St. Mary’s, and West Boca Medical Center remained the same, and the grade for Good Samaritan decreased by one letter grade (from “D” to “F”). I summarize these grades in **Table 1** below.

Table 1				
Summary of Actual and Adjusted Hospital Safety Grades for Plaintiff Hospitals Spring 2025				
<u>Hospital</u>	<u>Actual¹</u>		<u>As Adjusted²</u>	
	<u>Score</u>	<u>Grade</u>	<u>Score</u>	<u>Grade</u>
Delray Medical Center	1.6430	F	0.9410	F
Good Samaritan	1.9638	D	1.7760	F
Palm Beach Gardens Medical Center	1.7777	F	1.5117	F
St. Mary's	2.2512	D	2.3102	D
West Boca Medical Center	1.8346	F	1.5371	F
Notes:				
1. Per Exhibits 1-5 and Nicholson Report, Workpaper 5.				
2. Per Exhibits 6-10.				

VI. Additional Analysis and Demonstrative Aids

35. The opinions expressed herein are subject to change based upon any additional discovery related to this case or information that I may receive after the date of this report. I reserve the right to supplement or amend my analyses and opinions as additional information becomes available.
36. If I am called upon to testify, I may prepare demonstrative aids, such as graphs, charts, or tables.

⁴³ As a result of the exclusion of imputed scores, the grades for the Plaintiff Hospitals were derived from CMS data.

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Executed on September 4, 2025

A handwritten signature in blue ink, appearing to read 'Mark F. Rule', is positioned above a horizontal line.

Mark F. Rule, CFA

Appendix 1 - CV of Mark F. Rule, CFA, ABV

Partner & Managing Director
 mrule@alixpartners.com
 +1 312 705 3960, office

Mark applies more than 25 years of experience to help companies, law firms, boards of directors, board committees, independent directors, lenders, equity investors and government agencies solve complex problems. During his career, Mark has analyzed economic and financial issues, assisted in financial restructuring and bankruptcy engagements, analyzed fraudulent conveyance and preference actions, analyzed solvency, performed liquidation analyses, investigated fraud and accounting irregularities, prepared lost profits and damage analyses, analyzed indicia of alter ego, and valued a wide range of assets, intellectual property, securities and businesses. Mark has experience in over 30 industries.

Mark has been qualified and testified as a damages, valuation, solvency, accounting and alter ego expert in federal court, bankruptcy court, state court, and AAA/JAMS/ICC arbitrations.

Mark has served as an independent damages and valuation arbitrator. Mark has presented his opinions to the SEC and DOL.

Mark holds a Masters in Business Administration from the University of Chicago Booth School of Business with concentrations in accounting, finance, and economics. He holds a Bachelor of Business Administration degree in finance and computer applications from the University of Notre Dame. Mark is a Chartered Financial Analyst (CFA) charterholder and holds the Accredited in Business Valuation (ABV) designation from the American Institute of Certified Public Accountants (AICPA).

Testimony Within the Last Four years

- *In re: Purdue Pharma L.P., et al., Chapter 11 Case No. 19-23649 (RDD), United States Bankruptcy Court, Southern District of New York*
- *In re: Cinemex USA Real Estate Holdings, Inc. et al., Chapter 11 Case No. 20-14695-LMI, United States Bankruptcy Court, Southern District of Florida, Miami Division*
- *Jayson Weisz, SRC Medical Partners, LLC, and JRF Group, LLC v. PalliaTech Florida LLC, PalliaTech Florida, Inc., and Joseph Lusardi. Case No. 01-18-0004-5355, the American Arbitration Association*
- *CBPB Holdings, Inc. and Howard Kessler v. FSR Holdings, LLC and Felix Riccio. JAMS Ref. No. 1400017952*
- *Apneet S. Jolly v. Crypto Lotus, LLC, et al. Case No. 01-21-0004-0258, the American Arbitration Association*
- *Obrascón Huarte Lain S.A. and OHL USA, Inc. v. Astaldi S.p.A. and Astaldi Construction Corporation, Case No. 01-21-0004-3176, the American Arbitration Association*
- *ECB USA, Inc., and Atlantic Ventures Corp., v. Savencia, S.A., Case No.: 1:19-CV-00731-GBW-CJB, United States District Court for the District of Delaware*
- *Plastic Reclamation Partners, LLC v. MRC Polymers Inc., In The Circuit Court of Cook County, Illinois, County Department – Law Division*
- *Biote Medical, LLC, v. Dr. Gary Donovitz, DC-22-08737, District Court, Dallas County, Texas, 134th Judicial District*

Testimony Within the Last Four years (cont'd)

- *Binh Thanh Import Export Production & Trade Joint Stock Co., d/b/a Gilimex, Inc. v. Amazon.com Services LLC, d/b/a Amazon Robotics, Case No.: 1:23-cv-00292-LGS, United States District Court for the Southern District of New York*
- *In re: Wesco Aircraft Holdings, Inc., et al., Chapter 11 Case No. 23-90611 (MI), United States Bankruptcy Court, Southern District of Texas, Houston Division*
- *Emigrant Bank and Pacific Mercantile Bank v. SunTrust Bank, Truist Bank, and Does 1 through 10, inclusive, Case No.: 1:20-cv-02391-PGG, United States District Court for the Southern District of New York*
- *Catherine E. Youngman, in her capacity as Class 3 Trustee for the Speedcast SFA Lenders' Litigation Trust v. Peter Shaper, Cause No. 2022-01305, in the District Court of Harris County, Texas, 61st Judicial District*
- *AbbVie Inc. v. Quincy Bioscience Holding Company, Inc., JAMS*
- *Adviser Investments, LLC v. Jeffrey Powell, Case No.: N22C-12-096 MAA (CCLD), United States Superior Court for the State of Delaware*
- *T.F. Warren Group Corporation and Blastech Mobile LLC v. SSAB Alabama, Inc., SSAB Enterprises, LLC, and SSAB US Holdings, Inc. Case No. 01-22-0005-3556, the American Arbitration Association*
- *John Vincent, Wakem Global Opportunities Fund LP, and Wakem Capital Management LLC v. Linedata Services, Inc. and Gravitas Technology Services, LLC, Arbitration No. 28333/PDP, the International Court of Arbitration of the International Chamber of Commerce*
- *BBSR, LLC v. Anheuser-Busch, LLC, No. X03 HHD CV 226166055 S, Superior Court Judicial District of Stamford-Norwalk at Stamford*
- *Dominik Alfieri, Michael Alfieri, et al., v. Jennifer Alfieri Frank, et al., Docket No.: MRS-L-1947-22, Superior Court of new Jersey Law Division: Morris Country*
- *BR Fund IV Acq Inv, LLC (et. al.) v. Brightwood Capital Fund III-Institutional, LP (et. al.) Index No. 651756/2024 Supreme Court of the State of New York, County of New York*

Documents and Information Considered

Documents Produced in This Litigation

LEAPFROG00000032-048	PBHN000002602-603	PBHN000003614-670
LEAPFROG00000065-085	PBHN000002604-618	PBHN000003671-673
LEAPFROG00000122-140	PBHN000002619-625	PBHN000003674-685
LEAPFROG00020679	PBHN000002626-628	PBHN000003686-712
LEAPFROG00132898-899	PBHN000002629-631	PBHN000003713-735
LEAPFROG00140378-423	PBHN000002632-637	PBHN000003736-745
LEAPFROG00143080-108	PBHN000002638-640	PBHN000003746-750
LEAPFROG00178624-627	PBHN000002641-643	PBHN000003751-760
LEAPFROG00178625-633	PBHN000002644-650	PBHN000003761-776
LEAPFROG00197221-227	PBHN000002651-3003	PBHN000003777-778
LEAPFROG00238732-737	PBHN000003004-008	PBHN000003789-832
LEAPFROG00241845-851	PBHN000003009-011	PBHN000003833-848
LEAPFROG00323940-941	PBHN000003012-040	PBHN000003849-876
LEAPFROG00328568-573	PBHN000003041-043	PBHN000003877-892
LEAPFROG00387902	PBHN000003044-069	PBHN000003893-906
LEAPFROG00392834-840	PBHN000003070-075	PBHN000003907-924
LEAPFROG00400607-608	PBHN000003076-078	PBHN000003925-932
LEAPFROG00427863-868	PBHN000003079-081	PBHN000003933-951
LEAPFROG00439030	PBHN000003082-084	PBHN000003952-961
LEAPFROG00510740-770	PBHN000003085-098	PBHN000003962-4009
PBHN000002066-078	PBHN000003099-119	PBHN000004010-087
PBHN000002090-103	PBHN000003120-133	PBHN000004088-100
PBHN000002104-193	PBHN000003134-139	PBHN000004101-112
PBHN000002207-234	PBHN000003140-150	PBHN000004113-115
PBHN000002235-238	PBHN000003155-157	PBHN000004116-118
PBHN000002238	PBHN000003158-166	PBHN000004131-150
PBHN000002239-270	PBHN000003167-181	PBHN000004151-160
PBHN000002271-290	PBHN000003216-263	PBHN000004161-164
PBHN000002291-308	PBHN000003264-280	PBHN000004165-187
PBHN000002309-317	PBHN000003281-302	PBHN000004188-196
PBHN000002318-349	PBHN000003303-316	PBHN000004197
PBHN000002350-415	PBHN000003317-333	PBHN000004198-224
PBHN000002416-427	PBHN000003334-352	PBHN000004225-228
PBHN000002455-475	PBHN000003368-390	PBHN000004229-250
PBHN000002476-482	PBHN000003391-404	PBHN000004255-271
PBHN000002483-485	PBHN000003405-416	PBHN000004272-279
PBHN000002486-489	PBHN000003417-450	PBHN000004280-285
PBHN000002490-520	PBHN000003451-476	PBHN000004286-292
PBHN000002521-524	PBHN000003477-496	PBHN000004293-311
PBHN000002532-537	PBHN000003497-516	PBHN000004312-318
PBHN000002538-544	PBHN000003517-523	PBHN000004319-327

PBHN000002545-548	PBHN000003524-554	PBHN000004328-431
PBHN000002549-564	PBHN000003555-561	PBHN000004332-338
PBHN000002565-575	PBHN000003562-575	PBHN000004339-352
PBHN000002576	PBHN000003576-587	PBHN000004353
PBHN000002577-592	PBHN000003588-598	PBHN000004354-361
PBHN000002598-601	PBHN000003599-613	

Other Expert Reports

Expert Report of Jonah Berger, Ph.D., 8/7/25
Supplemental Expert Report of Jonah Berger, Ph.D., 8/21/25
Expert Report of Thoma Chakurda, 8/7/25
Expert Report of Professor Sean Nicholson, 8/7/25 (and associated data files)

Pleadings and Case Filings

Complaint and Demand for Jury Trial, 4/30/25
Plaintiffs' Expert Disclosure, 8/7/25
Defendant The Leapfrog Group's Motion to Dismiss Pursuant to Federal Rule of Civil Procedure 12(b)(2) and 12(b)(6) and Incorporated Memorandum of Law in Support of the Same, 6/27/25
Plaintiffs' Responses and Objections to Defendant's First Set of Requests for Production, 7/24/25
Plaintiff Delray Medical Center, Inc.'s Responses and Objections to Defendant The Leapfrog Group's First Set of Interrogatories to Delray Medical Center, 7/25/25
Plaintiff Good Samaritan Medical Center, Inc.'s Responses and Objections to Defendant The Leapfrog Group's First Set of Interrogatories to Good Samaritan Medical Center, Inc., 7/25/25
Plaintiff Palm Beach Gardens Medical Center's Responses and Objections to Defendant The Leapfrog Group's First Set of Interrogatories to Palm Beach Gardens Medical Center, 7/25/25
Plaintiff St. Mary's Medical Center, Inc.'s Responses and Objections to Defendant The Leapfrog Group's First Set of Interrogatories to St. Mary's Medical Center, 7/25/25
Plaintiff West Boca Medical Center, Inc.'s Responses and Objections to Defendant The Leapfrog Group's First Set of Interrogatories to West Boca Medical Center, 7/25/25

Other

Declaration of Cynthia McCauley, 5/13/25
Declaration of Erik Cazares, 5/13/25
Declaration of Heather Havericak, 5/14/25
Declaration of Professor Sean Nicholson, 5/17/25
Declaration of Sheri Montgomery, 5/14/25
Declaration of Jerad Hanlon, 5/13/25
Hospital Safety Score, Scoring Methodology, March 2014
Leapfrog Hospital Survey, 2025 Leapfrog Hospital Survey Binder
2025 Leapfrog Hospital Survey - Hard Copy

The Leapfrog Hospital Survey Scoring Algorithms

Leapfrog Hospital Safety Grade, Scoring Methodology, Fall 2024 Safety Grade

Leapfrog Hospital Safety Grade, Scoring Methodology, Spring 2025 Safety Grade

Hospital Safety Grade Calculator, Spring 2025

Leapfrog website

Hospital Safety Grade website

Litigation Services Handbook: The Role of the Financial Expert, Sixth edition (2017).

Exhibit 1

Hospital Safety Grade - Delray Medical Center

April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score ¹		Inputs to Weighting Individual Measures ²				Weight ³		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures ⁴	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	15.00	80.23	34.14	-1.9104	-1.9104	2	1.43	3	1	6.157%	7.9%	-0.1507
	Bar Code Medication Administration (BCMA)	25.00	81.87	30.45	-1.8675	-1.8675	2	1.37	3	1	6.000%	7.7%	-0.1435
	ICU Physician Staffing (IPS)	5.00	65.15	43.73	-1.3754	-1.3754	2	1.67	3	1	6.881%	8.8%	-0.1212
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.49	6.79	N/A	N/A	1	1.06	2	1	3.056%	0.0%	0.0000
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	N/A	116.85	13.98	N/A	N/A	1	1.12	2	1	3.178%	0.0%	0.0000
	Total Nursing Care Hours per Patient Day	N/A	77.07	31.61	N/A	N/A	2	1.41	2	1	4.729%	0.0%	0.0000
	Hand Hygiene	15.00	74.40	36.14	-1.6434	-1.6434	2	1.49	2	1	4.877%	6.2%	-0.1027
	H-COMP-1: Nurse Communication	79	90.19	2.51	-4.4536	-4.4536	1	1.03	2	1	2.998%	3.8%	-0.1710
	H-COMP-2: Doctor Communication	81	89.91	2.48	-3.5914	-3.5914	1	1.03	2	1	2.997%	3.8%	-0.1379
	H-COMP-3: Staff Responsiveness	64	81.63	4.36	-4.0450	-4.0450	1	1.05	2	1	3.048%	3.9%	-0.1579
	H-COMP-5: Communication about Medicines	58	74.42	4.13	-3.9795	-3.9795	1	1.06	2	1	3.052%	3.9%	-0.1555
Outcome Measures	H-COMP-6: Discharge Information	71	85.25	3.70	-3.8467	-3.8467	1	1.04	2	1	3.028%	3.9%	-0.1492
	Foreign Object Retained	0.000	0.014	0.05	0.2755	0.2755	1	3.00	2	1	4.208%	4.2%	0.0116
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.4%	0.0008
	Falls and Trauma	0.479	0.384	0.40	-0.2351	-0.2351	2	2.05	3	1	4.894%	4.9%	-0.0115
	CLABSI	1.477	0.651	0.55	-1.4958	-1.4958	2	1.85	3	1	4.536%	4.5%	-0.0679
	CAUTI	0.271	0.540	0.49	0.5450	0.5450	2	1.91	3	1	4.654%	4.7%	0.0254
	SSI: Colon	2.073	0.831	0.69	-1.8032	-1.8032	2	1.83	2	1	3.400%	3.4%	-0.0613
	MRSA	0.922	0.719	0.59	-0.3430	-0.3430	2	1.82	3	1	4.489%	4.5%	-0.0154
	C. Diff.	0.284	0.401	0.33	0.3575	0.3575	2	1.81	3	1	4.474%	4.5%	0.0160
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	108.94	177.45	24.02	2.8522	2.8522	1	1.14	2	1	1.966%	2.0%	0.0561
CMS Medicare PSI 90: Patient safety and adverse events composite		1.03	1.00	0.20	-0.1419	-0.1419	1	1.20	2	10	14.974%	15.0%	-0.0212
Process Measure Domain Score:		-1.2896											
Outcome Measure Domain Score:		-0.0675											
Process/Outcome Domains - Combined Score:		-1.3570											
Normalized Numerical Score:		1.6430											
Hospital Safety Grade (Letter Grade):		F											

Exhibit 2

Hospital Safety Grade - Good Samaritan

April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score ¹		Inputs to Weighting Individual Measures ²				Weight ³		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures ⁴	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	15.00	80.23	34.14	-1.9104	-1.9104	2	1.43	3	1	6.157%	7.9%	-0.1507
	Bar Code Medication Administration (BCMA)	25.00	81.87	30.45	-1.8675	-1.8675	2	1.37	3	1	6.000%	7.7%	-0.1435
	ICU Physician Staffing (IPS)	5.00	65.15	43.73	-1.3754	-1.3754	2	1.67	3	1	6.881%	8.8%	-0.1212
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.49	6.79	N/A	N/A	1	1.06	2	1	3.056%	0.0%	0.0000
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	N/A	116.85	13.98	N/A	N/A	1	1.12	2	1	3.178%	0.0%	0.0000
	Total Nursing Care Hours per Patient Day	N/A	77.07	31.61	N/A	N/A	2	1.41	2	1	4.729%	0.0%	0.0000
	Hand Hygiene	15.00	74.40	36.14	-1.6434	-1.6434	2	1.49	2	1	4.877%	6.2%	-0.1027
	H-COMP-1: Nurse Communication	84	90.19	2.51	-2.4637	-2.4637	1	1.03	2	1	2.998%	3.8%	-0.0946
	H-COMP-2: Doctor Communication	86	89.91	2.48	-1.5761	-1.5761	1	1.03	2	1	2.997%	3.8%	-0.0605
	H-COMP-3: Staff Responsiveness	72	81.63	4.36	-2.2091	-2.2091	1	1.05	2	1	3.048%	3.9%	-0.0862
	H-COMP-5: Communication about Medicines	63	74.42	4.13	-2.7680	-2.7680	1	1.06	2	1	3.052%	3.9%	-0.1082
	H-COMP-6: Discharge Information	76	85.25	3.70	-2.4971	-2.4971	1	1.04	2	1	3.028%	3.9%	-0.0969
Outcome Measures	Foreign Object Retained	0.000	0.014	0.05	0.2755	0.2755	1	3.00	2	1	4.208%	4.2%	0.0116
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.4%	0.0008
	Falls and Trauma	0.789	0.384	0.40	-1.0053	-1.0053	2	2.05	3	1	4.894%	4.9%	-0.0492
	CLABSI	0.538	0.651	0.55	0.2042	0.2042	2	1.85	3	1	4.536%	4.5%	0.0093
	CAUTI	1.567	0.540	0.49	-2.0799	-2.0799	2	1.91	3	1	4.654%	4.7%	-0.0968
	SSI: Colon	1.679	0.831	0.69	-1.2311	-1.2311	2	1.83	2	1	3.400%	3.4%	-0.0419
	MRSA	0.000	0.719	0.59	1.2161	1.2161	2	1.82	3	1	4.489%	4.5%	0.0546
	C. Diff.	0.250	0.401	0.33	0.4618	0.4618	2	1.81	3	1	4.474%	4.5%	0.0207
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	156.08	177.45	24.02	0.8897	0.8897	1	1.14	2	1	1.966%	2.0%	0.0175
	CMS Medicare PSI 90: Patient safety and adverse events composite	1.00	1.00	0.20	0.0113	0.0113	1	1.20	2	10	14.974%	15.0%	0.0017
Process Measure Domain Score:		-0.9644											
Outcome Measure Domain Score:		-0.0717											
Process/Outcome Domains - Combined Score:		-1.0362											
Normalized Numerical Score:		1.9638											
Hospital Safety Grade (Letter Grade):		D											

Exhibit 3

Hospital Safety Grade - Palm Beach Gardens Medical Center

April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score ¹		Inputs to Weighting Individual Measures ²				Weight ³		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures ⁴	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	15.00	80.23	34.14	-1.9104	-1.9104	2	1.43	3	1	6.157%	7.9%	-0.1507
	Bar Code Medication Administration (BCMA)	25.00	81.87	30.45	-1.8675	-1.8675	2	1.37	3	1	6.000%	7.7%	-0.1435
	ICU Physician Staffing (IPS)	5.00	65.15	43.73	-1.3754	-1.3754	2	1.67	3	1	6.881%	8.8%	-0.1212
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.49	6.79	N/A	N/A	1	1.06	2	1	3.056%	0.0%	0.0000
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	N/A	116.85	13.98	N/A	N/A	1	1.12	2	1	3.178%	0.0%	0.0000
	Total Nursing Care Hours per Patient Day	N/A	77.07	31.61	N/A	N/A	2	1.41	2	1	4.729%	0.0%	0.0000
	Hand Hygiene	15.00	74.40	36.14	-1.6434	-1.6434	2	1.49	2	1	4.877%	6.2%	-0.1027
	H-COMP-1: Nurse Communication	84	90.19	2.51	-2.4637	-2.4637	1	1.03	2	1	2.998%	3.8%	-0.0946
	H-COMP-2: Doctor Communication	84	89.91	2.48	-2.3822	-2.3822	1	1.03	2	1	2.997%	3.8%	-0.0914
	H-COMP-3: Staff Responsiveness	71	81.63	4.36	-2.4386	-2.4386	1	1.05	2	1	3.048%	3.9%	-0.0952
	H-COMP-5: Communication about Medicines	62	74.42	4.13	-3.0103	-3.0103	1	1.06	2	1	3.052%	3.9%	-0.1177
	H-COMP-6: Discharge Information	76	85.25	3.70	-2.4971	-2.4971	1	1.04	2	1	3.028%	3.9%	-0.0969
Outcome Measures	Foreign Object Retained	0.000	0.014	0.05	0.2755	0.2755	1	3.00	2	1	4.208%	4.2%	0.0116
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.4%	0.0008
	Falls and Trauma	0.439	0.384	0.40	-0.1357	-0.1357	2	2.05	3	1	4.894%	4.9%	-0.0066
	CLABSI	0.596	0.651	0.55	0.0992	0.0992	2	1.85	3	1	4.536%	4.5%	0.0045
	CAUTI	0.758	0.540	0.49	-0.4414	-0.4414	2	1.91	3	1	4.654%	4.7%	-0.0205
	SSI: Colon	0.511	0.831	0.69	0.4652	0.4652	2	1.83	2	1	3.400%	3.4%	0.0158
	MRSA	0.278	0.719	0.59	0.7460	0.7460	2	1.82	3	1	4.489%	4.5%	0.0335
	C. Diff.	0.395	0.401	0.33	0.0170	0.0170	2	1.81	3	1	4.474%	4.5%	0.0008
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	165.31	177.45	24.02	0.5055	0.5055	1	1.14	2	1	1.966%	2.0%	0.0099
	CMS Medicare PSI 90: Patient safety and adverse events composite	1.34	1.00	0.20	-1.7248	-1.7248	1	1.20	2	10	14.974%	15.0%	-0.2583
Process Measure Domain Score:		-1.0138											
Outcome Measure Domain Score:		-0.2085											
Process/Outcome Domains - Combined Score:		-1.2223											
Normalized Numerical Score:		1.7777											
Hospital Safety Grade (Letter Grade):		F											

Exhibit 4

Hospital Safety Grade - St. Mary's

April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score ¹		Inputs to Weighting Individual Measures ²				Weight ³		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures ⁴	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	15.00	80.23	34.14	-1.9104	-1.9104	2	1.43	3	1	6.157%	7.9%	-0.1507
	Bar Code Medication Administration (BCMA)	25.00	81.87	30.45	-1.8675	-1.8675	2	1.37	3	1	6.000%	7.7%	-0.1435
	ICU Physician Staffing (IPS)	5.00	65.15	43.73	-1.3754	-1.3754	2	1.67	3	1	6.881%	8.8%	-0.1212
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.49	6.79	N/A	N/A	1	1.06	2	1	3.056%	0.0%	0.0000
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	N/A	116.85	13.98	N/A	N/A	1	1.12	2	1	3.178%	0.0%	0.0000
	Total Nursing Care Hours per Patient Day	N/A	77.07	31.61	N/A	N/A	2	1.41	2	1	4.729%	0.0%	0.0000
	Hand Hygiene	15.00	74.40	36.14	-1.6434	-1.6434	2	1.49	2	1	4.877%	6.2%	-0.1027
	H-COMP-1: Nurse Communication	86	90.19	2.51	-1.6678	-1.6678	1	1.03	2	1	2.998%	3.8%	-0.0640
	H-COMP-2: Doctor Communication	86	89.91	2.48	-1.5761	-1.5761	1	1.03	2	1	2.997%	3.8%	-0.0605
	H-COMP-3: Staff Responsiveness	75	81.63	4.36	-1.5206	-1.5206	1	1.05	2	1	3.048%	3.9%	-0.0594
	H-COMP-5: Communication about Medicines	69	74.42	4.13	-1.3141	-1.3141	1	1.06	2	1	3.052%	3.9%	-0.0514
	H-COMP-6: Discharge Information	80	85.25	3.70	-1.4175	-1.4175	1	1.04	2	1	3.028%	3.9%	-0.0550
Outcome Measures	Foreign Object Retained	0.000	0.014	0.05	0.2755	0.2755	1	3.00	2	1	4.208%	4.2%	0.0116
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.4%	0.0008
	Falls and Trauma	0.665	0.384	0.40	-0.6972	-0.6972	2	2.05	3	1	4.894%	4.9%	-0.0341
	CLABSI	0.229	0.651	0.55	0.7637	0.7637	2	1.85	3	1	4.536%	4.5%	0.0346
	CAUTI	1.217	0.540	0.49	-1.3710	-1.3710	2	1.91	3	1	4.654%	4.7%	-0.0638
	SSI: Colon	0.354	0.831	0.69	0.6932	0.6932	2	1.83	2	1	3.400%	3.4%	0.0236
	MRSA	0.829	0.719	0.59	-0.1858	-0.1858	2	1.82	3	1	4.489%	4.5%	-0.0083
	C. Diff.	0.370	0.401	0.33	0.0937	0.0937	2	1.81	3	1	4.474%	4.5%	0.0042
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	152.54	177.45	24.02	1.0371	1.0371	1	1.14	2	1	1.966%	2.0%	0.0204
CMS Medicare PSI 90: Patient safety and adverse events composite		0.91	1.00	0.20	0.4708	0.4708	1	1.20	2	10	14.974%	15.0%	0.0705
Process Measure Domain Score:		-0.8083											
Outcome Measure Domain Score:		0.0595											
Process/Outcome Domains - Combined Score:		-0.7488											
Normalized Numerical Score:		2.2512											
Hospital Safety Grade (Letter Grade):		D											

Exhibit 5

Hospital Safety Grade - West Boca Medical Center

April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score ¹		Inputs to Weighting Individual Measures ²				Weight ³		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures ⁴	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	15.00	80.23	34.14	-1.9104	-1.9104	2	1.43	3	1	6.157%	7.9%	-0.1507
	Bar Code Medication Administration (BCMA)	25.00	81.87	30.45	-1.8675	-1.8675	2	1.37	3	1	6.000%	7.7%	-0.1435
	ICU Physician Staffing (IPS)	5.00	65.15	43.73	-1.3754	-1.3754	2	1.67	3	1	6.881%	8.8%	-0.1212
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.49	6.79	N/A	N/A	1	1.06	2	1	3.056%	0.0%	0.0000
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	N/A	116.85	13.98	N/A	N/A	1	1.12	2	1	3.178%	0.0%	0.0000
	Total Nursing Care Hours per Patient Day	N/A	77.07	31.61	N/A	N/A	2	1.41	2	1	4.729%	0.0%	0.0000
	Hand Hygiene	15.00	74.40	36.14	-1.6434	-1.6434	2	1.49	2	1	4.877%	6.2%	-0.1027
	H-COMP-1: Nurse Communication	82	90.19	2.51	-3.2597	-3.2597	1	1.03	2	1	2.998%	3.8%	-0.1252
	H-COMP-2: Doctor Communication	85	89.91	2.48	-1.9792	-1.9792	1	1.03	2	1	2.997%	3.8%	-0.0760
	H-COMP-3: Staff Responsiveness	66	81.63	4.36	-3.5861	-3.5861	1	1.05	2	1	3.048%	3.9%	-0.1400
	H-COMP-5: Communication about Medicines	64	74.42	4.13	-2.5257	-2.5257	1	1.06	2	1	3.052%	3.9%	-0.0987
	H-COMP-6: Discharge Information	78	85.25	3.70	-1.9573	-1.9573	1	1.04	2	1	3.028%	3.9%	-0.0759
Outcome Measures	Foreign Object Retained	0.000	0.014	0.05	0.2755	0.2755	1	3.00	2	1	4.208%	4.4%	0.0121
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.5%	0.0009
	Falls and Trauma	0.652	0.384	0.40	-0.6649	-0.6649	2	2.05	3	1	4.894%	5.1%	-0.0339
	CLABSI	1.144	0.651	0.55	-0.8929	-0.8929	2	1.85	3	1	4.536%	4.7%	-0.0422
	CAUTI	0.622	0.540	0.49	-0.1659	-0.1659	2	1.91	3	1	4.654%	4.8%	-0.0080
	SSI: Colon	2.922	0.831	0.69	-3.0362	-3.0362	2	1.83	2	1	3.400%	3.5%	-0.1075
	MRSA	1.318	0.719	0.59	-1.0127	-1.0127	2	1.82	3	1	4.489%	4.7%	-0.0473
	C. Diff.	0.198	0.401	0.33	0.6213	0.6213	2	1.81	3	1	4.474%	4.7%	0.0289
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	N/A	177.45	24.02	N/A	N/A	1	1.14	2	1	1.966%	0.0%	0.0000
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.92	1.00	0.20	0.4198	0.4198	1	1.20	2	10	14.974%	15.6%	0.0654
Process Measure Domain Score:		-1.0338											
Outcome Measure Domain Score:		-0.1316											
Process/Outcome Domains - Combined Score:		-1.1654											
Normalized Numerical Score:		1.8346											
Hospital Safety Grade (Letter Grade):		F											

Exhibit 6

Hospital Safety Grade - Delray Medical Center
Excludes Imputed Scores
April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score ¹		Inputs to Weighting Individual Measures ²				Weight ³		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures ⁴	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	N/A	80.23	34.14	N/A	N/A	2	1.43	3	1	6.157%	0.0%	0.0000
	Bar Code Medication Administration (BCMA)	N/A	81.87	30.45	N/A	N/A	2	1.37	3	1	6.000%	0.0%	0.0000
	ICU Physician Staffing (IPS)	N/A	65.15	43.73	N/A	N/A	2	1.67	3	1	6.881%	0.0%	0.0000
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.49	6.79	N/A	N/A	1	1.06	2	1	3.056%	0.0%	0.0000
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	N/A	116.85	13.98	N/A	N/A	1	1.12	2	1	3.178%	0.0%	0.0000
	Total Nursing Care Hours per Patient Day	N/A	77.07	31.61	N/A	N/A	2	1.41	2	1	4.729%	0.0%	0.0000
	Hand Hygiene	N/A	74.40	36.14	N/A	N/A	2	1.49	2	1	4.877%	0.0%	0.0000
	H-COMP-1: Nurse Communication	79	90.19	2.51	-4.4536	-4.4536	1	1.03	2	1	2.998%	9.9%	-0.4414
	H-COMP-2: Doctor Communication	81	89.91	2.48	-3.5914	-3.5914	1	1.03	2	1	2.997%	9.9%	-0.3559
	H-COMP-3: Staff Responsiveness	64	81.63	4.36	-4.0450	-4.0450	1	1.05	2	1	3.048%	10.1%	-0.4076
	H-COMP-5: Communication about Medicines	58	74.42	4.13	-3.9795	-3.9795	1	1.06	2	1	3.052%	10.1%	-0.4015
Outcome Measures	H-COMP-6: Discharge Information	71	85.25	3.70	-3.8467	-3.8467	1	1.04	2	1	3.028%	10.0%	-0.3851
	Foreign Object Retained	0.000	0.014	0.05	0.2755	0.2755	1	3.00	2	1	4.208%	4.2%	0.0116
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.4%	0.0008
	Falls and Trauma	0.479	0.384	0.40	-0.2351	-0.2351	2	2.05	3	1	4.894%	4.9%	-0.0115
	CLABSI	1.477	0.651	0.55	-1.4958	-1.4958	2	1.85	3	1	4.536%	4.5%	-0.0679
	CAUTI	0.271	0.540	0.49	0.5450	0.5450	2	1.91	3	1	4.654%	4.7%	0.0254
	SSI: Colon	2.073	0.831	0.69	-1.8032	-1.8032	2	1.83	2	1	3.400%	3.4%	-0.0613
	MRSA	0.922	0.719	0.59	-0.3430	-0.3430	2	1.82	3	1	4.489%	4.5%	-0.0154
	C. Diff.	0.284	0.401	0.33	0.3575	0.3575	2	1.81	3	1	4.474%	4.5%	0.0160
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	108.94	177.45	24.02	2.8522	2.8522	1	1.14	2	1	1.966%	2.0%	0.0561
CMS Medicare PSI 90: Patient safety and adverse events composite		1.03	1.00	0.20	-0.1419	-0.1419	1	1.20	2	10	14.974%	15.0%	-0.0212
Process Measure Domain Score:		-1.9916											
Outcome Measure Domain Score:		-0.0675											
Process/Outcome Domains - Combined Score:		-2.0590											
Normalized Numerical Score:		0.9410											
Hospital Safety Grade (Letter Grade):		F											

Exhibit 7

Hospital Safety Grade - Good Samaritan
Excludes Imputed Scores
April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score ¹		Inputs to Weighting Individual Measures ²				Weight ³		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures ⁴	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	N/A	80.23	34.14	N/A	N/A	2	1.43	3	1	6.157%	0.0%	0.0000
	Bar Code Medication Administration (BCMA)	N/A	81.87	30.45	N/A	N/A	2	1.37	3	1	6.000%	0.0%	0.0000
	ICU Physician Staffing (IPS)	N/A	65.15	43.73	N/A	N/A	2	1.67	3	1	6.881%	0.0%	0.0000
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.49	6.79	N/A	N/A	1	1.06	2	1	3.056%	0.0%	0.0000
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	N/A	116.85	13.98	N/A	N/A	1	1.12	2	1	3.178%	0.0%	0.0000
	Total Nursing Care Hours per Patient Day	N/A	77.07	31.61	N/A	N/A	2	1.41	2	1	4.729%	0.0%	0.0000
	Hand Hygiene	N/A	74.40	36.14	N/A	N/A	2	1.49	2	1	4.877%	0.0%	0.0000
	H-COMP-1: Nurse Communication	84	90.19	2.51	-2.4637	-2.4637	1	1.03	2	1	2.998%	9.9%	-0.2442
	H-COMP-2: Doctor Communication	86	89.91	2.48	-1.5761	-1.5761	1	1.03	2	1	2.997%	9.9%	-0.1562
	H-COMP-3: Staff Responsiveness	72	81.63	4.36	-2.2091	-2.2091	1	1.05	2	1	3.048%	10.1%	-0.2226
	H-COMP-5: Communication about Medicines	63	74.42	4.13	-2.7680	-2.7680	1	1.06	2	1	3.052%	10.1%	-0.2793
	H-COMP-6: Discharge Information	76	85.25	3.70	-2.4971	-2.4971	1	1.04	2	1	3.028%	10.0%	-0.2500
Outcome Measures	Foreign Object Retained	0.000	0.014	0.05	0.2755	0.2755	1	3.00	2	1	4.208%	4.2%	0.0116
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.4%	0.0008
	Falls and Trauma	0.789	0.384	0.40	-1.0053	-1.0053	2	2.05	3	1	4.894%	4.9%	-0.0492
	CLABSI	0.538	0.651	0.55	0.2042	0.2042	2	1.85	3	1	4.536%	4.5%	0.0093
	CAUTI	1.567	0.540	0.49	-2.0799	-2.0799	2	1.91	3	1	4.654%	4.7%	-0.0968
	SSI: Colon	1.679	0.831	0.69	-1.2311	-1.2311	2	1.83	2	1	3.400%	3.4%	-0.0419
	MRSA	0.000	0.719	0.59	1.2161	1.2161	2	1.82	3	1	4.489%	4.5%	0.0546
	C. Diff.	0.250	0.401	0.33	0.4618	0.4618	2	1.81	3	1	4.474%	4.5%	0.0207
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	156.08	177.45	24.02	0.8897	0.8897	1	1.14	2	1	1.966%	2.0%	0.0175
CMS Medicare PSI 90: Patient safety and adverse events composite		1.00	1.00	0.20	0.0113	0.0113	1	1.20	2	10	14.974%	15.0%	0.0017
Process Measure Domain Score:		-1.1523											
Outcome Measure Domain Score:		-0.0717											
Process/Outcome Domains - Combined Score:		-1.2240											
Normalized Numerical Score:		1.7760											
Hospital Safety Grade (Letter Grade):		F											

Exhibit 8

Hospital Safety Grade - Palm Beach Gardens Medical Center
Excludes Imputed Scores
April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score ¹		Inputs to Weighting Individual Measures ²				Weight ³		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures ⁴	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	N/A	80.23	34.14	N/A	N/A	2	1.43	3	1	6.157%	0.0%	0.0000
	Bar Code Medication Administration (BCMA)	N/A	81.87	30.45	N/A	N/A	2	1.37	3	1	6.000%	0.0%	0.0000
	ICU Physician Staffing (IPS)	N/A	65.15	43.73	N/A	N/A	2	1.67	3	1	6.881%	0.0%	0.0000
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.49	6.79	N/A	N/A	1	1.06	2	1	3.056%	0.0%	0.0000
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	N/A	116.85	13.98	N/A	N/A	1	1.12	2	1	3.178%	0.0%	0.0000
	Total Nursing Care Hours per Patient Day	N/A	77.07	31.61	N/A	N/A	2	1.41	2	1	4.729%	0.0%	0.0000
	Hand Hygiene	N/A	74.40	36.14	N/A	N/A	2	1.49	2	1	4.877%	0.0%	0.0000
	H-COMP-1: Nurse Communication	84	90.19	2.51	-2.4637	-2.4637	1	1.03	2	1	2.998%	9.9%	-0.2442
	H-COMP-2: Doctor Communication	84	89.91	2.48	-2.3822	-2.3822	1	1.03	2	1	2.997%	9.9%	-0.2361
	H-COMP-3: Staff Responsiveness	71	81.63	4.36	-2.4386	-2.4386	1	1.05	2	1	3.048%	10.1%	-0.2457
	H-COMP-5: Communication about Medicines	62	74.42	4.13	-3.0103	-3.0103	1	1.06	2	1	3.052%	10.1%	-0.3037
	H-COMP-6: Discharge Information	76	85.25	3.70	-2.4971	-2.4971	1	1.04	2	1	3.028%	10.0%	-0.2500
Outcome Measures	Foreign Object Retained	0.000	0.014	0.05	0.2755	0.2755	1	3.00	2	1	4.208%	4.2%	0.0116
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.4%	0.0008
	Falls and Trauma	0.439	0.384	0.40	-0.1357	-0.1357	2	2.05	3	1	4.894%	4.9%	-0.0066
	CLABSI	0.596	0.651	0.55	0.0992	0.0992	2	1.85	3	1	4.536%	4.5%	0.0045
	CAUTI	0.758	0.540	0.49	-0.4414	-0.4414	2	1.91	3	1	4.654%	4.7%	-0.0205
	SSI: Colon	0.511	0.831	0.69	0.4652	0.4652	2	1.83	2	1	3.400%	3.4%	0.0158
	MRSA	0.278	0.719	0.59	0.7460	0.7460	2	1.82	3	1	4.489%	4.5%	0.0335
	C. Diff.	0.395	0.401	0.33	0.0170	0.0170	2	1.81	3	1	4.474%	4.5%	0.0008
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	165.31	177.45	24.02	0.5055	0.5055	1	1.14	2	1	1.966%	2.0%	0.0099
CMS Medicare PSI 90: Patient safety and adverse events composite		1.34	1.00	0.20	-1.7248	-1.7248	1	1.20	2	10	14.974%	15.0%	-0.2583
Process Measure Domain Score:		-1.2797											
Outcome Measure Domain Score:		-0.2085											
Process/Outcome Domains - Combined Score:		-1.4883											
Normalized Numerical Score:		1.5117											
Hospital Safety Grade (Letter Grade):		F											

Exhibit 9

Hospital Safety Grade - St. Mary's
Excludes Imputed Scores
April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score ¹		Inputs to Weighting Individual Measures ²				Weight ³		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures ⁴	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	N/A	80.23	34.14	N/A	N/A	2	1.43	3	1	6.157%	0.0%	0.0000
	Bar Code Medication Administration (BCMA)	N/A	81.87	30.45	N/A	N/A	2	1.37	3	1	6.000%	0.0%	0.0000
	ICU Physician Staffing (IPS)	N/A	65.15	43.73	N/A	N/A	2	1.67	3	1	6.881%	0.0%	0.0000
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.49	6.79	N/A	N/A	1	1.06	2	1	3.056%	0.0%	0.0000
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	N/A	116.85	13.98	N/A	N/A	1	1.12	2	1	3.178%	0.0%	0.0000
	Total Nursing Care Hours per Patient Day	N/A	77.07	31.61	N/A	N/A	2	1.41	2	1	4.729%	0.0%	0.0000
	Hand Hygiene	N/A	74.40	36.14	N/A	N/A	2	1.49	2	1	4.877%	0.0%	0.0000
	H-COMP-1: Nurse Communication	86	90.19	2.51	-1.6678	-1.6678	1	1.03	2	1	2.998%	9.9%	-0.1653
	H-COMP-2: Doctor Communication	86	89.91	2.48	-1.5761	-1.5761	1	1.03	2	1	2.997%	9.9%	-0.1562
	H-COMP-3: Staff Responsiveness	75	81.63	4.36	-1.5206	-1.5206	1	1.05	2	1	3.048%	10.1%	-0.1532
	H-COMP-5: Communication about Medicines	69	74.42	4.13	-1.3141	-1.3141	1	1.06	2	1	3.052%	10.1%	-0.1326
	H-COMP-6: Discharge Information	80	85.25	3.70	-1.4175	-1.4175	1	1.04	2	1	3.028%	10.0%	-0.1419
Outcome Measures	Foreign Object Retained	0.000	0.014	0.05	0.2755	0.2755	1	3.00	2	1	4.208%	4.2%	0.0116
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.4%	0.0008
	Falls and Trauma	0.665	0.384	0.40	-0.6972	-0.6972	2	2.05	3	1	4.894%	4.9%	-0.0341
	CLABSI	0.229	0.651	0.55	0.7637	0.7637	2	1.85	3	1	4.536%	4.5%	0.0346
	CAUTI	1.217	0.540	0.49	-1.3710	-1.3710	2	1.91	3	1	4.654%	4.7%	-0.0638
	SSI: Colon	0.354	0.831	0.69	0.6932	0.6932	2	1.83	2	1	3.400%	3.4%	0.0236
	MRSA	0.829	0.719	0.59	-0.1858	-0.1858	2	1.82	3	1	4.489%	4.5%	-0.0083
	C. Diff.	0.370	0.401	0.33	0.0937	0.0937	2	1.81	3	1	4.474%	4.5%	0.0042
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	152.54	177.45	24.02	1.0371	1.0371	1	1.14	2	1	1.966%	2.0%	0.0204
CMS Medicare PSI 90: Patient safety and adverse events composite		0.91	1.00	0.20	0.4708	0.4708	1	1.20	2	10	14.974%	15.0%	0.0705
Process Measure Domain Score:		-0.7492											
Outcome Measure Domain Score:		0.0595											
Process/Outcome Domains - Combined Score:		-0.6898											
Normalized Numerical Score:		2.3102											
Hospital Safety Grade (Letter Grade):		D											

Exhibit 10

Hospital Safety Grade - West Boca Medical Center
Excludes Imputed Scores
April 2025

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score ¹		Inputs to Weighting Individual Measures ²				Weight ³		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures ⁴	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	N/A	80.23	34.14	N/A	N/A	2	1.43	3	1	6.157%	0.0%	0.0000
	Bar Code Medication Administration (BCMA)	N/A	81.87	30.45	N/A	N/A	2	1.37	3	1	6.000%	0.0%	0.0000
	ICU Physician Staffing (IPS)	N/A	65.15	43.73	N/A	N/A	2	1.67	3	1	6.881%	0.0%	0.0000
	Safe Practice 1: Culture of Leadership Structures and Systems	N/A	117.49	6.79	N/A	N/A	1	1.06	2	1	3.056%	0.0%	0.0000
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	N/A	116.85	13.98	N/A	N/A	1	1.12	2	1	3.178%	0.0%	0.0000
	Total Nursing Care Hours per Patient Day	N/A	77.07	31.61	N/A	N/A	2	1.41	2	1	4.729%	0.0%	0.0000
	Hand Hygiene	N/A	74.40	36.14	N/A	N/A	2	1.49	2	1	4.877%	0.0%	0.0000
	H-COMP-1: Nurse Communication	82	90.19	2.51	-3.2597	-3.2597	1	1.03	2	1	2.998%	9.9%	-0.3231
	H-COMP-2: Doctor Communication	85	89.91	2.48	-1.9792	-1.9792	1	1.03	2	1	2.997%	9.9%	-0.1961
	H-COMP-3: Staff Responsiveness	66	81.63	4.36	-3.5861	-3.5861	1	1.05	2	1	3.048%	10.1%	-0.3614
	H-COMP-5: Communication about Medicines	64	74.42	4.13	-2.5257	-2.5257	1	1.06	2	1	3.052%	10.1%	-0.2548
	H-COMP-6: Discharge Information	78	85.25	3.70	-1.9573	-1.9573	1	1.04	2	1	3.028%	10.0%	-0.1960
Outcome Measures	Foreign Object Retained	0.000	0.014	0.05	0.2755	0.2755	1	3.00	2	1	4.208%	4.4%	0.0121
	Air Embolism	0.000	0.002	0.06	0.0348	0.0348	1	3.00	1	1	2.405%	2.5%	0.0009
	Falls and Trauma	0.652	0.384	0.40	-0.6649	-0.6649	2	2.05	3	1	4.894%	5.1%	-0.0339
	CLABSI	1.144	0.651	0.55	-0.8929	-0.8929	2	1.85	3	1	4.536%	4.7%	-0.0422
	CAUTI	0.622	0.540	0.49	-0.1659	-0.1659	2	1.91	3	1	4.654%	4.8%	-0.0080
	SSI: Colon	2.922	0.831	0.69	-3.0362	-3.0362	2	1.83	2	1	3.400%	3.5%	-0.1075
	MRSA	1.318	0.719	0.59	-1.0127	-1.0127	2	1.82	3	1	4.489%	4.7%	-0.0473
	C. Diff.	0.198	0.401	0.33	0.6213	0.6213	2	1.81	3	1	4.474%	4.7%	0.0289
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	N/A	177.45	24.02	N/A	N/A	1	1.14	2	1	1.966%	0.0%	0.0000
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.92	1.00	0.20	0.4198	0.4198	1	1.20	2	10	14.974%	15.6%	0.0654
Process Measure Domain Score:		-1.3314											
Outcome Measure Domain Score:		-0.1316											
Process/Outcome Domains - Combined Score:		-1.4629											
Normalized Numerical Score:		1.5371											
Hospital Safety Grade (Letter Grade):		F											

EXHIBIT 4

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

GOOD SAMARITAN MEDICAL CENTER
INC., DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. D/B/A PALM BEACH
GARDENS MEDICAL CENTER, ST.
MARY'S MEDICAL CENTER, INC., AND
WEST BOCA MEDICAL CENTER, INC.,

Case No. 9:25-CV-80526

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

Expert Report of Michael Vredenburg, M.S.
September 4, 2025

I, Michael Vredenburg, hereby under penalty of perjury that the following is true and correct:

I. Qualifications

1. My name is Michael Vredenburg. My expertise is based upon a combination of education, original theoretical research, and professional experience in human factors engineering, with a focus on forensic applications, safety analysis, and innovative design. I currently serve as Founder and CEO of Cherry Tomato Engineering, LLC in San Diego, California, a position I have held since 2022, where I lead human factors consulting projects, develop patented technologies, and manage litigation support involving risk perception and system interactions nationwide. Prior to this, I progressed through several roles at Vredenburg & Zackowitz, Inc., also in San Diego, including Industrial and Human Factors Engineer from 2016 to 2024, Systems and Research Analyst from 2010 to 2016, and Forensic and Research Intern from 2006 to 2010, during which I conducted forensic investigations, site inspections across the country, biomechanical modeling, statistical analysis, and expert analyses for personal injury, product liability, and transportation matters, contributing to over 100 litigation cases as a primary retained expert.

2. Educationally, I hold a Master of Science in Industrial and Human Factors Engineering from Wright State University, earned in 2020, along with a User Experience (UX) and Design Thinking Certificate from the same institution in 2021. I also earned a Bachelor of Science in Bioengineering from the University of California, Berkeley in 2016, providing a strong foundation in human-system interactions and biomechanical principles.

3. My scholarly contributions include peer-reviewed publications on topics such as user experience in training platforms, perceptual analysis in dynamic environments, forensic ethics, and risk communication for consumer products, with works appearing in Proceedings of the Human Factors and Ergonomics Society Annual Meeting and Advances in Safety Management and Human Factors. I have presented at major conferences, including the Human Factors and Ergonomics Society Annual Meeting and AHFE International Conference, on subjects like amusement park injuries, risk prevention, and adolescent behavior; chairing sessions to advance the field.

4. Technically, I am skilled in computer programming for data analysis and automation, ergonomic and biomechanical modeling, data extraction and database management for forensic reconstructions, 3D design and prototyping, and statistical software for risk studies. Notable projects include designing and iterating a garage-sized construction 3D printer since 2023,

currently in the patent process, and winning top prize at AngelHack SF 2015 for a machine learning-based email optimization system applying human-computer interaction principles.

5. My research has specifically addressed literacy and comprehension of medical and health-related documents, emphasizing how factors such as literacy levels, language barriers, aging, and familiarity influence the understanding of health information. For instance, in “Public Health: An Epidemiological Study to Explore the Relationship between Literacy, Language, Aging, and Familiarity on Comprehension of Health Information” (Proceedings of the Human Factors and Ergonomics Society, 2009, pp. 744–748), I conducted an epidemiological analysis demonstrating how these variables affect individuals’ ability to process and apply health-related texts, with implications for designing clearer medical communications. Building on this, my co-authored works in *Advances in Safety Management and Human Factors* (2017), including “Risk Communication for Consumer Products” (pp. 225–235) and “An Epidemiological Perspective of Individual and Population Health Risk Prevention” (pp. 357–368), explore effective strategies for conveying health risks in consumer contexts, integrating epidemiological insights to enhance population-level prevention through accessible documentation and warnings, thereby reducing misunderstandings in medical and safety information.

6. Please refer to my enclosed Curriculum Vitae (please see **Appendix A**) for detailed qualifications, a complete list of publications, presentations, and prior testimony.

II. Prior Testimony

7. Please see **Appendix B** for my 4-year testimony list.

III. Case Background and Allegations

8. This case arises from allegations brought by five hospitals (Good Samaritan Medical Center, Delray Medical Center, Palm Beach Gardens Medical Center, St. Mary’s Medical Center, and West Boca Medical Center) against The Leapfrog Group, a not-for-profit organization that assigns hospital safety grades.¹ The plaintiff hospitals are allegedly recognized for their high-quality healthcare services. Allegedly each hospital has received numerous awards and

¹ Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group, Amended Complaint, United States District Court for the Southern District of Florida, Case No. 9:25-cv-80526, p. 1 (August 28, 2025).

certifications from reputable organizations such as the Joint Commission, the American College of Surgeons, and Healthgrades, underscoring their commitment to patient safety and clinical excellence.

9. The plaintiffs allege that The Leapfrog Group's grading methodology is deceptive, misleading, and harmful to both the hospitals and the public.² The Leapfrog Group assigns letter grades ranging from A to F to hospitals nationwide based on its "Hospital Safety Grade" system, which is prominently displayed on its websites and marketed to influence patient decisions. The plaintiffs contend that The Leapfrog Group operates a "pay-to-play" scheme, incentivizing hospitals to participate in its survey by rewarding them with inflated grades while penalizing non-participating hospitals with artificially deflated grades.³ Beginning in Fall 2024, The Leapfrog Group changed its methodology to assign the lowest possible scores to non-participating hospitals for certain metrics, resulting in failing grades for the plaintiff hospitals for the first time.⁴ The plaintiffs argue that these grades are based on imputed data rather than actual performance, and The Leapfrog Group allegedly has no factual basis to support its claims that the plaintiff hospitals are unsafe. For example, The Leapfrog Group assigned failing grades to the plaintiff hospitals for measures such as hand hygiene and ICU physician staffing, despite lacking any data to evaluate their performance in these areas.

10. The plaintiffs assert that The Leapfrog Group's misleading grades have caused significant harm to their reputation, patient trust, and financial stability. They allege that patients have chosen competitor hospitals based on The Leapfrog Group's grades, leading to reduced elective patient admissions and damaged relationships with physicians and business partners. The negative perception created by The Leapfrog Group's grades has also impacted the hospitals' ability to recruit medical staff. Furthermore, the plaintiffs argue that The Leapfrog Group's deceptive practices endanger public health by misleading patients into bypassing nearby hospitals for facilities with higher grades, even when those facilities lack the necessary certifications or capabilities to treat certain conditions. This delay in care increases mortality risks and worsens health outcomes, particularly for emergency patients.

² Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group, Amended Complaint, United States District Court for the Southern District of Florida, Case No. 9:25-cv-80526, p. 41 (August 28, 2025).

³ Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group, Amended Complaint, United States District Court for the Southern District of Florida, Case No. 9:25-cv-80526, p. 2 (August 28, 2025).

⁴ Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group, Amended Complaint, United States District Court for the Southern District of Florida, Case No. 9:25-cv-80526, p. 9 (August 28, 2025).

11. The plaintiffs contend that The Leapfrog Group's actions violate the Florida Deceptive and Unfair Trade Practices Act (FDUTPA) by engaging in unfair and deceptive trade practices.⁵ They seek injunctive relief to prevent The Leapfrog Group from including them in its grading system, declaratory relief to establish that The Leapfrog Group's methodology is deceptive, and damages for harm caused to their reputation and revenue. The plaintiffs argue that The Leapfrog Group's grading system prioritizes financial gain over accuracy and public health, penalizing non-participating hospitals, misleading consumers, and causing harm to both the hospitals and the communities they serve. This lawsuit seeks to address these deceptive practices and protect patients from making unsafe healthcare decisions based on misleading information.⁶

IV. Assignment

12. I have been asked by counsel for Defendant The Leapfrog Group to evaluate the clarity, transparency, and usability of the Leapfrog Hospital Safety Grade website (www.hospitalsafetygrade.org) from the perspective of a reasonable consumer seeking healthcare information. Specifically, this includes assessing whether a typical user interacting with the site would find its disclosures and tools clear and transparent, with adequate resources to understand key elements such as the imputation methodology for non-participating hospitals. In this evaluation, I am to highlight the role of visual cues like asterisks (*) in directing users to explanatory footnotes, emphasizing that a consumer-facing website designed for individuals researching hospital safety should prioritize accessible, straightforward information tailored to a non-expert audience, such as patients and families making healthcare decisions.

⁵ Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group, Amended Complaint, United States District Court for the Southern District of Florida, Case No. 9:25-cv-80526, p. 38 (August 28, 2025).

⁶ Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group, Amended Complaint, United States District Court for the Southern District of Florida, Case No. 9:25-cv-80526, p. 5 (August 28, 2025).

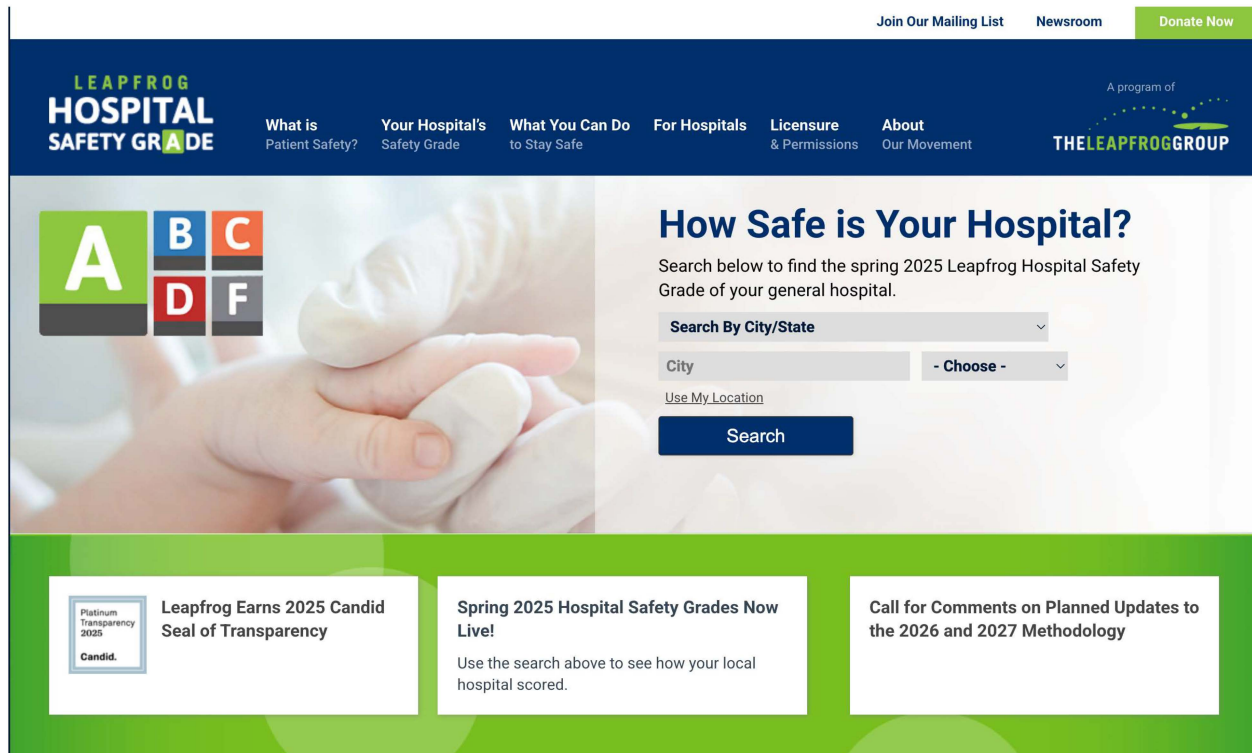


Figure 1: Screenshot of the homepage for the subject website of this litigation.⁷

13. Additionally, I have been tasked with determining the likelihood that a reasonable consumer would misunderstand the website's content, including its disclosures about hospital safety grades and imputation practices. This involves reviewing the expert report of Dr. Jonah Berger, which references the asterisk-linked footnotes but omits discussion of their high conspicuity; such as being presented in red and bold text to enhance visibility and draw user attention. My analysis will address how these design elements contribute to reducing potential confusion and ensuring that users can readily comprehend the basis for assigned grades, particularly for hospitals that decline to participate in Leapfrog's voluntary survey.

14. As part of this assignment, I am to evaluate Dr. Berger's methodology. I noted that he did not conduct a scientific user experience (UX) comprehension test to empirically assess consumer understanding of the website, despite having the opportunity to do so during his analysis. In contrast, I understand that The Leapfrog Group performed such UX testing and comprehension studies during the development and refinement of their site to optimize it for consumer clarity and effectiveness. My opinions will incorporate insights from these tests to demonstrate how the site's

⁷ The Leapfrog Group. (2025). *How safe is your hospital?* Hospital Safety Grade. Retrieved August 30, 2025, from <https://www.hospitalsafetygrade.org/>

design aligns with industry practices for transparent communication in healthcare ratings.

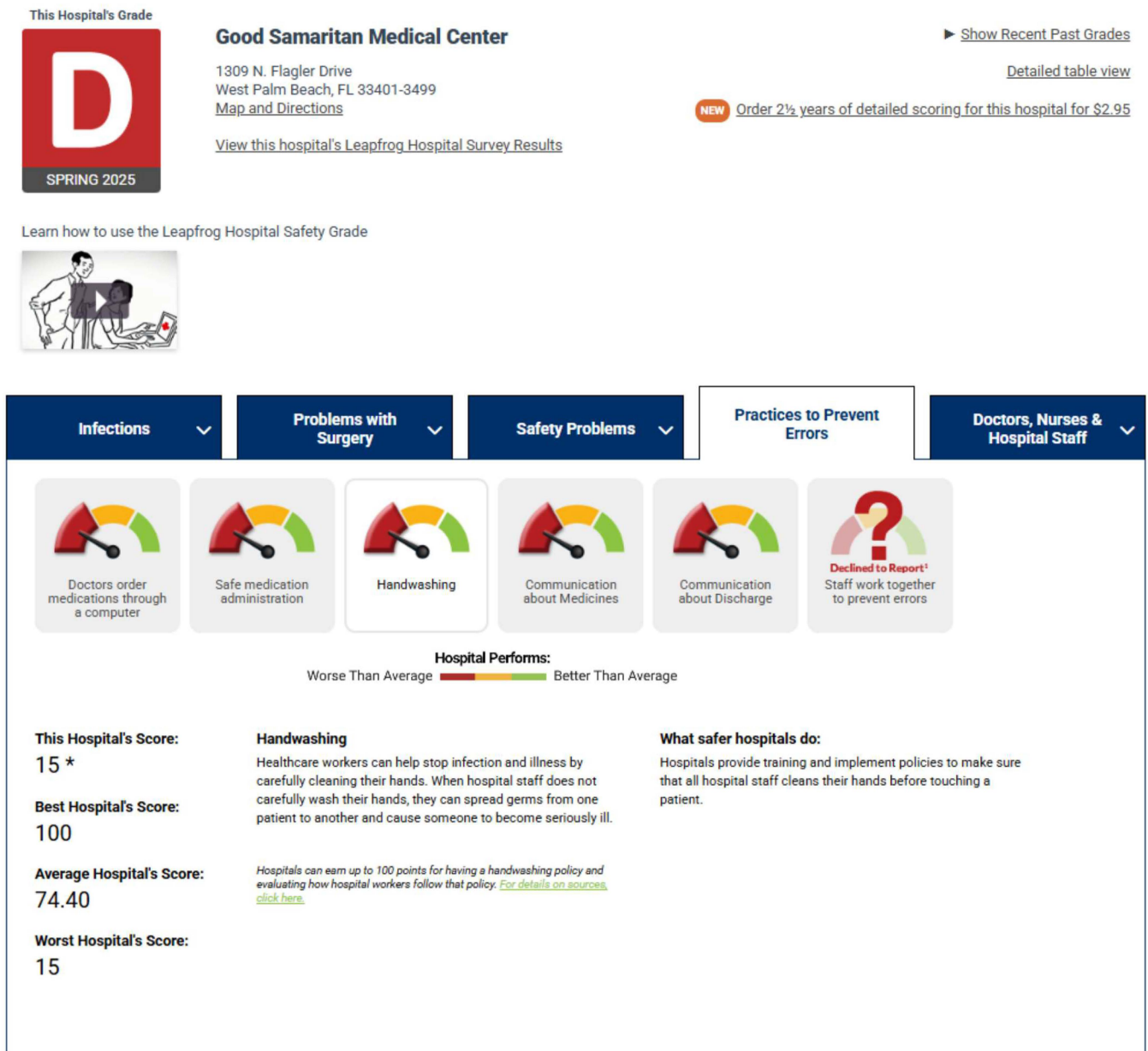


Figure 2: Example of plaintiffs hospital (Good Samaritan Medical Center) website page.⁸

⁸ The Leapfrog Group. (2025). *Good Samaritan Medical Center*. Hospital Safety Grade. Retrieved August 30, 2025, from https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center?findBy=city&city=Palm+Beach+Gardens&state_prov=FL&rPos=904&rSort=distance

15. Finally, I have been asked to evaluate and rebut certain notions in Dr. Berger's report using available data, including Google Analytics metrics from the Leapfrog website. This rebuttal will specifically address and counter the implication that stakeholders such as hospital CEOs, doctors, and other healthcare professionals inherently do not understand the imputation methodology. Drawing on analytics data showing user engagement patterns, search behaviors, and navigation flows, I will illustrate how the site effectively educates a broad audience, including these professionals, on the methodology, thereby mitigating any claims of widespread misunderstanding or inadequate transparency.

16. A list of materials I have considered to date in connection with this assignment is attached as Appendix C. I reserve the right to supplement or amend my opinions should new information become available. I am being compensated at my standard billing rate of \$450 per hour. My compensation in this matter is not in any way contingent or based on the content of my opinion or the outcome of this or any other matter.

V. Summary of Opinions

17. In this report, I present five key opinions derived from my evaluation of the Leapfrog Hospital Safety Grade website's clarity, transparency, and usability for reasonable consumers seeking healthcare information, drawing on principles of user experience design, readability analysis, and empirical data to rebut claims of potential misunderstandings, particularly regarding disclosures about the imputation methodology for non-participating hospitals.

18. Opinion 1: The website's design ensures high clarity and transparency for reasonable consumers.

19. Opinion 2: The website's readability enables accessibility for a general audience.

20. Opinion 3: Imputed scores are readily clear to users with basic reading comprehension.

21. Opinion 4: Leapfrog's UX testing validates the website's clarity in contrast to Berger's untested methodology.

22. Opinion 5: Google analytics data demonstrates high user engagement with full page content, ensuring visibility of key disclosures.

23. These opinions collectively demonstrate that the website effectively communicates essential information through accessible design features, empirical testing, and data-supported user behaviors, enabling non-expert audiences like patients and families to make informed decisions without undue confusion.

VI. Opinion 1: The Website’s Design Ensures High Clarity and Transparency for Reasonable Consumers

24. Based on my evaluation, the Leapfrog Hospital Safety Grade website demonstrates exemplary clarity, transparency, and usability for a reasonable consumer seeking healthcare information. A typical user, such as a patient or family member researching hospital options, would readily navigate the site’s intuitive search function to locate specific hospital grades, like that of Good Samaritan Medical Center, where the overall “D” grade is prominently displayed alongside comparative data (e.g., best, average, and worst scores for measures). Disclosures about the imputation methodology for non-participating hospitals (such as assigning low “Limited Achievement” scores to measures like Handwashing or Computerized Physician Order Entry when survey data is unavailable) are accessible via linked methodology documents, footnotes, and scores are displayed on the main graded page. This ensures users can understand that grades reflect non-participation rather than direct performance data. Visual cues, including asterisks (#*) next to imputed scores (e.g., 25 for “Doctors order medications through a computer”), conspicuously direct users to explanatory footnotes, bolded and in red, and source details, which explain terms like “Declined to Report” in simple language (e.g., “The hospital was asked to provide this information to the public, but did not”). Research supports that such red and bold text enhances conspicuity and visual attention in user interfaces; for instance, a study on form field search tasks found that bold identifiers significantly improved efficiency and scan paths by drawing attention more effectively than non-bold formats.⁹ Similarly, studies on web page color combinations indicate that high-contrast red elements increase legibility and attention-grabbing during visual search, reducing cognitive strain.¹⁰ This design prioritizes accessible,

⁹ Joseph, K. M., Knott, B. A., & Grier, R. A. (2002). The effects of bold text on visual search of form fields. *Proceedings of the Human Factors and Ergonomics Society Annual Meeting*, 46(5), 589–593. <https://doi.org/10.1177/154193120204600514>

¹⁰ Ling, J., & van Schaik, P. (2002). The effect of text and background colour on visual search of Web pages. *Displays*, 23(5), 223–230. [https://doi.org/10.1016/S0141-9382\(02\)00041-0](https://doi.org/10.1016/S0141-9382(02)00041-0)

straightforward information for non-experts, with layman-friendly explanatory text for each measure (e.g., “MRSA can cause life-threatening bloodstream infections”) and links to educational videos on using the grades, making the site an effective tool for informed decision-making without requiring technical expertise.

VII. Opinion 2: The Website’s Readability Enables Accessibility for a General Audience

25. In my qualitative and quantitative evaluation of the Leapfrog Hospital Safety Grade website, I conclude that its clarity, transparency, and usability are significantly bolstered by content written at an accessible reading level, specifically tailored for a general audience with an 8th-grade comprehension level as evidenced by a Flesch-Kincaid Grade Level score of 7.9 and a Gunning Fog Index score of 8.3. The Flesch-Kincaid Grade Level, developed by Rudolf Flesch and J. Peter Kincaid in the 1970s for the U.S. Navy to assess technical manual readability, calculates an approximate U.S. school grade level based on average sentence length and syllables per word, with lower scores indicating easier text.¹¹ Similarly, the Gunning Fog Index, created by Robert Gunning in 1952, estimates the years of formal education required to understand text by factoring in sentence complexity and the percentage of polysyllabic words, promoting simpler writing for broader accessibility.¹² These metrics are widely used in healthcare to evaluate patient education materials, where research recommends aiming for 6th- to 8th-grade levels to accommodate diverse literacy abilities and reduce comprehension barriers in health information.¹³ A reasonable consumer, such as a patient or family member without specialized medical knowledge researching hospital safety, would find the site’s language straightforward and easy to comprehend, with key sections like hospital profile pages (e.g., for Good Samaritan Medical Center) using simple sentences to explain overall grades and measures. Visual cues, such as prominent red and bold asterisks and text on the bottom of the page, further enhance

¹¹ Kincaid, J. P., Fishburne, R. P., Rogers, R. L., & Chissom, B. S. (1975). Derivation of new readability formulas (Automated Readability Index, Fog Count and Flesch Reading Ease Formula) for Navy enlisted personnel. Institute for Simulation and Training, 56. <https://stars.library.ucf.edu/istlibrary/56>

¹² Gunning, R. (1952). *The technique of clear writing*. McGraw-Hill.

¹³ Eltorai, A. E., Ghanian, S., Adams, C. A., Born, C. T., & Daniels, A. H. (2015). Readability of patient education materials on the American Orthopaedic Society for Sports Medicine website. *The Physician and Sportsmedicine*, 43(2), 125–130. <https://doi.org/10.1080/00913847.2015.1006548>

transparency by guiding users to these readable explanations, which use everyday language (e.g., “The hospital chose not to provide this information”). This readability-focused design, aligned with industry practices for consumer-facing healthcare sites, provides adequate tools like explanatory videos, measure definitions (e.g., “C. diff can spread on hands from person to person”), and comparative benchmarks, empowering non-expert audiences to make informed decisions about hospital choices without confusion or the need for advanced literacy skills.

VIII. Opinion 3: Imputed Scores Are Readily Clear to Users with Basic Reading Comprehension

26. In evaluating the clarity, transparency, and usability of the Leapfrog Hospital Safety Grade website, I conclude that it is readily apparent to a reasonable consumer with at least an 8th-grade reading level that scores for missing data, such as the Handwashing measure, are assigned a minimum imputed value when hospitals decline to participate in the voluntary survey. A typical user, like a patient or family member researching options without advanced expertise, would be able to discern this on primary hospital grading pages, such as that for Good Samaritan Medical Center, where the site’s structured layout prominently displays “This Hospital’s Score” alongside comparative benchmarks including “Best Hospital’s Score,” “Average Hospital’s Score,” and “Worst Hospital’s Score.” For instance, in cases of imputed measures like Handwashing, the hospital’s assigned score consistently matches the “Worst Hospital’s Score” value (e.g., both at 15 on a 0-100 scale), making it clear and reasonably deducible that the imputed value represents the lower threshold or minimum for non-participating hospitals, as this alignment signals a default low assignment rather than actual performance data. This consumer-facing design, informed by readability standards and UX best practices, provides adequate tools for lay users and expert users through progressive disclosure, where information is layered to reveal complexity gradually and reduce cognitive overload.¹⁴ For example, users seeking more details can click the

¹⁴ Spillers, F. (n.d.). Progressive disclosure: The best interaction design technique? Experience Dynamics. <https://frankspillers.com/progressive-disclosure-the-best-interaction-design-technique/>

“Detailed table view” hyperlink on the main page, which expands to a comprehensive table with additional data on measures, sources, and scoring, serving as a “next level” for general consumers or more experienced users interested in deeper insights without overwhelming the initial view. From this expanded table, users can further access the full methodology via the link “For a full description of the methodology, click here,” which leads to a dense 29-page document; this represents the “highest level” for advanced consumers, such as researchers or professionals, who may wish to scrutinize algorithmic changes or validation methods in detail. Expert medical users can dive deep into how values are computed with the linked methodology documents detailing imputation processes. Lay users can view educational videos on grade interpretation; thus, ensuring non-experts and experts alike can comprehend how non-participation results in minimum scores, thereby fostering informed healthcare decisions through straightforward, accessible information.

IX. Opinion 4: Leapfrog’s UX Testing Validates the Website’s Clarity in Contrast to Berger’s Untested Methodology

27. In evaluating the clarity, transparency, and usability of the Leapfrog Hospital Safety Grade website, I conclude that its design aligns with best practices for transparent communication in healthcare ratings, as demonstrated by Leapfrog’s own UX testing (lead by Dr. Christina Zarcadoolas)¹⁵ and comprehension studies,¹⁶ which empirically optimized the site for consumer effectiveness (unlike Dr. Berger’s methodology, which notably omitted any scientific UX comprehension test to assess actual user understanding despite the opportunity to do so).¹⁷ A reasonable consumer, such as a patient or family member seeking healthcare information without expert knowledge, would find the site’s disclosures and tools highly accessible, with features like the intuitive hospital search and profile pages presenting overall grades and measures in a straightforward manner, where scores are transparently displayed for every category to explicitly show imputed values aligning with the lowest

¹⁵ Zarcadoolas, C. (2013). Biographical sketch.

¹⁶ Leapfrog Group. (2014). *Final Narrative Report: Educating the Public on Patient Safety*.

¹⁷ Ratwani, R. M., Reider, J., & Singh, H. (2019). A decade of veteran affairs patient safety and health information technology-related contributions. *Journal of Patient Safety*, 15(4), e80–e83. <https://doi.org/10.1097/PTS.0000000000000644>

possible scores (e.g., “Limited Achievement” equivalents like 15 for Handwashing or 5 for ICU Physician Staffing). While linked methodology documents provide detailed explanations of the imputation process (such as assigning minimum points to non-participating hospitals without recent survey data and are oriented toward experts or those interested in validating methods or potential algorithm changes announced publicly beforehand), typical users would not rely on them, instead benefiting from the site’s public-facing transparency that allows for easy comprehension without deep dives. Visual cues, including prominent red and bold asterisks (*) next to imputed scores (e.g., 25 for Safe Medication Administration), conspicuously guide users to footnotes that explain non-participation in simple terms (e.g., “The hospital was asked to provide this information to the public, but did not”), enhancing understanding for non-experts.¹⁸ Insights from Leapfrog’s UX testing during site development and refinement reveal that these elements were iteratively improved based on user feedback to ensure clarity, such as structuring comparative benchmarks (e.g., “Best,” “Average,” and “Worst” scores) for easy deduction of minimum imputed values, and it is important to note that hospitals can still receive an A rating even with imputed scores, as weight redistribution to other strong-performing measures can compensate for low imputed values. Leapfrog adopted the “Worst Hospital's Score” benchmark in their methodology because consumer testing revealed potential confusion with scales where low values are worst in outcome measures (e.g., infection rates) and high values are worst in process/structural measures (e.g., compliance scores); this is also why they employ a “gas meter” visual with colors to clearly indicate good or bad performance, standardizing perceptions through Z-scores and bar representations like “Fully Meets Standards” (green bar) for better clarity. This consumer-centric design prioritizes accessible, straightforward information for non-experts, empowering informed decision-making in healthcare choices.

¹⁸ Ling, J., & van Schaik, P. (2002). The effect of text and background colour on visual search of Web pages. *Displays*, 23(5), 223–230. [https://doi.org/10.1016/S0141-9382\(02\)00041-0](https://doi.org/10.1016/S0141-9382(02)00041-0)

28.

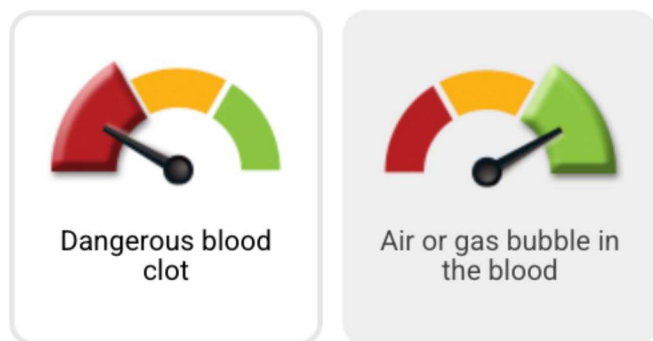


Figure 3: The figure displays two side-by-side semi-circular gauge indicators, resembling fuel gauges or “gas meters,” used to visually represent hospital performance metrics in a color-coded manner for easy interpretation. The left gauge, labeled “Dangerous blood clot,” has its black needle pointing leftward into the red zone (indicating poor or high-risk performance), with the arc segmented from red on the left, transitioning through yellow in the middle, to green on the right. The right gauge, labeled “Air or gas bubble in the blood,” has its needle pointing rightward into the green zone (indicating good or low-risk performance), following the same color progression of red (left/bad), yellow (middle/neutral), and green (right/good). These visuals simplify complex data by using intuitive color cues to convey whether a hospital's score meets safety standards, with red signaling areas of concern and green denoting stronger performance.

X. Opinion 5: Google Analytics Data Demonstrates High User Engagement with Full Page Content, Ensuring Visibility of Key Disclosures

29. In evaluating the clarity, transparency, and usability of the Leapfrog Hospital Safety Grade website, I conclude that Google Analytics data from November 15, 2024, to August 5, 2025, reveals exceptionally high user engagement across hospital profile pages, indicating that reasonable consumers are likely to scroll deeply and interact with the entire page, including bottom-placed footnotes and high-conspicuity visual cues like red and bold asterisks (*), thereby enhancing their understanding of critical elements such as the imputation methodology for non-participating hospitals.

30.

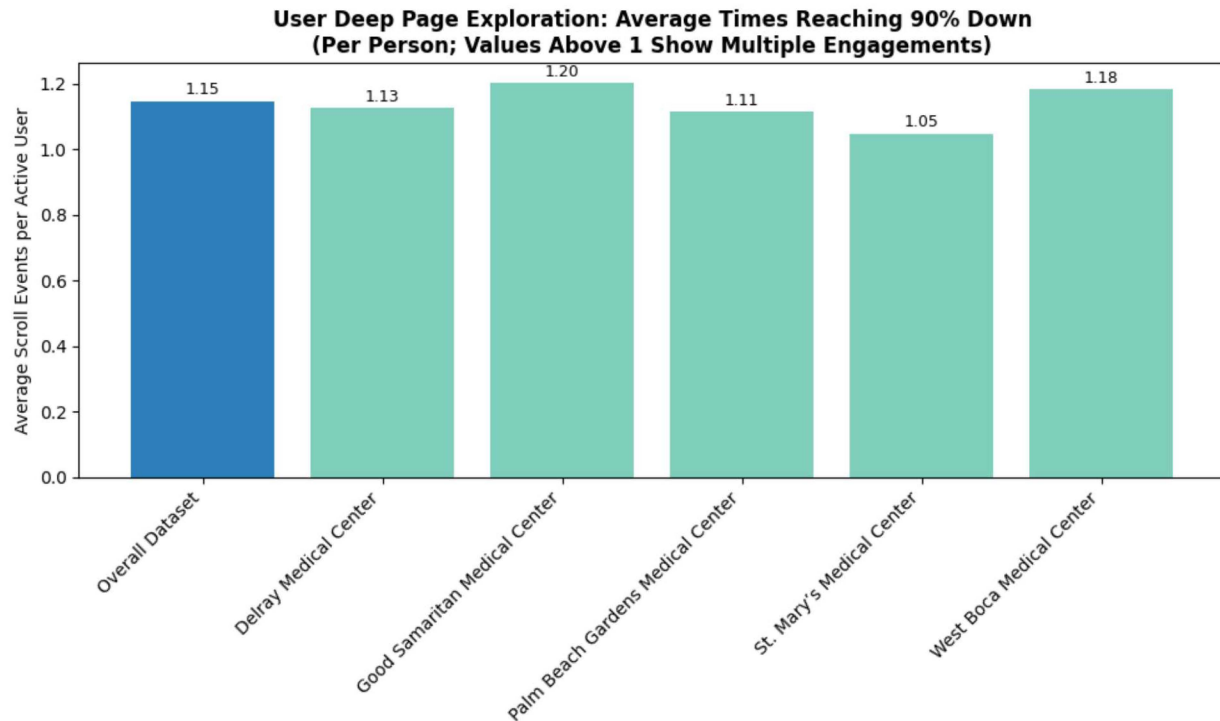


Figure 4: Visitors to the plaintiff hospitals' pages scroll to the bottom about as often as visitors across the rest of the Leapfrog database. This high rate of unique users scrolling all the way to the bottom (sometimes more than once) indicates strong engagement with the plaintiff hospitals' pages, similar to the overall pattern seen across the Leapfrog database

31. A typical user, such as a patient or family member researching healthcare options without specialized knowledge, would encounter a structured layout on pages like that for Good Samaritan Medical Center, where the overall “D” grade is displayed at the top, followed by detailed measures in the middle with comparative benchmarks (e.g., “*This Hospital’s Score*” aligning with “*Worst Hospital’s Score*” for imputed measures like Handwashing at 15), and footnotes at the bottom explaining terms like “Declined to Report” in simple language (e.g., “The hospital was asked to provide this information to the public, but did not”).

32. The analytics data shows over 28,000 scroll events site-wide, triggered when users first reach 90% vertical depth on a page,¹⁹ with high totals specifically for plaintiff hospitals such as Delray Medical Center and Good Samaritan Medical Center, suggesting not only initial deep

¹⁹ Google. (n.d.). *[GA4] Enhanced measurement events*. Analytics Help. <https://support.google.com/analytics/answer/9216061>

scrolling but also repeat engagements that bring users to near-bottom content. These patterns rebut claims that consumers are unlikely to read footnotes or disclosures (as argued in Dr. Berger’s report, Section VIII), as the analytic data strongly indicates that users view the prominent red and bold asterisks (*) on imputed scores (e.g., 15 for Safe Medication Administration), which conspicuously direct attention to explanatory footnotes and source links, allowing easy deduction that non-participation results in minimum “Limited Achievement” values without requiring expert analysis.²⁰ Furthermore, aggregates for plaintiff hospital pages are consistent with site-wide averages, indicating sustained interest that ensures visibility of transparency features like layman-friendly measure descriptions (e.g., “MRSA can cause life-threatening bloodstream infections”) and “What safer hospitals do” sections, all tailored for non-experts.

33.

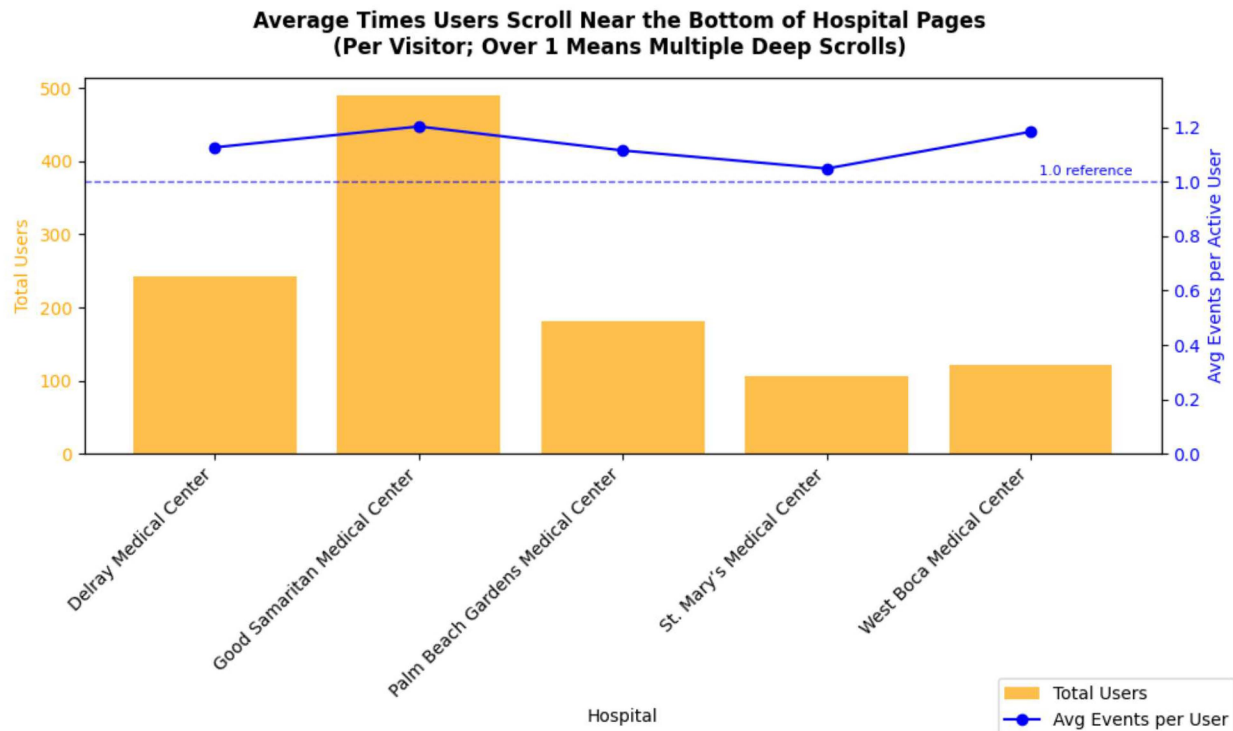


Figure 5: This figure shows that even though the total number of users (in yellow bars) differs from hospital to hospital, the average visitor scrolls down near the bottom of the page more than once on average (shown by the blue line). The dotted blue line at 1.0 is our reference point: it means that a value above this line indicates users are scrolling deeply more than once per visit. In other

²⁰ Milosevic, I., & Nielsen, J. (2018). Scrolling and attention. Nielsen Norman Group. <https://www.nngroup.com/articles/scrolling-and-attention/>

words, the yellow bars show how many people are visiting each hospital's page, and the blue line shows that those visitors are engaged because they scroll down thoroughly.

34. This data-driven insight from Leapfrog's UX-optimized design empowers reasonable consumers to comprehend imputation impacts through accessible, straightforward information, fostering informed healthcare decisions without confusion.

XI. Conclusion

35. My evaluation of the Leapfrog Hospital Safety Grade website demonstrates that it is designed with high clarity, transparency, and usability, effectively communicating hospital safety information to reasonable consumers, including non-experts like patients and families. Through intuitive navigation, accessible readability at an 8th-grade level, conspicuous visual cues such as red and bold asterisks directing to explanatory footnotes, empirical UX testing, and Google Analytics data showing deep user engagement (with averages exceeding one deep scrolling events per user on plaintiff hospital pages), the site ensures that key disclosures. This is particularly true regarding the imputation methodology for non-participating hospitals; they are readily understandable and unlikely to cause confusion. These features rebut claims of deception or misunderstanding in Dr. Berger's report, as they empower users to deduce minimum imputed scores from comparative benchmarks and access straightforward explanations without requiring advanced expertise. Ultimately, the website aligns with industry practices in human factors and user experience, promoting informed healthcare decisions while mitigating risks of misinterpretation.

All of my opinions are expressed to a reasonable degree of professional certainty. As more materials and documents become available, I reserve the right to amend or supplement this report. I appreciate the opportunity to assist you in this case and am available for any further work that may be required.

Executed on September 4th, 2025.

Sincerely,

Michael Vredenburg

Michael Vredenburg, M.S.

APPENDIX A



CURRICULUM VITAE OF

Michael Vredenburg, M.S.Cherry Tomato Engineering, LLC - mv@hfexpert.com**Professional Summary****Expert Witness and Testimony Experience****Professional Experience****Education****Scholarly Contributions****Technical Skills****Selected Projects****Volunteer & Leadership****Professional Summary**

Human Factors Engineering expert with 15+ years of forensic consulting experience, serving as the primary retained expert in over 100 litigation matters. Deposed 11 times and testified at trial twice, delivering impartial, evidence-based analyses grounded in scientific rigor and truth-seeking, regardless of retaining party—balancing substantial work for both plaintiff and defense sides. Demonstrated excellence through rigorous education (M.S. in Industrial and Human Factors Engineering), peer-reviewed research on risk perception and human-system interactions, and presentations at leading conferences like HFES. Innovative product developer and entrepreneur, creating technical engineering inventions from first principles to enhance safety and efficiency in manufacturing.

List of Specialties:

Medical Device Usability and Healthcare Human Factors, Warnings and Labeling in Product/Pharmaceutical Liability, Product User-Interface Design, Distracted/Drowsy Driving and Automotive Human Factors, Work Zone Safety, Premises Safety, Autonomous Systems and AI Human Factors

Expert Witness and Testimony Experience

- Served as primary retained expert in over 100 litigation matters in the last 4 years, applying human factors principles to evaluate human-system interactions, visibility issues, and risk perception in dynamic environments.
- Deposed 11 times and testified at trial twice, providing impartial analyses grounded in scientific rigor for both plaintiff (approximately 60%) and defense (40%) sides.
- Worked on cases nationwide, providing testimony in courts on both coasts, with no Daubert exclusions to date.
- Contributed to settlements in 70% of cases through evidence-based opinions on accident causation and safety protocols.
- Specialized in applying standards from major agencies to assess compliance and mitigate risks in high-stakes environments.
- Collaborated with multidisciplinary teams, including attorneys, engineers, and medical experts, to develop demonstrative aids and reconstructions that clarify complex human error scenarios for juries.
- Detailed testimony list available upon request.

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APPENDIX A

**Professional Summary****Expert Witness and
Testimony Experience****Professional
Experience****Education****Scholarly
Contributions****Technical Skills****Selected Projects****Volunteer &
Leadership**

CURRICULUM VITAE OF

Michael Vredenburg, M.S.Cherry Tomato Engineering, LLC - mv@hfexpert.com**Professional Experience****Cherry Tomato Engineering, LLC, San Diego, CA***Founder and CEO (2022–Present)*

- Established the company to serve as a platform for human factors engineering consulting and patenting innovative technologies focused on safety enhancements.
- Applying HF principles to assess safety, liability, and system interactions in diverse cases across the country.
- Led product development, prototyping, and production for novel house construction 3D printer. (See sculpted-spaces.com)

Vredenburg & Zackowitz, Inc., San Diego, CA*Industrial and Human Factors Engineer (2016–2024)**Systems and Research Analyst (2010–2016)**Forensic and Research Intern (2006–2010)*

- Progressed through roles to lead engineering analyses in forensic investigations, working up cases for partners and serving as primary retained expert in personal injury, product liability, and transportation matters.
- Conducted site inspections nationwide, evaluating human-system interactions, driver reaction times, visibility obstructions, and compliance with safety standards to support expert reports and testimony.
- Integrated biomechanical modeling, statistical analysis, and research on risk factors to reconstruct accidents and clarify human error scenarios for litigation resolutions.

Education**Wright State University***M.S. Industrial and Human Factors Engineering (2020)**User Experience (UX) and Design Thinking Certificate (2021)***University of California, Berkeley***B.S. Bioengineering (2016)*Cherry Tomato
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7/25

APPENDIX A



CURRICULUM VITAE OF

Michael Vredenburg, M.S.Cherry Tomato Engineering, LLC - mv@hfexpert.com**Professional Summary****Expert Witness and
Testimony Experience****Professional
Experience****Education****Scholarly
Contributions****Technical Skills****Selected Projects****Volunteer &
Leadership*****Scholarly Contributions****Publications (Last 10 Years):*

Vredenburg, M.J., Stone, P.B., & Cao, C.G.L. (2021). *User Experience: An evaluation of the Pilot Education Platform and Online Learning at Wright State University*. In Proceedings of the Human Factors and Ergonomics Society Annual Meeting, vol. 65, 1: pp. 1215-1219 (evaluated cognitive factors in training, relevant to safety protocols).

Vredenburg, A. & **Vredenburg, M.** (2020). *Human Factors Analysis of a Rotating Restaurant*. In Proceedings of the Human Factors and Ergonomics Society Annual Meeting, vol. 64, 1 (analyzed perceptual disorientation in dynamic environments).

Borzendowski, S., **Vredenburg, M.**, Darlson, C., Hersh, M., Vredenburg, A., & Zackowitz, I. (2019). *Children's safety workshop: A demonstration of human factors professionals' preparation with practicing attorneys*. In Proceedings of the Human Factors and Ergonomics Society 2019 Annual Meeting, Santa Monica, CA: Human Factors and Ergonomics Society, 227.

Vredenburg, M.J., Bench, M.L., Zackowitz, I.B., Runge, K., & Vredenburg, A.G. (2018). *Amusement Park Guest Injured on a Water Ride: A Human Factors and Biomechanics Evaluation*. In Proceedings of the Human Factors and Ergonomics Society 2018 Annual Meeting, Santa Monica, CA: Human Factors and Ergonomics Society, 440-444.

Bench, M.L., **Vredenburg, M.J.**, Zackowitz, I.B. & Vredenburg, A.G. (2017). *An epidemiological perspective of individual and population health risk prevention*. Pedro Arezes (ed.), In Advances in Safety Management and Human Factors, (pp. 357-368). Warsaw, Poland: Springer International Publishing.

Bench, M.L., **Vredenburg, M.J.**, Zackowitz, I.B. & Vredenburg, A.G. (2017). *Risk Communication for Consumer Products*. Pedro Arezes (ed.), In Advances in Safety Management and Human Factors, (pp. 225-235). Warsaw, Poland: Springer International Publishing.

Zackowitz, I.B., **Vredenburg, M.J.**, Bench, M.L., & Vredenburg, A.G. (2017). *Types of Consumer Products*. In G. Emilien, R. Weitkunat & Ludicke (Eds.). Consumer Perception of Product Risks and Benefits. (pp. 3-22). Switzerland: Springer.

Presentations

- *Human Factors Analysis of a Rotating Restaurant*. Human Factors and Ergonomics Society 2020 Annual Meeting, October 5, 2020.

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APPENDIX A

**Professional Summary****Expert Witness and
Testimony Experience****Professional
Experience****Education****Scholarly
Contributions****Technical Skills****Selected Projects****Volunteer &
Leadership**

CURRICULUM VITAE OF

Michael Vredenburg, M.S.Cherry Tomato Engineering, LLC - mv@hfexpert.com

Children's safety workshop: A demonstration of human factors professionals' preparation with practicing attorneys. (Chair). Seattle, WA: Human Factors and Ergonomics Society 2018 Annual Meeting, October 30, 2019.

Amusement Park Guest Injured on a Water Ride: A Human Factors and Biomechanics Evaluation. Presented at the Human Factors and Ergonomics Society 2018 Annual Meeting, Philadelphia, PA: October 3, 2018.

Risk Communication for Consumer Products. Presented at the AHFE 2017 International conference on safety management and human factors, Los Angeles, California, July 20, 2017.

Technical Skills

- Expertise in modeling human ergonomics, biomechanical simulations, and tools for analyzing human-system interactions (e.g., using software like MATLAB to study perception).
- Experienced in 3D design and prototyping.
- Studied risk patterns in health and accident data with statistical software (e.g., R, SPSS).

Selected Projects

- • Garage-Sized Construction 3D Printer (2023–Present): Designed, built, and iterated over two years on a large-scale 3D printer for construction applications; currently in patent process.
- • AngelHack SF 2015 Top Prize Winner: Developed back-end for a real-time transactional email service using machine learning to optimize user engagement based on click data, applying human-computer interaction principles.

Volunteer & Leadership

- Elected Secretary/treasurer, Forensics Professional Group, Human Factors & Ergonomics Society (2020-2022).
- Chaired the technical session, "Risk Prevention and Assessment." AHFE 2017 International conference on safety management and human factors, Los Angeles, California (July 20, 2017).
- Founding President of Delta Sigma Phi fraternity at UC Berkeley. Was responsible for recruiting, running meetings, acquiring real estate, and hosting and attending leadership training.

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APPENDIX B



2021-Present

TESTIMONY LIST OF

Michael Vredenburg, M.S.

Cherry Tomato Engineering, LLC - mv@hfexpert.com

1. *Smith vs. San Diego Unified School District (SDUSD)*- July 27th, 2022 – Plaintiff Deposition
2. *Lee vs. Southeast Logging, Inc* - June 3rd, 2022 – Plaintiff Deposition
3. *Martinez vs. McKibbon Hotel Group, Inc* - December 8th, 2021 – Plaintiff Deposition
4. *Sanchez vs. Big 5* - June 26th, 2023 – Plaintiff Deposition
5. *Colins vs. Urban Air* - April 5th, 2023 – Plaintiff Deposition
6. *Alexander vs. Richie Bros* - April 13th, 2023 – Defense Deposition
7. *Brannum vs. City of Corcoran* – November 21st, 2023 – Plaintiff Deposition
8. *Brannum vs. City of Corcoran* – December 7th, 2023 – Plaintiff Trial
9. *Newman vs. City of San Diego* – February 1st, 2024 – Plaintiff Deposition
10. *Torres vs. Rivera* – March 29th, 2024 – Defense Deposition
11. *Torres vs. Rivera* – April 26th, 2024 – Defense Trial
12. *Sarazen vs. Costco* – June 27th, 2024 – Plaintiff Deposition
13. *Velasquez vs. LA County Metropolitan Transportation Authority*– August 2nd, 2024 – Plaintiff Deposition



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APPENDIX C

References

- Eltorai, A. E., Ghanian, S., Adams, C. A., Born, C. T., & Daniels, A. H. (2015). Readability of patient education materials on the American Orthopaedic Society for Sports Medicine website. *The Physician and Sportsmedicine*, 43(2), 125–130.
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<https://support.google.com/analytics/answer/9216061>
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<https://www.nngroup.com/articles/scrolling-and-attention/>
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<https://doi.org/10.1001/jama.2019.0161>
- Spillers, F. (n.d.). Progressive disclosure: The best interaction design technique? *Experience Dynamics*. <https://frankspillers.com/progressive-disclosure-the-best-interaction-design-technique/>
- Zarcadoolas, C. (2013). Biographical sketch.

EXHIBIT 5

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

GOOD SAMARITAN MEDICAL CENTER
INC., DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. D/B/A PALM BEACH
GARDENS MEDICAL CENTER, ST.
MARY'S MEDICAL CENTER, INC., AND
WEST BOCA MEDICAL CENTER, INC.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

Case No. 9:25-CV-80526

**Amendment to Expert Report of Michael Vredenburg, M.S.
September 19, 2025**

I, Michael Vredenburg, hereby declare under penalty of perjury that the following is true and correct:

After the issuance of my expert report dated September 4, 2025, new information became available to me regarding redundancies in very similar names for hospitals. The exact names provided allowed me to refine my analysis, which previously included extra hospitals in the initial data analysis due to these similarities. This has been corrected, and the updated analysis reflects only the precise matches for the plaintiff hospitals in the Google Analytic data.¹

The new values are close (but even higher than the general dataset) to the previous values, and my report's analysis, opinions, and conclusions do not change. This indicates that users were especially engaged and scrolling to the bottom of the webpage for the plaintiff hospitals. Below are the updated Figure 4 and Figure 5 with the new data.

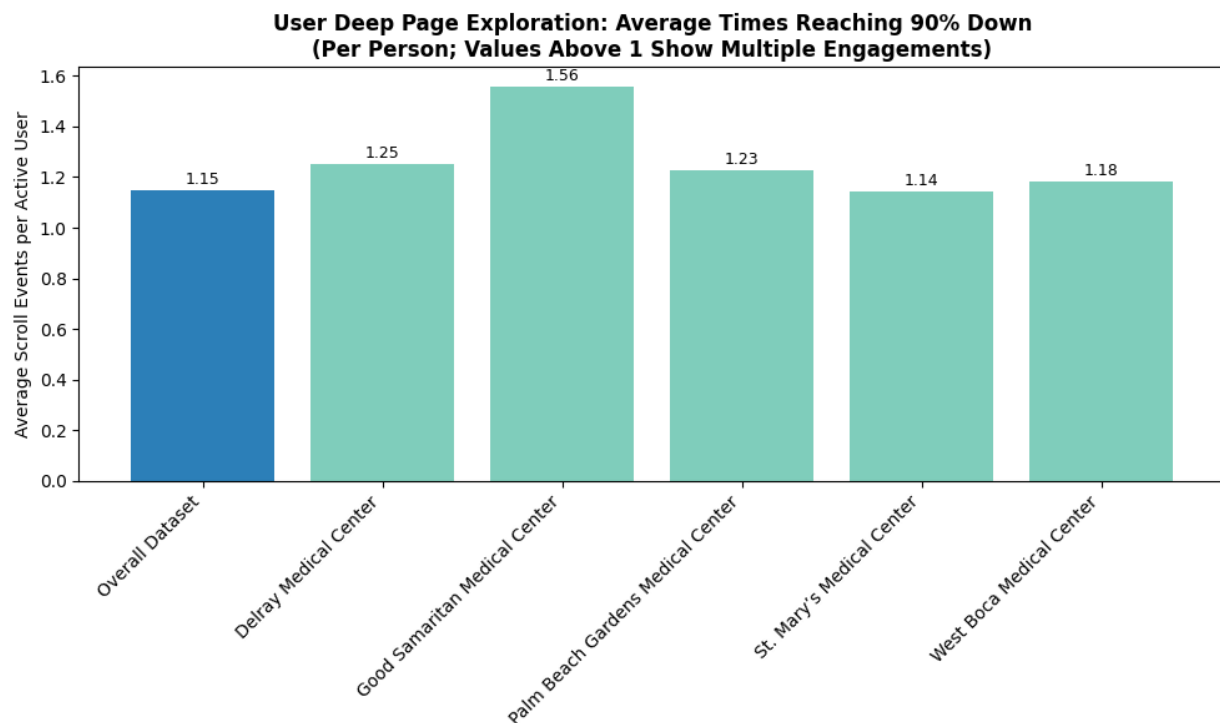


Figure 4 (Updated): Visitors to the plaintiff hospitals' pages scroll to the bottom about as often as visitors across the rest of the Leapfrog database. This high rate of unique users scrolling all

¹ LEAPFROG02864704.CSV (Google Analytics data file provided in Berger Supplemental Materials to the Expert Report of Jonah Berger, Ph.D., dated August 21, 2025)

the way to the bottom (sometimes more than once) indicates strong engagement with the plaintiff hospitals' pages, similar to the overall pattern seen across the Leapfrog database. (Figure text unchanged)

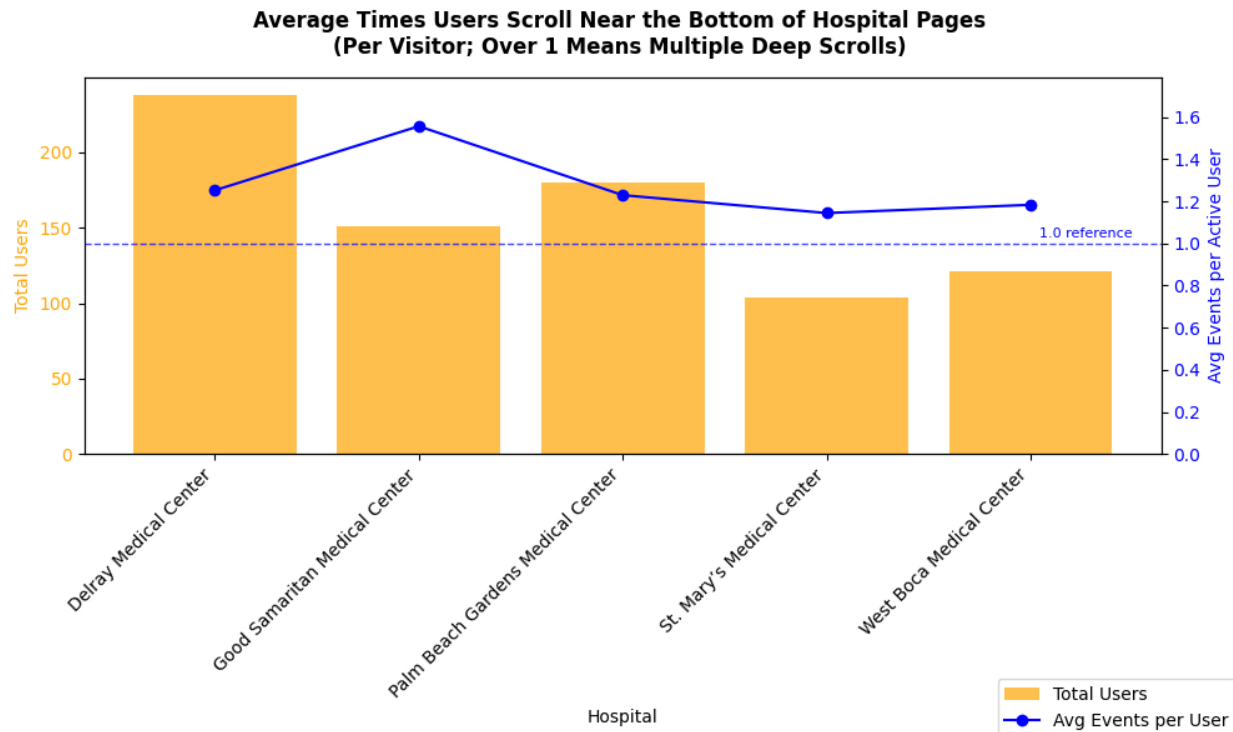


Figure 5 (Updated): This figure shows that even though the total number of users (in yellow bars) differs from hospital to hospital, the average visitor scrolls down near the bottom of the page more than once on average (shown by the blue line). The dotted blue line at 1.0 is our reference point: it means that a value above this line indicates users are scrolling deeply more than once per visit. In other words, the yellow bars show how many people are visiting each hospital's page, and the blue line shows that those visitors are engaged because they scroll down thoroughly. (Figure text unchanged)

In summary, the main difference that is observed is that the total number of users for each hospital dropped to reflect the true values. Calculated deep scrolling increased or stayed the same as before as a result of this refinement in the analyzed data set.

All of my opinions remain expressed to a reasonable degree of professional certainty. I reserve the right to further amend or supplement this report should additional information become available.

Executed on September 19, 2025.

Sincerely,

Michael Vredenburg

Michael Vredenburg, M.S.

EXHIBIT 6

A P P E A R A N C E S

FOR THE PLAINTIFFS:

ALLYSON PARKS
Gibson Dunn
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New York, New York 10166
212.351.2308
aparks@gibsondunn.com

MONICA GROVER
Gibson Dunn
1700 M Street Northwest
Washington, DC 20036
202.887.3514
mgrover@gibsondunn.com

FOR THE DEFENDANT:

KIMBERLY E. BLAIR
Wilson Elser
161 North Clark, Suite 4500
Chicago, Illinois 60601
312.821.6139
kimberly.blair@wilsonelser.com

ALSO PRESENT:

LORI TALBOTT, Videographer

I N D E X

EXAMINATION BY: PAGE:LINE

Ms. Parks	6:22
(Afternoon Session) Ms. Parks	158:10
Ms. Blair	287:20
Ms. Parks	295: 2
Ms. Blair	301:13
Ms. Parks	305: 8

EXHIBITS FOR IDENTIFICATION MARKED

Exhibit 1	Curriculum Vitae of Farrokh	32:24
	Farrokhi, MD	
Exhibit 2	Expert Report of Dr. Farrokh	55: 9
	Farrokhi, 9/4/25	
Exhibit 3	QAPI Description and Background	187:20
Exhibit 4	QAPI Five Elements	187:20
Exhibit 5	Expert Report of Thomas Chakurda ...	229: 6
Exhibit 6	Leapfrog Accolade Licensure -	246:13
	Letter of Agreement,	
	LEAPFROG02815278 - 2815282	
Exhibit 7	Email, 3/30/24,	272: 3
	LEAPFROG01585754 - 158755	

EXHIBITS FOR IDENTIFICATION

MARKED

Exhibit 8 Leapfrog Hospital Safety Grade281:11
Scoring Methodology, Spring 2025
Safety Grade, LFROG_CP015_000000061
Exhibit 9 Leapfrog Ratings, Virginia Mason ...291: 2
Medical Center, 7/17/25

REPORTER'S NOTE: All quotations from exhibits are
reflected in the manner in which they were read into the
record and do not necessarily indicate an exact quote
from the document.

1 SEATTLE, WASHINGTON; FRIDAY, OCTOBER 3, 2025

2 8:56 A.M.

3 --000--

4
5 THE VIDEOGRAPHER: Good morning. We are going
6 on the record at 8:56 a.m. on October 3rd, 2025.

7 Please note that the microphones are sensitive
8 and may pick up whispering and private conversations.
9 Please mute your phones at this time. Audio and video
10 recording will continue to take place unless both
11 parties agree to go off the record.

12 This is Media Unit 1 in the video-recorded
13 deposition of Farrokh Farrokhi, in the matter of Good
14 Samaritan Medical Center, Inc., et al., versus The
15 Leapfrog Group, filed in the United States District
16 Court, Southern District of Florida, West Palm Beach
17 Division, Case Number 9:25-cv-80526-DMM.

18 The location of the deposition is 520 Pike
19 Street, Suite 2350, Seattle, Washington.

20 My name is Lori Talbott, representing
21 Veritext. I am the videographer. The court reporter is
22 Tami Vondran from the firm Veritext.

23 I am not related to any party in this action,
24 nor am I financially interested in the outcome.

25 If there are any objections to proceeding,

Page 5

1 please state them at the time of your appearance.

2 Counsel will now state their appearances and
3 affiliations for the record, beginning with the noticing
4 attorney.

5 MS. PARKS: I am Allyson Parks, from Gibson
6 Dunn. And I'm joined by my colleague, Monica Grover,
7 also from Gibson Dunn. And we represent the plaintiff.

8 MS. BLAIR: Kim Blair, Wilson Elser, on behalf
9 of the defendant.

10 THE VIDEOGRAPHER: Thank you.

11 Would the court reporter please swear in the
12 witness.

13
14 FARROKH FARROKHI, MD,
15 sworn as a witness by the Certified Court Reporter,
16 testified as follows:

17
18 THE COURT REPORTER: Thank you.
19 Please proceed.

20
21 EXAMINATION

22 BY MS. PARKS:

23 Q. Good morning, Dr. Farrokhi.

24 A. Good morning.

25 Q. As I said, my name is Allyson Parks, and I'm

1 going to be taking your deposition today.

2 Can you state your full name for the record.

3 A. Farrokh Reza Farrokhi.

4 Q. Thank you.

5 Have you ever gone by any other names?

6 A. I have not.

7 Q. Have you been deposed before?

8 A. I have.

9 Q. Okay. And what was the nature of the
10 litigation in which you were deposed?

11 A. Mostly insurance matters for supporting
12 patients in their medicolegal cases.

13 Q. Okay. And so are you thinking of multiple
14 matters in that response?

15 A. Over my lifetime career, yes.

16 Q. Approximately, how many times have you been
17 deposed?

18 A. Probably only four or five times.

19 Q. Okay. And in those -- in those matters, were
20 you providing testimony as a fact witness or as an
21 expert witness?

22 A. Would you define "fact witness" and "expert
23 witness" in regards to medicolegal cases?

24 Q. Sure.

25 So maybe could you tell me what you mean by a

1 medicolegal case?

2 A. Someone was in a car accident, they had
3 injured themselves, I took care of them, and they needed
4 details about their medical care. So I provided those
5 details during a deposition for -- on behalf of the
6 attorneys who were supporting the case.

7 Q. Okay. So you were providing fact testimony
8 about what medical care you provided to your patients?

9 A. Correct.

10 Q. Okay. And have you ever been deposed as an
11 expert witness?

12 A. I have done a -- one expert witness case in
13 court. I don't know if that counts as a deposition. It
14 was a trial.

15 Q. Okay. So you testified live at trial --

16 A. Yes.

17 Q. -- but you didn't have a meeting in a
18 conference room like this?

19 A. No.

20 Q. Okay. Did -- what was the nature of that
21 litigation?

22 A. It was a medicolegal case, and -- where the
23 patient was claiming negligence in care of a different
24 physician.

25 Q. And did you testify on behalf of the patient

1 or the physician?

2 A. The patient.

3 Q. The patient.

4 Do you recall the substance of your opinions
5 in the case?

6 A. I couldn't speak to it adequately. It was a
7 few years ago.

8 Q. Okay. Because you can't recall or because of
9 confidentiality restrictions?

10 A. I am sure I can't recall it accurately, and I
11 am sure there's confidentiality pieces in it. And I
12 don't think it was at all material to my opinions for
13 today.

14 Q. Okay. Do you recall if that case involved
15 issues of quality of the care provided?

16 A. I do not.

17 Q. Okay.

18 All right. And I skipped through all of the
19 ground rules, but I'm just going to go through them
20 briefly.

21 A. Sure. Of course.

22 Q. So you understand that we are transcribing
23 your testimony today; correct?

24 I'll need --

25 A. Yes.

1 Q. -- a verbal response. That's where I was
2 going with that.

3 A. Sorry. He nods.

4 Q. Yes.

5 And you understand that you are under oath
6 today?

7 A. I do.

8 Q. Is there anything that would prevent you from
9 testifying truthfully today?

10 A. No.

11 Q. And we will try to take breaks every so often,
12 but if you need a break, just let me know. Okay?

13 A. Thank you. I will.

14 Q. And if you don't understand a question, please
15 ask me to clarify. If you don't ask me to clarify, I
16 will assume that you understood the question; is that
17 fair?

18 A. Fair. Thank you.

19 Q. Okay. And are you aware that you're appearing
20 as an expert in a case between The Leapfrog Group and
21 five hospitals in the south of Florida?

22 A. I am.

23 Q. And if I refer to those five hospitals
24 collectively as the "plaintiffs' hospitals," will you
25 understand what I'm talking about?

1 A. I will.

2 Q. Okay. And what is your understanding of the
3 dispute between Leapfrog and the plaintiff hospitals?

4 A. I understand that the hospitals were not
5 satisfied with the grades they received under the
6 quality assessment system and have issues about being
7 reported on when they were not participating in the
8 survey during a certain period of time, which I couldn't
9 quote you.

10 Q. Okay. What is your understanding of the
11 relationship between Tenet Corporation and the plaintiff
12 hospitals?

13 A. I don't think I have any detailed knowledge of
14 the relationship.

15 Q. Have you heard of Tenet Corporation?

16 A. Only as much as it's a large healthcare
17 system.

18 Q. Okay. Do you know whether or not the five
19 plaintiff hospitals are part of the hospital system of
20 Tenet?

21 A. I believe they are, yes.

22 Q. Are you familiar with the term "Tenet
23 affiliates"?

24 A. I am not.

25 Q. Okay. And are you employed by Virginia Mason

1 Franciscan Health?

2 A. I am.

3 Q. Okay. And do you have any understanding of
4 whether the hospitals within the Virginia Mason
5 Franciscan Health system have any relationship with
6 Tenet Corporation?

7 A. I do not know.

8 Q. And so you also don't know if any of the
9 hospitals within the Virginia Mason system are Tenet
10 affiliates?

11 A. Correct, I would not know.

12 Q. Do you have any understanding of the
13 relationship between Virginia Mason Franciscan Health
14 and CommonSpirit?

15 A. Yes.

16 Q. What is your understanding of that
17 relationship?

18 A. From what I understand, CommonSpirit acquired
19 Virginia Mason Franciscan Health approximately four or
20 five years ago, and we're now under one umbrella as
21 CommonSpirit.

22 Q. Okay. Do you know if there is a relationship
23 between CommonSpirit and Tenet Corporation?

24 A. I do not know.

25 Q. So you also do not know if CommonSpirit is a

1 Tenet affiliate?

2 A. Correct, I do not know.

3 Q. Okay. And we can come back to that.

4 So who retained you as an expert in this
5 litigation?

6 A. Ms. Blair's firm.

7 Q. When were you first contacted?

8 A. I couldn't tell you an exact date. I'm sure
9 we could look up the records. A few months ago.

10 Q. A few months ago.

11 So sometime over the summer; is that fair?

12 A. I think so, yes.

13 Q. Okay. And do you recall who first contacted
14 you?

15 A. I believe it was Kavi. Again, I'm sure it's
16 in a -- it's in an email transcript somewhere --

17 Q. Okay.

18 A. -- but I do not know.

19 Q. And before your engagement for this
20 litigation, had you ever spoken to anyone from Wilson
21 Elser?

22 A. I do not believe so, no.

23 Q. Okay. And to the best of your recollection,
24 have you ever been involved in another case involving
25 Wilson Elser?

1 A. I don't think so, no.

2 Q. Okay. Before your engagement, had you heard
3 about Leapfrog?

4 A. Yes.

5 Q. And before your engagement, had you ever
6 spoken to anyone from Leapfrog?

7 A. I don't think on any formal occasion. I may
8 have seen them at various healthcare improvement
9 conferences over the years, but none that I could point
10 to.

11 Q. And when you say you may have seen Leapfrog,
12 are there particular individuals at Leapfrog you're
13 thinking of or just the Leapfrog brand?

14 A. The brand.

15 Q. And since your engagement in this matter, have
16 you spoken to anyone from Leapfrog?

17 A. I have not.

18 Q. Have you ever been asked to be on any of
19 Leapfrog's advisory panels?

20 A. I have not.

21 Q. Have you ever attended an event sponsored by
22 Leapfrog?

23 A. I have not.

24 Q. Have you ever been asked to attend any of
25 Leapfrog's events?

1 A. I have not.

2 Q. Do you follow Leapfrog on social media?

3 A. No.

4 Q. Okay. Do you follow anyone from Leapfrog on
5 social media?

6 A. I don't think so. Does LinkedIn count as
7 social media?

8 Q. Well, we can break it up.

9 Apart from LinkedIn, do you follow anyone from
10 Leapfrog on social media?

11 A. Apart from LinkedIn, I do not participate in
12 social media --

13 Q. Okay.

14 A. -- to my teenager's dismay.

15 Q. And do you follow Leapfrog or anyone from
16 Leapfrog on LinkedIn?

17 A. I don't think so.

18 Q. You submitted an expert report in this case;
19 correct?

20 A. I did.

21 Q. And does that report describe all of the
22 opinions that you intend to offer in this case?

23 A. Yes. I would support the opinions I put in
24 that document, and happy to offer them in this
25 deposition.

1 Q. Have you formed any opinions in this case that
2 are not set forth in your report?

3 A. It's a vague question. I don't know if I
4 understand.

5 Q. Okay.

6 A. Can you clarify your question?

7 Q. When you were preparing your expert report,
8 did you endeavor to put all of your opinions down in
9 writing in it?

10 A. Within the confines of that size document,
11 yes. I do not think that's a comprehensive expository
12 of all my opinions regarding any topic or this one in
13 particular, so...

14 Q. Okay. And just to be clear, I'm just speaking
15 of opinions that you formed that are particular to this
16 matter, not, you know, your opinions in the broader
17 world.

18 But have you formed any additional opinions
19 since you drafted your expert report?

20 A. I don't think so. I think it was a focused
21 document for the purposes of the primary questions to be
22 answered. And I am certain I have further opinions on
23 the topic that were not expressed in that document. So
24 I may offer them if the situation arises.

25 So it is not comprehensive, I guess --

1 Q. Okay.

2 A. -- if that's what you're asking.

3 Q. Is it fair to say that, you know, to limits of
4 human language and 14 pages, your report includes all
5 of, you know, the opinions you could fit within those
6 constraints?

7 A. Correct. Yes.

8 Q. Okay. Did you receive any support in
9 preparing the expert opinions -- the expert opinions in
10 your report?

11 A. Please define "support."

12 Q. Did anyone help you draft your expert report?

13 A. No. That was all my evaluation and my
14 interpretation.

15 Q. Did anyone help revise your expert report?

16 A. No.

17 Q. Did anyone provide you with information that
18 you refer to in your expert report?

19 A. There were the case documents that were in the
20 folder from the law firm. I think it was the lawsuit,
21 the opinions of some of the other experts, and the
22 survey, and the relevant material of the case.

23 Q. Okay. So if I understand correctly, Wilson
24 Elser gave you a folder of materials related to the
25 litigation, and you used that to help you draft your

1 report?

2 A. Correct.

3 Q. Okay. Did anyone else give you any
4 information that you used to draft your report?

5 A. No.

6 Q. Have you reviewed the testimony of any other
7 witnesses in this litigation?

8 A. I briefly reviewed the one testimony. And I
9 cannot recall the expert's case. But it was -- it
10 wasn't a media expert, but it was a marketing expert's
11 opinion.

12 Q. Was it Mr. Chakurda?

13 A. That's the one.

14 Q. Okay.

15 A. Yes. Sorry. I'm terrible with names.

16 Q. Okay. So did you review his deposition
17 transcript or just his expert report?

18 A. I believe it was his expert report that was in
19 the folder, yes.

20 Q. Okay. Do you recall approximately when Wilson
21 Elser provided you with that folder?

22 A. Probably in the weeks prior to when I
23 submitted my opinion. I think it was all over a pretty
24 short timeline of a few weeks, yeah.

25 Q. What was your assignment in this case?

1 A. I was asked to give my opinion as a customer
2 or end user of a facility that uses Leapfrog in their
3 daily quality work and to interpret my experience over
4 the two decades that I've worked for this facility. And
5 they've been participating in quality improvement
6 efforts.

7 Q. Okay. And I just want to break that down a
8 little bit.

9 So when you refer to a "facility that uses
10 Leapfrog in their daily quality work," are you speaking
11 of Virginia Mason Franciscan Health system or a
12 particular hospital?

13 A. Virginia Mason Medical Center in particular.
14 There's been some changes in the organizational
15 structure since we became Virginia Mason Franciscan
16 Health and then subsequently CommonSpirit, which I don't
17 think are relevant to this case.

18 But my -- the confines of the work I do are
19 within Virginia Mason Medical Center Hospital and, for
20 years, its affiliated clinical sites, which were about
21 eight or ten at various years.

22 Q. Okay. And you referred to yourself as a
23 "customer of Leapfrog."

24 Can you elaborate on what you meant by that?

25 A. Not necessarily a customer of Leapfrog, but a

1 customer of a healthcare system that prioritizes
2 quality.

3 So as an employee, I get benefits and get to
4 participate in improving quality. As a patient or a
5 family member of patients, I reap the benefits of the
6 quality work that's done, prompted in part by Leapfrog
7 and other organizations similar to it that publish this
8 data and make it transparent for us.

9 Q. So do you use Leapfrog data to decide which
10 hospital you affiliate with?

11 MS. BLAIR: Objection. Form.

12 A. No, I don't think I have used Leapfrog
13 specifically to decide which hospital I affiliate with.

14 Q. (BY MS. PARKS) Okay. So why is it important
15 to you that Leapfrog makes data transparent to you?

16 A. That is a very complicated question, and I
17 wonder which aspects of it you want me to answer. But I
18 could go on for a while.

19 Primarily, it sets the stage for an
20 organization whose leadership prioritizes quality in the
21 daily work of what we do as clinicians and of what I
22 would want as a patient or a patient family member.

23 So having visibility to data on all levels
24 from patient, to provider, to leadership, to national
25 available data, helps us do better work every day for

1 every single patient.

2 And I've come to learn over the last 20 years
3 how critical that is. In the detailed work that I do in
4 neurosurgery, it's not just me, it's a whole army of
5 people that are getting things ready for the piece of
6 care that I deliver.

7 And having that sort of transparent vision and
8 prioritization of quality, and watching and measuring,
9 and reacting to measurements, I think sets the stage for
10 an environment that we can do the best work for our
11 patients, which has historically been the focus of why
12 we do what we do at Virginia Mason.

13 Q. Okay. So when you are talking about relying
14 on Leapfrog data to improve quality, are you referring
15 to the Leapfrog hospital safety grades or some other set
16 of Leapfrog data?

17 A. So I'm going to go back. I don't think
18 relying on Leapfrog data -- if I said that, I apologize.
19 I don't think there's a reliance on any one data source.

20 It is the concept of being aware of your
21 quality to the level that you can measure it and
22 reacting to that. And Leapfrog is a contributor to our
23 larger quality framework --

24 Q. Okay.

25 A. -- so...

1 Q. And what specific contributions does Leapfrog
2 provide to your quality framework?

3 A. I think it has not only a very scripted recipe
4 as part of the survey of what you have to measure, but
5 it keeps on the forefront of all the members of the
6 quality team and the clinical care provider team and the
7 leadership team that measuring quality is important.
8 And so it helps encourage the language and the practice
9 of measuring things, like how often we wash our hands,
10 how often patients with sepsis survive once they enter
11 our hospital.

12 These -- each of these questions are very
13 complicated and require a lot of attention. And I think
14 organizations like Leapfrog that measure, as well as CMS
15 and other national organizations, prompt us to put more
16 of our attention in those areas and then dig down into
17 the details of how it can help provide a safer
18 experience for our patients.

19 Q. Okay. And so if I understand you correctly,
20 you are referring to the framework in the hospital
21 safety survey; is that correct -- or the Leapfrog
22 hospital survey?

23 A. That is one of the contributors to the
24 framework.

25 So if I may, a little bit of the quality

1 organizational structure of a hospital is that you
2 measure a lot of data, a lot of things. All that data
3 is usually measured, at least within our organization,
4 within sections of experts -- the infection team, the
5 cardiac team, the nerves team. And they measure markers
6 of quality that are different in their realms. They
7 decide what to measure, how to measure it, and report
8 that up to leadership.

9 And we follow these like gauges on the
10 dashboard of your car. And if the gauges show alarming
11 numbers, then the hospital quality department and the
12 hospital as a whole brings resources to that department
13 to help figure out why something looks like it's going
14 to provide less than ideal or optimal quality care for a
15 particular patient situation. And then we come together
16 in a quality committee to help that particular
17 department solve that particular problem.

18 So if the oil light is going on on your
19 dashboard, you know to go check the oil first; you're
20 not going to check the tires.

21 So Leapfrog, and other organizations that tell
22 us these are the things that are relevant in healthcare
23 to measure, help us focus our attention on measuring
24 things that in today's world have the most relevance
25 based on what we can judge as where we should put our

1 resources to help deliver good patient care.

2 Q. Okay. So Leapfrog says you have to measure X,
3 you have to measure Y, you have to measure Z, and then
4 it's your opinion that drawing hospital attention to the
5 metrics for X, Y, and Z improves hospital quality?

6 A. Correct.

7 Q. Okay. And do you have any empirical evidence
8 that shows a relationship between the specific metrics
9 included in the Leapfrog hospital survey and
10 improvements in quality of care at hospitals?

11 A. I can cite numerous things, specific care
12 issues that over my career have improved.

13 So 25 years ago, before we measured these
14 numbers, I would, as a resident, go to a patient who
15 needed a central line placed for getting medications or
16 nutrition. And I would consent them for the procedure,
17 saying, "We are going to put this long catheter into
18 your body, and it has these risks: We could puncture a
19 lung, we could cause bleeding, we could cause infection.
20 And it is likely that if we don't change this line
21 within seven days, you may have more than a 20,
22 25 percent risk of infection, and so we'll have to
23 change it in seven days."

24 Based on measurements, like what Leapfrog has
25 done over its lifetime, we have learned that if you

1 follow a strict protocol of washing your hands, putting
2 on gloves, putting on a gown, washing the patient,
3 making sure they're not infected, using a particular
4 tool set to put in this central line -- by simply
5 following that recipe, we have reduced the infection
6 rate for central lines in my hospital to -- not even a
7 percentage, but we measure days until last central line
8 infection. So we'll put in thousands over the course of
9 months in a hospital-wide setting and not get
10 infections.

11 And if we do get an infection, we dig down
12 into that particular case and figure out why that
13 patient became infected and is there something we can do
14 to improve our protocol to prevent the next patient, 1-,
15 2,000 patients down the road from getting infected.

16 Like, that makes me so proud of our healthcare
17 system and so proud that we have such a transparent
18 focus on how we're taking care of every single patient.
19 And I no longer have to tell my patient that they have a
20 one-in-four chance of getting infected within a week
21 because of something I need to do that's needed for
22 their care.

23 So there are publications on these topics
24 and -- I don't have them handy, but I'm sure we could
25 come up with that data. But this is -- this is the -- a

1 case example of why measuring for quality and then
2 reacting to it is relevant.

3 Q. Okay. So these publications you're thinking
4 of that might show an empirical relationship between
5 Leapfrog metrics and patient/hospital quality, are any
6 of those cited in your report?

7 A. I don't have -- if you have my report, I can
8 look through and point to them. But I think I had some
9 references listed. I don't know which one in particular
10 cited this.

11 This is sort of -- in our world, if something
12 is published more than three times, it's sort of decided
13 that it's common knowledge. So I think it's common
14 knowledge that quality metrics drive improvement in
15 quality care and reduce complications and reduce risk.

16 Q. Okay. And are you aware of more than three
17 publications tying the specific metrics in the Leapfrog
18 hospital survey to improved outcomes?

19 A. I could not point to that specific publication
20 at this time --

21 Q. So --

22 A. -- but I'm sure many exist.

23 Q. -- is it your view that it's common knowledge
24 that each of the metrics in the Leapfrog hospital survey
25 leads to improved outcomes?

1 MS. BLAIR: Objection to form.

2 A. I believe the metrics that Leapfrog sets out
3 through the structure in which they build the survey is
4 thoughtful and surveys all the evidence that's in
5 medical literature, brings together experts to help
6 consolidate that medical knowledge, and builds its
7 survey questions based on the best data we have.

8 And so that -- I don't think their -- every
9 single point and everything we measure in quality in
10 healthcare has data behind it. And in our monthly
11 quality meetings, we prime the 25 members of the quality
12 committee to ask this exact question every time: What's
13 the best data you have for measuring this particular
14 measurement? We call them "key performance indicators,"
15 KPIs.

16 In the absence of evidence, what do the
17 experts who know the work think would be the reason you
18 should measure this thing? If this metric -- if this
19 KPI is out of this range, what are you going to do to
20 try to improve it to make care for that patient better?

21 So I believe that structure of building the
22 specific questions within a survey, like Leapfrog and
23 CMS and others, is the common methodology and rationale
24 for building those survey questions and how we do our
25 quality work every day.

1 We may not have randomized controlled trials
2 that prove X, Y, or Z to statistical significance, but
3 we take the best information we have and try to put our
4 resources towards the most relevant topics. And I
5 believe the Leapfrog survey has, very much, put a good
6 faith effort into doing that.

7 Q. (BY MS. PARKS) What's your basis for saying
8 that Leapfrog -- the Leapfrog survey puts a good faith
9 effort into identifying metrics?

10 A. I think their -- they publish how they choose
11 the methodology and build their structure. And
12 they're -- within our world of quality, there are
13 constant discussions about how metrics are measured, and
14 what to measure, and how to measure them. And people
15 reference that structure.

16 And whether it's Leapfrog or the other
17 organizations that do reporting, there is an overall
18 sense, from my perception and my opinion of what I hear,
19 that the work that Leapfrog has put into building this
20 particular methodology and this structure is the most
21 sound that it can be.

22 And I'm not a methodology expert. Again, I'm
23 a customer of the methodology, but I have to -- I have
24 to have faith in this methodology. And from where I
25 stand as a customer, it seems sound.

1 Q. Are you saying that you could infer Leapfrog's
2 good faith from their transparency?

3 MS. BLAIR: Objection to form.
4 Mischaracterizes the testimony.

5 A. Yeah, I don't know if I understand that
6 question.

7 Q. (BY MS. PARKS) Okay. So you said -- I asked
8 you what is your basis for saying that the Leapfrog
9 survey puts a good faith effort into identifying
10 metrics, and you initially answered, "I think they
11 publish how they choose the methodology and build their
12 structure."

13 So is it your opinion that you can -- because
14 they're transparent about their methodology, they are
15 necessarily acting in good faith?

16 MS. BLAIR: Objection to form.

17 A. Again, I don't understand what "good faith"
18 means in the legal terms.

19 I think I would much rather follow the
20 methodologies of a process in my workspace that I have
21 visibility to than a methodology that was invisible to
22 me.

23 So the transparency in how you get a
24 particular piece of data, at least in our medical
25 education, seems to be the most reliable way to get

1 information.

2 So if I get a blood count on you, and the
3 blood count is read as X or Y or Z, I have to trust that
4 if your hematocrit is 30 as the lab states it, and their
5 range is plus or minus one, that your blood count is
6 going to be 29 to 31, and I will choose not to transfuse
7 blood if you're critically ill.

8 And I know that because the laboratory in our
9 hospital publishes how they check, how they run that
10 hematocrit in a transparent way, which machine they use,
11 what the variances on that machine are, what data they
12 have to support that machine. So that is an open source
13 of information. So I can have the best way to validate
14 that open source.

15 So Leapfrog, similarly, because the
16 methodology is transparent, gives me more confidence
17 that it is an appropriate measure, and then I can weigh
18 the pros and cons of that as I do my work as a customer,
19 as a clinician, and as a quality director.

20 Q. (BY MS. PARKS) Okay. And when you're talking
21 about the Leapfrog methodology that is transparent, are
22 you speaking to Leapfrog's methodology for choosing the
23 metrics to include in their safety grades, or are you
24 choosing -- are you referring to their method of
25 calculating the safety grade?

1 MS. BLAIR: Objection to form. I'm not sure
2 he's ever said "safety grade."

3 Q. (BY MS. PARKS) Okay. Well --

4 MS. BLAIR: I want to make sure we're all
5 talking about the same thing. He's not here for the
6 safety grade.

7 Q. (BY MS. PARKS) What Leapfrog methodology do
8 you believe is transparent?

9 A. The survey itself is a dense document that is
10 made available to us. And so the -- if you look in
11 through the survey, each particular metric has some
12 details associated with it. And then if you -- so if
13 you don't understand what you're measuring, you can go
14 into the document and figure out exactly what's being
15 measured, and why, and how they came up with that
16 methodology.

17 And I don't know how much more specific you
18 want me to get. I mean, we can pull out the document
19 and look at -- and we call this doing a tracer where you
20 sort of follow the path of information as to where it
21 came from. So we can go through that path and figure
22 out for Measurement A, how they're measuring it, and
23 what path they went through to come up with that data.

24 But that is transparent and visible in most of
25 the metrics.

1 Q. Do you agree with counsel that you're not here
2 to speak about the safety grade in this case?

3 A. I was asked to speak about the survey as a --
4 in my position as medical director of quality for my
5 hospital and, again, as I discussed, sort of as an end
6 user of the results and what participating in that
7 survey does to my organization's improvement on quality.

8 So I'm not a methodology expert.

9 Q. Okay. And so fair to say you don't have any
10 opinions about whether Leapfrog is transparent with
11 patients about how it calculates the safety grade?

12 A. I guess I couldn't delve into the details of
13 that, no.

14 Q. Okay. And do all of your opinions relate to
15 the relationship between the Leapfrog hospital safety
16 survey and hospital quality?

17 A. I think that's the area where I have expertise
18 and what I was asked to speak on here today.

19 Q. Okay. And were you asked to speak on any
20 other areas?

21 A. No.

22 Q. Okay.

23 MS. PARKS: Okay. Can I have -- thank you.

24 (Exhibit Number 1 marked for identification.)

25 Q. (BY MS. PARKS) Okay. So I'm going to hand

1 you a copy of what's been marked Exhibit 1.

2 MS. BLAIR: Thank you.

3 Q. (BY MS. PARKS) Is this the version of your CV
4 that you provided with your expert report?

5 A. I believe it is.

6 Q. Okay.

7 All right. And I think we might have covered
8 this already, but looking under "Positions," are all of
9 these positions that you listed -- these were all
10 positions you held with Virginia Mason Franciscan
11 Health; is that right?

12 A. Correct.

13 Q. And I believe you said you treat patients, in
14 particular, at Virginia Mason Medical Center; is that
15 right?

16 A. Correct.

17 Q. Do you treat patients at any other hospitals
18 within the -- can I call it VMFH network?

19 A. You can call it VMFH, yes.

20 Q. Okay.

21 A. I am credentialed at the other VMFH sites.
22 And I have helped my colleagues take care of patients at
23 some of the other sites on rare occasions.

24 Q. Okay. Would you be able -- like, when you say
25 "rare occasions," is that once a month? Once a week?

1 Less frequently?

2 A. Less frequently than once a month. A couple
3 of times a year.

4 Q. Okay. And do you have privileges at any
5 hospital outside of the VMFH network?

6 A. I do not believe I have current privileges at
7 any other hospital outside of this network for the
8 purposes of clinical work.

9 Q. Okay. So can you just describe for me, like,
10 a day in your life, like how often do you perform
11 surgery at the hospital? How many hours are you
12 spending -- just kind of speak a little bit about what
13 your role looks like.

14 A. Sure.

15 My clinical world is very typical. I go to
16 our hospital on clinic. I see patients in conjunction
17 with other colleagues and other experts. We have joint
18 clinics. We take care of patients, diagnose them with
19 neurosurgical problems or non-neurosurgical problems,
20 refer to the appropriate care if we're not the care
21 providers. If they need surgical care, educate them on
22 what care they need. If they choose to proceed with
23 that care, prepare them for the surgeries.

24 And then on surgical days, we perform those
25 surgeries, again, as a very large and complicated team,

1 because most of these disease processes require a
2 complex set of experts and tools and preparation and
3 follow-up. Then we see these patients in the hospital
4 after their surgeries. And once they go home, we see
5 them in follow-up in the clinic.

6 So that's the bulk of the clinical work that I
7 do and have done.

8 My work with the quality department basically
9 involves reviewing data with a team of quality experts
10 of hundreds of metrics that we follow continuously
11 within our medical center. These metrics are decided
12 upon within our medical center, external to our medical
13 center from VMFH, external to VMFH from CommonSpirit,
14 external to CommonSpirit from CMS, Leapfrog, DOH, and
15 various other entities.

16 And so our job is to filter and decide what
17 quality metrics we are following every day, which ones
18 are out of range, and which experts we bring together to
19 figure out if those are concerning and require reaction
20 or a change in our processes.

21 And that feeds back into my day job, which is:
22 Am I doing the best thing for my patient when I see them
23 in clinic, when I operate on them, when I care for them
24 after?

25 Q. Okay.

1 A. So that work sort of blends, which makes it
2 enjoyable.

3 Q. And do you also spend time on research?

4 A. I do. That's -- in our system, it's kind of
5 voluntary. We're not a university system, so we don't
6 have a research obligation.

7 But our group has found, over the last
8 20 years, that many of these questions of how can we do
9 better for our patients don't have answers. And so most
10 of our research has been focused on what data can we
11 gather from our environment to improve the quality of
12 care and answer some of these unanswered questions about
13 X, Y, or Z.

14 From, you know, years ago when you came in and
15 you needed a lumbar fusion surgery, you would spend many
16 days in the hospital. A lot of it sort of waiting. And
17 you would get all these tests. And when we looked at
18 the complication rates of that surgery and all the steps
19 in that process, we realized that a lot of those steps
20 were waste and were actually causing harm.

21 So we iteratively improved that process to the
22 point now where these patients have a much lower risk of
23 complications. And we have research data to support
24 that. And are going home and leaving the hospital in a
25 much shorter period of time. So less exposure to all

1 the harms that are within a hospital system.

2 So, again, the research sort of goes hand in
3 hand with the quality work and with the clinical work.

4 Q. So how do you divide your time among research,
5 quality work, and clinical work?

6 A. Divide your time?

7 I don't -- there's not a designated FTE
8 differentiation in that work. That's, I think, why I
9 referred to it all as being sort of hand in hand. We
10 don't have time-designated FTEs in our world.

11 Q. Are you able to estimate, like, what
12 percentage of your time you spend working with your
13 quality committees?

14 A. Roughly 10 percent of the hours of a standard
15 workweek is probably spent on quality.

16 Q. Okay. And fair to say that most of the
17 remaining 90 percent goes to clinical work?

18 A. Yes.

19 Q. Okay. So going back to these positions under
20 your -- on your CV, are the medical director of quality
21 and chairman of quality council -- are those two
22 different positions, or is this one position?

23 A. They are blended.

24 Q. Okay.

25 A. So chairing the quality council has a distinct

1 job description and tasks. Being medical director of
2 quality has a slightly broader scope outside of the work
3 of the quality committee work and leadership of that
4 committee, but they're very intertwined.

5 Q. Okay. So let's start with medical director of
6 quality. Is that just for Virginia Mason Medical
7 Center?

8 A. Correct.

9 Q. And what are the roles that are distinct -- or
10 the responsibilities that are distinct to your role as
11 medical director of quality?

12 A. I'm a resource for any quality questions that
13 come up during any surveys or building the structure of
14 quality, and putting together a group of individuals
15 that can evaluate, react to, and improve quality on a
16 continuous basis.

17 So we have quality managers, infection
18 preventionists, various other directors of quality for
19 the different sections of the hospital. My job is to
20 support them and make sure that they are doing the
21 detailed work of improving quality on a daily basis for
22 all areas in our hospital.

23 Q. Do those individuals, the quality managers,
24 infection preventionists, and other directors of
25 quality -- do they report to you?

1 A. No. The org structure has a different
2 operational reporting structure for them. So they are
3 sort of dotted-line reports to me.

4 Q. Okay. And is your role to supervise them?

5 A. Officially not, because I do not have to fill
6 out their supervisory evaluations, but to collaborate
7 with them in achieving the mutual goals of quality for
8 the hospital.

9 Q. So are you giving them assignments and tasks
10 to complete, or is it more of an advisory relationship
11 between them and you?

12 MS. BLAIR: Objection to form.

13 A. A little bit of both, depending on the
14 occasion, yeah. It's a very collaborative environment.
15 It is not hierarchical at all.

16 Q. (BY MS. PARKS) Okay.

17 A. That's just culturally what our system has
18 been. And it's hard to understand because I've lived in
19 a different environment than this one. But the focus of
20 all members of all teams at Virginia Mason is to take
21 care of the patient, whichever patient is in front of
22 you at that time.

23 And so we approach all meetings, all work, all
24 clinical work, all quality work, even how we decide how
25 to reorganize our physical infrastructure, our hospital

1 spaces, really based on a meeting where we bring
2 everyone together and say, "Okay. What are we trying to
3 achieve for the patient today?"

4 And so it is not militaristic. It is not
5 hierarchical. It is very collaborative and focused on
6 improving the care of each patient every time.

7 Q. Okay.

8 A. That's a hard thing to explain if you haven't
9 lived in that space, but it -- hence, I hesitate when
10 trying to answer your structural questions about the
11 hierarchy of how the medical quality leadership roles
12 work.

13 Q. Do you speak with the quality managers,
14 infection preventionists, and directors of quality on a
15 daily basis?

16 A. No. Probably weekly.

17 Q. Okay. And if you tell them to do something,
18 do they have to listen to you, or do they have a
19 different person who's responsible for setting their
20 purviews?

21 A. Again --

22 MS. BLAIR: Objection to form.

23 A. Again, we don't do a "have to." That's not
24 our culture. Everybody wants to do what's best for the
25 patient.

1 And so I don't think I've ever told anyone, in
2 my 20 years at VM, that "you have to do this." I say,
3 "This seems to be the best path forward," we all agree,
4 and then people usually volunteer to do whatever the
5 work at hand is.

6 Q. (BY MS. PARKS) Okay. So it sounds like
7 that's a no. If you say "you have to do this," the
8 person can either listen or not if they're a quality
9 manager, or infection preventionist, or director of
10 quality; is that right?

11 MS. BLAIR: Objection to form.
12 Mischaracterizes the testimony.

13 A. Yes. They would have the choice to say no,
14 should they choose.

15 Q. (BY MS. PARKS) Okay.

16 A. I've not run into that occasion yet.

17 Q. Okay. And how does the responsibilities of
18 the chairman of the quality council differ from the
19 responsibilities we just discussed?

20 A. Those tasks are in particular operational for
21 the committee. So helping make sure that we hold the
22 committee meetings on a routine basis, we have a work
23 plan for what topics have to go through the committee
24 over the course of a year, what topics have to be
25 presented at what timeframes, who the members of the

1 committee are, that they are selected by the appropriate
2 processes.

3 Once a year, we look through and revise our
4 charter to make sure that we are -- we are staying up to
5 date with how we do our work.

6 So all those operational pieces of running the
7 committee are what I'm involved in.

8 Q. How many members are on the quality council?

9 A. Anywhere from 20 to 30, and a subset of those
10 are voting members, some are ad hoc, so on and so forth.

11 Q. And this, again, would just be the quality
12 council for Virginia Mason Medical Center?

13 A. Correct.

14 Q. Okay.

15 A. They're a good bunch.

16 Q. And then from 2014 to 2020, you were the
17 section head of the department of neurosurgery.

18 Was that, again, for Virginia Mason Medical
19 Center?

20 A. Correct.

21 Q. And what were your responsibilities in that
22 role?

23 A. Those were more operational responsibilities
24 and running the group of neurosurgeons, and hiring,
25 building their practices, building the support structure

1 they needed, making sure their educational needs were
2 met, mentorship for the younger surgeons, so on and so
3 forth.

4 Q. Okay. And then you're now currently the chair
5 of functional neurosurgery.

6 Is that at the system level, or is that...

7 A. At VMFH, yes. And since we've become larger
8 and restructured, those of us with specific clinical
9 expertise have taken on the role of developing that
10 particular clinical subsection of neurosurgery within
11 the larger VMFH system.

12 Q. Okay. And are those -- are your
13 responsibilities in that role similar to when you were
14 section head, or are they different?

15 A. More program building, less operational.

16 Q. And what do you mean by "program building"?

17 A. So in a large complex healthcare system,
18 again, with less hierarchy than, like, a military
19 structure where you have a map of who does what, you
20 have to decide what the population that you're serving
21 needs.

22 So of the millions of people in the Washington
23 State area that are Virginia Mason Franciscan Health
24 service leads -- or services, what percent of them have
25 functional neurosurgical problems, what resources do we

1 need -- neurologists, physical therapists,
2 neuropsychologists, neurosurgeons -- to take care of
3 them? Where are these patients? And so where do we
4 need to set up clinics to take care of them?

5 We have a monthly meeting to not only bring
6 those people together, evaluate specific patients, but
7 also work on quality improvement, research, building
8 structure and getting resources from the institution to
9 build that structure to take care of this patient
10 population.

11 So very much like leading the quality
12 committee. It's just like bringing a lot of people
13 together to take care of this particular job or this
14 task of this particular subpopulation of neuroscience
15 patients.

16 Q. Is all of your medical experience as a
17 physician related to neurosurgery?

18 A. Correct. Yes.

19 Q. Okay. Do you have any other positions within
20 the VMFH system besides those listed here?

21 A. No. Just various committees and sort of ad
22 hoc work --

23 Q. Okay.

24 A. -- but most of it is reflected here.

25 Q. All right. And then on page 2, you list a

1 number of current and past memberships in different
2 societies and professional organizations.

3 Do you see that?

4 A. Yes.

5 Q. In any of those positions, have you provided
6 advice regarding hospital ratings?

7 A. I have not.

8 Q. In any of those positions, did you provide
9 advice regarding hospital safety?

10 A. I have not.

11 Q. All right. And then in the next section --
12 I'm sorry, two sections down under
13 "Education/Teaching/Mentorship Appointments" --

14 Do you see that section?

15 A. Uh-huh.

16 Q. -- you identify your role as a research
17 supervisor at Washington State University.

18 In that role, do you work with graduate
19 students?

20 A. There are medical students who, through those
21 institutions, reach out to us and typically come and
22 spend a designated summer block, or a different period
23 of time, working on research projects that are in line
24 with their educational goals.

25 Q. Okay. And what is the subject matter of the

1 research you've supervised?

2 A. It's all within the world of neurosurgery and
3 neuroscience and functional neurosurgery, as noted on
4 all the publications and presentations that you see
5 there.

6 Q. Okay. And then next item down, you also
7 served as a summer research mentor at the University of
8 Washington School of Medicine.

9 Is that also with medical students?

10 A. Correct.

11 Q. And what is the subject matter of the research
12 you supervised?

13 A. Same. Those -- although the students are from
14 different organizations, once they come to us, under our
15 research program, which is PhD and MD researchers as
16 well, they all sort of work together. They don't have
17 separate paths.

18 Q. Okay. And then in the undergraduate mentor
19 program at Seattle Pacific University, are you
20 supervising research in that role?

21 A. Usually those are undergraduate students who
22 think they have an interest in healthcare or law or
23 whatever the topic may be. They connect with us, they
24 come and spend some time with us.

25 And if the particular experience is -- speaks

1 to them, some of them have gone on to do research with
2 us, some of them have then gone on to medical school and
3 residency, and have gone on to work in the field of
4 neurosurgery. The majority choose not to work in
5 neurosurgery, so I think we do an adequate job of
6 scaring them away.

7 Q. Okay. And then on the next page, I'd like to
8 look at the committees section.

9 What is the utilization management committee?

10 A. So part of how we have to document our care
11 for reimbursement from insurance companies and Medicare
12 is organized through a committee called utilization
13 management committee.

14 As an example, if a patient comes in and has
15 surgery X, and Medicare says that should have been coded
16 as surgery Y, or inpatient versus outpatient, that
17 particular feedback from the payor comes through the
18 utilization management committee. And they have a group
19 of experts who will review that case and write the
20 appropriate documentation to appeal the -- either the
21 defect in the documentation or correct the payor as to
22 what the true situation was so that they can get
23 reimbursed for that care of a hospital. And these are
24 hospitalized patients in particular.

25 Q. Okay. And so are you one of the experts who

1 would do that work?

2 A. Correct. So from the cases that involve
3 neurosurgical patients, if there's a question, then we
4 can speak to whether or not technically that was an
5 inpatient, an outpatient, this type of surgery, that
6 type of surgery, underlying condition, an acquired
7 condition.

8 But interesting work. A little bit separate
9 from everything else we do, but unfortunately, necessary
10 as it runs the financial structure of the healthcare
11 system.

12 Q. And then I see the finance committee of NSC.
13 What does "NSC" stand for?

14 A. That is the neuroscience -- neurosciences
15 collaborative. That is one of the new committees that
16 our national organization, CommonSpirit, has organized
17 to bring neurologists, neurosurgeons, and affiliated
18 providers from all over the country together on a
19 routine basis to evaluate much the same thing we do for
20 quality and also for advancing various aspects of care
21 that require new technologies or new implementation.

22 So the hope is that if we have the reach of
23 140 hospitals and the experts in all of those 140
24 hospitals, that if we get the subspecialists within each
25 of those hospitals together on a routine basis, they can

1 talk about things that are on the forefront of their
2 field and help redirect the resources of the
3 organization towards that particular work and prioritize
4 what's important.

5 So the most recent topic is this new
6 stimulator that goes on your vagus nerve that has been
7 shown to improve hand function if your hand is paralyzed
8 after a stroke.

9 Super cool technology. The science seems
10 really promising.

11 Now, we have to decide, as we were speaking
12 earlier, whether the evidence is adequate, we bring the
13 experts together, make a best guess as to whether we
14 should put resources into doing this to make our
15 patients better. And then how do we work through the
16 finance committee? What does it cost? The people, the
17 equipment, the liabilities, and all those things for the
18 organization to bring a new technology in to try to help
19 stroke patients have better hand function.

20 So, again, super cool work.

21 Q. Does any of your work on the utilization
22 management committee, the neuroscience collaborative, or
23 finance committee of that collaborative relate to
24 improving safety?

25 MS. BLAIR: Object to form.

1 A. Yes. I think it is -- again, going back to
2 the previous statement of the focus is really what's
3 best for every patient every time.

4 So safety and quality are ever present in
5 every aspect of every piece of work we do. So I don't
6 think we pull it out as a separate topic. It is, is
7 this the best thing for the patient? Is this safe? And
8 then everything else follows.

9 Q. (BY MS. PARKS) Are any of those three
10 committees specifically tasked with improving safety?

11 MS. BLAIR: Objection to form.

12 A. I do not believe they're specifically tasked
13 with improving safety, no.

14 Q. (BY MS. PARKS) Okay. And working our way
15 down, what is the medical executive committee?

16 A. So in most hospitals, there is a committee of
17 medical leaders that has to meet on a routine basis to
18 advise on and adjust the hospital policies. And so this
19 includes the executive leadership, leaders of the
20 various departments, ad hoc members, the quality
21 leadership. And that's how I'm a part of the executive
22 committee.

23 And we go through the routine daily work of
24 how to run a hospital.

25 Q. Okay. In that role, are you involved with the

1 finances of the hospital?

2 A. No, not -- oh. We get global reports just to
3 keep everyone informed, but we do that in all staff
4 meetings anyway.

5 Q. Okay. So you're not responsible for, like,
6 allocating or prioritizing funds?

7 A. No, we are not.

8 Q. Okay. And then what is the medical staff
9 committee?

10 A. It's a subcommittee specific to the rules and
11 regulations of how members of the medical staff come on
12 and get onboarded and what credentials you need. You
13 need to be a board-certified neurosurgeon within
14 two years of graduation to be on staff. And each member
15 of the medical staff has certain criteria which they
16 have to meet so that they can be a member in good
17 standing and so on and so forth.

18 More mundane work but still important.

19 Q. Okay. And then lastly, what's the metrics
20 committee?

21 A. That was actually a wonderful experience. It
22 was a grassroots sort of organizational effort on behalf
23 of dozens, if not hundreds, of surgeons within the state
24 of Washington, to start -- way back, probably in the
25 early 2000s -- to measure the work we did specific to

1 surgical care and specific, in our committee, to spine
2 surgical care.

3 So we spent easily two years, once a week at
4 6:00 a.m. meetings, putting together a list of metrics
5 that all the hospitals in our participating state group
6 would voluntarily follow, and we would collect this data
7 so that we could improve care of that particular subtype
8 of patient.

9 And that organization now lives under the
10 Foundation for Health Care Quality, which is an
11 independent organization in the state. And that work
12 continues. They still collect data. They report on it.
13 The hospitals that participate in that pose research
14 questions. They do research on it. They do quality
15 improvement projects.

16 Again, very near and dear to my heart. A
17 bunch of do-gooders trying to get data from each other
18 within the geographic location of the state of
19 Washington to figure out how we can do better for the
20 next patient.

21 Q. Okay. So that organization, the Spine
22 Surgical Care and Outcomes Assessment Program, was
23 independent from VMFH?

24 A. Correct, correct, correct.

25 Q. And did that program publish any of its

1 findings or policies?

2 A. Yes. SCOAP has had a lot of publications.
3 I'm not as intimately involved with them anymore. But
4 they still -- they still do a lot of great work.

5 Q. Are you an author on any of those
6 publications?

7 A. I think I am. I couldn't tell you which ones,
8 but they're somewhere in my CV.

9 Q. Okay. And then, sort of an administrative
10 question, but on the bottom-left corner of your CV, do
11 you see the revision date appears to be January 21,
12 2024?

13 A. I see that.

14 Q. Is that date the last date that you updated
15 this version of your CV?

16 A. I do not believe so because it looks like I
17 have publications that are listed in 2025. So thanks
18 for pointing that out. I didn't even know that existed
19 on my digital CV. I'll have to remember to update that.

20 Q. Sitting here today, can you think of anything
21 that's not identified on your CV that should fall under
22 any of the categories listed here?

23 A. I don't think there's been a dramatic change,
24 no. There may have been some new presentations. You
25 know, I spoke last week at our state neurosurgery

1 society meeting on ergonomics of -- in neurosurgery. So
2 that's not listed.

3 Yeah, little things like that.

4 Q. Okay.

5 A. I just don't get to updating this as often as
6 I should.

7 Q. Have you ever been involved in developing a
8 grading methodology for hospitals?

9 A. I have not.

10 Q. Have you ever been involved in developing any
11 methods for rating the performance of hospitals in terms
12 of safety?

13 A. I have not.

14 Q. Would you consider yourself to be an expert in
15 developing those types of rating systems?

16 A. I would not.

17 Q. Do you have any experience with health
18 economics?

19 MS. BLAIR: Objection to form.

20 A. That is a broad topic.

21 Anything more specific I can answer?

22 Q. (BY MS. PARKS) Would you consider yourself to
23 be an expert in any area of health economics?

24 A. No. I definitely would say I do not have any
25 formal training or experience in health economics, just

1 armchair quarterback in how our healthcare is being run
2 these days.

3 Q. Okay. So I think I'm going to mark your
4 report next.

5 We've been going like an hour. So I'm happy
6 to take a break here, or we can just keep going.

7 A. I'm okay if you are.

8 Q. All right.

9 (Exhibit Number 2 marked for identification.)

10 MS. PARKS: Okay. I'm passing the witness a
11 copy of Exhibit 2.

12 Q. (BY MS. PARKS) Dr. Farrokhi, is Exhibit 2 a
13 copy of the report that you submitted in this matter?

14 A. It is.

15 Q. And on the -- I guess, page 13, is that your
16 signature?

17 A. I'm sure it is, yes. If you can't read it,
18 that's my signature.

19 Q. And I believe you told me earlier that you
20 were solely responsible for drafting and revising this
21 report; right?

22 A. Correct. I think the only difference is Kavi
23 may have reformatted it and changed the cover to reflect
24 the case number and all these things.

25 Q. So is it fair to say you agree with everything

1 that's written in this report?

2 A. Yes.

3 Q. And, again, this report, to the best of your
4 ability to put it down in writing, contains all of your
5 opinions?

6 A. These are my opinions, yes.

7 Q. And these are all of your opinions that you
8 were able to put down in the writing?

9 A. These are all the opinions that I put down in
10 writing, yes.

11 Q. I think my question was a little bit
12 different.

13 These were -- to the best of your ability, you
14 put all of your opinions into writing in this document;
15 right?

16 A. Yes. I guess I'm having trouble understanding
17 your question.

18 Are you -- are you wanting me to speak to the
19 opinions that I've written here? Or -- and limit our
20 further questions to this document? Or -- I guess I --
21 could you expound on that so I know why you're asking,
22 because I think we're not understanding each other, or
23 at least I'm not understanding your question.

24 Q. Yeah. I just -- I want to understand the sort
25 of perimeter of the opinions you intend to offer in this

1 case. And I'm trying to understand if we can use this
2 report as, you know, a high-level understanding of that
3 perimeter, or whether there's other opinions that are
4 not written down here.

5 A. So I -- to that, I would say this generally
6 represents my views on Leapfrog and other rating
7 organizations within the context of the work and
8 experience I have in healthcare.

9 And it, I think, illustrates some examples of
10 that. I could probably provide further examples that
11 are not documented here to illustrate the same points.

12 But the general concept remains that, in my
13 opinion, measuring what we do in healthcare is
14 critically important and is as important as the delivery
15 of that care.

16 And I hope that this document conveys that
17 that was the gist of what I was trying to convey.

18 Q. Okay.

19 All right. So let's see. On page 3, under
20 "Introduction & Scope," in the second paragraph, you
21 state you are -- or you have been asked to provide your
22 opinions and experience as a practicing physician and
23 leader in hospital quality systems.

24 A. Uh-huh.

25 Q. What qualifies you as a leader in hospital

1 quality systems?

2 A. In -- I think those words reference my
3 position as the chair of the quality committee and
4 medical director of quality at Virginia Mason Medical
5 Center over the last decade.

6 Q. Do you view yourself as a leader in developing
7 hospital quality systems?

8 A. For the confines of our healthcare system, our
9 quality system has evolved and developed, and yes, I've
10 contributed to that.

11 Have I been asked to develop this for other
12 healthcare systems? No.

13 Do I speak to how we did our quality work so
14 that other systems can learn from it? Yes.

15 So just last week I was asked to speak to
16 the -- there was a group here from the National Health
17 Service in England, who are coming to study how Virginia
18 Mason does its quality work and how to incorporate the
19 elements of how we do that quality work into England's
20 NHS system.

21 So much of the same examples I just shared
22 with you, and what may be written in the report, I
23 shared with them as we come together, we bring the
24 experts together, we measure what we can measure, we
25 decide if that's important, we react to it to the best

1 of our ability at the time to make it better, and then
2 we continue to keep track of these things so that
3 everyone knows that we are going to be better tomorrow
4 than we were today.

5 And so that is the extent of my contribution
6 as a leader, is I can keep repeating the stories that
7 support that cause of: We should come together, we
8 should measure what we're doing, we should try to
9 improve it, and we should never stop looking at that.

10 Q. Would you consider yourself an expert in how
11 to develop new hospital quality systems?

12 A. I don't know what that would mean, so I can't
13 say that I would be an expert in how to develop new
14 hospital quality systems.

15 I am -- I am knowledgeable in the confines of
16 my experience in what I've done, but I would not know
17 how to rate that expertise.

18 Q. Would you consider yourself an expert in how
19 hospitals can improve their quality systems?

20 A. I think I could contribute in that realm, yes.

21 Q. Would you call yourself an expert in that
22 realm?

23 A. In general, I have a hard time calling myself
24 an expert in anything because I feel like I'm constantly
25 learning.

1 So the terms -- calling yourself an expert
2 just culturally doesn't apply to how I think of myself
3 in my work as a neurosurgeon, as a quality leader, as
4 anything. I feel like I'm a learner.

5 Q. Would you be comfortable if counsel put you up
6 in court and referred to you as an expert in
7 developing -- or sorry.

8 Would you be comfortable sitting in court and
9 having counsel refer to you as an expert in improving
10 quality systems at hospitals?

11 A. I can't have control over how people refer to
12 me, but I would repeat the same words in court, yeah.

13 Again, I think, just as you referred to how we
14 chose to follow certain Leapfrog metrics or CMS metrics,
15 you look at the sources of that information and you
16 assess within the topic of what you're working on if
17 that information is relevant and you should incorporate
18 it into your thinking and your decision-making.

19 I hope that me being transparent about my
20 experiences, whether it's documented in my CV or the
21 questions you're asking about my work, will let you and
22 whoever the audience is decide how relevant my expertise
23 is in that topic.

24 I don't know the value of labeling myself as
25 an expert or not. That's not for me to judge, that's

1 for the consumer of the data I'm providing.

2 Q. Okay. So sitting here today, you're not
3 willing to say one way or the other whether you are an
4 expert in improving quality systems at hospitals?

5 MS. BLAIR: Objection to form. Calls for a
6 legal conclusion.

7 A. If I heard the question right, then the answer
8 is yes.

9 Q. (BY MS. PARKS) Yes, you're not willing to
10 answer? Okay.

11 A. Correct.

12 Q. Okay. Thank you.

13 And -- okay. I forgot what my other question
14 was, but that's okay.

15 Do you have any certifications specifically
16 relating to hospital quality systems?

17 A. I do not.

18 Q. And do you have any publications specifically
19 relating to hospital quality systems?

20 A. I do not. I do not believe I do.

21 Q. Have you given any, like, presentations at
22 conferences relating to hospital quality systems?

23 MS. BLAIR: Objection to form. Asked and
24 answered.

25 A. Yes. I've given multiple talks related to

1 quality and sharing our experiences with how we
2 formulated our quality system.

3 Q. (BY MS. PARKS) And were those -- the talks
4 you're referring to, were -- did any of them have to go
5 through -- taking a step back.

6 My understanding is, if you want to present at
7 a conference, there's, like, an approval process to get
8 your presentation accepted sometimes.

9 A. Uh-huh.

10 Q. Have you ever gone through a process like that
11 to give a presentation about hospital quality systems?

12 A. I'm sure I have. The majority of occasions
13 when I'm asked to speak are either invitations to speak
14 because of my experience, or it's a conference where
15 colleagues have suggested we submit some of our work for
16 potentially putting presentations at those conferences.

17 So those are the two general buckets of where
18 these talks may have been presented.

19 Q. Okay. And -- doesn't matter.

20 So in the -- we're still look- -- now we're
21 still looking at this same paragraph, the second
22 paragraph under "Introduction & Scope."

23 You say, in part, that you were asked to
24 comment on how participation in externally reported
25 quality metrics impacts the daily work at hospitals.

1 I'm paraphrasing a little bit.

2 Whose daily work are you referring to in that
3 sentence?

4 A. All of our -- all of the people that work
5 within a hospital. So in particular -- and that goes
6 back to the earlier discussions about how this becomes
7 part of the cultural expectations of everyone who is
8 taking care of patients in our hospital system, to have
9 on the forefront safety and quality, and how to do it
10 better.

11 So literally from the person who's moving the
12 linens around from room to room, deciding how relevant
13 it is for them to wash their hands before they enter a
14 patient's room and wash their hands when they leave, to
15 our executive team deciding whether they are going to
16 implement participation in Leapfrog or other external
17 quality reporting system or invest a large sum of money
18 into some sort of infrastructure that would improve the
19 care.

20 So I think -- I hope I can offer examples in
21 that realm of what I've seen over the last 20 years of
22 how it affects the daily decisions of all the members of
23 our team.

24 Q. So taking your example of whether someone
25 who's going into a room to change linens should wash

1 their hands before doing that, can you explain to me how
2 participation in externally reported quality metrics
3 impacts whether or not that person is going to wash
4 their hands?

5 A. Sure. And it's not easy, and it's
6 complicated.

7 So hand hygiene has been well documented as a
8 connection between care of a patient and reduction in
9 risk of communication -- of communicable diseases and
10 infection rates, and so on and so forth.

11 So how do you measure that? Not easy.

12 You -- in our world, we have members of our
13 team who are tasked with spending a certain number of
14 hours of their day observing as people walk in and out
15 of a patient's room in the hospital, or in and out of a
16 patient room in the clinic, whether they use the gel
17 dispenser outside the door, and then they log the
18 percentage of those patients per day, per week, per
19 month that actually used the gel dispenser and paused
20 for the few seconds it takes to let that gel dry, where
21 we know that it does its effect, before they enter the
22 room. And same in reverse on their way out.

23 Direct visual auditing has been the most
24 effective mode of measurement. And it allows -- as you
25 distribute this work among many members of the team, it

1 allows for an increased awareness. So when I fail to do
2 that, if I were in a rush, I would notice a nurse
3 assistant tapping me on the shoulder, "Hey, Doc, you
4 forgot to wash your hands on the way in." And I would
5 say -- and it creates a cultural environment where, if I
6 forget, someone can help me remember. And that's why
7 it's the work of everyone in the environment.

8 There are other mechanisms, like measuring the
9 volume of gel consumed in a hospital. Technological
10 options have come up, too, where the doors won't open to
11 a patient's space until you gel in and -- or you have a
12 badge that will trigger an alarm if you walk through
13 without getting close enough to the gel dispenser and
14 the gel dispenser dispensing the appropriate volume of
15 gel.

16 So a really complicated way to measure a
17 really, really important -- one tiny little metric of
18 these hundreds that we have to measure. But not only is
19 that particular measure relevant to improving the health
20 of our patients, but the cultural environment it
21 establishes when you make that a priority in your work
22 environment, in getting everyone to think about washing
23 their hands, and that that's better for your patient.

24 Then you start thinking about the next thing
25 and the next thing. Did I give the right medicine? Did

1 I do my protocol when I put in their central line? Did
2 I make sure their beta blockers were given before
3 surgery? And it's an infinite list of work.

4 But I know I went on a little bit. But it's
5 really relevant and really hard to understand unless you
6 lived in this space because we're always overburdened in
7 healthcare. There are more sick people than we can take
8 care of. There's a ton of things that we have to do.
9 And unless this step becomes habit, and it's part of our
10 daily work, we'll miss it.

11 And I may have just touched a doorknob that
12 somebody touched that had a terribly infectious disease
13 and not even notice that I did that, and walk into
14 another room who's immunocompromised and then given that
15 disease to that patient.

16 And unless that two-week, fresh-out-of-school
17 nursing assistant who is there is living in a cultural
18 environment where they can challenge the old bald guy
19 who's walking in with an army of residents and students
20 and -- I'm going to hurt that patient.

21 And so the essence of what I hope that
22 sentence conveys is, how do we make it as easy for the
23 lowest person on our totem pole, all the way to the CEO,
24 to build an environment that actually delivers this
25 care? And what we're talking about today is part of

1 that.

2 Q. Okay. So I think we can all agree that
3 tracking the metrics is important, but I'm -- what I
4 want to understand is why it matters that the metrics
5 are externally reported.

6 How does the external reporting of hand
7 hygiene metrics impact the daily work of that person
8 who's changing the linens?

9 A. Very good question.

10 If my teenagers didn't have report cards and I
11 asked them every day, "How was school," I get that
12 "fine." Because they have other things to do, they
13 progress, and I may not know that they're not learning
14 as much as they should be learning.

15 If a hospital system, who is inundated with
16 lots of pulls on their attention, thinks that they're
17 doing their best every day, they're going to continue to
18 think that they're doing their best and going forward.
19 No ill intention but just a diversion of their
20 attention.

21 A tangible example that we recently went
22 through in recent years was external reporting of
23 surgical site infections for abdominal surgery where --
24 bowel problems. There's a very strict national level
25 metric. And I can't quote to you who the particular

1 organization is that provides the guidance on this one
2 particular metric. But if there's any documentation
3 that there was an infection or a positive culture and an
4 abdominal surgery, that is flagged as an infection in
5 that environment.

6 So we were flagged as having -- you know, in
7 our huge system, having, like, seven infections one
8 year, which puts us out of range. You're not supposed
9 to have five for your size hospital. And -- so we
10 brought everyone together and was like, "What's going
11 on?"

12 And everyone is, like, "We're doing everything
13 that we should be doing." And everyone agreed that they
14 were. And when we delved into it, we realized that we
15 weren't actually documenting that we were doing
16 everything. Making sure the patient's temperature
17 during time of surgery was normal, making sure their
18 blood glucoses for 48 hours after surgery were normal,
19 making sure that they got the right antibiotics.

20 We did not have a mechanism to document the
21 processes that were known by -- and within published
22 guidelines for this type of care, but we were not
23 documenting the details of a checklist of following
24 those processes for that patient population, and we were
25 not documenting how to do that; hence, these particular

1 patients were coming up as red flags of concern on those
2 quality metrics through reporting through our VMFH
3 board, and then going to CommonSpirit, and then going up
4 to higher levels.

5 Q. I'm sorry. Was that reporting external to
6 CommonSpirit?

7 A. It's an external metric on a national scale
8 that has to be reported on by us as a hospital. And I
9 do believe the Department of Health checks this
10 particular metric of this -- there are hundreds. This
11 is just one example.

12 The point being: If we did not have the
13 external visibility or the external eyes to say, "Hey,
14 go look into this particular problem," it may have
15 seemed too small for us to put the effort in to realize
16 that we did not have a good daily process for measuring
17 the known quality standards for getting optimal care for
18 those patients for that work.

19 So how -- to your question of how does an
20 externally reported metric translate to the daily work
21 of an individual, if it is publicly reported, if it's
22 available to a much larger audience -- both regulators,
23 hospitals, patients, families, everyone -- then the
24 group will have a whole army to help improve our
25 quality.

1 I, as a clinician, will have a whole set of
2 eyes looking at my work to help me improve my work on a
3 daily basis. And I think that's where transparent
4 visible metrics kind of have the most impact on our
5 daily work.

6 Q. So --

7 THE VIDEOGRAPHER: Counsel, and I'm really
8 sorry to interrupt, can we go off the record just a
9 moment?

10 MS. PARKS: Sure.

11 THE VIDEOGRAPHER: We are going off the record
12 at 10:25.

13 (Brief break taken.)

14 THE VIDEOGRAPHER: We are back on the record.
15 The time is 10:26.

16 Please proceed.

17 Q. (BY MS. PARKS) So in the example you just
18 provided of surgical site infections for abdominal
19 surgery, that was a metric that you reported to
20 CommonSpirit; correct?

21 A. It's reported --

22 MS. BLAIR: Objection to form.

23 A. It's reported at many levels. So it starts by
24 being reported through the perioperative quality
25 committee that's around anything surgical. And that

1 metric then reports up through infection prevention to
2 our hospital quality committee. We have mechanisms
3 within Virginia Mason Franciscan Health and CommonSpirit
4 to report that up on a national dashboard to allow us to
5 compare ourselves with other hospitals within the larger
6 CommonSpirit system.

7 So it's multiple levels of early warning
8 systems. And then it -- and then I think it rolls up
9 into a more global metrics that's reported out to CMS
10 and national reporting agencies.

11 Q. (BY MS. PARKS) Okay.

12 A. I could not tell you what that trail is, but
13 we could dig it up. But --

14 Q. So you're not sure, like, one way or the other
15 if that data is reported to CMS or Department of Health;
16 you just -- you think it might be?

17 MS. BLAIR: Objection to form.
18 Mischaracterizes testimony.

19 A. I am certain that the roll-up of the metrics
20 that we report to CMS includes variables like this tiny
21 little variable in one hospital in a large system that
22 is affecting two more patients than it should have.

23 It is that national pressure on the larger
24 system and how that trickles down to the smaller
25 systems, and then to the individual patient, that leads

1 to the question you asked. Like, how does that change
2 the daily work?

3 So that type of reporting leads to us paying
4 attention to it at the single-patient level in making
5 sure we've run a checklist for that next patient and
6 we've done all the things that science and opinion knows
7 is the safest thing we can do for this patient.

8 And in the case of hand washing, it trickles
9 all the way back down. We have hand-washing campaigns
10 that are constantly going on in hospitals because we get
11 new members. And so everybody needs to be educated on
12 washing their hands and making it a habit.

13 So there are numerous examples where these
14 publicly reported metrics translate to better work,
15 safer work on a daily basis for our team members.

16 Q. (BY MS. PARKS) And so in that answer you just
17 gave, you referred to national pressure.

18 Is that pressure from CommonSpirit or from
19 some other source?

20 A. I think those are -- there are multiple
21 sources. So our national organization cares about
22 quality, so they signal that downstream. They build
23 structures for that signal downstream.

24 I think publicly reported metrics, like
25 Leapfrog, like the other organizations -- both

1 nonprofit, profit, regulatory -- all use the same tool.
2 If you measure something and you make it visible to the
3 people who are producing that metric and the people who
4 are customers of that metric, you start a dialogue.
5 And, hopefully, both parties there have the same
6 purpose.

7 If I'm a patient, I want the best care. If
8 I'm a provider, I want to give the best care. And
9 because that's a complex job, we need guidance from more
10 than just those two individuals in that interaction to
11 do that transaction in the best way possible. For me to
12 take the best care of you, and for you to get the best
13 care, we need more than just us in that interaction. We
14 need all the minds in this country and in this world.

15 And that's incredibly necessary. And I am so
16 glad that we live in a world where that's actionable
17 now.

18 Q. Does CommonSpirit make its national dashboard
19 available to the public?

20 A. I don't think it makes its internal dashboard
21 available to the public. It uses publicly reported
22 dashboards to normalize it across, like CMS star rating
23 metrics, Leapfrog, Healthgrades, and all the various
24 other organizations. Because --

25 Q. So --

1 A. -- translating that in a -- in an
2 understandable way, I can't tell the hand washing or the
3 abdominal infection story to every single patient across
4 every single encounter.

5 So hopefully this is distilled in a way that
6 is more consumable to a national stage and a public of
7 regulators, hospital leaders, physicians, patients.

8 So I hope that's what they do. That is not my
9 expertise in how to market that, but I hope that's what
10 they do.

11 Q. So in your view, the existence of that
12 national dashboard by CommonSpirit trickles down to
13 improve the quality at your hospital; correct?

14 A. Absolutely. Yes.

15 Q. Okay. And that is despite the fact that the
16 national dashboard is not public, it's just internal to
17 CommonSpirit; correct?

18 MS. BLAIR: Objection to form.

19 A. It is one of the tools used. It is not the
20 only tool used.

21 So there are publicly reported metrics that we
22 participate in, like Leapfrog, which is the point of
23 this discussion. And I think the ability to share your
24 data with the public in a transparent way, that is
25 visible across all healthcare spectrums, brings

1 questions out that will help us do better.

2 So if you don't have that data available, you
3 can't -- you can't act on it.

4 Q. (BY MS. PARKS) Okay. But in the case of the
5 abdominal surgery infections we were talking about, you
6 acted on that data despite the fact that it was not made
7 public; correct?

8 MS. BLAIR: Objection to form.

9 A. Yes. But the hope is that because the
10 structure exists to report on hand washing or abdominal
11 infections, we are catching that at the patient level
12 and not waiting for it.

13 So I would not want my hospital to measure
14 hand-washing rates, or have an external reviewer come
15 and measure hand-washing rates, and wait an entire year
16 to report those results nationally so that then we would
17 see those results and then act on them.

18 I would much rather have that structure in
19 place but have the ability and visibility on Level 17 of
20 the hospital where our neurosurgical patients go to not
21 only be measuring and tracking that data, but have the
22 personnel that are watching each other perform that task
23 have visibility that this is something you measure and
24 be able to intervene to direct it towards better care.

25 So it's all part and parcel.

1 If it is not important at many levels, it is
2 not likely something that will be important in that
3 moment when it matters most.

4 So we live in a complex world. It is not --
5 it is not simple. And you can't just say, "100 percent
6 of you have to wash your hands before you go touch a
7 patient," and just that happens instantly. It just -- I
8 wish it were the case. But we're human, we make errors.
9 And so we need not only rules and education,
10 encouragement, public education, public pressure,
11 public -- regulatory pressure, regulatory -- you know,
12 you need all these pieces to make this soup as good as
13 it can be.

14 Q. (BY MS. PARKS) So is it the case you can be
15 sort of a little more nimble in responding to internally
16 reported data because you're able to collect and analyze
17 it faster?

18 MS. BLAIR: Objection to form.

19 A. I think if you're the one doing the collecting
20 and reporting, and you're the first to have access to a
21 data set, certainly, you would be able to react to that
22 much better than if you waited for data to come from a
23 different source to you.

24 Q. (BY MS. PARKS) Are you aware of any empirical
25 evidence that public reporting of hospital safety data

1 leads to better outcomes?

2 A. I believe that there is -- there is literature
3 on that topic. I couldn't quote you exactly what, but I
4 think there are multiple publications that have asked
5 that same question.

6 And, in general, the field believes that, yes.
7 And I think that's what this whole healthcare
8 transformation for quality and safety over the last
9 20 years has been about, is if you make it visible, you
10 get the most minds together to try to figure out a
11 solution to any problems that are identified.

12 Q. Did you rely on any empirical evidence showing
13 that public reporting leads to better outcomes in
14 preparing your report?

15 MS. BLAIR: Objection to form.

16 A. I think some of the references were -- there
17 are numerous articles that discuss that topic in our
18 literature.

19 So surgical safety checklists --

20 Q. (BY MS. PARKS) And sorry, just for the
21 record, are you looking at page 14 of your report?

22 A. I am looking at page 14 of the report, and
23 there are some of the works that were cited. And within
24 those citations and those publications, there are
25 multiple references that are also cited that kind of

1 have done the analytical work of seeing the relevance of
2 public reporting on quality, improving public health.

3 I couldn't speak to each of those individual
4 references that are referenced by these sort of more
5 collective studies. That is something we can -- we can
6 dig up. But --

7 Q. And sorry, which of the publications on
8 page 14 cite other publications on which you relied?

9 A. I am sure almost all of these references have
10 a reference list within them. And I don't have them in
11 front of me, so I -- we could pull them up and go
12 through it and go through the exercise of pulling those
13 article out.

14 But I cannot point to one reference in
15 particular that answers the question you're asking right
16 now, if that's what you're asking.

17 Q. And in preparing your report, did you go to
18 any of the articles cited in the articles listed on
19 page 14?

20 A. I may have. I spent some time reading a lot
21 of the various literature, but I could not tell you
22 which ones in particular and which specific article I
23 relied on solely for an opinion.

24 I think any time we are faced with a patient
25 case of a diagnosis and a treatment, or a project like

1 this where we're asked to give our opinion on a topic
2 that we have some experience in, my natural reaction or
3 my natural work flow is to go look at published data in
4 that arena and educate myself to make sure that I know
5 all the latest peer-reviewed publications in that area
6 and at least look through to look for any changes in
7 what I know from my experience to what may be published
8 in the literature.

9 If I'm going to create a peer-reviewed
10 publication as a summary for a particular medical
11 methodology, then I would methodically go through all
12 those articles. I did not do that for this report.

13 Q. And so just to make sure I understand, for
14 purposes of this report, you did not go out and see if
15 there were peer-reviewed publications assessing whether
16 there is empirical evidence that public reporting of
17 hospital safety metrics leads to improved outcomes?

18 A. Correct. I could not point you to an article
19 where I specifically reference that.

20 Q. Okay. And you think you might have looked at
21 articles that were cited in the items listed on page 14,
22 but sitting here today, you can't recall what those
23 articles were?

24 A. Correct.

25 Q. Okay. And are you aware that under the

1 federal rules, you have to disclose all of the facts and
2 data on which you rely in forming your opinions?

3 A. Yes. To the best of my knowledge, I will --
4 like I said, I will promise to speak to everything I
5 remember and that I can speak to. So I don't think
6 I'm -- yes. So the answer is yes.

7 Q. Did counsel advise you that your expert report
8 needs to list all of the facts and data on which you
9 rely?

10 A. They did. And, again, to the level that I
11 looked at literature that was available to me, I put
12 those references in and they're as it's written in this
13 report.

14 Q. Okay. But if I understood you correctly, you
15 think there might be publications you looked at that are
16 not listed on page 14.

17 Did I understand that correctly?

18 MS. BLAIR: Objection to form.

19 A. I -- there are publications within the
20 references of the publications that I cited that I am
21 100 percent sure I did not look at.

22 Q. (BY MS. PARKS) Okay. So you did not, like,
23 click on one of these items listed on page 14 and then
24 do the further clicking of looking of something inside
25 of it?

1 A. All of their -- yes, exactly. So each of
2 these peer-reviewed publications has a reference list.
3 I did not methodically go through all the references in
4 those.

5 Q. Okay. We went a little bit far afield, but
6 going back --

7 A. I'm sorry.

8 Q. That's okay. I'm still on this, like, same
9 sentence on page 3 --

10 A. Okay.

11 Q. -- which was the second sentence of the second
12 paragraph, under "Introduction & Scope." You refer to
13 "ultimate quality of care for patients at hospitals."

14 What do you mean by "ultimate quality of
15 care"?

16 A. Much like what we've talked about, that every
17 action that we can take towards a better patient
18 outcome, a better patient experience, a reduction in
19 risk that's known is acted upon and is made available to
20 the team members delivering that care.

21 Q. And how do you assess ultimate quality of
22 care?

23 A. That's the million-dollar question, isn't it?

24 Q. So you agree there's multiple ways of
25 assessing it?

1 A. Oh, there are many, many ways of assessing it,
2 yes.

3 Q. Okay.

4 A. And we have to decide -- like I said, that's
5 part of the work we do in the quality committee on a
6 daily basis. I advise all the members of my committee
7 every time there's a report to ask the speaker, "Why did
8 you choose to measure that metric? Why is it relevant?
9 If it is off target, what are you going to do about it?"

10 So I think we all have to make that assessment
11 with every action we take -- I personally think in our
12 lives -- but within healthcare, certainly, in taking
13 care of patients, make sure every step we take is high
14 value, high safety, high quality.

15 So, yes, I think the ultimate quality of care
16 is a conglomeration of all of those things.

17 Q. Are patients able to assess for themselves
18 whether they received quality care?

19 A. It is challenging. We have these discussions
20 all the time. There is -- there is the perception of
21 quality care, and then from the medical science, there
22 are measurable things, like infection rates, mortality,
23 morbidity, time to return to work, number of days of
24 pain medicines required, number of times you're
25 readmitted to the hospital, number of times you had to

1 have a reoperation, you know.

2 So the number of ways to assess the quality of
3 care are innumerable. But they fall into two buckets,
4 that around which we have data that we can measure, and
5 then that around which is patient perception.

6 So one of the things you get every time you go
7 to the hospital, you get a survey from Press Ganey or
8 someone that says, "How did you feel? Did they pay
9 attention to you? Did they educate you on your
10 medications? Was the environment clean? Was it loud?"

11 Our hospital used to get dinged for loud. And
12 then they fixed the curtains or something, and it got
13 better.

14 So complicated answer. So I think it is
15 challenging in today's complicated healthcare world for
16 a patient to assess the quality of the care they're
17 getting.

18 And, you know -- and if I can share from a
19 personal experience, my 15-year-old just had a -- tore
20 her ACL this summer and had to go through ACL surgery.

21 Even as, as you say -- or as discussed as an
22 expert in the field, my ability to assess the quality of
23 care that she received did not rely on a single data
24 source. It was a -- coalescing all the publicly
25 reported data that I -- that we could find, all the

1 reputational data from communicating with colleagues who
2 knew the healthcare providers who were caring, my
3 communication with the healthcare provider, with their
4 secretary, with their nurse.

5 So that is a very challenging thing. I
6 probably get better data out of consumer reports about
7 my toaster, right, because they can put that toaster
8 through a set of very measurable tests on temperature
9 and heat transmission and electrical consumption up
10 against all the other toasters. Healthcare is not that
11 easy.

12 We're working on it. We're getting better at
13 it, but it's not that easy.

14 Q. In that example, did your daughter have her
15 surgery at one of the Virginia Mason system hospitals?

16 A. Yes.

17 Q. Just curious.

18 So what are the -- you said you looked at all
19 the publicly reported data that you could find and all
20 of the reputational data from communicating with
21 colleagues.

22 What were the sources of publicly reported
23 data that you could find in that instance?

24 A. I think the -- that's a good question. Like,
25 if I go back and -- because I sort of swim in this

1 world, I don't know if I went to seek out any publicly
2 reported data about the hospital because I sort of get
3 those feeds from our public feeds in the quality realm.

4 So I think I see the CMS star rating data, I
5 see the Leapfrog data through my work, so I didn't go
6 out and look for it myself.

7 I asked the surgeon, who was a newer surgeon
8 in our institution, their experience, their
9 methodologies. I asked other patients' family members
10 who had been cared for by him, and it was the
11 combination of that data, the other people I knew who
12 had care, and what I know of the hospital environment.

13 But you bring up a really good point. I live
14 in a city -- I live in Seattle. There's University of
15 Washington healthcare system. There's Swedish
16 Providence healthcare system. There's our healthcare
17 system. There are multiple smaller ones.

18 I trained at the University of Washington. I
19 have colleagues who work at Swedish. We all talk about
20 our environments and how the daily work proceeds. And
21 we're fortunate, I think in Seattle, people -- the
22 healthcare systems all function at a very high level.

23 But the pressure and the prioritization of
24 quality in the daily work of everyone that works within
25 my system is very different than the pressure and the

1 prioritization on quality at our organizations across
2 town.

3 Q. How do you know that?

4 A. One, because I worked at the University of
5 Washington and trained there. So I did not see the
6 visible forward-facing communications internal to the
7 system about quality on a routine basis.

8 My colleagues --

9 Q. And that was 20 years ago?

10 A. Correct.

11 Q. Okay.

12 A. My colleagues who work there now see more of
13 it, but they don't seem to have it as part of their
14 daily work as much as we have it as part of our daily
15 work. And that's common knowledge within our medical
16 communities.

17 So what, as a parent and a family member or a
18 patient, made me select care at our -- at Virginia Mason
19 versus our other institutions, which have great medical
20 care, really is the understanding of quality as a
21 primary priority throughout the whole organization
22 versus the priorities on academics at the university and
23 education versus other priorities at other
24 organizations.

25 It's a complicated process. And you asked the

1 question: How do you -- how do you assess? It's a
2 super complicated process. We are making huge headway
3 in having that be more visible. We still have a long
4 way to go in American healthcare systems to get to a
5 patient the level of knowledge that you and the people
6 in this room will have about assessment of a healthcare
7 system at the end of this.

8 I wish we could get our patients to have that
9 level of knowledge and understanding when making choices
10 about their healthcare. I don't think anyone's going to
11 get there. But I think all the things we're doing,
12 hopefully, will make the healthcare system so safe
13 that -- I don't check airplane safety ratings before I
14 book my ticket.

15 You know, it's more relevant whether I get
16 extra points on Alaska so that the next family vacation
17 I don't have to pay for my four kids' tickets, right,
18 because the quality is so good and the chances that an
19 airplane is going to crash is so low. Because when an
20 airplane crashes, the entire world knows instantly.

21 We had some friends that died in a plane crash
22 in Nepal, which is somewhere we go to do volunteer work.
23 The quality reporting on airlines in Nepal -- which a
24 pilot friend of mine sent me this data right before our
25 trip in 2019 or something, because we were going to go

1 to some small towns and see -- and he sent me some data
2 that says, like, the Nepali airlines' flight safety
3 rating numbers were atrocious. One in four planes
4 crashed, is what the report said.

5 I had three different internal Nepali airlines
6 to choose from. I chose the one that had, like, the
7 82 percent safety rating over the 74 percent safety
8 rating and rolled the dice instead of taking an
9 eight-hour bus ride through the mountains, which has its
10 own safety risks because those buses fall off --

11 I hope we're at a level of safety in American
12 healthcare where we're not talking about those kinds of
13 numbers. But we're certainly not at the level of safety
14 in American healthcare that the airline industry has
15 achieved. So we need to try harder.

16 We need to do everything we can so that when I
17 touch that dirty doorknob and give an immunocompromised
18 patient an infection, it makes as much of a public
19 display of our failure as a system as an airplane crash
20 does. So that all of our minds are focused around how
21 to prevent that next airplane from crashing or how to
22 make that -- make sure that next person washes their
23 hands before communicating that disease to that next
24 patient.

25 Sorry, you keep -- you keep touching on things

1 that are very important to me professionally and
2 personally. But I hope I'm conveying that I think we're
3 doing better. I think we need to keep pushing on this
4 system of transparency in public reporting and --
5 because it matters. It matters.

6 Q. Okay. So there was a lot there, but...

7 So I think what I heard you say at the
8 beginning of that is that you -- it's your view that the
9 University of Washington hospitals don't prioritize
10 safety as much as your hospitals, and that's based on
11 your experience working there as well as conversations
12 you've had with colleagues; is that right?

13 A. Correct.

14 Q. Is it based on any other information?

15 A. No. I have not done research into that
16 particular question that you just asked, so...

17 Q. Okay.

18 A. Those would be the resources I have available
19 for that example.

20 Q. And do you have any information about whether
21 or not the hospitals that are plaintiffs in this case
22 prioritize safety more or less than Virginia Mason?

23 A. Nothing more than what was sort of in the
24 report on the case and what was in that folder in -- of
25 information that was provided, yeah.

1 Q. And so that would be --

2 A. I'm going to paraphrase because I can't
3 reference a particular document. But I was -- from what
4 I understand, they chose not to participate in publicly
5 reporting certain Leapfrog metrics, and hence, the --
6 they were assigned a score that they felt did not
7 reflect their prioritization on quality.

8 Q. Okay. So you conclude that the plaintiff
9 hospitals do not prioritize safety because they don't
10 participate in Leapfrog; is that right?

11 A. No. I did not say that.

12 Q. Okay. What did you say?

13 A. You asked me how I knew what their
14 prioritization about safety was. And I said the only
15 thing I know is that they chose not to participate in
16 Leapfrog and that they were given a score that they felt
17 was not reflective of their priority of safety --

18 Q. Okay.

19 A. -- so...

20 Q. And is it your view that choosing to not
21 participate in Leapfrog is a reflection of how a
22 hospital prioritizes safety?

23 A. Yes. I think if you really care about making
24 sure you save every potential patient, you would use
25 every tool at your disposal to make sure that next

1 patient -- if it's your mother, sister, brother -- gets
2 the best care possible.

3 And this is a tool that's available. Why
4 wouldn't you use it?

5 Q. Does Virginia Mason use every tool available,
6 in your view?

7 A. I think everything that we have access to,
8 that we know about, we try to incorporate.

9 Q. Are there any voluntary surveys that you do
10 not participate in?

11 A. I do not know. I do not have visibility to
12 all the voluntary surveys that are out there. And that
13 is decided at a national level in CommonSpirit now, and
14 so I couldn't -- I couldn't speak to that.

15 Q. Okay. And in your view, would it be fair for
16 someone to say that Virginia Mason doesn't prioritize
17 safety because they don't participate in a voluntary
18 survey?

19 MS. BLAIR: Objection to form. Calls for
20 speculation.

21 A. So, yeah, I don't understand the -- I don't
22 understand the question.

23 Q. (BY MS. PARKS) So if someone came to you and
24 said, "Complete my survey on hospital safety," and
25 CommonSpirit made the decision not to do that, would it

1 be fair then for someone to conclude that Virginia Mason
2 does not prioritize safety?

3 A. So if someone came to me -- so in this
4 example, if someone came to me and said, "We have a
5 legitimate proven publicly reported safety system that
6 we would like you to participate in, that we believe
7 will improve the care of your patients," and
8 CommonSpirit chose not to, I would pursue efforts to
9 evaluate that particular system and take it up to my
10 leadership and get my colleagues, who are experts in the
11 arena, to make sure that we weren't missing anything
12 that this system could offer for the care of our
13 patients and try to get our system to participate in
14 that, so...

15 Q. Are there any systems that CommonSpirit does
16 not participate in that you would like them to?

17 A. I -- so I can't comment on CommonSpirit's
18 global participation. I just don't have visibility to
19 all the details of that, so --

20 Q. Okay.

21 A. -- so it's hard for me to answer that question
22 just because I live within my system and I know within
23 my hospital how the information flow travels. But I do
24 not have national organizational level visibility on the
25 questions you're asking, so I have a challenging time

1 kind of formulating an answer. It would be a lot of
2 conjecture.

3 Q. Is there anything that -- at the system level,
4 the Virginia Mason system level, that they don't
5 participate in that you think they should?

6 A. None that I have visibility to, no, because
7 the systems that we have and participate in are the most
8 comprehensive that we can look at.

9 As you referenced, I worked with the SCOAP
10 Committee 15 years ago, or longer. That was a data
11 point that we did not have for improving the care of our
12 very specific population of spine surgical patients.
13 And so in the absence of anyone else giving us that data
14 so that we could improve that arena, we lobbied the
15 organization to invest in the resources to collect that
16 data and participate in that registry.

17 So I can point to that as an example of when
18 we saw something where we didn't have good comparable
19 data, comparative data, we went and solved that problem.

20 So I look forward to future organizations
21 coming to me and saying, "Hey, we have data that can
22 help you get better." And we're going to do our best to
23 participate.

24 Q. If CommonSpirit made the decision to stop
25 participating in Leapfrog, do you think the safety at

1 your hospital would get worse?

2 A. I think so, yeah.

3 Q. Do you have any basis for that other than your
4 own --

5 A. Everything we've been talking about, yeah.

6 Q. Okay. Would you change something about the
7 metrics you analyze at your hospital?

8 MS. BLAIR: Objection to form.

9 A. I don't -- I don't know. So you asked a
10 couple of questions, and I don't know how they relate.
11 So what --

12 Q. (BY MS. PARKS) So I guess what I'm asking is:
13 If CommonSpirit told your hospital to stop reporting to
14 Leapfrog, would that change anything about the
15 day-to-day KPIs you monitor and policies you implement?

16 MS. BLAIR: Objection to form. Calls for
17 speculation.

18 A. Well, the first thing I would do is I would
19 take it up the chain and try to decipher why they'd want
20 to step away from something that had such relevant --

21 Q. (BY MS. PARKS) My question is whether it
22 would change anything about the quality systems you've
23 implemented at your hospital?

24 MS. BLAIR: Same objection.

25 A. Yeah, it would be hard to -- hard to judge

1 that. But I -- so the question you're asking is if
2 leadership deprioritizes quality?

3 Q. (BY MS. PARKS) That's not my question.

4 My question is: If CommonSpirit says, "We're
5 not giving you money anymore to spend the time to fill
6 out the Leapfrog hospital survey" --

7 A. Correct.

8 Q. -- would that change anything about the
9 quality systems you've implemented at your hospital?

10 A. Yeah, because I would interpret that action as
11 deprioritizing quality.

12 Q. Okay. Why?

13 A. For all the reasons we've been talking about.

14 Q. What if they said, "We're going to take that
15 time and put it towards a different survey"?

16 A. What is that different survey? Show me the
17 data and the history that that survey is going to be as
18 detailed and relevant and as well thought out for the
19 dollars spent as this survey is.

20 Q. What if they said, "We're going to take that
21 money and put it towards an external consultant on
22 quality"?

23 A. Show me the data that external consultant has
24 the history, the data, the expertise to move the needle
25 in a quality positive direction.

1 Q. Is it your opinion that Leapfrog is the only
2 survey out there that can improve the quality at
3 hospitals?

4 A. I think it is one of the best surveys out
5 there to improve quality at hospitals because of all of
6 what we've been talking about and how long they've been
7 in the game, their transparency, their methodology.

8 They, within their realm, do a very good job. CMS,
9 within its realm, does a very good job. Like, all these
10 different pieces of the puzzle do really good work.

11 Q. What are the other best ones out there,
12 besides CMS and Leapfrog?

13 A. I would say the ones that are -- well, there
14 are many, and I couldn't speak to all of them. So, for
15 the record, I'm not an expert on all external surveys to
16 hospitals.

17 But each one has its positives and negatives
18 and advantages and disadvantages for the -- because then
19 you'll get me started on having lots of discussions
20 about other theoreticals that I don't think are relevant
21 to the confines of this discussion.

22 For the work of reporting transparently the --
23 on actionable quality metrics, I think Leapfrog does the
24 best within the confines of what it does on its survey.
25 So for those metrics, it does a very thorough job of

1 getting hospitals to think about and work on those
2 quality improvement metrics.

3 So to do a comparative analysis of all the
4 other quality reporting organizations out there is
5 outside the scope of what we can talk about today.

6 Q. Do you think that Virginia Mason Franciscan
7 Health couldn't have the levels of safety it has right
8 now if it didn't participate in Leapfrog?

9 A. Yes. I do not think it would if it had not
10 spent the time and effort on Leapfrog as part of a
11 larger quality prioritization effort.

12 Q. And what is your evidence for that opinion?

13 MS. BLAIR: Objection. Asked and answered.

14 A. My evidence is the -- everything that we've
15 been talking about so far and as in my report. I can
16 reiterate my examples and my framework, if you want, but
17 I think that's already been documented.

18 Q. (BY MS. PARKS) Do you have any empirical
19 evidence that participation in Leapfrog improves
20 hospital quality?

21 MS. BLAIR: Objection. Asked and answered.

22 A. Again, outside of what we've already
23 discussed, what I've referenced -- I mean, I could come
24 up with more and more examples from my experience and my
25 history. You can go do a literature search on that

1 question and review the publicly available literature.

2 Q. (BY MS. PARKS) Have you conducted that
3 literature search?

4 A. Not for a level of a publication, no.

5 Q. Okay. And do you consider anecdotal
6 experience to be empirical evidence?

7 A. No. Empirical evidence and anecdotal
8 experience have two different definitions, so no.

9 Q. Okay. So all of the anecdotes you've shared
10 with me today, those are not empirical evidence of any
11 of the things we've spoken about; correct?

12 MS. BLAIR: Objection to form.

13 A. I've shared my experiences with you and what I
14 see.

15 Q. (BY MS. PARKS) Okay. And have you ever
16 published a peer-reviewed article based purely on your
17 anecdotal experiences?

18 A. Yes. There -- no. That is a very good
19 question.

20 So we publish peer-reviewed articles that are
21 scientific based, that have scientific methodology and
22 data -- statistical data analytics. And we publish
23 experiential publications in peer review like -- such as
24 a case report of a rare or unique finding, or a new
25 technology, or a new technique, that don't have

1 statistically supported data as the foundation for
2 sharing that information but have a structure for
3 sharing my experience in this particular case with this
4 particular patient and relying on my experience to get
5 that information out in the world so other people can
6 add it to their experience and then make better
7 decisions and hopefully then turn it into more
8 data-based science.

9 So the answer is yes to both.

10 Q. Okay. But if you want to draw a
11 scientifically reliable conclusion from data, you
12 typically will do the statistical analysis you referred
13 to?

14 A. When data is available. So if data is not
15 available -- and so we have this discussion with the
16 research students all the time. They come up with a
17 question, and I say, "Well, go find data. If data
18 exists, then analyze it and see within the mathematics
19 of what we do in statistics, does that make sense? Then
20 draw a conclusion from there. If data doesn't exist,
21 then you go to second- and third-tier options."

22 So you can do a -- if lots of data exists, you
23 can do a metastatic -- meta-analysis and review. If
24 data doesn't exist, you can do something called a
25 scoping review, which includes all these case reports

1 that don't actually add up to statistical data,
2 interviews with experts in the field, anything that's in
3 lay press, and conversations with colleagues.

4 If -- another option if data doesn't exist is
5 to do something called a Delphi study. You bring a
6 group of experts together -- which I think is much like
7 what you guys do for your legal work -- is, you bring a
8 bunch of experts in the field together and you hear what
9 their life experience and work experiences are, and then
10 you put all that together and try to interpret the best
11 answer from it.

12 So I think those are the ways we solve our
13 questions in healthcare and quality that have some rigor
14 and structure around them. But it isn't all just
15 randomized controlled trials with P values of less than
16 .05. I wish it were, but it's not.

17 Q. But if you have the data available, you're
18 going to want to see the statistical analysis before you
19 draw a scientific conclusion from the data; right?

20 A. Yes. That is the best way to draw a
21 conclusion. Much of what we do in healthcare -- so I'll
22 point to the -- years ago, I worked on the Bree
23 committee for -- the state of Washington knew there
24 was -- there was discrepancies in healthcare delivery,
25 and so they put together committees of doctors and

1 therapists and hospital leaders and insurance leaders to
2 come up with -- so the best case solutions to some of
3 the best -- the biggest problems they were facing as far
4 as healthcare expenditure.

5 One of them was spinal fusion surgery. And so
6 the Bree Collaborative had a subgroup to look at how a
7 healthcare system should take a patient with back pain
8 through their journey to get spinal fusion surgery.

9 Those criteria that were after six months or a
10 year of work by this committee -- all the folks,
11 including epidemiologists -- showed that in particular
12 questions, only about 20 percent of those were
13 answerable with data. The rest were answered by kind of
14 the best opinion of the cohort of experts from all the
15 disciplines.

16 So, yes, absolutely, if you have data, that's
17 the best way. But in our world of healthcare today,
18 unfortunately, we're not yet at the stage where the
19 majority of our work is driven purely by data. And so
20 you have to take the data you have and then add the
21 experience of the experts in the arena to try to draw
22 the best conclusions.

23 Q. Okay. So your report, on pages 3 through 5,
24 includes a section on your relevant professional
25 background.

1 You see that?

2 A. Uh-huh, yes.

3 Q. Okay. So I'd like to look at the last
4 paragraph on page 4, starting "In the last two decades."

5 So in the last sentence, you say you have seen
6 measurable improvement in patient care at local,
7 regional, and national levels.

8 Can you tell me what improvements you've seen
9 that are measurable and how you measured them?

10 A. Absolutely.

11 So I'll reference the central line infection
12 data over the last 20 years.

13 So we've gone from double-digit complication
14 rates to these becoming never events.

15 Some of the more fun projects that really --
16 it was fun to see the light bulbs going off in the heads
17 of my colleagues -- were the presurgical pause.

18 So I don't know how much you know about before
19 any surgical procedure, any procedure in healthcare.
20 When I started, we would walk into the OR and we'd start
21 surgery. That's how it was because everything was fine.
22 And the wrong knees would get operated on, the wrong
23 levels of spine would get operated on, and the wrong
24 patients would get the wrong -- get operated on.

25 So through a very simple methodology of:

1 Before we start on a surgery, we all come into the room,
2 every member of the team introduces themselves and their
3 role, reiterates the name of the patient, the procedure,
4 what the expectations are for the risks in that
5 procedure, and then there's a debrief at the end if
6 anything went wrong.

7 But simply implementing that two-minute pause,
8 which my colleagues fought against, tooth and nail.
9 "You're going to slow me down. This is unnecessary."
10 And to watch over my -- the arc of my career, is this
11 has become routine all over the world. This has caused
12 a dramatic reduction in surgical complications and has
13 become sort of standard work in all hospitals in the US
14 and now spreading all over other countries.

15 And we introduced this in the hospital system
16 in Nepal in 2019, and they absorbed it and implemented
17 it and are seeing lower risks, lower complications,
18 better communications.

19 So there are numerous examples of how we've
20 seen healthcare improve.

21 Q. Okay. Understood.

22 I think this sentence is referring to your own
23 collaborations and publications.

24 What are the measurable improvements that have
25 been created by your collaborations and subsequent

1 publications?

2 A. So the Bree bundle for lumbar fusions that I
3 was discussing earlier has reduced the number of
4 unindicated surgeries in the state of Washington. The
5 state of Washington Health Care Authority, who is the
6 insurance carrier for Washington State employees, made
7 the decision for many arenas of its care under the --
8 under the Bree bundles -- hip and knee surgery, spinal
9 fusion surgery -- to only let their patients go to
10 hospitals that would follow this protocol.

11 And there have been publications out of our
12 group that have shown that once you go through this
13 collaborative team effort where you don't make a
14 decision for a spinal fusion surgery just between the
15 patient and the doctor, that it has to go to a committee
16 where they assess the rehabilitation, medicine doctors
17 are there, the pain medicine doc, the nurses,
18 therapists, everyone, and as a group, they decide on
19 that surgery. There are publications that show we
20 showed a 50 percent reduction in unnecessary surgeries.

21 So that's a very prominent example of how
22 collaboration focused on healthcare improvement can
23 avoid risk and avoid unnecessary harm to patients.

24 Q. And unnecessary surgeries, is that an issue of
25 hospital safety, or does that take place prior to sort

1 of the point at which hospital safety becomes relevant?

2 A. I think it's all hand in hand because none of
3 the members of the healthcare team, prior to
4 implementation of these knowledge-based prompts for
5 decision-making, thought they were doing anything wrong.
6 They were doing the best that they could for their
7 patients with the knowledge they had in front of them.

8 Simply redirecting their workflows to these
9 standards that -- a portion of which were based on
10 evidence, a portion of which were just based on expert
11 kind of consensus -- showed an improvement in the
12 outcomes for those patient populations. So people got
13 better, they had less harm, they had less risk, they had
14 less healthcare spent.

15 So maybe I drifted from the point of your
16 question. But the -- this -- these are examples where,
17 I think, patient care is improved very specifically to
18 pieces of this healthcare world that I've seen change
19 over my career.

20 Q. Okay. And can you think of any other examples
21 where your collaborations and subsequent publications
22 led to measurable improvements in hospital safety?

23 A. So the -- well, hospital safety is such a
24 broad category. So I can point to specific examples.

25 So we figured out, through our collaborations

1 and research, that smoking before doing deep-brain
2 stimulator surgery led to an increased risk of
3 infection. So we implemented a protocol where we would
4 have people stop smoking and stop using nicotine. And
5 yes, that led to a lower infection rate over the last
6 20 years.

7 People have subsequently done research in that
8 topic of smoking cessation in other surgeries and have
9 realized that it can be -- it has made things safer.
10 And so that particular decision point, about postponing
11 surgery that's nonurgent until smoking cessation has
12 been activated for four to six weeks, has led to
13 improvements in wound healing, reduction in
14 complications, reduction in infections, reduction in
15 pneumonia, so on and so forth.

16 So that -- those are all things that fit
17 within the realm of hospital safety; right. You go to
18 the hospital, you need something, you want to make sure
19 it's safe.

20 So these things have really -- have been
21 amazing improvers of safety in healthcare, which I think
22 may speak to the term "hospital safety" that you're --
23 you're referencing.

24 Q. Okay. So we have the Bree bundle for -- I'm
25 going to try to say this -- these words in the right

1 order, lumbar spinal fusion; is that right?

2 A. Uh-huh.

3 Q. And then we have the smoking cessation before
4 deep-brain stimulation.

5 Can you think of any other examples?

6 MS. BLAIR: Objection to form.

7 A. Yes. How many do you want? And in what --
8 so, yes, I have numerous examples in many arenas. What
9 would -- what would be helpful to you? Because there
10 are a lot of these examples. There --

11 Q. (BY MS. PARKS) I guess, are the two examples
12 you've already given -- are those the best examples you
13 can think of where your work led to measurable
14 improvements in hospital safety?

15 MS. BLAIR: Objection to form.

16 A. I don't know how you define "best." I was
17 pulling examples that hopefully would reflect how a --
18 how a group's focus on quality, and trying to improve
19 quality through communication, review of the evidence,
20 best expert opinion, has led to improvements in the
21 quality of healthcare we deliver.

22 Q. (BY MS. PARKS) Are there any other examples
23 you'd like to speak to that you were thinking of when
24 you wrote this sentence, or are those kind of the two
25 you were thinking of?

1 A. I can't tell you exactly what I was thinking
2 when I wrote that sentence. But these were -- these are
3 examples, and there are many other similar examples
4 that -- of how following this mode of paying attention
5 to what you're doing, figuring out where the potential
6 risks are, and then having a culture where people will
7 collaborate towards making it safer for patients, kind
8 of works.

9 And, again, I'm happy to keep enumerating
10 other examples, but I think they would all convey the
11 same things, the same concepts.

12 Q. Do you have any examples where your
13 collaborations and subsequent publications led to
14 measurable improvements outside of the neurosurgery
15 space?

16 MS. BLAIR: Objection to form. Asked and
17 answered.

18 A. Yeah, I think my publications are public and
19 available. So you can reference those if you -- if you
20 want.

21 Q. (BY MS. PARKS) Sitting here today, can you
22 point me to a publication that shows a memorable
23 improvement in hospital quality outside of the
24 neurosurgery space?

25 A. I don't think I can --

1 Q. Okay.

2 A. -- so...

3 THE COURT REPORTER: When you get to a good
4 stop, I would love a restroom break.

5 MS. PARKS: Okay. Yeah, why don't we take a
6 break now.

7 THE WITNESS: Okay. Good idea.

8 THE VIDEOGRAPHER: We are going off the record
9 at 11:24.

10 (Brief break taken.)

11 THE VIDEOGRAPHER: We are back on the record.
12 The time is 11:41.

13 Please proceed.

14 Q. (BY MS. PARKS) Welcome back, Dr. Farrokhi.

15 A. Thank you.

16 Q. So I would like to turn to the "Summary of
17 Review" section of your report, which is on pages 5
18 through 7.

19 What is the purpose of the "Summary of Review"
20 section in your report?

21 A. In general, I wanted to convey what I've
22 learned in the last two decades and the experiences I've
23 had being in a healthcare system that functions in the
24 way we've described this morning.

25 A focus on quality, collaboration, bringing

1 together people to make the best decision with the
2 information you have, holding each other accountable to
3 making the best decisions, and then moving forward in a
4 positive way to try to improve patient care.

5 So -- and to, basically, try to connect that
6 to the essence of what this -- what I was asked to
7 comment on in this case, as an end user of the Leapfrog
8 survey, and of seeing the consequences of having to work
9 in an environment where those metrics are being measured
10 and how they have fed back to help us be better at what
11 we do.

12 Q. Okay. So is this "Summary of Review" section
13 a summary of the substance of the following pages of
14 your report, or is it sort of its own topic?

15 A. I guess I don't understand the purpose of that
16 question.

17 Q. I'm trying to understand if the "Summary of
18 Review" section is meant to provide sort of an overview
19 of the things you're going to talk about in the rest of
20 your report or if it is a standalone section setting
21 forth, you know, additional information that's not
22 addressed elsewhere?

23 A. Again, as we were just discussing about my ESL
24 skills, I'd say a little bit of both. I was trying to
25 convey, with some small tangible examples, the concepts

1 I was trying to share. And this, hopefully, was to wrap
2 up those tangible examples into a cohesive, relevant
3 description of what those examples were trying to point
4 out.

5 Q. Okay. Can you just read to yourself the first
6 paragraph in "Summary of Review."

7 A. Okay.

8 Q. What would you say is the thesis statement of
9 that first paragraph?

10 MS. BLAIR: Objection to form.

11 A. That taking good care of patients in complex
12 settings is challenging and it takes a cultural and a
13 structural foundation or environment.

14 Q. (BY MS. PARKS) Okay. Is it okay if I call
15 that thesis statement -- or that thesis something like
16 "Patient care requires culture and structure"?

17 A. Sure.

18 Q. Okay.

19 Okay. And then can you do the same for the
20 second paragraph.

21 MS. BLAIR: Objection to form.

22 A. Okay. You wanted me to summarize it?

23 Q. (BY MS. PARKS) Yes, please.

24 A. I think all the elements mentioned are
25 important to continue to improve healthcare, the

1 elements of external reporting and transparency.

2 Q. Okay. So could I summarize that as
3 participation in multiple transparent external reporting
4 systems is essential to hospital quality?

5 MS. BLAIR: Objection to form.

6 A. I suppose, yes.

7 Q. (BY MS. PARKS) Okay. Can you read the third
8 paragraph to yourself.

9 A. Uh-huh.

10 Q. And what is the thesis statement of that
11 paragraph?

12 MS. BLAIR: Objection to form.

13 A. Again, I think it follows the same theme. We
14 have to constantly be looking for ways to improve the
15 work we do in taking care of patients.

16 Q. (BY MS. PARKS) Okay. So hospitals must
17 constantly look for ways to improve?

18 A. Correct.

19 Q. Okay.

20 Okay. Can you read the fourth paragraph.

21 A. That references that as part of the quality
22 leadership structure, we have to do the same thing.

23 Q. So could I call that, like, "Hospital quality
24 leadership structure is essential"?

25 MS. BLAIR: Objection to form.

1 A. That is a fair statement.

2 Q. (BY MS. PARKS) Would you prefer -- like, if
3 we were going to come up with a shorthand for that
4 paragraph, what would you prefer?

5 MS. BLAIR: Objection. Form.

6 It says what it says.

7 A. Yeah, I guess, not knowing your big picture of
8 how you're trying to translate these paragraphs into
9 something else, I have a hard time translating them into
10 the product that you're trying to achieve.

11 Q. (BY MS. PARKS) Yeah.

12 A. So what are you -- what are you -- what would
13 you like as the output of this methodical step-by-step
14 paragraph translation?

15 MS. BLAIR: It's a four-sentence paragraph.

16 Q. (BY MS. PARKS) I want to basically see if we
17 can map what's in this section to the following sections
18 of your report so I can sort of understand the buckets
19 of the opinions you're presenting in this report.

20 MS. BLAIR: Well, objection to form.

21 Q. (BY MS. PARKS) I mean, that wasn't a
22 question.

23 A. Yeah. So yes, you can bucket this into as
24 many ways as you want. You can -- culture and structure
25 are two big buckets. Culture would be the bucket of

1 "Does everyone who's working in that space have a shared
2 understanding and a shared mission towards a common
3 goal?"

4 Do -- and then within sub-buckets of culture:
5 "Do they feel safe to speak up? Do they feel that
6 elevating patient safety concerns and quality concerns
7 are a relevant part of their job, and are they in a
8 space where they can do it?"

9 Under structure, you can break that into many
10 different buckets: External reporting and transparency
11 and accountability and -- by CMS, Leapfrog Group, and
12 other organizations. Internal transparency and
13 accountability of internal data you have. Structure of
14 how to decide on a single one of these metrics, how to
15 measure them, how to know when they're out of range, how
16 to bring them up to the people who can make change and
17 implement that change.

18 So you -- depending on what you are trying to
19 achieve with those buckets, much like what we're trying
20 to achieve in quality work, you can take pieces of it
21 and then translate it to the audience that is going to
22 be doing that improvement work.

23 So my hope with this summary was to try to
24 touch on all of those things, to make the point that it
25 is a complicated issue. It is not simple. And we

1 haven't figured it all out yet, but these are the
2 general arenas where putting effort and putting
3 structure and encouraging a culture of safety have been
4 effective within what I've seen in this environment.

5 Q. Okay. So if I could just try to reduce what
6 we've talked about into four buckets, I have "patient
7 care requires culture, patient care requires structure,
8 participation in multiple external reporting systems is
9 essential to quality, and hospitals must constantly look
10 for ways to improve."

11 A. I agree with all four of those as relevant
12 buckets in this great work --

13 Q. Okay.

14 A. -- so...

15 Q. Are there any other -- is there any
16 information described in the "Summary of Review" section
17 that falls outside of those four buckets?

18 MS. BLAIR: Objection to form, but --

19 A. I don't think so. I think I would -- you
20 could get most everything into those general buckets.

21 Q. (BY MS. PARKS) Okay. Great.

22 So let's start with the first one, "patient
23 care requires culture."

24 What is the relevance of that to this
25 litigation?

1 A. I didn't understand this when I graduated at
2 age 35 and started my first job. And I will bring in a
3 dear friend of mine, who was a cardiothoracic surgeon,
4 who -- I think this was our second year of practice we
5 started together. And this question came up about
6 culture. And we were implementing the preoperative
7 surgical safety checklist. And he hadn't had to do it
8 yet.

9 But we walked into a case where he was
10 resecting a left lung that had cancer in it, and he was
11 doing a thoracotomy. And so after this discussion, he
12 went to his OR, I went to mine. He asked the six people
13 in his OR team, "Hey, guys, if I were about to cut into
14 the right lung, how many of you would say something or
15 would stop me?" And only one person out of the six
16 raised their hand.

17 And then he went around and said, "Why?"
18 Somebody said, "Well, I'm afraid," and says, "You're the
19 doctor. I shouldn't speak."

20 Somebody said, "Well, It's not my job. I'm
21 the anesthesiologist. I'm over here."

22 Somebody else said, you know, "I'm scared."

23 Fast-forward five, ten years later, there --
24 that -- if I'm about to do something even -- that seems
25 concerning to any of the five to ten or 15 people that

1 can be in the OR with me or with my colleagues, someone
2 is going to speak up and say, "Hey, doc, are you sure
3 you want to do that?"

4 So stark contrast, and the change of people's
5 ability to contribute to the safety of each individual
6 patient is culture.

7 So the structure of the checklist is an
8 element of that change. But that shift in culture where
9 everyone feels invested in the care and the good
10 outcomes of that particular patient, to make sure that
11 their right chest doesn't get opened when their cancer
12 is on their left chest, didn't really exist in
13 healthcare prior to the last two decades. And still
14 doesn't exist in many places.

15 And so the structural elements that make our
16 work -- our successes and our failures visible to
17 external environments and create that accountability
18 translate into leaders of organizations allowing a safe
19 space for this culture of quality to develop within
20 hospitals. And we know that's better for patient care.

21 Q. Do you have any information about the culture
22 of quality at any of the five plaintiff hospitals?

23 A. I did not do any research in that arena.

24 Q. So just to make sure I have a clean answer to
25 that, you do not have any information about the culture

1 of quality at any of the five plaintiff hospitals?

2 A. Outside of what were in the documents provided
3 for this case, I do not have any further information on
4 the culture of quality in those hospitals.

5 Q. Okay. And did you do -- and you said -- you
6 already answered this question, so I don't need to ask
7 that again.

8 Did you ask counsel to provide you with any
9 information regarding the culture at plaintiffs'
10 hospitals?

11 A. I don't believe I did, no.

12 Q. Okay. Is it your opinion in this case that
13 the culture of plaintiffs' hospitals would improve if
14 they participated in Leapfrog?

15 A. Yes, I believe so.

16 Q. Okay. And how can you know that their culture
17 would improve if you don't know the current state of
18 their culture?

19 A. Because I know healthcare is not perfect. We
20 can all get better. And for all the reasons stated,
21 both in the discussions up to this point and what I
22 wrote down, the more you participate in structural and
23 accountable elements that help people know that you
24 care, the more likely you are to get more of the humans
25 in your space to come along on that ride.

1 Q. Okay. So if I could sum that up a little bit,
2 your view is that plaintiffs' culture would improve if
3 they participated in Leapfrog because every hospital has
4 room for improvement?

5 MS. BLAIR: Objection to form.
6 Mischaracterizes his testimony. Asked and answered.

7 A. So I -- yes, I agree that every hospital,
8 every healthcare system, every physician has room for
9 improvement.

10 Q. (BY MS. PARKS) Okay. And that understanding
11 is the only basis you have for saying that plaintiffs'
12 hospital's cultures would improve if they participated
13 in Leapfrog; correct?

14 MS. BLAIR: Objection to form.

15 A. It's the opinion I have formed from 20 years
16 of practice and exposure to the healthcare and
17 healthcare quality system with all the elements that
18 we've already discussed so far, so I won't reiterate.

19 Q. (BY MS. PARKS) Okay. And, again, nothing in
20 your 20 years of practice and exposure to the healthcare
21 system gave you any particular insight into the culture
22 of plaintiffs' hospitals; right?

23 A. Again, I do not know anything specific about
24 the internal functions of an environment in which I have
25 not worked. So I cannot comment on that.

1 Q. Okay. And then the second bucket we have,
2 patient care requires structure.

3 Do you have any particular information
4 regarding the structure of the quality reporting systems
5 of plaintiffs' hospitals?

6 A. Again, I would not because I am not part of
7 their hospital, so no.

8 Q. So you don't know one way or the other whether
9 they have quality committees like the ones you sit on?

10 A. Correct, do not know.

11 Q. Okay. And you don't know one way or the other
12 what types of KPIs they track?

13 A. I do not.

14 Q. And you don't know one way or the other
15 whether those KPIs are reported internally between the
16 hospitals or to Tenet Corporation?

17 A. I do not.

18 Q. And you also don't know one way or the other
19 what effort it is plaintiffs' hospitals put into making
20 improvements in quality?

21 MS. BLAIR: Objection to form.

22 A. I have no visibility into that.

23 Q. (BY MS. PARKS) Okay. And did you attempt to
24 research any of that information?

25 A. I did not.

1 Q. Did you ask counsel to provide you with any of
2 that information?

3 A. I did not.

4 Q. Is it your opinion that the structure -- the
5 quality structure of plaintiffs' hospitals would improve
6 if they participated in Leapfrog?

7 MS. BLAIR: Objection to form.

8 A. Again, not knowing what their current
9 structure is and what their leadership structure is --
10 so I can't comment on that not knowing the details.
11 That wasn't the scope of what I was asked to comment on.

12 Q. (BY MS. PARKS) Okay.

13 A. That would be a whole different bucket of
14 work.

15 Q. Okay. So my third bucket is participation in
16 multiple external reporting systems is essential to
17 hospital quality.

18 Do you know which external reporting systems
19 any of the plaintiffs' hospitals do report to?

20 A. I do not.

21 Q. And I think we've already spoken about this
22 earlier, but am I correct that you did not look for any
23 empirical publications showing a connection between
24 external reporting systems and hospital quality?

25 MS. BLAIR: Objection to form.

1 A. I believe you are correct, if I understood the
2 question right.

3 Q. (BY MS. PARKS) And then the last bucket,
4 hospitals must constantly look for ways to improve.

5 Do you have any information about whether
6 plaintiffs' hospitals are looking for ways to improve?

7 MS. BLAIR: Objection to form.

8 A. Again, I do not.

9 Q. (BY MS. PARKS) Okay. All right.

10 Okay. So I want to dig in on the paragraph
11 that spans between pages 6 and 7 for a little bit.

12 So there's a sentence that starts -- it's --
13 this is the sentence that breaks across the page. It
14 starts, "To do this, we need to process an overwhelming
15 amount of information and decide how best to direct
16 resources towards improving certain key performance
17 indicators."

18 So would you agree that it's not possible to
19 thoughtfully evaluate each possible key performance
20 indicator?

21 MS. BLAIR: Objection to form.

22 A. No, I would not agree with that statement.

23 Q. (BY MS. PARKS) Do you -- does -- I think you
24 reference in here somewhere that your hospital tracks
25 280 key performance indicators?

1 A. Somewhere around there, yes.

2 Q. Are there other key performance indicators
3 that you could? Could that number be 380 instead?

4 A. Yes, absolutely.

5 Q. Okay. And if you could -- if you can't have
6 380, why do you only have 280?

7 MS. BLAIR: Objection to form.

8 A. So that goes back to the structure that we
9 talked about of evaluating every element for its value.
10 And I think I mentioned that we educate our quality
11 committee members. As they come on board, there's an
12 onboarding, and we speak to it at almost every meeting.

13 As people come and speak on their list of --
14 transplant team comes and reports on the 18 metrics --
15 the 18 KPIs that they report on every year. The quality
16 committee is charged with asking why they are following
17 those specific metrics.

18 So my quality committee member, who's the head
19 of pharmacy, will, within the scope of her experience in
20 pharmacy, ask the questions of those KPI metrics that
21 are relevant to medicines. You know, "Are you getting X
22 drug within X number of hours of X event?"

23 And the objective is to be thoughtful about
24 every single metric that you're measuring to that level
25 of detail.

1 Is it important to get your immunosuppressant
2 medication within a range of two hours once every
3 24 hours, or can it be given twice a day? Are you
4 measuring it -- are you measuring that you're giving
5 that medication at the particular hour that you're
6 supposed to give it? Is that relevant?

7 No. This medicine has a half-life that's
8 48 hours, so you could give it eight or ten hours off
9 and it doesn't make a difference.

10 Okay. So you can stop following that metric
11 and use your energy to follow another more relevant
12 metric.

13 And so that cycle of improving how we improve
14 has to happen continuously. And so how we've landed on
15 the particular 280-some-odd metrics that we follow
16 today, which were different than they were last year,
17 and they're going to be different than what they have
18 next year, goes through an iterative process that
19 requires a structure and a culture where people can be
20 in a meeting to ask the questions with the data in front
21 of them and then make a thoughtful assessment with their
22 colleagues about: "Are you looking at the right thing?
23 Are you measuring the right thing? When is it out of
24 range? And then what are you going to do if it's out of
25 range?"

1 So the answer to your question is yes, it's
2 hard. It's complicated. You're not going to follow
3 everything all the time, but your environment --
4 hopefully, our healthcare environment will tell us what
5 is relevant. And things that are highly relevant have
6 bubbled up to CMS standards and Leapfrog standards,
7 because of the thousands of things we could measure, the
8 things that these high-level organizations are prompting
9 us to follow are the most impactful for the population
10 of patients we serve in a hospital setting.

11 So with an airplane, it may be that the doors
12 don't blow open when you're flying around. I think we
13 can all agree that that's an important measure. And so
14 Boeing now has to put extra effort into that quality.

15 So for us, hand washing, central line
16 infections, all of these things have bubbled up as
17 relevant measures, not only because they are important
18 as specific relevant measures, but they bring attention
19 to such a complex structure of care that following this
20 particular measurable target makes sure -- making sure
21 your door doesn't open in the middle of a flight, make
22 sure that the hinges are tight, the bolts are tight, the
23 handle is tight, the lock is tight, the electronic
24 sensor that says it's tight is tight. All the elements
25 that make that door not open.

1 So yes, very complicated work, and it takes a
2 lot of effort, but very important to do.

3 Q. (BY MS. PARKS) Okay. So when you said that
4 the most relevant measures have bubbled up to the CMS
5 standards and Leapfrog standards, are you relying on the
6 expertise of CMS and Leapfrog to judge what's most
7 relevant? Or is it your opinion, based on your own
8 expertise, that the metrics they measure are the most
9 relevant?

10 MS. BLAIR: Objection to form.

11 A. So CMS is not a thing. Leapfrog is not a
12 thing. It's a conglomeration of experts in their fields
13 who have come together with a shared goal of measuring
14 things that are relevant for taking care of patients;
15 right.

16 Q. (BY MS. PARKS) I understand that.

17 A. So I have to -- I have to have some faith in
18 my system of healthcare delivery and healthcare
19 improvement measurement. So yes, I believe that they
20 are doing good work.

21 And are they perfect and without fault? No.

22 Are they trying to get better? Yes.

23 Are they getting better decade after decade,
24 from what I see from a customer's perspective? Yes.

25 Is their methodology sound? Are they

1 transparent about how they're coming to these
2 conclusions and measuring these things? Yes. They're
3 doing the best with the information they have.

4 And I am grateful that there are people doing
5 that work, that are giving our hospital systems things
6 to measure that are making our work better and our
7 patients safer.

8 Q. Okay. So when you told me that the measures
9 included in the CMS standards and Leapfrog standards are
10 the most relevant, are you relying on what CMS and
11 Leapfrog say about their standards, or is it your
12 independent opinion that those measures are the most
13 relevant?

14 MS. BLAIR: Objection. Asked and answered.

15 MS. PARKS: I don't think he answered it. I'm
16 sorry, Kim.

17 A. I guess I don't understand.

18 So -- so --

19 Q. (BY MS. PARKS) I guess I can --

20 A. -- I think they're relevant.

21 Go ahead.

22 Q. Yeah.

23 Are you presenting the opinion that the
24 measures included as part of the Leapfrog safety grade
25 are the most relevant measures for hospital safety?

1 A. In the clearest way I can hopefully present
2 this: My opinion, with my experience today of the
3 measures that are being measured today seem to be
4 achieving the goals of patient safety, hence making them
5 relevant measures with the information and the science
6 and the environment of healthcare that we have today.

7 Q. So it's your opinion that they're relevant?

8 A. Yes, it is my opinion that these are -- these
9 are relevant metrics to be followed --

10 Q. Okay. So --

11 A. -- if that's what you were trying to get me to
12 convey. But, I guess, I still don't understand the crux
13 of your question.

14 Q. Well, you told me -- you told me they're the
15 most relevant, and that seems to include some sort of
16 judgment about what measures are the most important for
17 hospital quality.

18 A. Oh.

19 Q. And I want to understand if you are saying
20 that you've looked at the measures that go into the
21 Leapfrog safety grade and you agree those are the most
22 relevant or if you're relying on Leapfrog to make that
23 judgment for you?

24 MS. BLAIR: I'm going to object to form. He's
25 not here to provide any testimony about the safety

1 grade.

2 Q. (BY MS. PARKS) Oh. And to confirm, not about
3 the safety grade itself, but what about the -- like,
4 elements that go into the safety grade?

5 MS. BLAIR: No. He's here to testify about
6 the survey per his report. And so if he has opinions
7 about the safety grade, he's not given them. But if you
8 want him to opine, I'm not sure he has any. So I just
9 wanted that to be clear for the record. I don't want to
10 confuse the safety grade and the survey.

11 MS. PARKS: Okay.

12 Q. (BY MS. PARKS) So do you believe that the
13 measures included in the Leapfrog hospital survey are
14 the most relevant measures for hospital safety?

15 A. Yes. So all the -- all the metrics that we
16 are currently following, including Leapfrog, and CMS --

17 Q. That wasn't -- my question is specific to the
18 measure --

19 A. Yes.

20 Q. -- included in the Leapfrog survey.

21 A. Yes.

22 Q. I don't know how many are included. Let's say
23 it's 50. Are those the 50 most relevant measures?

24 MS. BLAIR: Objection to form.

25 A. So I -- most relevant relative to what other

1 comparator?

2 Q. (BY MS. PARKS) You used the phrase "most
3 relevant." You said that "the most relevant measures
4 for hospital safety, they bubble up into the CMS
5 standards and the Leapfrog standards."

6 So is it your opinion that the measures of CMS
7 and Leapfrog -- I guess, in the Leapfrog hospital
8 survey, per counsel's clarification -- is it your
9 opinion that those measures are the most relevant, or is
10 that Leapfrog's opinion that you are relying on?

11 A. Oh. Okay. Now I understand your question.

12 Yes. I trust the experts and the
13 methodologies that have chosen these as the most
14 relevant metrics of all the things that we could
15 measure. So they could say, "Go measure the thickness

16 of the soles of your doctors and see how their foot
17 health is affecting their performance and safety."

18 That wouldn't be a really relevant -- it may
19 be someday. We'll figure it out. AI will tell us it
20 may not be relevant.

21 But I'm assuming that these committees who sit
22 down and evaluate each individual metric, much like our
23 committee evaluates it within our environment, are doing
24 the holistic work of giving us a set of targets and
25 measures that apply well across the thousands of

1 hospitals that have to measure them so that they get
2 actionable data towards the goal of quality improvement.

3 So, yes, I have to have some faith in the
4 committees, the subcommittee on hand washing from
5 Leapfrog, or the subcommittee on SSI infection from CMS,
6 that those individuals are thoughtful and educated, and
7 have looked in the data that's available, looked at
8 methodology, have brought in epidemiologists,
9 methodology experts and so on, and have deciphered from
10 all this data that that one little question that they
11 put on page 324 of the survey is the right one to put,
12 and make me and my hospital measure that thing, and then
13 share it so that I can compare myself with the hospital
14 in New York or Cincinnati and then learn from that and
15 make it better.

16 So, yes, the answer to your question is, it is
17 their opinion that they have made these as relevant
18 metrics. I believe them. I support them.

19 Q. Okay. Have you done anything to independently
20 validate the metrics included in the Leapfrog hospital
21 survey?

22 A. No, I have not done anything independently to
23 validate them other than to run them through our
24 hospital structure, as I just described to you, about
25 questioning every metric. That questioning, that

1 evaluation applies to all the Leapfrog metrics, as well
2 as the CMS metrics, as well as the DOH metrics, as well
3 as our internal metrics in CommonSpirit.

4 So we ask that same question regardless of the
5 source of the KPI.

6 And the reason I brought forth the coalesced
7 SSI measure is we did follow that thread all the way to
8 the national organization. We saw that there were
9 multiple publications from other academic centers that
10 challenged the efficacy of that particular measure. And
11 despite all that thoughtful analysis, the national
12 organization that set forth that measure said, "We
13 acknowledge that it is faulty, and we acknowledge that
14 it is not the best measure that solves all the problems,
15 but it is the best measure we have today for the most
16 positive impact on patient safety in this arena."

17 So that question of what's best literally
18 changes day to day; hence, we have to -- we need culture
19 and structure to fall back on so that tomorrow we can
20 decide what's the best thing that we're doing.

21 Q. Do you track a KPI for each metric included in
22 the Leapfrog hospital survey?

23 A. I couldn't answer that question. I think some
24 of them we do, some of them we don't. But we -- yeah, I
25 have not done that crosswalk. It's a dense document.

1 Q. Okay.

2 A. It's a lot of measures.

3 Q. Okay. And then in the very last paragraph on
4 page 7, you state here, "Although I do not agree with
5 the details of every metric used to measure our
6 performance by governmental, for profit, and non-profit
7 organizations that work in this space," and then you go
8 on.

9 Are there any Leapfrog metrics that you do not
10 agree with?

11 A. I -- so I can't think of one that I would not
12 agree with right now. I am sure that over the years we
13 have come across metrics that didn't make sense, and
14 we've questioned them and asked for Leapfrog and other
15 organizations, just like the example I just gave, to go
16 and evaluate whether, for that time period in healthcare
17 with the data that was available, that was the best
18 measure.

19 So having this bidirectional ability to
20 communicate with your measuring entities is also really
21 important. And my general sense is that most of these
22 entities are open to these communications. Like, I've
23 never not been able to track someone down who sat on the
24 committee and explained why they came to that
25 conclusion, if it weren't clear in their publicly

1 available reports.

2 Q. Are there any CMS metrics that you disagree
3 with?

4 A. Again, I couldn't enumerate those right now.

5 Q. Okay.

6 A. But, again, I'm sure there were many. I mean,
7 we do this on a daily basis. So our purpose is to
8 question to make sure we're doing the best thing every
9 day.

10 Q. Okay. So going back to -- recall we were
11 talking about how your hospital tracks 280 KPIs, could
12 be 380, but you decided these 280 were the most relevant
13 for you.

14 Can different hospitals reach a different
15 conclusion about which KPIs are the best for them to
16 track?

17 MS. BLAIR: Objection to form.

18 A. I'm assuming that every hospital must choose
19 within its available resources and metrics.

20 Yeah, I -- the answer to your question is yes.
21 It's their hospital; they get to choose.

22 Q. (BY MS. PARKS) And would you go to another
23 hospital and say, "These are the 280 we do at Virginia
24 Mason. You should use these exact 280 as well"?

25 A. I would not use that sentence. I would say:

1 "These are the way -- we have come to measure these.
2 These are the -- this is the structure and the culture
3 that we have built to make sure that the X number of
4 metrics that we measure are always the most relevant
5 that we can be putting our resources into. And I hope
6 that you can incorporate some of this structure and
7 culture into how you do it," so...

8 Q. So in other words, there's not, like, a
9 one-size-fits-all set of KPIs that's appropriate for
10 each hospital to follow?

11 A. Yeah, we don't currently deliver babies or
12 take care of pediatric patients, so those are not
13 relevant metrics to us. Does everyone need to wash
14 their hands? Yes.

15 So those are the extremes of the examples;
16 right.

17 Q. Okay.

18 Okay. And then, also on page 7, the
19 second-to-last paragraph, starting, "The reporting of an
20 A or F grade is only the beginning of the quality
21 improvement work."

22 When you refer to the reporting of an A or F
23 grade, are you referring to Leapfrog's reporting of
24 those grades here?

25 A. Any grading system. Like, I used A and F just

1 because those are relevant to my current grade-school
2 kids. But it -- any report that gives you a feedback on
3 how you're doing is only the first step.

4 Q. Going to your example of the report cards, do
5 your kids -- they receive their report card, has an A or
6 an F, and does that cause them to improve their grades,
7 you know, or maintain good grades if they got an A, I
8 suppose?

9 A. So it is -- I feel bad for my children because
10 their parents swim in healthcare and healthcare quality,
11 so I hope we have established a culture and a structure
12 that makes them use the data they have for improving
13 themselves.

14 So they know that they will sit down at the
15 end of a semester and we will go through their report
16 cards with them. We also talk about every test at
17 dinner: What they have coming up tomorrow, what they
18 had yesterday, how they scored, why they scored the way
19 they did? Do they feel like they could do better?
20 Could we get them help to do better? Can they help each
21 other to do better?

22 No different than my team in the OR. You have
23 to trust each other, talk to each other, have some sort
24 of relevant metric that holds you accountable to do your
25 best. And you have to believe in wanting to do your

1 best.

2 Q. Do you think that your kids would get better
3 grades if their report cards were published?

4 A. Yes. I think that any visibility by a
5 community helps people perform to the ideals of that
6 community.

7 Q. Do you think it would hurt your kids'
8 reputations if there was an F on a report card published
9 about them?

10 MS. BLAIR: Objection to form.

11 A. What do you mean by "their reputations"?

12 Q. (BY MS. PARKS) Do you think that people in
13 your community would negatively judge your children if
14 they knew that they received an F on a report card?

15 MS. BLAIR: Objection to form.

16 A. I can't comment on how people would judge
17 my -- the relevant. I think the -- that the
18 overwhelmingly more relevant piece of that is how would
19 the individual judge themselves based on this external
20 review, and do they live in an environment and a culture
21 where they can use that feedback to improve what they
22 want to improve in their lives.

23 If they don't mind getting Fs, then they
24 shouldn't mind Fs being reported publicly. If they
25 chose to put their energies into something else, and

1 this is not a relevant metric for them, then they should
2 own that.

3 Q. (BY MS. PARKS) Would you be embarrassed if
4 your kids had their Fs publicly reported?

5 MS. BLAIR: Objection to form.

6 A. So it's a question of what I'm embarrassed
7 about or not, and if you ask my children, nothing
8 embarrasses me, so -- but you bring up a really good
9 point.

10 Embarrassment should not drive how we care for
11 other human beings, at least in my interpretation of how
12 we deliver healthcare. My embarrassment should not be
13 what gets me to do a good job for you as my patient. I
14 should want the best for you from whatever resource I
15 have to deliver the best care for you. It should not be
16 about me and my embarrassment; right. It's not my
17 emotional state that is the work at hand. It is the
18 patient and their health and doing it the best way.

19 I don't want the -- embarrassment denotes that
20 there's ego involved; right. And we have proven time
21 after time that ego gets in the way of safety.

22 Q. (BY MS. PARKS) Yeah, but then why is it
23 valuable for Leapfrog to publicly shame hospitals that
24 get Fs?

25 MS. BLAIR: Objection to form.

1 A. So --

2 MS. BLAIR: I don't -- "publicly shame" is a
3 bit much.

4 A. So would you like to restate that question? I
5 can't --

6 MS. BLAIR: You can answer it.

7 Q. (BY MS. PARKS) No, please answer it.

8 A. I can't comment on public shaming. I think
9 they're make- -- they're making transparent a data
10 measurement system and tool that they have available.

11 So I don't think it is -- so your
12 interpretation that that's public shaming goes back to
13 your interpretation that there must be ego involved
14 because shame comes from a sense of self and ego. It is
15 not a focus on quality and improvement; right.

16 So you are taking a piece of data and taking
17 it far away from the goals of that data, which is: Keep
18 that patient with immunosuppression from getting that
19 nasty bug. It has nothing to do with ego. It is all
20 about the patient.

21 And once you make that leap in your thinking
22 in delivering healthcare, none of that stuff matters.
23 We're all in this together to do things better for
24 people who are sick.

25 Q. Are you aware that the experts on both sides

1 of this case have concluded that the plaintiff hospitals
2 would have gotten higher grades had they participated in
3 the Leapfrog scores due to Leapfrog's imputation
4 methodology?

5 MS. BLAIR: Objection to form. Outside the
6 scope of his opinion.

7 A. Yeah, I --

8 Q. (BY MS. PARKS) So you're not aware of that?

9 A. I'm not aware of that. That's outside of my
10 scope.

11 Q. I forgot where we were. Oh, we were talking
12 about reporting of an A or F grade.

13 Okay. So I believe you said that reporting of
14 an A or F grade -- that's referring to your children,
15 that's not referring to Leapfrog; right?

16 MS. BLAIR: Objection to form.

17 A. Any reporting of any data is a metric for --

18 Q. (BY MS. PARKS) Do any other systems report
19 hospital quality on an A-to-F scale?

20 A. I do not know.

21 Q. So when you wrote this sentence, were you
22 thinking about Leapfrog, or were you not thinking about
23 Leapfrog?

24 MS. BLAIR: Objection to form. Asked and
25 answered.

1 A. I don't know what I was thinking about when I
2 wrote that sentence. But the grading matters, so you
3 have to report the data.

4 So whether it's an A or an F, or CMS'
5 five-star rating, or my kids' grade-school report cards,
6 which were ones, twos, and threes, it's still an
7 assessment. And it has to be bucketed into something
8 that's translatable to the audience that's receiving it
9 that says that you are performing at the level that you
10 wish or you are not performing at the level you wish.

11 So we can quibble about those three letters,
12 but it's a measure.

13 Q. (BY MS. PARKS) Who's the audience for the A
14 and F grades assigned by Leapfrog?

15 MS. BLAIR: Objection to form. Outside the
16 scope.

17 A. Yeah, I think the -- that's the whole
18 marketing side of it all, so I can't comment on that.

19 Q. (BY MS. PARKS) Okay. So do you want to
20 withdraw your testimony that the grades have to be
21 bucketed into -- bucketed into something that's
22 translatable to the audience that's receiving it?

23 MS. BLAIR: Objection to form.

24 You asked him a question, he answered it.

25 MS. PARKS: I asked him whether the A and Fs

1 refer to Leapfrog, and then he said that the grades have
2 to be bucketed in response to that.

3 Q. (BY MS. PARKS) So what's -- what is your
4 basis for saying that "information has to be bucketed
5 into something that's translatable to the audience
6 that's receiving it"?

7 Do you have research on that point?

8 A. No, but if I were to have this conversation in
9 German, I don't think we would communicate as well.

10 So what I was hopefully referring to is a
11 simply translatable piece of information that's
12 actionable towards our goal of quality improvement.

13 Q. And this simply translatable piece of
14 information, are you referring to the information that's
15 given to hospitals or information that's given to
16 patients?

17 A. I was not being specific on purpose, because I
18 think information should be shared broadly so that there
19 should be no filter to -- who the audiences are. But it
20 should make the most meaning for the people who are most
21 impacted.

22 Q. Okay. And do you have an opinion on the best
23 way to provide data to patients?

24 A. That's a really intense area of study, which I
25 am not an expert on. But, yes, you know, the old school

1 way was: "Make sure anything you publish that's going
2 to be consumable by patients is at a fifth grade reading
3 level." I think that's a little dated at this time.

4 But -- so there's a whole area of science,
5 again, that I am not able to comment on, but I know
6 people study this and how to translate that. So I would
7 defer to their knowledge and advice on how to translate
8 the data.

9 Q. Okay.

10 Okay. And I just -- I'm still puzzled by this
11 reporting of an A or F grade sentence. You say that is
12 the beginning of the quality improvement work.

13 Can you -- are you saying that a hospital
14 shouldn't begin to improve their quality until they
15 receive an A or F grade?

16 MS. BLAIR: Objection to form.

17 Q. (BY MS. PARKS) Like, what is the temporal
18 relationship you're trying to describe in this sentence?

19 A. I'll try to summarize again so it makes that
20 sentence relevant.

21 You need to create a culture of quality and a
22 structure in which you can build quality reporting and
23 reaction to that reporting.

24 So you have to, first, start with measuring,
25 like a speedometer on a car that tells you your speed.

1 You need to have a structure to say that the speed limit
2 is X, and you need to be able to cross-reference what
3 your speedometer is telling you with what the signs are
4 telling you on the road to know that if you're traveling
5 at a safe speed or a non-safe speed.

6 So the grading system that we are discussing,
7 or the quality performance indicator system that we are
8 discussing, whether it's Leapfrog or CMS, all of this
9 fits within that simple example of, it's a speedometer
10 on a dashboard that gives us information to act on so
11 that we can safely get to our destination.

12 Q. Okay.

13 A. So temporal relationship of how you build the
14 car, the speedometer, the highway, the speed sign on --
15 how you decide that 60 miles an hour is safe here and 35
16 is safe somewhere else, all relevant discussions. And I
17 don't think they have a specific temporal relationship.
18 We're deep into this quality work.

19 Q. I think --

20 A. All of this exists now.

21 Q. I think where I'm getting confused is the
22 sentence seems to imply that there's some kind of
23 reporting that happens before quality improvement work.

24 And is that reporting the reporting that the
25 hospitals do, or is that the reporting that ratings

1 agencies like Leapfrog do?

2 MS. BLAIR: Objection to form.

3 A. So I disagree with you saying "this sentence
4 implies."

5 Q. (BY MS. PARKS) Okay.

6 A. Because that is not what I meant to imply. So
7 I can't answer that question because that's not what I
8 meant by that sentence.

9 Q. Okay. So what -- when you wrote this
10 sentence, what reporting were you referring to when you
11 said "the reporting is the beginning of the quality
12 improvement work"?

13 A. Maybe another way I should have put it, or to
14 put it, is that the assessment after actions have
15 happened and data has been reported and a -- a dashboard
16 is not the end point of a quality improvement measure.

17 The -- it is part of the whole journey. Like,
18 you always have to keep an eye on that speedometer. You
19 just don't look at the speedometer at your end point,
20 right, when you're at your destination. You have to
21 look at it all along.

22 So maybe my word choice with saying "only the
23 beginning" was poor use of language. Maybe I should
24 have put "it is an integral daily part of our quality
25 improvement work."

1 Q. Okay. So are you saying that it's getting the
2 data that is the integral daily part of your quality
3 improvement work?

4 Or are you saying that getting the results
5 from Leapfrog are the integral part of your daily
6 improvement work?

7 A. Yes and yes. Because like I said, if we
8 notice that -- so we report to Leapfrog at a certain
9 date every year. We report to CMS at a certain date
10 every year. Certain metrics we report every month,
11 certain metrics we report once a year.

12 No -- no single one of those events is the
13 crux of the whole problem. It's that you have someone
14 who's figured out what you're actually measuring and
15 submitting and reporting on. You have people that know
16 you're reporting on it and checking to make sure you're
17 reporting is high fidelity within your local system.
18 You have people questioning whether or not you should be
19 doing that work of reporting. And then that report goes
20 out, and as soon as it's visible to anyone who is doing
21 the work, if it's off-kilter, those people are going to
22 start reacting to that and try to fix the problem that's
23 been made relevant. And at a sudden temporal point
24 thereafter, there may be exposure at a larger level than
25 the micro-environment where that work is happening to

1 keep you accountable to do -- to put the effort in to do
2 that quality improvement work.

3 So if all of these pieces are constantly
4 happening along this spectrum -- yeah, so it's all
5 integral. You can't -- you can't just say one piece of
6 it is relevant. It's all relevant.

7 Q. And is there data that Leapfrog provides to
8 your hospital that your hospital doesn't already have?

9 MS. BLAIR: Objection to form.

10 A. I wouldn't be able to comment on that. I
11 don't know if there's bidirectional flow of Leapfrog
12 data that's different than publicly available data, but
13 I don't think so. I think all their data is public.

14 Q. (BY MS. PARKS) And by "all their data is
15 public," are you referring to the safety grade, or are
16 you referring to something else?

17 MS. BLAIR: Objection to form.

18 A. Again, I do not know the details of that piece
19 of data feedback and flow, but...

20 Q. (BY MS. PARKS) What is the Leapfrog data
21 that's public in the answer you just gave?

22 A. So I believe -- and, again, not being an
23 expert and this is not my work of going and checking --
24 but I believe Leapfrog puts on their website the data
25 they collect about hospitals, how they get them, what

1 they report out for the hospitals in some form or
2 fashion, that -- again, I fully admit that I don't do
3 the data dives into this stuff.

4 But that data for Leapfrog, CMS, Healthgrades,
5 our own internal dashboards, each time a question comes
6 up or a problem comes up that -- where we could improve
7 the safety, that expert panel has the ability to go out
8 and seek this data and bring it in as part of the
9 information they use to solve that safety problem.

10 Q. I think what I'm trying to understand -- I
11 understand one element of your opinion to be that the
12 process of saying Leapfrog wants us to give data on X,
13 and then you going out and getting the data on X prompts
14 your hospital to improve on X.

15 A. Right.

16 Q. Is there also an element to your opinion that
17 relates to information that you can't go out and get for
18 yourself? Like, information that Leapfrog is providing
19 to you that then prompts quality improvement?

20 MS. BLAIR: Objection to form.

21 A. Yeah, I couldn't comment on the details of
22 that. But the general concept that you bring out is
23 very important, very sound.

24 We only can improve if we're measuring against
25 other -- against others who are measuring similar

1 things.

2 So if I'm trying to figure out if I can be
3 better as a hospital in doing X, Y, or Z, I do better if
4 I compare myself to everyone who's out there and decide
5 who's doing better than me, who's doing worse than me,
6 avoid the problems that those who are doing worse are
7 just grappling with, and implement the improvement
8 measures that the members who are performing better do.

9 So we do that in our -- in our quality work
10 internal to the hospital. So if we have multiple groups
11 that are performing at different rates on different
12 grades -- let's use the grades -- if -- and Department 1
13 is getting an A and Department C is getting an F, we
14 tell the department that's not doing well -- and we put
15 them in a room with the department that's doing well,
16 and say, "Hey, share your ideas. You're the experts in
17 this arena. You'll be able to communicate best about
18 that particular topic." And that's usually the shortest
19 route to getting the poor-performing department to
20 perform well.

21 And so on a hospital scale, these national
22 reporting systems provide that same resource. So if I
23 were not performing well as a department of neurosurgery
24 on my readmission rates, as we did the -- on this
25 wonderful collaborative that we had about ten years ago

1 with orthopedics, we were getting a lot of readmissions
2 to the hospital because people were constipated. And,
3 you know, poop matters.

4 But they were winding up in the emergency
5 room, taking up time. So we had our quality
6 collaborative, and we noticed that orthopedics was
7 nailing it out of the park. They were getting no
8 readmissions. So we brought the two teams together and
9 we talked.

10 You know what the solution was? Not only were
11 they giving laxatives, but they were calling two days
12 after discharge and saying, "Hey, are you taking your
13 laxatives?" And nine out of ten times the patients were
14 like, "Oh, I didn't know I was supposed to take it
15 regularly," or "I forgot."

16 And so when we implemented that nurse phone
17 call on day two, on the -- which they had, but on their
18 checklist, "Hey, are you taking your medicines," not
19 specific to just medicines, but "Are you taking your
20 pain medicines? Are you taking your laxatives," lo and
21 behold, our patients didn't wind up constipated and in
22 the emergency room anymore.

23 So getting a bad grade, and knowing who's
24 getting a good grade in that particular arena and
25 getting that communication going, is a wonderful mode

1 for healthcare quality improvement. So hence, why we
2 need the grading system, and hence, why we need to
3 communicate between the hospitals as to how their
4 performance is panning out.

5 Q. (BY MS. PARKS) Okay. So part of the
6 value-add of Leapfrog is that it lets you do sort of an
7 apples-to-apples comparison between your hospital and
8 other hospitals on the same metrics?

9 A. Correct.

10 Q. Okay. And as part of doing that
11 apples-to-apples comparison, is it important that the --
12 that the way Leapfrog collates the data for the
13 hospitals is done the same way for those two hospitals?

14 Like, should they use the same methodology for
15 Hospital A and Hospital B to allow you to compare those
16 two hospitals?

17 MS. BLAIR: Objection to form to the extent
18 we're talking about the survey, I assume.

19 A. Yes. I'm not a methodology expert. There's a
20 lot of nuance in all that that people get PhDs in, so I
21 will defer to them.

22 Q. (BY MS. PARKS) Does the --

23 A. But the general concept, yes.

24 Q. I do have a clarification based on counsel's
25 clarification.

1 Does Leapfrog give you the responses from
2 other hospital surveys?

3 A. Again, I don't know because I'm not -- I'm not
4 the person or the relevant department that communicates
5 directly with Leapfrog and -- if they do. So I can't
6 comment on that. But I --

7 Q. So you can't -- can you say how your hospital
8 could do an apples-to-apples comparison using Leapfrog
9 data with another hospital?

10 A. So I can imagine that if we were getting a
11 poor grade, or a grade that we thought we could improve,
12 we could reach out to a hospital that is getting a good
13 grade and say, "Hey, how are you doing this piece
14 better?"

15 Q. Okay. And you just said "you can imagine
16 that."

17 Are you aware of that ever happening in real
18 life?

19 A. Yes. So if -- do you know what the Institute
20 for Healthcare Improvement is? The IHI?

21 Q. Well, I mean, we're talking about Leapfrog.

22 Are you aware of your hospital going to
23 another hospital and asking for advice on how to improve
24 on a Leapfrog metric?

25 A. I believe that was the question I was trying

1 to answer.

2 So at the IHI meetings, which happen
3 thankfully in December in Orlando, if they're still
4 happening there, we would -- we would share all of these
5 different metrics for quality reporting on all the
6 hospitals. And you would bring the quality leaders of
7 all these hospitals together to do exactly what you're
8 saying. "You're doing well, I'm not doing well. What
9 can I learn from you?"

10 And so everything was on the table.

11 Q. Okay. Can you explain to me --

12 A. So Leapfrog data is on the table.

13 Q. What Leapfrog data is on the table? Is it the
14 safety grade which you're not opining on, or is it
15 something else?

16 A. So, again, I was giving examples of an
17 environment where that information helped -- so it's --

18 Q. But I'm trying to understand what information.
19 What information from Leapfrog helped you at
20 that IHI meeting?

21 MS. BLAIR: I'm going to object to form. I
22 think you're confusing the grade and the survey, and
23 he's getting confused.

24 A. Yeah. So I will have to abstain from
25 answering that question, because I think I'm speaking in

1 a general context of how publicly reported information
2 can -- and I'm giving you tangible examples within my
3 environment of how sharing information can bring
4 disparate performance groups together to improve the
5 performance of the low-performing groups. And you're
6 asking specifics of the methodology of Leapfrog data,
7 which, I apologize, I do not have the expertise on --

8 Q. (BY MS. PARKS) No, no. I'm --

9 A. -- to comment, so --

10 Q. -- I'm really not trying to ask you about
11 methodology.

12 What I -- I believe you told me that
13 Leapfrog's public reporting across all hospitals allows
14 you to compare your hospital to other hospitals.

15 And I want to know what data Leapfrog is
16 reporting that you're using to do that apples-to-apples
17 comparison?

18 A. Okay. I can't give you that specific answer
19 because I just don't have that information.

20 Q. Okay. That's fine.

21 A. So I can give you "for instance" examples, and
22 we know it's happening. Just like I don't know which
23 airspeed numbers the 747s are using to compare fuel
24 efficiency standards between Qatar Airways and Alaska
25 Airways. Like, again, outside of my scope. But I know

1 they're doing it. So --

2 Q. Okay.

3 A. -- I'll have to pass on that one.

4 Q. That's fine.

5 Okay. So taking a step back, I think now
6 we've talked about two ways in which Leapfrog helps
7 hospitals improve quality. And I'll try to summarize
8 them. Of course, let me know if you disagree.

9 The first is that Leapfrog says, "Look at
10 metric X," the hospital looks at metric X, metric X
11 improves for that hospital.

12 The second is that hospitals can use Leapfrog
13 data to do an apples-to-apples comparison with other
14 hospitals.

15 Are there any other ways that Leapfrog helps
16 hospitals improve quality?

17 A. I think those are the two big buckets. The
18 only thing I know otherwise is there -- there's
19 resources offered about understanding how and why
20 measures are improved, or how they're measured, and
21 sharing of information of, like, how other hospitals are
22 improving that. Again, not being in those meetings, I
23 can't talk to the specifics of it. But it goes under
24 that same bucket of sharing knowledge and sharing best
25 practice.

1 Q. Okay. So the last bucket would be Leapfrog,
2 like, providing educational resources to hospitals on
3 how to improve. Okay.

4 And do you have any familiarity with whether
5 those are, like, print materials Leapfrog provides?
6 Meetings? Anything like that?

7 A. I'm sure you could get that from Leapfrog.

8 Q. Okay.

9 Okay. Completely forgot how we went down that
10 path, but that was -- that was helpful.

11 A. But it's good discussion.

12 Q. Yes.

13 A. No. This is fun stuff to talk about. This
14 is -- it's relevant. And you're helping me better
15 understand my work because it --

16 Q. I think that's giving me too much credit.

17 A. No, but it's important. It's important for me
18 to be able to translate -- because I live in this stuff
19 all the time, and it needs to be translatable to others
20 so that we do it better. It just needs that.

21 Q. Okay.

22 MS. BLAIR: And while we're at a break, do
23 you -- I don't know what time -- I've literally no clue
24 what time it is.

25 MS. PARKS: Oh, yeah. It's almost 1:00.

1 Should we go off the record?

2 MS. BLAIR: Does anybody need a lunch break?

3 THE COURT REPORTER: At some point.

4 THE VIDEOGRAPHER: Do you want to go off the
5 record first?

6 MS. BLAIR: Yeah, let's go off the record.

7 THE VIDEOGRAPHER: We are going off the record
8 at 12:50.

9 (Deposition recessed at 12:50 p.m., to be
10 reconvened at 1:35 p.m.)

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1 AFTERNOON SESSION

2 1:54 P.M.

3 --000--

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5 THE VIDEOGRAPHER: We are back on the record.
6 The time is 1:54.

7 Please proceed.

8
9 EXAMINATION RESUMED

10 BY MS. PARKS:

11 Q. Welcome back, Dr. Farrokhi.

12 A. Thank you.

13 Q. I would like to keep going through your
14 report, which I see you still have in front of you.

15 So starting on page 8, there's a section
16 entitled "Physician Consumer Perspective on Quality
17 Culture."

18 Do you see that?

19 A. Uh-huh.

20 Q. Okay. And do you recall, before we all had
21 lunch and forgot everything, that we had sort of four
22 buckets that were addressed in the summary section of
23 your report?

24 And I'll refresh you on what those were. They
25 were: Patient care requires culture, patient care

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1 requires structure, participation in multiple external
2 reporting systems is essential to hospital quality, and
3 hospitals must constantly look for ways to improve.

4 Does this section -- based on the title of
5 this section, you were referring to quality culture. My
6 guess is it falls into the first bucket: Patient care
7 requires culture.

8 Do you agree with that?

9 A. I think that --

10 MS. BLAIR: Objection to form.

11 A. Yes, I think that's a -- it's a part of it. I
12 think it requires all those things.

13 Q. (BY MS. PARKS) Okay. So this section
14 addresses all four of those buckets?

15 A. I hope so. I hope -- these are -- these are
16 indistinguishable parts, really --

17 Q. Okay.

18 A. -- but...

19 Q. And is there anything in this section that
20 doesn't fall into one of those four buckets?

21 A. I don't know. I would have to read it in
22 reference to your buckets and try to reassign it in that
23 way. So I can't comment on that question right now.

24 Q. Why don't you take a look at -- you can read
25 it to yourself and let me know.

1 MS. BLAIR: And, again, for the record, the
2 buckets you're asking about are...?

3 MS. PARKS: I can repeat them.

4 MS. BLAIR: Yeah, sorry.

5 Q. (BY MS. PARKS) It was, patient care requires
6 culture, patient care requires structure, participation
7 in multiple external reporting systems is essential to
8 hospital quality, and hospitals must constantly look for
9 ways to improve.

10 A. So it doesn't seem value-added for me to read
11 this whole document and try to rebucket it into that.
12 So I'll speak to the -- what I hope is the theme of your
13 question.

14 These, hopefully, are examples of how all four
15 of those buckets impact the ultimate work of the
16 quality. So if there's specific things that you wish to
17 pull out, let me know and give me some direction as --
18 so I can focus on that; otherwise, that's sort of a
19 vague task that you're assigning, which I think will
20 consume a lot of time. And I'm not sure if I could
21 yield you much benefit.

22 Q. Are there discussions in your report that
23 don't fall into those four buckets?

24 A. Are there discussions you've seen in my report
25 that don't -- that you want me to talk about?

1 Q. I just -- I'm trying to understand, as we've
2 talked about, is the perimeter of your opinions.

3 And, like, is it fair to say that all of your
4 opinions fall into those four buckets, or do you have
5 opinions in this case that do not fall into those four
6 buckets?

7 MS. BLAIR: Objection to form.

8 A. And, again, my apologies for my lack of
9 understanding of how you distinguish opinions. I am
10 here in particular to comment about my experiences in a
11 career, in an environment that uses quality metrics like
12 Leapfrog to build a structure for quality improvement.

13 I'm happy to answer any questions, which would
14 be my opinion, about any aspects of that, that I can
15 comment on.

16 Specific to the survey, which is what the
17 discussions here are, specific to my background and to
18 what I've documented, I'm having a hard time
19 understanding where to draw the perimeter more clearly
20 than that about what you wish me to comment on.

21 So if there's a particular piece that I
22 haven't commented on deeply enough, I'm happy to expound
23 on it. Please let me know. But I have a hard time
24 answering those free-form questions with limited
25 boundaries.

1 Q. (BY MS. PARKS) I don't think that my question
2 is particularly free-form.

3 I feel like you're refusing to tell me what
4 the scope of your opinions in this case are.

5 Do you understand that under the federal rules
6 you have to put all of the opinions on which you intend
7 to testify into this report?

8 A. No. I am not an expert on the federal rules,
9 so I can't say I can speak to understanding that.

10 I -- the scope of my opinion that I've been
11 asked to comment on is my experience as it relates to
12 working in an environment that is subject to the
13 Leapfrog survey. And I hope I'm doing that in an honest
14 and forthcoming way.

15 I have a hard time understanding what you're
16 asking about to define that scope any more specifically
17 than that.

18 I'm happy to do it, I just -- I genuinely
19 don't understand what -- where else you would like me to
20 go with that, so...

21 Q. Okay. So in the first paragraph on page 8,
22 you've -- in the last sentence of the first paragraph,
23 you write, "Knowing these truths, choosing a system that
24 holds safety and quality care as a public and constant
25 priority, is basic and necessary."

1 Do you see that?

2 A. Yes.

3 Q. When you refer to "choosing a system," who --
4 who are you referring to? Who is doing the choosing?

5 A. I was referring to me as the physician
6 consumer of the product of the hospital in which I do my
7 work and referencing the first two questions that the
8 work I do is complicated and relies on many individuals
9 across the spectrum of that work environment.

10 And so as an individual, I chose to work in a
11 healthcare system which makes the priority of quality in
12 that -- in all arenas highly visible, and highly public,
13 and highly relevant to the daily work, outside of, you
14 know -- compared to other facilities that I could have
15 worked at, which made profit a higher priority than
16 quality.

17 So I think that sentence comes from my
18 experience when I was job hunting, where people told me,
19 "You're here to make money for the hospital," versus the
20 hospital I chose to work at, which said, "You're here to
21 serve the patient."

22 So I hope that makes it clear.

23 Q. So in your experience, doctors make that
24 assessment based on word-of-mouth discussions with
25 other --

1 A. I don't know what other doctors do, but that
2 is -- that is what I did based on my experience.

3 Q. Okay. Did you consider any other sources of
4 information when you were choosing a system to work at?

5 A. I -- this is 20 years ago, and I'm sure I
6 chose -- I looked at many sources of information when I
7 chose the job I ultimately landed in and still am.

8 Q. Okay. So is it fair to say that you don't
9 have a view on how a physician would choose a system
10 today?

11 MS. BLAIR: Objection to form.

12 A. I think physicians and how they would choose
13 healthcare systems vary. And, again, I think that the
14 scope of what we were talking about here is my
15 experience. And this was trying to set some background
16 of how I chose to enter into this particular
17 environment.

18 So I can comment on my decisions, but I don't
19 know if I'm an expert on how physicians choose their
20 jobs globally.

21 Q. (BY MS. PARKS) So you can't say one way or
22 the other whether a doctor choosing a system today would
23 look at Leapfrog grades, for example?

24 MS. BLAIR: Objection to form.

25 A. I cannot.

1 Q. (BY MS. PARKS) Okay.

2 Okay. So in the next sentence, which is the
3 first sentence of the second paragraph, you write, "The
4 contribution of multiple doctors," and then you go on to
5 list other participants in the hospital environment.
6 And you write that these contributions "to the care of
7 every patient in every episode of care is critical."

8 Is it your opinion that each of these
9 individuals is critical in the care of each patient?

10 A. Yes. I believe that's what I stated.

11 Q. Okay. And do you have any data or evidence
12 that each of these individuals contributes to the care
13 of every patient?

14 A. Only my experience over the last two decades
15 of working in this healthcare system.

16 Q. And by "this healthcare system," you refer to
17 your experience at Virginia Mason?

18 A. Uh-huh.

19 Q. Okay. And what is your basis for saying that
20 these contributions are critical for other hospital
21 systems?

22 Or maybe you're not.

23 Is this paragraph supposed to be specific to
24 Virginia Mason?

25 A. Again, it's an explanation of my

1 interpretation of what the critical elements for a safe
2 environment for delivering hospital-based care are.

3 I have seen how these elements, and the
4 contribution of these individuals, lead to better care.
5 And I'm sharing that experience and opinion.

6 Q. Okay. And your experience and opinion would
7 be limited to your experiences at Virginia Mason; is
8 that right?

9 A. My experience would be limited to the
10 experiences I've had in my life, yes, and all my
11 interactions, and the work that I've done at Virginia
12 Mason, yes.

13 Q. Okay. So in the first sentence of the third
14 paragraph, you write, "Many healthcare systems
15 participate in multiple transparent external reporting
16 systems on quality."

17 What is your basis for saying that "many
18 healthcare systems participate in multiple external
19 reporting systems"?

20 A. By "many," I mean "more than three." And if
21 you look at the CMS website or the Leapfrog website,
22 there are many hospitals that they report on. So based
23 on those two data points, I say many healthcare systems
24 participate in multiple transparent external reporting
25 systems on quality.

1 Q. Okay. And the -- these external reporting
2 systems, you mentioned Leapfrog and CMS.

3 Would you also include Healthgrades in that
4 list?

5 A. Sure.

6 Q. Would you include U.S. News and World Report?

7 A. Yes.

8 Q. Would you include Newsweek?

9 A. I've seen healthcare reporting in Newsweek as
10 well, but I'm not as familiar with it.

11 Q. Okay. And would you include the reporting
12 that Virginia Mason does to CommonSpirit as an external
13 reporting system?

14 MS. BLAIR: Objection to form.

15 A. Each layer of a healthcare system has
16 different definitions of internal and external
17 reporting. So I would -- it would depend on which layer
18 you're talking to and who you were talking to about
19 that. But it is not publicly available if you're
20 referring to external as publicly available data.

21 Q. (BY MS. PARKS) Okay. And when you wrote
22 "external" here in your report, were you limiting
23 yourself to publicly reported data, or were you
24 considering situations like the reporting to
25 CommonSpirit?

1 A. I think in my next sentence I read, "these
2 include, government-based organizations such as the
3 Centers for Medicare and Medicaid Services, ('Quality,
4 Safety & Oversight Group'). Others are non-profit
5 organizations such as TLG" -- referencing the TLG
6 website -- "while many others are for profit companies
7 in the public information space for healthcare, such as
8 Healthgrades and U.S. News and World Report."

9 So I think I was talking about those things
10 that I wrote down.

11 Q. Okay. So the external reporting systems
12 referred to in the first sentence refer only to CMS,
13 Leapfrog, Healthgrades, and U.S. News and World Report?

14 A. I didn't use the word "only." I think I said
15 "include such as," so there was not a limiting to those
16 only.

17 Q. Okay.

18 A. So I'm sure there's others that I do not know
19 about and I have not referenced in my report.

20 Q. Okay. That's fine.

21 I guess, I just -- when you're using the
22 syntax "external reporting systems" in your report, are
23 you referring only to publicly reported data?

24 MS. BLAIR: Objection to form.

25 A. I guess I don't know to what extent systems

1 like SCOAP, the reference we made earlier, is publicly
2 reported versus just shared among the hospitals that
3 participate, so that -- and that's why I did not limit
4 myself to saying "these are -- this is the only sources
5 of truth, or information," because I -- I've seen enough
6 to know that there are many other things out there that
7 share data at different levels of transparency to the
8 participants and to the public and to regulatory bodies.

9 So you could draw that line of internal and
10 external in many different ways.

11 Q. (BY MS. PARKS) Okay. I think -- now I think
12 I see why this is tripping us up.

13 A. Okay.

14 Q. So to you, to be external, it has to be, like,
15 with something that's not -- like, with another
16 organization that you're not affiliated with, but it
17 doesn't necessarily need to be public?

18 A. Yes. So I would say having data through SCOAP
19 about all the spine surgery in the state of Washington
20 and comparing ourselves on a -- on a sliding scale to
21 those other organizations, although I wouldn't
22 necessarily -- I don't recall if SCOAP actually
23 identified them by name or by a neutralizing number, but
24 it would show us where on the performance scale we fit
25 in that spectrum of 50-some-odd hospitals.

1 And so that is a form of external reporting,
2 because our data is in there somewhere and another
3 hospital can see what we're doing. And so -- but we get
4 to compare ourselves and decide for ourselves how much
5 we want to be better in that arena of external
6 reporting.

7 And then the more public external reporting,
8 like CMS and TLG, are where everybody can see
9 everybody's grades. And it's a higher level of
10 transparency for that publicly consumable data.

11 So, yeah, that -- there are different buckets
12 of "external" as well.

13 Q. Okay. And do you personally think of the
14 reporting up to CommonSpirit as external reporting or
15 internal reporting?

16 A. I think it's internal to our system but
17 external to my hospital.

18 So I will use data from my hospital against
19 other CommonSpirit hospitals that are performing better
20 to question our teams on how we can improve our
21 performance, or vice versa if we're not performing on
22 average.

23 But it's -- the data is not -- since it's not
24 available to patients, that would not call it the --
25 like, the most transparent external data. I don't know

1 how we want -- if we want to put public-facing external
2 data in one bucket and system-facing external data in
3 another bucket.

4 But, yeah, there's different layers of this.

5 And I -- and there's reasons for that as well.

6 So the ability of people to interpret that
7 data varies depending on how much of a language they
8 have of that work. And so a lot of the internal
9 dashboards on quality that CommonSpirit uses may not be
10 translatable to a public measure that would mean
11 anything to a consuming patient. It may be more
12 specific to the operations of a hospital.

13 So, again, we're building this as we're
14 learning from it, so...

15 Q. Okay. And then at the -- I think it's the
16 same paragraph, yes -- at the very end of that same
17 paragraph, you write, "The degree of participation in
18 for profit and non-profit quality reporting systems is a
19 choice for and by leaders of healthcare systems."

20 Are you part of making this decision in your
21 healthcare system?

22 A. I don't know if I've ever sat on a committee
23 to discuss the participation in a reporting system. I
24 think our system has -- as a default, tries to
25 participate in as many as possible on a national scale

1 because that's culturally important to us. So --

2 Q. So is there --

3 A. -- no, I'm not part of the decision-making --
4 I don't even know if there is a decision-making
5 committee for that. I don't know if I've -- we have a
6 committee that says -- a committee to choose which
7 external reporting systems we are participating in. I
8 don't know that I've ever heard of that existing in our
9 system.

10 Q. Well, I admittedly know very little about how
11 this works, but if you are -- if your hospital wants to
12 go for, like, an accolade from U.S. News and World
13 Report, don't you need to kind of decide which one
14 you're going for and, like, provide the data that is
15 needed to get that award?

16 A. I don't know how U.S. News and World Report
17 gets its data. But a lot of these are -- your -- it's a
18 conglomeration of work.

19 So I'll give you the example of our local
20 magazine, Seattle Metropolitan magazine. It does its
21 own annual publication of top doctors and top lawyers.
22 It sends a survey to all the docs and lawyers in the
23 community, and it uses that data to judge performance.

24 Q. But at your hospital someone has to decide
25 whether or not to do that survey?

1 A. No. So that's just done.

2 Q. By whom?

3 A. By whoever runs the magazine and runs the
4 survey.

5 But the individuals who, in the community,
6 participate on checking the boxes -- so I'll get an
7 email, a personal email that says, "Hey, go through
8 these 56 specialties, and here are the list of names of
9 the specialists in your area, and pick three in each
10 group that you think are exceptional." And it coalesces
11 that data and shares that data publicly.

12 Q. Okay.

13 A. So, similarly, I'm sure there are systems that
14 coalesce data and share it publicly but without the
15 participation of the hospital. And then there are some
16 that the hospital has to do some active work for to
17 submit data.

18 Q. So let's go back to your SCOAP example.

19 When you started sharing your hospital's data
20 with SCOAP, did anyone need to give you permission to do
21 that?

22 A. That was a -- you needed to actually hire an
23 abstractor to abstract these specific data elements.
24 And that was an investment by the hospital leadership to
25 bring on the workforce to pull these specific elements

1 because they were very manual chart review work.

2 Q. Okay.

3 A. So, yes, somebody --

4 Q. And were you part of the leadership team that
5 made that decision?

6 A. No, I was not part of the leadership team that
7 made that decision.

8 Q. And was that, like, the executive leadership
9 team? Like, what was the name of the team that made
10 that decision?

11 A. I don't know.

12 Q. Okay.

13 A. That's a long time ago. I'm sure it rolled up
14 through the executive team at some point. But, yeah.
15 So -- but it was a -- it was a decision that -- will the
16 cost of participating add enough value for our patients
17 that it is worth spending this money here versus putting
18 new furniture in the lobby on the third floor; right.

19 So somebody made that decision. It wasn't me.

20 Q. Yeah.

21 And do hospitals have to do a similar
22 assessment for Leapfrog, deciding if the cost of
23 participating adds enough value for the patients?

24 A. I am sure that if they are thoughtful, they
25 should, yes.

1 Q. Okay. But you don't know who at your hospital
2 does that assessment?

3 A. I do not.

4 Q. It's not you?

5 A. Not me.

6 Q. Okay. If someone came to you with a new
7 survey, and your hospital was going to decide whether or
8 not to participate in it, what are the factors you would
9 tell them to consider?

10 A. Broadly, I think I would want to look at their
11 methodology, their ability or their history, their
12 acceptance within the community; who are the experts
13 they employ to build their methodology? What kind of
14 resources are required? What would be the impact of
15 that on fostering a culture of improvement within our
16 own system? And what would be important for building
17 the structure to collect that data with high fidelity so
18 we could honestly report on it?

19 Q. Okay. Can you think of any other factors?

20 A. Those are the majority, I think.

21 Q. Okay. So I think we were talking about this
22 on page 8. You talk about transparent external
23 reporting systems. And you kind of use this phrase
24 "transparent external reporting systems" a few times.

25 What do you mean by "transparent"? Like,

1 transparent as to whom?

2 A. Transparent as to, if I wanted to go and look
3 up hospital X and see what their results were, if the
4 Department of Health wanted to go look that up, or if
5 Premera Blue Cross wanted to go look that up, that they
6 would all have access to it.

7 Q. Okay. And that would be -- when you said
8 "look it up," that would be look up the reported data?

9 A. Yes.

10 Q. Okay.

11 A. Versus?

12 Q. Well, I mean -- so I guess you could be
13 transparent about -- well, most of these organizations,
14 like CMS, for example, they get data from the hospitals,
15 and then they process that data and come up with, like,
16 a star rating, let's say. And they also have sort of
17 the techniques and methodology they use to come up with
18 that star rating. So, you know, you could be
19 transparent as to all three of those things, or you
20 could only be transparent as to one or two.

21 And I'm just trying to understand which of
22 those is important to you.

23 MS. BLAIR: Objection to form.
24 Mischaracterizes CMS' data.

25 A. I would say all of it is important. I think,

1 as we talked about earlier, you have to have some trust
2 in the methods by which you are receiving the data and
3 know that it's viable data.

4 And I think how you do that best as an
5 organization who is reporting data is you share how
6 you're collecting that data, and how you're processing
7 it, and how you're reporting it so that when people ask,
8 "You're calling this bottle green," you can say, "Yes, I
9 called it green. Here's my color chart," and it matches
10 with the green. And so I know why you're choosing to
11 call this green and not blue, because it -- this is the
12 ruler I used.

13 So I would hope that all of those segments are
14 transparent and that that data is distilled in a way --
15 when you spoke earlier about the different audiences of,
16 you know -- I think a hospital executive would like to
17 see different pieces of that data dashboard than a
18 leader of an ICU unit, than a patient, than, you know,
19 an insurance company.

20 I think the bits and pieces of that data may
21 be differently relevant to these different individual
22 customers, but the essence that that data is reliable,
23 and if it is not reliable, at least -- if you know the
24 methodology, at least you know where the fault is in the
25 data.

1 Q. (BY MS. PARKS) Okay.

2 A. Gets you to the point of being able to, up or
3 down, regulate its relevance in your decision-making.

4 So I saw some guy run across the street in the
5 dark alley, I'm not going to trust that I know who that
6 guy was versus the person sitting in front of me in
7 broad daylight.

8 So -- and that's what a lot of this work has
9 been is, like, how do you -- how do you get that murky
10 data into the light so it makes sense and it's reliable
11 and high fidelity?

12 Q. Should hospitals only participate in
13 transparent reporting systems?

14 MS. BLAIR: Objection to form.

15 A. I have a hard time saying "only" to anything.
16 So I think there's probably arenas where completely
17 transparent reporting systems can't achieve what
18 different types of systems might.

19 So, yeah, I would have a hard time saying
20 "only" would be specific to the case.

21 Q. (BY MS. PARKS) Do you think that transparency
22 is a factor that hospitals should consider in whether or
23 not to participate in a reporting system?

24 A. Yes. I think that that is an important
25 factor.

1 Q. Okay. So on page 10, the first full sentence,
2 "It has shown that early and public disclosure of
3 medical errors has reduced liability for physicians in
4 health systems."

5 Are you referring to a particular study in
6 that sentence?

7 A. No. That's taught commonly in a lot of
8 courses that I've taken and people teach about medical
9 liability.

10 Q. Okay. So in your view, that's just common
11 knowledge among --

12 A. I think it is now. I don't think it was when
13 I started. People were afraid to tell the truth about
14 error. And I think that that's been another wonderful
15 culture shift.

16 Like, if something happens that you didn't
17 expect, you share that publicly, apologize for errors
18 that were made, and work together to try to prevent
19 those errors from happening again.

20 Q. And then you write, "Applying this ethos to
21 quality reporting is no different."

22 A. Yeah.

23 Q. Why -- do you have any documents or data that
24 you're relying on to say that you can take a strategy
25 that works for liability and apply it to quality

1 reporting?

2 A. Again, I think that comes from my experience
3 over the last 20 years living in this environment, that
4 if we don't measure, we can't improve.

5 Q. Okay. Is it based on anything else?

6 A. No.

7 Q. So in the paragraph that starts "Over the last
8 20 years" -- I think we already spoke about both of
9 these earlier in the day, but this paragraph appears to
10 talk about the surgical safety checklist.

11 A. Yes.

12 Q. And you write that you've seen much resistance
13 by individuals to a cultural shift -- to this cultural
14 shift from individual performance to team success.

15 Apart from this surgical safety checklist that
16 you describe in this paragraph, do you have any other
17 examples of individuals resisting this cultural shift?

18 A. I think they're -- in high-risk arenas, such
19 as surgery, much of the prior teaching, at least in my
20 generation of surgical education, was that it was the
21 work of the individual to single-handedly control the
22 environment for the best outcomes for the patient, which
23 is an honorable goal. The goal is to do the best for
24 your patient.

25 Healthcare and surgical education in

1 particular, at least through my experience and that of
2 my colleagues, was very much focused on the single
3 individual achieving that goal.

4 Over the last 20 years, I've seen that shift,
5 from an individual as the only driver of that success,
6 to teams working towards that mutual goal achieve much
7 better results. And the elements of that we've already
8 spoken about, which is sharing of data, a culture of
9 safety where everyone can speak up and contribute, and
10 good communication skills built on a structure such as
11 checklists, quality data reporting and review,
12 improvement committees. It kind of brings it all
13 together.

14 And that's been a pretty awesome cultural
15 shift to be a part of. Honestly, it takes the stress
16 off the individual surgeon.

17 Q. And at the very top of the page, there's a
18 sentence that sort of straddles the page. But you
19 basically advise that hospitals "do not resist bad
20 reports as a negative reflection of individuals or the
21 system."

22 So is it your view that a bad report about a
23 hospital is not a negative reflection of the hospital?

24 A. Culturally, if my patient didn't do well in
25 the previous culture that I spoke of, it was a bad

1 reflection of me as the individual doctor.

2 And what we've done within our system -- and I
3 hope healthcare is doing in general in the US -- is
4 turning that around. And it's not a defect within the
5 individual but an opportunity for improvement within the
6 system.

7 So what were the factors that led to that
8 individual making that decision that led to that
9 consequence, that negative consequence, or an infection,
10 bad surgical outcome, bad quality report, and so on and
11 so forth.

12 So the mind shift that a bad report reflects
13 poorly on someone or some entity to a mind shift that a
14 bad report only highlights an opportunity for us to get
15 better is quite a profound shift. And I think a lot of
16 us in healthcare have done that. Some of us still need
17 to do that.

18 Q. But does a bad report reflect an issue of
19 safety at a hospital?

20 MS. BLAIR: Objection to form.

21 A. So what specific report are you referring to,
22 to what specific safety concern at a hospital? Can you
23 give me an example so I can expound on that for you?

24 Q. (BY MS. PARKS) So why don't we talk about,
25 like, CMS star ratings.

1 If a hospital has a one- or two-star rating,
2 shouldn't that be taken as a negative reflection of the
3 hospital?

4 A. So you can use the words "negative reflection"
5 or you can use the words as "opportunity for
6 improvement," so --

7 Q. But if I'm a patient, like, I can't help the
8 hospital improve. Or shouldn't the patient interpret
9 that as a negative reflection of the hospital?

10 MS. BLAIR: Objection to form.

11 A. It is a piece of data that the patient may
12 use, along with a much broader scale of what their
13 funding is, where they live, what other resources are
14 available, to make a decision about their opinion of
15 that hospital or whether they choose to seek care at
16 that hospital. So it is an additional piece of
17 information.

18 Where it becomes relevant is what -- the
19 people who can make a change to get that star rating up
20 from two stars to three stars. If that star rating is
21 available, that -- that is a point for which a
22 discussion can start on, "Why is that at two stars? And
23 how can we bring it to three stars?"

24 So that's -- the paradigm shift is using these
25 reports and these data as a starting point for doing

1 better, not as a punishment for being bad.

2 Q. (BY MS. PARKS) But if getting a bad star
3 rating is not a negative reflection of the hospital, why
4 should the hospital try to improve that bad report?

5 A. Would you like to rephrase your question?

6 Q. That's okay.

7 MS. BLAIR: Or just answer it.

8 Q. (BY MS. PARKS) It wasn't a very good
9 question.

10 MS. BLAIR: I'd like the answer.

11 Q. (BY MS. PARKS) So earlier you said that,
12 like, a CMS star rating is a piece of data that the
13 patient can use, along with other information in
14 choosing where to seek care.

15 Would you say the same of a Leapfrog grade?
16 Is that a piece of information that the patient should
17 use?

18 A. Yes.

19 I'll stop nodding.

20 Q. Okay. So let's go to Section 6, "Operational
21 Quality Leadership Experience and Impact."

22 Okay. So -- and I apologize, but this
23 paragraph refers to QAPI.

24 Is that -- do you say it like that, QAPI, or
25 do you say QAPI?

1 A. QAPI.

2 Q. QAPI, okay. All right.

3 A. There's no U in it, but QAPI sounds funny.

4 Q. Yeah.

5 Okay. So does CMS require hospitals to
6 implement QAPI programs?

7 A. Yes, I believe they do.

8 Q. Okay. And what is the basis for you believing
9 that? Is it based on -- like, have you implemented a
10 QAPI program because of a CMS requirement, or can you
11 speak to that?

12 A. Yes. I couldn't speak to the specific, but I
13 believe it's on the CMS website. It says if the
14 hospital wants to get paid by Medicare, they must meet
15 these quality criteria, one of them being having a QAPI
16 in place, which is a document and a structure for how
17 they assess and respond to quality.

18 Q. Okay. And then you have a quote here from the
19 CMS website, I think.

20 Is that the CMS website you're thinking of
21 here --

22 A. Yes.

23 Q. -- that requires hospitals --

24 A. Yes.

25 Q. Okay. Sorry. We kind of spoke over each

1 other.

2 So this CMS website that you're quoting here
3 on pages 10 and 11, that's -- that's the CMS website
4 that sets out what a hospital must do to implement QAPI?

5 A. Correct.

6 Q. Okay. And then in the next paragraph, you
7 write, "For members of the quality leadership team at a
8 hospital, this is their focus."

9 And when you write "this is your -- this is
10 their focus," are you referring to following CMS's QAPI
11 mandate or something else?

12 A. I think that the definition is very telling.
13 Again, the application of two mutually reinforcing
14 aspects of a quality management system, quality
15 assurance and performance improvement. So the quality
16 assurance would be the systematic comprehensive
17 data-driven approach. And then the performance
18 improvement is the improving safety and quality.

19 So the -- yes, I like the way the CMS has
20 chosen to state that, and I agree with it.

21 Q. Okay. And then on page 14, where you have
22 your list of materials considered -- or works cited -- I
23 apologize for misquoting that -- Item 2, is that the
24 QAPI website that you reviewed --

25 A. Yes.

1 Q. -- to prepare this report?

2 A. Yes.

3 Q. Okay. And then on page 8, I think that also
4 appears as Item B9.

5 Do you see that?

6 A. Correct.

7 Q. Okay.

8 MS. PARKS: And I apologize. These are not
9 stapled because I didn't have a stapler this morning.

10 THE WITNESS: That's okay.

11 MS. BLAIR: We'll deal.

12 Thanks. But is it all -- is it two different
13 ones?

14 MS. PARKS: It's going to be two different
15 ones.

16 MS. BLAIR: Okay.

17 MS. PARKS: So the one on the top is going to
18 be 4.

19 MS. BLAIR: Got it.

20 (Exhibit Numbers 3 & 4 marked for
21 identification.)

22 Q. (BY MS. PARKS) Okay. So, Dr. Farrokhi, I'm
23 handing you Exhibits 3 and 4.

24 MS. BLAIR: Oh, 3 and 4?

25 MS. PARKS: Yes. This one is 3.

1 MS. BLAIR: I had this one as 5.

2 MS. PARKS: I'm sorry about that.

3 MS. BLAIR: No, no.

4 Q. (BY MS. PARKS) Okay. So let's look at --
5 maybe I numbered these in the wrong order. Why don't we
6 look at 4 first.

7 Okay. So this is the download that is
8 available when you go to the link that you have in your
9 report.

10 A. Uh-huh -- yes.

11 Q. And I didn't -- I couldn't find the quote from
12 your report on this page, but I did find it on a page
13 that links to this page, so I think we can look at that
14 next.

15 So why don't -- actually, why don't we just
16 look at Exhibit 3. Sorry.

17 So if you turn to Exhibit 3, if you look at
18 the second page, you see it says "Five elements"?

19 A. Uh-huh -- yes.

20 Q. And it says, "Click here for PDF"?

21 A. Yes.

22 Q. I'll represent to you that this PDF that you
23 cite in your report is what pops up when you say, "Click
24 here for PDF" right there.

25 A. Okay.

1 Q. So --

2 MS. BLAIR: Can we just read into the record
3 what that "five elements" paragraph says?

4 MS. PARKS: I'm sorry.

5 MS. BLAIR: It's for -- it looks like it's for
6 nursing homes; right. So I just want to make sure
7 that's in the record, unless I'm not looking at the
8 right thing.

9 MS. PARKS: Well, that's where I'm getting at
10 this.

11 MS. BLAIR: Oh, okay. I'm sorry.

12 MS. PARKS: Because Dr. Farrokhi includes a
13 quote from Exhibit 3 in his report, but he appears to,
14 basically, ellipsis out the part about nursing homes.

15 So I just want to understand if that QAPI
16 document -- or this QAPI program, the CMS program, truly
17 does apply to hospitals.

18 Q. (BY MS. PARKS) So why don't we look at that
19 together, Dr. Farrokhi.

20 So where was that quote?

21 So -- yes, so between pages 10 to 11, starting
22 with the "coordinated application," do you see that that
23 also appears right at the beginning of Exhibit 3?

24 A. Yes.

25 Q. Okay. So can you read for me the first

1 paragraph of Exhibit 3?

2 Just read it out loud into the record for me,
3 please.

4 A. After "QAPI Description"?

5 Q. Yes, exactly.

6 A. Sure.

7 "QAPI is the coordinated application of two
8 mutually-reinforcing aspects of quality management
9 System: Quality Assurance and Performance Improvement.
10 QAPI takes a systematic, comprehensive, and data-driven
11 approach to maintaining and improving safety and quality
12 in nursing homes while involving all nursing home
13 caregivers in practical and creative problem solving."

14 Q. Okay. So would you agree with me that this
15 quote from Exhibit 3 is -- includes language that
16 appears in your report on pages 10 to 11?

17 A. Yes. I believe I cut and pasted that
18 definition of QAPI from that.

19 Q. Okay. And can you tell me why you used the
20 definition of QAPI about nursing homes in your report?

21 A. I think I looked up "QAPI" and "CMS," and that
22 was the most comprehensive definition that I found.

23 Q. Okay. And do you cite any documents
24 explaining that this QAPI definition applicable to
25 nursing homes is also applicable to hospitals?

1 A. I don't know if I cited anything specifically.
2 And I don't know where I would point to that on the CMS
3 website.

4 It's a rather extensive website, if you've
5 ever looked through it. It's pretty complicated, as
6 most government things are.

7 Q. Okay. And so when you said that if a hospital
8 wants to get paid by Medicare, they have to implement
9 QAPI, did you have any basis for saying that, other than
10 this website that we're looking at together in
11 Exhibit 3?

12 MS. BLAIR: Objection to form.

13 A. So my basis is that we -- the regulatory
14 members of our quality teams share with us every year
15 that we have to update our QAPI program documentation as
16 part of the requirements of a CMS survey. CMS comes and
17 surveys hospitals, and this is a document they wish to
18 access and make sure that it's been reviewed and updated
19 by the quality leadership every year.

20 In the absence of having a QAPI document on
21 file in the hospital that has been recently reviewed and
22 updated and meets all the criteria, I am told by my
23 regulatory bodies that -- or employees that there is a
24 risk of us losing payment from CMS for our Medicare and
25 Medicaid patient population.

1 So that statement comes from those elements,
2 in my experience.

3 Q. (BY MS. PARKS) And in terms of this
4 particular definition of QAPI that you quote on pages 10
5 to 11, can you say with certainty that that's the
6 definition that applied to the QAPI requirements for
7 hospitals?

8 A. No. I don't have that document in front of
9 me.

10 Q. Okay. And you also don't cite that document
11 in your report; correct?

12 A. Correct.

13 Q. Okay. So sitting here today, you're not able
14 to say what the QAPI requirements are for hospitals;
15 right?

16 A. I am not.

17 MS. BLAIR: Objection to form.

18 Q. (BY MS. PARKS) Okay. The -- I guess the
19 second full paragraph that starts "As Chair of the
20 Quality Council," about halfway down that paragraph, you
21 write, "This requires members to be educated on how
22 quality measurement works, how improvement science can
23 be applied, and how to interpret the results of this
24 work."

25 And the members you're referring to here,

1 these would be hospital staff and doctors?

2 A. Correct.

3 Q. Okay. How are hospital staff and doctors
4 educated at Virginia Mason?

5 A. It's a pretty extensive quality education
6 process, from orientation courses in quality and our
7 quality improvement mechanisms to many of the mandatory
8 annual elements that we have to do.

9 I'm sure -- I don't know if in the legal world
10 it applies. But in the healthcare world, you have to do
11 these modules every year, and those modules are updated.
12 And some of them are meeting regulatory needs that you
13 have taught all your employees to not roll the
14 wheelchair into the MRI machine because of MRI safety,
15 some about washing your hands, some about infection
16 prevention.

17 So there's the introductory quality education,
18 the ongoing quality education, to all staff, variable by
19 your degree of medical licensure.

20 And then of the subset of leaders that come to
21 the quality committee, we have a quality primer that
22 educates them on how to focus their thoughts and
23 experience from their world into the quality committee
24 participation so that they can, in a more relevant way,
25 judge the presentations that they're receiving and

1 question them from their perspectives so we get the
2 input of all the various parts of a healthcare system on
3 every quality metric that's being represented and
4 discussed.

5 Q. Do you have any information about whether the
6 five plaintiff hospitals implement any of the education
7 techniques you just described?

8 A. I do not.

9 Q. And you can't say one way or the other whether
10 their education is more or less robust than what you
11 just described?

12 A. I cannot.

13 Q. Okay. So earlier when we were talking about
14 transparency -- and I'm going to paraphrase you a little
15 bit -- but I think you told -- you were using the bottle
16 as an example and you said, basically, that you should
17 be able to audit how hospitals are able to, like,
18 collect and assess their data; is that right?

19 A. Yes.

20 Q. Okay. So if you're in -- let's take the
21 hand-washing KPI, I think, we've been talking about.

22 A. Correct.

23 Q. And I think that you said you -- does your
24 hospital use the, like, observation technique?

25 A. It does. It does.

1 Q. Does it also use the gel volume technique?

2 A. I do not believe we're doing that currently.

3 Q. Okay. So in the observation technique, how
4 would you -- how would you audit that KPI?

5 A. Again, the auditors are in the infection
6 prevention team. But from my understanding of how they
7 audit that, it is assigned to certain employees within
8 each unit to do a certain number of employee --
9 observations per unit time, and then they
10 cross-reference those observations with other employees
11 doing observations in those areas to get internal
12 consistency, and they have to accumulate a certain
13 number, and then they report that number out.

14 Not easy, not perfect, but the best we could
15 come up with in the current environment.

16 Q. And does your hospital preserve the reports
17 that they create based on observing the hand washing?

18 A. I couldn't speak to that directly. I don't
19 have that data set.

20 Q. Okay. And how frequently do you perform these
21 audits on hand washing?

22 A. I don't have that exact number. There's a
23 cadence that meets our external reporting quality
24 metrics. And the quality teams who are tasked with that
25 KPI, if it's off target, may increase their cadence and

1 simultaneously have interventions in place, such as
2 signage, education, counseling, and other improvement
3 projects.

4 During that time, they usually increase the
5 cadence until the quality performance indicator reaches
6 a level of acceptable. And if it maintains it for a
7 certain time, then they go -- in a general sense, they
8 go from daily to weekly. If it maintains on a weekly
9 basis after a certain number of weeks, they'll go
10 monthly. If it maintains a monthly, they'll go
11 quarterly, and so on, so that we don't burn resources on
12 problems that have already achieved successful
13 solutions.

14 Q. And is auditing important to ensuring the data
15 is reliable?

16 A. It's the best form of reliability we have
17 available right now.

18 Q. Okay. Do you know whether or not Leapfrog
19 audits data that's reported in the hospital survey?

20 A. I do not know their audit mechanisms, no.

21 Q. Do you know if they have an audit mechanism?

22 A. I do not.

23 Q. Okay. Do -- would you expect that they have
24 an audit mechanism to ensure the data they're receiving
25 is reliable?

1 A. I expect that they have some sort of data
2 validation methodology. Again, outside of my scope to
3 know the specifics of it, yeah.

4 Q. Okay. And then, just to confirm, you don't --
5 do you know whether any of the Virginia Mason hospitals
6 have been audited by Leapfrog?

7 A. I do not know.

8 Q. Okay.

9 Okay. Do you have any experience with
10 hospital marketing?

11 A. Only as much as they made me sit in front of a
12 camera and answer some questions and put it on the
13 website.

14 Q. So you would not consider yourself an expert
15 in hospital marketing?

16 A. Not at all.

17 Q. And do you have any experience with consumer
18 behavior?

19 A. Again, only in my teenagers' sugary snacks.

20 Q. So you would not consider yourself an expert
21 in consumer behavior?

22 A. Not at all.

23 Q. And so would you agree that you don't have the
24 expertise to assess whether patients understand
25 Leapfrog's public disclosures?

1 A. Correct. I could not comment on that.

2 Q. And I understand this is outside of the scope
3 of your expert opinions, but do you have any personal
4 understanding of how Leapfrog assigns grades to
5 hospitals that don't participate in the hospital survey?

6 A. In general, my understanding is that there is
7 a bucket of publicly available data that is used and a
8 bucket of voluntary data that has to be submitted that
9 takes time and effort. And those hospitals that do not
10 supply the voluntary data are assigned a score for those
11 elements based on a formula that I'm not an expert on,
12 and that some methodology experts have helped them come
13 up with that formula.

14 Q. Okay. And you don't know what that
15 methodology is, you just know it exists?

16 A. Too much math.

17 Q. Okay. So I just want to make sure I quote you
18 properly.

19 You referred to the time and effort to gather
20 the voluntary data for Leapfrog.

21 Do you recall that?

22 A. Yes.

23 Q. Does your hospital have a budget applicable to
24 completing the Leapfrog survey?

25 A. I don't know, since I do not control the

1 budgets.

2 Q. Do you know who within your hospital is
3 responsible for completing the survey?

4 A. I don't think it's a single individual. I
5 think it's -- the work is distributed among the quality
6 team based on which segments apply to their specific
7 work.

8 Q. How many individuals are on the quality team
9 at your hospital?

10 A. That structure has changed as we've become a
11 part of VMFH and CommonSpirit, so I don't have the
12 answer.

13 Q. How many individuals was it before?

14 A. I couldn't even tell you. The integration of
15 quality within our health system was so ubiquitous at
16 all levels that you didn't necessarily just have a
17 quality person or a quality department, you sort of
18 distributed the work. Just as 10 percent of my work is
19 quality, as we said, probably twice or triple that if
20 you actually measure it, that work was distributed among
21 formally recognized and informal members of the team who
22 contributed to the quality work.

23 So as an example, our department of
24 neurosurgery director would lead the QAPI meetings for
25 neurosciences on a weekly basis. But she did not have a

1 title as the quality leader for neurosciences. But she
2 did the work of bringing all the team members together
3 and doing that quality work.

4 Some of that data fed up into many of the
5 reporting -- reports that we had to generate to external
6 reporting agencies.

7 So it's distributed work. It's not one
8 person's task.

9 Q. Are you able to estimate how many individuals
10 are involved in collecting and reporting the data for
11 the Leapfrog survey?

12 A. No. I don't think I could, no.

13 Q. Do you expect it would be a large number of
14 individuals?

15 A. I think it's a little bit of work for a large
16 number of individuals. But when it's incorporated into
17 a quality culture and a quality structure, everybody has
18 a small piece of it, so it's hard to -- hard to measure
19 exactly.

20 Q. Have you personally been involved in providing
21 data to respond to a Leapfrog survey?

22 A. I don't believe I have, no.

23 Q. Have you ever seen the Leapfrog survey?

24 A. Yes.

25 Q. Have you ever been involved in, like,

1 completing the Leapfrog survey, like actually filling it
2 out?

3 A. No.

4 Q. Okay. Has anyone ever come to you with a
5 question about the Leapfrog survey?

6 A. Yes.

7 Q. Has anyone ever come to you with a question
8 about how to answer a question on the Leapfrog survey?

9 A. No. So the earliest experiences, when I
10 learned about Leapfrog 15 years ago, was when -- as the
11 various members of the team were filling out the
12 different buckets and they would need clarification
13 about a definition relative to neurosurgery, they would
14 come to me and say, "What is this -- does this operation
15 qualify in this reporting in this bucket for
16 neurosurgery? And like, this is what the term
17 requests." And they would come to the clinicians for
18 clarifications about clinical definitions.

19 Q. And then on -- looking at page 8 of your
20 report again, where you're listing the materials you
21 reviewed for your report, Items 6 and 7 are the Leapfrog
22 hospital survey and the Leapfrog ambulatory surgery
23 center survey.

24 Do you see that?

25 A. Yes.

1 Q. Do you recall -- or taking a step back.

2 The Leapfrog hospital survey changes from year
3 to year; right?

4 MS. BLAIR: Objection to form.

5 A. Yes. I believe that they update the sections
6 as they get more information or change their
7 methodology.

8 Q. (BY MS. PARKS) Which version of the Leapfrog
9 hospital survey did you review for your report?

10 A. I couldn't tell you. I do not look at the
11 version item.

12 Q. Okay. And do you know which version of the
13 Leapfrog ambulatory surgery center survey you reviewed?

14 A. I do not.

15 Q. What is the relevance, if any, of the Leapfrog
16 ambulatory surgery center survey to the opinions in your
17 report?

18 A. Only that it was part of the question, and I
19 know Leapfrog surveys ambulatory surgery centers. They
20 have a document that equally spells out hundreds of
21 pages of detail about how they measure what they
22 measure, and hence, it's included there as a reference.

23 Q. Does your hospital system include any
24 ambulatory surgery centers?

25 A. We have ambulatory surgery centers, yes.

1 Q. And do you have visibility into the quality
2 systems of those centers?

3 A. At various times, the ambulatory surgery
4 quality has fed through our quality council. At this
5 point, they've restructured it to feed through a
6 different quality metric that I don't see.

7 Q. Would you consider yourself to be an expert in
8 quality systems for ambulatory surgery centers?

9 A. No.

10 Q. Do you rely on the Leapfrog ambulatory surgery
11 center survey for any of the opinions in your report?

12 A. I do not.

13 Q. Okay. Is there a person at your hospital who
14 is responsible for -- I'm searching for the right word.
15 Strike that.

16 Is there a person at your hospital who's
17 responsible for shepherding your hospital through the
18 Leapfrog survey process, like a project manager, someone
19 who coordinates all of the teams?

20 A. I think the work is distributed among various
21 members of the quality group. I don't think it's
22 assigned to one individual.

23 Q. Okay. And do you know the names of any
24 individuals who work on the Leapfrog survey in your
25 quality group?

1 MS. BLAIR: Objection to form. Asked and
2 answered.

3 A. Again, I know the names of many individuals in
4 my quality group; which of them fills out which portions
5 of the survey, I do not know.

6 Q. (BY MS. PARKS) Okay. And does -- responding
7 to the Leapfrog survey, does that take place at the
8 hospital level or at the VMFH system level?

9 A. That's a good question. I don't know how they
10 restructured that these days. I do not know.

11 Q. Okay. Do you know how many hours your
12 hospital spends to respond to the Leapfrog hospital
13 survey?

14 A. I do not.

15 Q. And do you know how much money your hospital
16 spends to respond to the Leapfrog hospital survey?

17 A. I do not.

18 Q. Do you have any basis to say whether
19 responding to the Leapfrog hospital survey is burdensome
20 or not for hospitals?

21 A. I have no basis to judge the level of burden.

22 Q. Are you aware that VMFH participates in pilots
23 of the Leapfrog hospital survey and provides feedback on
24 survey questions?

25 MS. BLAIR: Objection to form.

1 A. I am not aware of the details of any of those
2 pilots.

3 Q. (BY MS. PARKS) Have you heard about the
4 pilots before?

5 MS. BLAIR: Objection to form.

6 A. I've heard about them in general, not relevant
7 to -- not relative to VMFH or the work.

8 Q. (BY MS. PARKS) So to make sure I understand,
9 you know that Leapfrog does pilot the survey, but you
10 don't know whether VMFH participates?

11 MS. BLAIR: Objection to form.

12 A. In discussions about Leapfrog and their
13 surveys, I have heard that they often -- or sometimes do
14 pilots to test to see if collection of certain data
15 elements is feasible, and what its fidelity is, and what
16 its utility is. It's like test-driving new tires on
17 your car.

18 So -- but I don't know of any VMFH
19 participation in those pilots, at least none that I've
20 been involved in.

21 Q. (BY MS. PARKS) Do you know an individual
22 named Dana Kahn?

23 A. Yes. I worked with Dana Kahn for many years.
24 She was director of quality at Virginia Mason Medical
25 Center for a while and then at VMFH for a while.

1 Q. Okay. Is she still with VMFH?

2 A. No. I think she went back home near her
3 family. Wisconsin, maybe. Maybe Chicago.

4 Q. Have you ever spoken to anyone about whether
5 VMFH should participate in a pilot of the Leapfrog
6 survey?

7 A. No.

8 Q. Do you know who Gary Kaplan is?

9 A. Yes.

10 Q. Who is Gary Kaplan?

11 A. He was the previous CEO of Virginia Mason
12 Medical Center. Now sits on the board of CommonSpirit,
13 I believe.

14 Q. Do you know if -- is it Mr. Kaplan or
15 Dr. Kaplan?

16 A. Doctor. He was a primary care doctor.

17 Q. Do you know if Dr. Kaplan has any influence
18 over whether the VMFH hospitals participate in --
19 participate in Leapfrog?

20 A. Don't know the scope of his work as a member
21 of the board right now.

22 Q. Did you have personal interactions -- or do
23 you have personal interactions with Dr. Kaplan?

24 A. Yes.

25 Q. Did Dr. Kaplan ever discuss Leapfrog in your

1 presence?

2 A. Again, on -- in probably multiple meetings
3 where he announced our participation, our scoring, at
4 IHI meetings. So it was, again, very much a part of
5 quality improvement work, and as much as CMS, IHI, VMPS
6 and all the other -- he was very quality focused.

7 Q. Are you aware that Dr. Kaplan has a leadership
8 role at Leapfrog?

9 MS. BLAIR: Objection to form.

10 A. I do not know what his participation with
11 Leapfrog is.

12 Q. (BY MS. PARKS) Do you -- are you aware
13 whether or not Dr. Kaplan has participation with
14 Leapfrog?

15 A. Again, I'm unaware of what his relationship
16 with Leapfrog is.

17 Q. But are you aware or unaware of there being a
18 relationship between Dr. Kaplan and Leapfrog?

19 A. Unaware.

20 Q. Sorry. Just trying to be precise. It's very
21 annoying.

22 Okay. Do you know if representatives of
23 Virginia Mason -- sorry, I'm going to go back to VMFH.

24 Do you -- are you aware if representatives
25 from VMFH attend events given by Leapfrog?

1 A. I am not.

2 Q. Do you know if VMFH expends resources
3 attending meetings hosted by Leapfrog?

4 A. I am unaware.

5 Q. Would it surprise you to learn that VMFH
6 expends money to attend meetings hosted by Leapfrog?

7 MS. BLAIR: Objection to form.

8 A. Surprise is not an emotion that I am often
9 faced with in my professional life.

10 Q. (BY MS. PARKS) Okay. So you're not surprised
11 if representatives of VMFH attend Leapfrog events?

12 MS. BLAIR: Objection to form.

13 A. Yeah, again, I don't have any knowledge. I've
14 not attended or have not heard of any Leapfrog events,
15 so I can't comment on any of this.

16 Q. (BY MS. PARKS) Do you know if your hospital
17 pays any money to Leapfrog for anything?

18 A. I do not know.

19 Q. Do you know if VMFH pays any money to Leapfrog
20 for anything?

21 A. I do not know.

22 Q. Do you know if CommonSpirit pays any money to
23 Leapfrog for anything?

24 A. I do not know.

25 Q. Do you know whether any of the VMFH hospitals

1 ever provide support to other hospitals to help them
2 respond to the Leapfrog survey?

3 MS. BLAIR: Objection to form.

4 A. I don't have knowledge of that -- VMFH
5 hospitals participating. But there's a group called the
6 Virginia Mason Institute, which is a separate entity,
7 that is a consulting group for whom I have given
8 educational lectures for. They help other hospitals,
9 like the one I mentioned, improve their quality systems.
10 I don't know if I've ever heard them doing anything
11 specific for Leapfrog. Most of their work is culture
12 and structure.

13 Q. (BY MS. PARKS) Okay. So just to make sure I
14 understand, you're not aware of any instances where a
15 VMFH hospital provided support to another hospital to
16 help them complete the Leapfrog survey?

17 A. Correct.

18 Q. Okay. Are you aware that hospitals can pay to
19 license their Leapfrog safety grades?

20 A. No.

21 Q. So do you know one way or the other whether
22 your hospital licenses its Leapfrog safety grade?

23 A. No.

24 Q. Have you ever seen any press releases or
25 advertisements from your hospital that talk about the

1 Leapfrog safety grade?

2 A. Yes. Everyone's very proud of that.

3 Q. Okay. So what have you seen in terms of press
4 releases and advertisements?

5 A. That Virginia Mason got a good Leapfrog grade.

6 Q. Okay. My question was bad.

7 Have you seen both press releases and
8 advertisements or just one of those two?

9 A. What's the difference? I don't know if I
10 have --

11 Q. Okay.

12 A. -- the parlance to know the difference between
13 a press release and an advertisement.

14 Q. Okay. So have you seen, like, news reports
15 put out by the hospitals about their Leapfrog safety
16 grades?

17 A. So let me share what I see so then you can put
18 it into the bucket you wish.

19 Q. Okay.

20 A. There are internal emails that are sent that
21 says, "Hey, good job VM. You got an A on Leapfrog," or
22 "You got five stars on CMS," or you got this accolade or
23 that accolade. These are a constant barrage that come
24 to us.

25 There are posts on LinkedIn that says, "Hey,

1 good job. You scored this. You got the award for being
2 the best transplant or cardiac."

3 So in those contexts, we see that information
4 all the time. How those are generated, whether there's
5 money exchanged for them, whether there's licensing, I'm
6 completely blind to that part of the world.

7 So I see it as much as a consumer as you would
8 and as an employee of the system for internal emails
9 that share these successes.

10 Q. Okay. Have you ever seen any, like,
11 billboards or print advertisements or brochures
12 discussing the Leapfrog safety grades of your hospitals?

13 A. I cannot recall.

14 Q. If I walk into one of your hospitals, could I
15 see, like, a banner discussing your Leapfrog safety
16 grade?

17 A. Maybe.

18 Q. You're not sure?

19 A. There's a lot of banners.

20 So, yes, when the hospital scores well on any
21 of these externally reported metrics, it is common for
22 our hospital, and many others, to advertise their
23 success in getting good grades and having a high-quality
24 system.

25 So I am certain that our hospitals are not

1 hiding their successes.

2 Q. Do you have an understanding of why your
3 hospitals advertise their successes in getting good
4 Leapfrog grades?

5 MS. BLAIR: Objection to form. Lacks
6 foundation.

7 A. Not in a professional regard, but I think
8 everybody likes a gold star.

9 Q. (BY MS. PARKS) Okay. So let's just turn to
10 the last section of your report. Starts on page 12.
11 The heading is "Why Participation Matters."

12 A. Okay.

13 Q. Okay. So in the first paragraph, you refer to
14 the fact that "new techniques and technologies are
15 infiltrating the place," I think is what you meant to
16 write there; is that right?

17 A. Yes.

18 Q. Okay. And then you write in the last sentence
19 that "each of these additions introduces another point
20 of possible error."

21 Do you see that?

22 A. Yes.

23 Q. So are you saying that healthcare delivery is
24 becoming more error prone with time?

25 MS. BLAIR: Objection to form.

1 A. I don't have data to make that assessment. I
2 extrapolate from the fact that as you make any system
3 more complicated, the probability of error increases.

4 Q. (BY MS. PARKS) Okay. And then in the next
5 paragraph you write, "Industries focused on measuring
6 and improving the outcomes of healthcare delivery are
7 required, now more than ever, to keep patients safe."

8 Why do you say they're "required, now more
9 than ever"?

10 A. Because of the previous paragraph suggesting
11 that as they become more complex, they are less safe.

12 Q. Okay.

13 A. As the car goes faster, you need better air
14 bags.

15 Q. Okay. And just to make sure I understand, you
16 don't have any data to confirm that the complexity is
17 leading to additional medical errors; is that right?

18 A. I do not.

19 Q. Okay. And then you write, "TLG and others
20 must continue their work of bringing the healthcare
21 industry together," and you go on.

22 When you wrote "TLG and others," what others
23 were you thinking of?

24 A. Healthgrades, CMS, any other organizations
25 that will take on the challenge of transparently

1 translating the quality of healthcare to payors, the
2 public, regulators, and each other, so that we can work
3 together to make it better.

4 THE VIDEOGRAPHER: Counsel, I'm wondering if
5 we can go off the record for a short moment.

6 MS. PARKS: Sure.

7 THE VIDEOGRAPHER: Thank you.

8 We are going off the record at 3:20.

9 (Brief break taken.)

10 THE VIDEOGRAPHER: We are back on the record.
11 The time is 3:22.

12 Please proceed.

13 Q. (BY MS. PARKS) Okay. So on page 13, in the
14 first full paragraph, you write, "The Leapfrog Group
15 Grade offers an easily visible and transparent
16 representation of the complex quality and safety
17 evaluation system that exists in the US healthcare
18 today."

19 Sorry, I think I added an extra "the" there,
20 but you get the gist.

21 A. Yes.

22 Q. So is this an opinion you're offering about
23 the safety grade, or is this about the survey?

24 A. I think the participation in this survey leads
25 to an externally reported data set, which includes all

1 the details that are publicly reported in the grade. I
2 think that whole system is what is necessary and leads
3 to better healthcare.

4 Q. And is it your opinion that The Leapfrog Group
5 grade itself is easily visible?

6 A. I think one can easily look up a grade for a
7 hospital for that grade, for -- on Leapfrog's safety
8 grade system. Again, yes.

9 Q. And are you speaking as an expert when you say
10 "one can easily look up a Leapfrog safety grade," or are
11 you speaking based on personal?

12 A. I'm speaking as a consumer who has seen safety
13 grades for hospitals on the internet.

14 Q. Okay. So is it within the scope of your
15 opinions in this case to opine on whether the Leapfrog
16 grade is easily visible to consumers?

17 A. No, because -- and I don't know what "easily
18 visible" means from a consumer visibility standpoint.

19 Q. Okay. And is it within the scope of your
20 opinions in this case to opine on whether the Leapfrog
21 grade is easily visible to hospitals?

22 A. No, it is not.

23 Q. Okay. And is it within the scope of your
24 opinions in this case to opine on whether the Leapfrog
25 grade is a transparent representation of anything?

1 A. That's a vague question.

2 MS. BLAIR: Objection to form.

3 A. Anything? Transparent?

4 Q. (BY MS. PARKS) Well, I could read the whole
5 sentence.

6 But are you offering an opinion in this case
7 that The Leapfrog Group grade is a transparent
8 representation of the complex quality and safety
9 evaluation system that exists in US healthcare today?

10 A. Yes. I think the Leapfrog grade represents or
11 gives information to the consuming public about a very
12 complicated healthcare structure that we've been
13 discussing all day.

14 You lost your favorite pen.

15 MS. BLAIR: Yeah.

16 A. And -- so any further details about the
17 quantification or the availability rely -- and
18 accessibility of that grade, I can't really comment on.

19 But yes, in general, I think Leapfrog grades,
20 CMS grades being out there available to the public are
21 useful and they help healthcare systems improve the
22 quality of their work.

23 Q. (BY MS. PARKS) Okay. So was -- were you
24 being accurate when you told me earlier today that you
25 didn't have any opinions about the Leapfrog safety

1 grade?

2 A. So I don't understand your question.

3 Q. Your counsel represented to me multiple times
4 today that you don't have any opinions on the Leapfrog
5 safety grade, and I believe you also confirmed that in
6 your testimony earlier today, but now you're telling me
7 that it's your opinion that the Leapfrog grade
8 represents or gives information to the consuming public
9 about a very complicated healthcare structure we've been
10 discussing all day.

11 So do you in fact have opinions in this case
12 regarding the Leapfrog grade?

13 MS. BLAIR: Objection to form.

14 In terms of safety grade methodology, he has
15 no opinion.

16 But you can answer.

17 A. So, yes, I've been asked as an expert to share
18 details about my experience of our hospital system and
19 my work in the safety survey. As a general rule, I
20 think the structure around what that survey leads to as
21 a reporting of quality is value added.

22 Going into the details of how that reporting
23 is translated publicly is outside of my scope.

24 Q. (BY MS. PARKS) Okay. So is the statement
25 that -- in your report that "The Leapfrog Group Grade

1 offers a transparent representation of the complex
2 quality and safety evaluation system that exists in US
3 healthcare today," is that within or outside of the
4 scope of your opinions in this case?

5 A. That sentence is within the scope. Any
6 details or further questions about any of the
7 background, methodology, the -- how it relates to the
8 consumer, is outside the scope.

9 I think the concept and the structure of
10 Leapfrog, and participating in it, is useful and
11 valuable.

12 Q. What is your basis for saying that The
13 Leapfrog Group grade is transparent?

14 A. Because it's publicly available on a website
15 that anyone can look up.

16 Q. Okay. But you just told me that information
17 about how the grade relates to the consumer is outside
18 of the scope of your opinions.

19 So what within the scope of your opinions
20 provides the basis for saying that The Leapfrog Group
21 grade is transparent?

22 MS. BLAIR: Objection to form.

23 A. I'm going to have to not answer that question
24 because I don't understand how else to say it other than
25 previously stated.

1 Q. (BY MS. PARKS) Can you please state for me
2 all of your opinions that you're offering in this case
3 that relate to the Leapfrog safety grade?

4 A. I am not -- I was not brought in to opine on
5 the Leapfrog safety grade and its details.

6 The portions of this document in this
7 deposition should apply to my work in the consumer and
8 physician side of a hospital system that participates in
9 Leapfrog and other safety systems. And through that
10 experience, to share its value in improving quality and
11 improving patient care.

12 The semantics of opining on the word "grade,"
13 and any of the methodologies that go into that grade,
14 and how a consumer or the public may interpret that
15 grade, are outside of scope of this discussion.

16 Q. Are you offering an opinion that the Leapfrog
17 letter grades, A, B, C, D, F, have value at improving
18 quality and improving patient care?

19 A. No.

20 Q. No. Okay.

21 And are you offering an opinion that the
22 Leapfrog letter grades A, B, C, D, F, are transparent?

23 A. No.

24 Q. And are you offering an opinion that the
25 Leapfrog letter grades, A, B, C, D, F, are easily

1 visible?

2 A. No.

3 Q. Okay. And are you offering an opinion that
4 the Leapfrog letter grades, A, B, C, D, F, are an
5 accurate representation of the complex quality and
6 safety evaluation system that exists in US healthcare
7 today?

8 A. I see what you did there.

9 Again, I think what I had hoped to convey from
10 that statement is the concept as a whole -- it's an
11 easily visible and transparent representation of a
12 complex system.

13 Q. Okay.

14 A. And you were asking specifically about the
15 word "grade," and the grading A through F, and the
16 specifics of that grading system are outside of the
17 scope.

18 If it would make it simpler, can I strike the
19 word "grade" from that sentence in my document and just
20 say, "The Leapfrog Group offers an easily visible and
21 transparent representation of the complex quality and
22 safety evaluation system that exists in the US
23 healthcare today"?

24 Q. Okay. So would you like to make that
25 correction to your report?

1 A. That would be lovely. Thank you. Yes.

2 Q. Sure.

3 And just to completely close the loop, you
4 don't have an opinion on whether the grade itself, A, B,
5 C, D, F, is an accurate representation of how safe a
6 hospital is or not?

7 A. Correct. That's outside of scope.

8 Q. Okay.

9 Okay. And then the last sentence of this
10 paragraph you write, "Patients, providers, and payors
11 need visibility into the healthcare system."

12 And is it your view that Leapfrog provides
13 this visibility into the healthcare system?

14 A. Yes.

15 Q. How does Leapfrog provide visibility into the
16 healthcare system for payors?

17 A. I think the reporting that -- again, it is no
18 different than the visibility it provides for everyone
19 else on all the data they report publicly. And I'm not
20 a payor, so I can't say which elements they may or may
21 not choose to incorporate into their negotiations with
22 healthcare systems.

23 But I think, having sat at committees with
24 payors, they want to know the product that they are
25 paying for has high quality, and they value any metrics

1 that report on that quality.

2 Q. And am I remembering correctly that you don't
3 know with particularity what data Leapfrog reports
4 publicly?

5 MS. BLAIR: Objection to form.

6 A. I don't know from memory exactly what data
7 Leapfrog reports, but I'm sure it's visible on their
8 publicly reported websites.

9 Q. (BY MS. PARKS) Okay. And those publicly
10 reported websites, that would be -- are they in this
11 list? -- like, Item 7 on page 14?

12 A. That appears to be the correct website. We'd
13 have to click on it to confirm.

14 Q. Okay. And do you know if Leapfrog publicly
15 reports data on any other websites?

16 A. I do not know --

17 Q. Okay.

18 A. -- how many websites and how they report their
19 data.

20 Q. Okay. So when you wrote that Leapfrog
21 provides visibility into the healthcare system, were you
22 referring exclusively to the data provided on the
23 website you list as Item 7?

24 A. No. I -- when there's things reported
25 publicly, I rarely make it an exclusive reference. I

1 think they push data, as you pointed out previously, in
2 press releases, news reports, internal hospital
3 communication, so on and so forth.

4 So there's a lot of different ways where
5 Leapfrog communicates their evaluation of different
6 healthcare systems in the world. And as a consumer, I
7 see those.

8 So I was referencing all the ways that
9 Leapfrog's reporting is made public to the world.

10 Q. Okay.

11 A. But I did not enumerate each of those and make
12 any of them exclusive.

13 Q. Do you find your patients to be participatory
14 in choosing their healthcare providers?

15 MS. BLAIR: Objection to form.

16 A. Define "participatory."

17 Q. (BY MS. PARKS) So earlier today, I think we
18 were talking about your personal experience selecting a
19 provider for your daughter's surgery.

20 In your experience, do most patients do some
21 kind of research before choosing their healthcare
22 providers?

23 A. My experience would be limited to what I hear
24 from my patients as to what tools they used to assess
25 choosing to come to us for care or those whom I refer to

1 other specialists or -- for care.

2 And there's a subset of patients that search
3 the internet and look for any bits and pieces of data to
4 help guide them. And there are others who rely on
5 family member referrals. There are others who rely on
6 their primary care referrals and don't do any further
7 digging.

8 So I've seen a variety of ways how people
9 choose their healthcare.

10 Q. Do you -- strike that.

11 In your experience, have patients done more
12 research on their own now that they have access to the
13 internet and cell phones and more data sources?

14 A. Yes. I think, having access to more data, I
15 am seeing more patients that are more educated about
16 what's publicly available as far as reviews of their
17 healthcare providers and the healthcare systems they
18 work in.

19 Q. Do you have a view on whether patients are
20 likely to come across Leapfrog safety grades if they
21 perform that type of research?

22 A. I do not have a view.

23 Q. Okay. And then I think earlier you were
24 telling me that there's many different sources of
25 information from Leapfrog. So we talked about the

1 website. I think you also mentioned, like, online and
2 print news that's put out by Leapfrog.

3 Do you know whether Leapfrog has -- or puts
4 out information by television?

5 A. I don't.

6 Q. Okay. Do you know whether Leapfrog puts out
7 any information on the radio?

8 A. I do not.

9 Q. Do you know whether Leapfrog puts out any
10 information on social media?

11 A. I do not.

12 Q. Do you know whether Leapfrog has a press
13 strategy with respect to its safety grades?

14 A. I do not.

15 Q. Have you had any conversations directly with
16 patients about the Leapfrog safety grade?

17 A. I do not recall.

18 Q. And do you recall ever having conversations
19 with patients directly about Leapfrog, more generally?

20 A. Nothing specific that I recall. I'm sure
21 someone brought it up at some point, yes.

22 Q. Do you have an understanding of whether the
23 Leapfrog safety grade impacts how patients view a
24 hospital's quality?

25 MS. BLAIR: Objection to form. Outside the

1 scope.

2 A. Yeah, that's outside of my scope.

3 Q. (BY MS. PARKS) Okay. Are any of your
4 opinions based on conversations that you've had with
5 doctors regarding the Leapfrog safety grade?

6 MS. BLAIR: Objection to form.

7 A. No, I...

8 Q. (BY MS. PARKS) Are any of your opinions based
9 on conversations that you've had with doctors regarding
10 Leapfrog, more generally?

11 A. No.

12 Q. And are any of your opinions based on
13 conversations that you've had with anyone about Leapfrog
14 or the Leapfrog safety grade?

15 A. No, not specifically.

16 Q. Okay.

17 A. But you cannot exclude 20 years' worth of
18 conversations about quality.

19 Q. Okay. I understand.

20 A. So the...

21 Q. Okay. I am going to move on to a different
22 topic, so we can keep pressing, or we can take a break.
23 It's up to you.

24 THE WITNESS: Whatever the team wants.

25 MS. BLAIR: I'm fine to keep going.

1 THE COURT REPORTER: I would love a restroom
2 break at some point.

3 MS. BLAIR: Why don't we do it now.

4 MS. PARKS: Yeah.

5 THE VIDEOGRAPHER: We are going off the record
6 at 3:41.

7 (Brief break taken.)

8 THE VIDEOGRAPHER: We are back on the record.
9 The time is 4:04.

10 Please proceed.

11 Q. (BY MS. PARKS) Okay. Dr. Farrokhi, on
12 pages -- or, I guess, page 7 of your report, under
13 "Materials Reviewed," you identify Mr. Chakurda's expert
14 report.

15 Do you see that?

16 A. Yes.

17 Q. Did you review Mr. Chakurda's report in its
18 entirety?

19 A. I briefly reviewed it, but it was outside of
20 my scope.

21 Q. Okay.

22 A. But I included it because it was part of the
23 documentation provided to me that I reviewed, so...

24 Q. Okay. And when you say that Mr. Chakurda's
25 report was outside of the scope of your opinions, does

1 that mean you were not asked to provide any opinions to
2 rebut Mr. Chakurda's report?

3 A. Correct.

4 Q. Okay. And do you have any opinions to rebut
5 Mr. Chakurda's report?

6 A. I do not. I didn't delve into it. It seemed
7 like a topic that was outside of my expertise.

8 Q. Is there anything in Mr. Chakurda's report
9 that you disagree with?

10 MS. BLAIR: Objection to form.

11 A. Again, I have no opinions.

12 Q. (BY MS. PARKS) Okay. And in your "Materials
13 Reviewed," you also list the "Chakurda Exhibit B
14 Materials" and the "Leapfrog Materials Cited by
15 Chakurda."

16 Did you review all of those materials as well?

17 A. Again, they were in the folder of material
18 provided to me. I identified them as such, and as they
19 were not relevant, I did not go into them in detail.
20 But since they were provided to me, I included them in
21 this report for transparency.

22 Q. Okay. And so just to make sure I understand,
23 none of the materials in Categories 4 and 5, the
24 Chakurda Exhibit B materials and Leapfrog materials
25 cited by Charkurda, were relevant to you in forming your

1 opinions in this case; is that right?

2 A. Correct.

3 Q. Okay. And why don't we look at Mr. Chakurda's
4 report.

5 So I'm going to hand you Exhibit 5.

6 (Exhibit Number 5 marked for identification.)

7 Q. (BY MS. PARKS) Is that a copy of
8 Mr. Chakurda's report that you reviewed in connection
9 with preparing your report?

10 A. It appears to be a report by Chakurda, yes.

11 Q. Okay.

12 Okay. And can we look at page 3 of
13 Mr. Chakurda's report.

14 In paragraph 12, in the last sentence,
15 Mr. Chakurda writes that "a strong hospital brand
16 impacts all of the hospital's stakeholders because it
17 drives patients and caregivers to choose that hospital,
18 and also increases patient referrals and doctor and
19 staff recruitment and retention."

20 Do you agree or disagree with that statement?

21 MS. BLAIR: Objection to form. Outside the
22 scope.

23 A. I can't comment on this.

24 Q. (BY MS. PARKS) In your personal experience,
25 is a hospital's brand important?

1 MS. BLAIR: Objection to form.

2 A. Again, it's outside the scope of what I was
3 asked to share my expertise on. Branding is not my
4 expertise, and so I can't make any comments on branding.

5 Q. (BY MS. PARKS) Is Virginia Mason Medical
6 Center's brand part of the reason that you work at that
7 hospital?

8 MS. BLAIR: Objection to form.

9 A. Again, I -- I'm not an expert on branding, so
10 I don't know the definition of "branding." But the
11 reasons I chose to work at that hospital were varied and
12 outside the scope of this deposition.

13 Q. (BY MS. PARKS) Is Virginia Mason Medical
14 Center's reputation part of the reason that you work at
15 that hospital?

16 MS. BLAIR: Objection to form. Asked and
17 answered.

18 A. Again, yes, I chose to work at Virginia Mason
19 for many reasons, and many of them had to do with known
20 involvement, prioritization, and effort towards quality
21 as a primary driver of how they cared for patients.

22 Q. (BY MS. PARKS) So would you agree that
23 Virginia Mason's reputation for quality is part of the
24 reason why you chose to work there?

25 MS. BLAIR: Objection to form. Asked and

1 answered.

2 A. I chose to work there because I learned of
3 good people that work there who I spoke to, who I
4 believed and I trusted, and they turned out to be good
5 people to work with.

6 Q. (BY MS. PARKS) Is it your testimony that you
7 did not consider the reputation of Virginia Mason when
8 choosing to work there?

9 MS. BLAIR: Objection to form. Asked and
10 answered.

11 A. I'll repeat my last -- I'll reference my last
12 answer.

13 Q. (BY MS. PARKS) I actually prefer you answer
14 my question, which is --

15 MS. BLAIR: He's answered it.

16 Q. (BY MS. PARKS) Maybe I missed it. Could you
17 please just answer it again, then?

18 Did you consider the reputation of Virginia
19 Mason when you chose to work there?

20 A. I don't remember 20 years ago if I considered
21 the reputation of Virginia Mason when I chose to work
22 there.

23 Q. So you can't say one way or the other whether
24 the reputation of Virginia Mason was part of -- was a
25 factor in you choosing to go to work there?

1 MS. BLAIR: Objection to form. Asked and
2 answered.

3 A. Again, 20 years ago, I -- I'm not sure what
4 was going through the mind of a young, freshly
5 graduating, sleep-deprived neurosurgery resident.

6 Q. (BY MS. PARKS) Okay. And is Virginia Mason's
7 reputation part of the reason that you choose to
8 continue working there today?

9 A. I choose to continue working at Virginia Mason
10 because I know that they do good work and have good
11 healthcare providers and provide the highest possible
12 quality of care for their patients. And I like being
13 part of that team.

14 Q. Is -- does Virginia Mason's reputation play
15 any role in your choice to continue working there today?

16 MS. BLAIR: Objection to form. Asked and
17 answered.

18 A. Again, I continue to work there for reasons
19 that have to do with the people and the priorities of
20 the institution.

21 Q. (BY MS. PARKS) Okay. So am I understanding
22 you correctly that Virginia's -- Virginia Mason's
23 reputation does not play any role in your choice to
24 continue working there today?

25 MS. BLAIR: Objection to form.

1 A. I'm uncertain of what you're hoping to get out
2 of these answers to these questions.

3 Within the scope of this discussion, my
4 interpretation of the word "reputation, brand," or
5 anything having to do with public perception of an
6 institution, I can't speak to with the history or the
7 experience as I can to neurosurgical care and leading a
8 quality effort.

9 So trying to answer your questions regarding
10 these decisions based on that word "reputation" or the
11 word "brand" become challenging because that is outside
12 of the scope of what I was asked to comment on in this
13 deposition.

14 Q. (BY MS. PARKS) So are you saying that in your
15 day-to-day life, you have not considered the reputation
16 of Virginia Mason Medical Center?

17 MS. BLAIR: Objection to form.

18 A. No, I have not.

19 Q. (BY MS. PARKS) Okay. You've given no thought
20 to how Virginia Mason Medical Center is perceived in the
21 community?

22 MS. BLAIR: Objection to form.

23 A. Can I answer "no comment"?

24 Q. (BY MS. PARKS) No.

25 A. Again, I do not understand the scope of the

1 word "reputation." If we want to have a discussion
2 about the details of the word "reputation" and what it
3 means relative to me as an individual, I'm happy to have
4 a discussion to try to better define what you're trying
5 to glean by asking me of my consideration of the word
6 "reputation."

7 The decisions I make in my personal life, and
8 how that's impacted by the information I have available
9 to me, are usually based on the validity of the
10 information, the source, the reliability, the volume, my
11 personal experiences and how I interpret that
12 information, interpretations from trusted friends and
13 colleagues and family members. And that is how I make
14 decisions about my healthcare, where I work, what car I
15 buy, which toaster I buy.

16 So those are the elements which I hope make up
17 a sensible way of making decisions.

18 I don't know which of those elements you're
19 referencing by saying "reputation," because it's a
20 rather vague term for me.

21 Q. Is it sensible for a doctor to consider
22 whether a hospital has a reputation for good quality or
23 bad quality in choosing to work there?

24 A. I think it's sensible for a doctor to consider
25 how an organization treats the structure of quality, the

1 culture of quality, and how it prioritizes quality.

2 Those three elements may make up something
3 that you call "reputation," but I couldn't -- since
4 that's a very subjective evaluation, I couldn't comment
5 on that.

6 Q. What do you -- what is your reputation,
7 Dr. Farrokhi?

8 MS. BLAIR: Objection to form.

9 A. So, again, I do not know what you mean by
10 "reputation," so I have a hard time answering the
11 question.

12 My assumption is that the reputation would be
13 how I'm perceived by others; hence, I cannot answer the
14 question because I perceive myself. I am not a
15 perceiver of me from another's point of view.

16 Q. (BY MS. PARKS) How do you hope that you are
17 perceived by others?

18 A. I have no hopes of my perception. I do what I
19 do because of what I believe in my life, and I let the
20 world judge it as they may.

21 Q. Do you care whether your patients perceive you
22 as caring about quality?

23 A. Their perceptions are irrelevant. I care
24 about quality because I believe it will deliver the best
25 healthcare to my patients, and that is what I want to do

1 with the hours of my life.

2 Q. Do you care whether your patients perceive you
3 as delivering the best healthcare?

4 A. Again, their perceptions are -- they're going
5 to be theirs. I just want to deliver the best
6 healthcare.

7 Q. Do you care one way or the other whether your
8 patients think you're a good doctor or a bad doctor?

9 MS. BLAIR: Objection to form.

10 A. I'm going to do my best to be the best doctor
11 I can be. The world will be the judge of how I achieve
12 that.

13 Q. (BY MS. PARKS) And just -- so you don't care
14 if your patients think you're a good doctor or a bad
15 doctor; correct?

16 MS. BLAIR: Objection to form.

17 Mischaracterizes his testimony.

18 A. I did not say that. I said I will do my best
19 to be the best doctor that I can be, and I will let
20 others choose how they perceive that.

21 Q. (BY MS. PARKS) Okay. Well, you haven't
22 answered my question of whether you care how others
23 perceive that.

24 So do you care if your patients perceive you
25 to be a good doctor or a bad doctor?

1 MS. BLAIR: Objection to form. Outside the
2 scope. Argumentative. And asked and answered.

3 But you can answer again.

4 A. Again, I'm going to do my best every day in
5 everything I do. I'll do my best in this deposition to
6 answer your questions as they are relevant to the topic
7 at hand.

8 Getting into my -- what my caring of my
9 reputation, I think, is outside the scope.

10 Q. (BY MS. PARKS) Is it your understanding that
11 you can refuse to answer my question because you judge
12 it to be outside of the scope of relevance?

13 MS. BLAIR: Objection to form.

14 But at some point you can't ask him the same
15 question 42 times. He's answered it.

16 Q. (BY MS. PARKS) I can ask him the question as
17 many times as I want until he provides an answer on
18 whether he cares.

19 MS. BLAIR: He's answered it. And I'm about
20 to instruct him not to answer it.

21 Q. (BY MS. PARKS) Yes or no, do you care whether
22 your patients think of you as a good doctor or a bad
23 doctor? It's a yes-or-no question. Give me a yes-or-no
24 answer, and we'll move on.

25 A. Do I care if they think I'm a good doctor or a

1 bad doctor? I would hope that they cared. I am
2 providing them the best care. And if in that caring
3 they think I'm a good doctor, and that gets them what
4 they need to feel good about their care, then yes, I
5 hope they think I'm a good doctor.

6 MS. PARKS: Let the record show that the
7 witness is still refusing to answer the question --

8 MS. BLAIR: Absolutely not.

9 MS. PARKS: -- but we can move on.

10 MS. BLAIR: Absolutely not. He's answered
11 that question. He's not even here as an expert about
12 his own reputation.

13 MS. PARKS: I'm asking him about his personal
14 perception, and he's offering his opinions based on his
15 20 years of experience, as he said multiple times today.

16 Q. (BY MS. PARKS) Okay. Do you agree with
17 Mr. Chakurda that TLG safety grades are among the more
18 prominent of these hospital ratings?

19 MS. BLAIR: Objection to form.

20 A. Outside of my scope for this discussion.

21 Q. (BY MS. PARKS) Do you have any opinion on the
22 relative visibility of the various hospital ratings?

23 A. I do not.

24 Q. Do you have any opinion on whether TLG --
25 strike that.

1 Do you have any opinion on whether Leapfrog
2 ratings have any impact on patient referrals?

3 A. I do not.

4 Q. Do you have any opinion on whether Leapfrog --
5 sorry. Why can't I say this the same way every time?

6 Do you have any opinion on whether Leapfrog
7 ratings have any impact on recruitment and retention at
8 hospitals?

9 A. I do not.

10 Q. Does the reputation of a hospital affect its
11 economic success?

12 MS. BLAIR: Objection to form. Outside the
13 scope.

14 A. I do not know.

15 Q. (BY MS. PARKS) Do you know how much your
16 hospital spends on marketing?

17 A. I do not.

18 Q. Have you ever been provided with information
19 regarding the budget for your hospital?

20 A. I have not.

21 Q. So you don't know one way or the other whether
22 your hospital spends more on marketing or more on
23 developing its quality systems?

24 A. I do not.

25 Q. Do you agree with Mr. Chakurda's statement in

1 paragraph 25, that referring physicians are highly
2 influential in choosing where to refer patients?

3 MS. BLAIR: Objection to form.

4 A. I agree with the statement that "referring
5 physicians are highly influential in choosing where to
6 refer patients," because that physician is doing the
7 referring, so they have 100 percent control of where
8 they refer patients.

9 So that statement sort of is -- just says
10 itself.

11 Q. (BY MS. PARKS) And do you agree that referral
12 relationships between hospitals and doctors are
13 exceedingly important?

14 MS. BLAIR: Objection to form.

15 A. I believe referral relationships and trust
16 within healthcare networks are important. I don't know
17 what "exceedingly" means.

18 Q. (BY MS. PARKS) Do you do anything with your
19 hospital to develop its referral relationships with
20 doctors?

21 MS. BLAIR: Objection to form.

22 A. I'm primarily doing my -- the breadth of what
23 I do to the best of my ability.

24 Q. (BY MS. PARKS) And when patients come to you
25 from a referral relationship, are they typically

1 referred to Virginia Mason, or are they referred to you
2 specifically?

3 A. Both. And our clinic is sort of agnostic to
4 that referral source.

5 Q. What does that mean, that your clinic is
6 agnostic?

7 A. I don't know who sent me the patient when I go
8 to speak with them.

9 Q. Oh, okay. I understand.

10 A. I -- we try to deliver the same care for
11 everyone, and so we -- there's no differentiation of
12 referrals from Provider A or Provider B.

13 Q. And -- but you would agree that sometimes
14 patients are referred to the clinic and not to a
15 particular doctor within the clinic?

16 A. Yes. I'm sure that happens.

17 Q. Do you agree with Mr. Chakurda's statement in
18 paragraph 27, that referring physicians are very
19 responsive to their patients' preferences?

20 A. I cannot comment.

21 Q. Do you have an understanding of what factors
22 might impact a referring physician to refer a patient to
23 a particular hospital?

24 MS. BLAIR: Objection to form. Outside the
25 scope.

1 A. And, again, outside of my range of expertise.

2 Q. (BY MS. PARKS) Do you have an understanding
3 from your personal experience of what factors might
4 impact a referring physician to refer a patient to a
5 particular hospital?

6 MS. BLAIR: Objection to form.

7 A. So in regards to what -- my understanding of
8 how to be a good doctor, and for physicians to trust me
9 to send their patients to me, or what I've been taught
10 and what I teach is to be kind and do the best job you
11 can, and treat every patient as though they're a member
12 of your own family. And so that is the overarching
13 ethos by which we approach our clinical practice.

14 And honestly, I appreciate that I am kept
15 separate from what -- the world of marketing that I know
16 goes on in healthcare. But it is not an area of
17 interest for me, not an area of expertise, so I can't
18 comment on it because I don't delve into it. And I have
19 been kept very separate from it, for which I am
20 grateful. I can concentrate on the pieces of healthcare
21 that are important to me, which is neurosurgery and
22 quality of care improvement.

23 Q. (BY MS. PARKS) Okay. So I had asked you
24 whether you have an understanding from your personal
25 experience of what factors might impact a referring

1 physician to refer a patient to a particular hospital.

2 Can you list out the factors that you just
3 provided in that answer?

4 A. No. I've shared with you not those factors
5 because I do not have expertise on what those factors
6 may be. I shared with you what I've learned about how
7 to be a good doctor. And my hope is that that breeds
8 confidence in patients being referred when they need the
9 care I can provide.

10 Q. So when I asked you whether you had an
11 understanding from your personal experience of what
12 factors might impact a referring physician to refer a
13 patient to a particular hospital, the answer was "no";
14 right?

15 A. Right. So I --

16 Q. So you could have answered my question with
17 one word, and instead you gave me multiple paragraphs of
18 answer.

19 Do you understand that we are time limited in
20 today's deposition?

21 MS. BLAIR: Objection to form. Argumentative.

22 He's providing answers about topics he's not
23 even here as an expert on.

24 A. Again, I'm doing my best to answer your
25 questions and hopefully get an understanding for you of

1 how I'm going to contribute to the information you need
2 for this case. I am in no way trying to be deceptive or
3 to burn time. But I --

4 Q. (BY MS. PARKS) When the Leapfrog survey asks
5 you a yes-or-no question, do you say yes or no, or do
6 you give them multiple paragraphs of answers?

7 A. I don't answer the Leapfrog survey,
8 personally. And their answers are very discrete.

9 Q. Would you advise the individuals at Virginia
10 Mason to answer their questions precisely and concisely?

11 A. I think individuals get to answer things the
12 way they want to answer things.

13 Q. Okay. I have been very patient with you
14 providing very long answers today. So I'd appreciate it
15 if we can use the rest of our time to have a direct
16 response to my questions.

17 A. Of course.

18 MS. BLAIR: I'm just going to object to the
19 extent that's argumentative with the witness.

20 Q. (BY MS. PARKS) Do you agree or disagree with
21 the statement that admitting doctors are aware that
22 their reputations will be tied to the hospital at which
23 they have admitting privileges?

24 MS. BLAIR: Objection to form. Outside the
25 scope.

1 A. Again, I don't know if I can comment on that
2 topic.

3 Q. (BY MS. PARKS) Are you an admitting doctor at
4 Virginia Mason Medical Center?

5 A. Yes.

6 Q. And are you aware that your reputation will be
7 tied to Virginia Mason Medical Center's reputation?

8 MS. BLAIR: Objection to form.

9 A. Again, getting into the definition of
10 "reputation."

11 Q. (BY MS. PARKS) Are you aware that your name
12 and picture appear on VMFH's website?

13 A. Yes. It's not a very good picture.

14 Q. Will -- do you advertise your services as a
15 doctor on any other platforms?

16 A. I don't do any personal advertising. What my
17 employer does with their rights over my name and
18 likeness is separate from my scope.

19 Q. So do you do anything to separate your
20 professional reputation from that of Virginia Mason
21 Franciscan Health?

22 MS. BLAIR: Objection to form.

23 A. Again, you're asking if I actively pursue
24 activities or thoughts, or put any effort into what
25 you're calling "reputation." And I hope I've conveyed

1 that that is not a driver of how I do my work or how I
2 live my life. And I just try to do the best at my job
3 and as a human as part of this community.

4 And how that is perceived by others, which I
5 hope is what you're asking about reputation, will land
6 where it may. But the perception is not the end point
7 of the actions that I -- and the decisions I undertake.

8 And I mean that with all honesty. I'm not
9 trying to sidestep, but that is how I make my decisions
10 every day.

11 Q. (BY MS. PARKS) Okay. We can put that aside.

12 Okay. We're going to mark Exhibit 6.

13 (Exhibit Number 6 marked for identification.)

14 Q. (BY MS. PARKS) Okay. Dr. Farrokhi, have you
15 ever seen Exhibit 6 before?

16 A. No.

17 Q. Okay. So this -- I'll represent to you that
18 this is a document that Leapfrog produced to us in the
19 litigation. You can tell because it has these numbers
20 in the bottom-right corner.

21 A. Uh-huh.

22 Q. And this is an agreement between Virginia
23 Mason Medical Center and The Leapfrog Group.

24 Do you see that at the top of the page?

25 A. I do.

1 Q. Okay. And pursuant to this agreement, you
2 see, about halfway down the page, "Total Price"?

3 A. Yes.

4 Q. Okay. So under this agreement, Virginia Mason
5 Medical Center paid \$17,900 to The Leapfrog Group.

6 Do you see that?

7 A. Yes.

8 MS. BLAIR: Objection to form.

9 A. Yes.

10 Q. (BY MS. PARKS) Okay. And then there's quite
11 a bit of legalese here. But it says under that that in
12 exchange for that \$17,900, Virginia Mason Medical Center
13 received a license to use the designated Leapfrog logos.

14 Do you see that?

15 A. I do.

16 Q. Okay. So does this document help you to
17 understand whether or not Virginia Mason Medical Center
18 has licensed its Leapfrog safety grades?

19 MS. BLAIR: Objection to form.

20 A. It appears to be a accolade licensure letter
21 of agreement between Leapfrog and Virginia Mason.

22 Q. (BY MS. PARKS) Okay. And on the very bottom
23 there, it's signed by Denise Dolack.

24 Do you know Denise Dolack?

25 A. I do not.

1 Q. Okay. And then it writes that her title is
2 MarCom Trafficker.

3 Do you see that?

4 A. I do.

5 Q. What is a MarCom Trafficker, do you know?

6 A. I do not, but that's a cool title.

7 Q. Do you know whether Leapfrog has agreements
8 like this with other hospitals?

9 A. I do not.

10 Q. Do you realize that Leapfrog makes money,
11 revenue, from licensing the Leapfrog safety grades?

12 MS. BLAIR: Objection to form.

13 A. I can't comment on their financial structure.

14 Q. (BY MS. PARKS) Okay. Would you agree that if
15 every hospital who licensed their Leapfrog -- or strike
16 that.

17 Do you agree that if every hospital who
18 participated in the Leapfrog survey went on to sign an
19 agreement like this, Leapfrog would stand to make more
20 revenue?

21 MS. BLAIR: Objection to form. Calls for
22 speculation.

23 A. Again, I can't comment on their financial
24 structure.

25 Q. (BY MS. PARKS) Okay. But it's simple math;

1 right? If more hospitals pay this licensing fee,
2 Leapfrog gets more revenue?

3 MS. BLAIR: Objection to form.

4 A. Yes.

5 MS. BLAIR: Outside the scope.

6 A. And outside of my scope. I don't know their
7 cost structure.

8 Q. (BY MS. PARKS) Okay. But do you agree with
9 the math?

10 A. Well, you did the multiplication, you didn't
11 do the subtraction for cost of running a business. So,
12 again, we don't know the details. So making more money
13 doesn't necessarily -- so yes, if they collected 2X of
14 the hospital, they would create -- collect more revenue,
15 yes.

16 Q. Okay.

17 A. I do not dispute your math.

18 Q. And do you have any understanding of
19 Leapfrog's costs associated with licensing?

20 A. I do not.

21 Q. Okay. So earlier today do you recall we were
22 talking about the audits that your hospital does on hand
23 washing?

24 A. Yes.

25 MS. BLAIR: Objection. Form.

1 Q. (BY MS. PARKS) Are those audits exactly the
2 same as the hand-washing guidelines that Leapfrog
3 requires as part of the hospital survey, or does your
4 hospital go above and beyond what Leapfrog asks for?

5 A. I couldn't crosswalk the policy and procedures
6 between our internal hand-washing metric and Leapfrog at
7 this time.

8 Q. And if Leapfrog's survey stopped asking you
9 for data on hand washing, would you stop auditing hand
10 washing at Virginia Mason?

11 MS. BLAIR: Objection to form.

12 A. I am not the sole decision-maker on that KPI,
13 so we would bring together a task force to evaluate it,
14 much like we've referenced previously with having the
15 relevant stakeholders help make that decision.

16 Q. (BY MS. PARKS) Okay. Would it be your
17 recommendation that Virginia Mason should stop measuring
18 the hand-washing KPI if Leapfrog stopped asking for it?

19 MS. BLAIR: Objection to form.

20 A. I would not make a recommendation for or
21 against that particular KPI. I would, again, defer to
22 the committee that does the work and brings it into our
23 larger committee to pick its relevance relative to other
24 KPIs. The same process that we went into detail with
25 before.

1 Q. (BY MS. PARKS) And so you said you would
2 defer to the committee that does that work.

3 Is that the -- is there, like, an expert
4 committee on hand washing?

5 A. When our hand washing becomes an off-metric, a
6 committee is formed as part of infection prevention to
7 bring that metric back on to target.

8 Q. Okay. And is it -- is that the committee that
9 would make the recommendation as to whether hand washing
10 should be one of the KPIs tracked by Virginia Mason?

11 A. So it would go through the same process that
12 we reviewed earlier today. When there's a change in
13 either an external pressure or an internal pressure
14 about a metric, that metric is evaluated with all
15 relevant inputs to that metric: Local, regulatory, what
16 it may mean as harm to our patients.

17 And as a group of experts, we come together,
18 we discuss that topic and decide whether we should keep
19 or eliminate a KPI.

20 Q. So in your report on page 11, you speak to the
21 fact that you've known that clean hands reduce risk of
22 disease transmission since 1847.

23 Do you see that?

24 A. Correct.

25 Q. So how would Leapfrog -- Leapfrog's decision

1 to stop asking you for data on hand washing change your
2 understanding of the importance of having clean hands in
3 a hospital setting?

4 MS. BLAIR: Objection to form.

5 A. So that would -- Leapfrog's theoretical
6 decision that you have posed, which doesn't seem to be a
7 relevant decision because our healthcare world hasn't
8 learned how to keep 100 percent of hands clean without
9 all the effort that we're putting towards it. So it's
10 an unlikely scenario unless we come up with some
11 technological advance that eliminates transmission of
12 disease through touch.

13 So in the current healthcare structure, with
14 the current understanding of infection prevention
15 measures, that is an unlikely possibility. It's like
16 suggesting we're going to take the doors off a 747 to
17 save on air conditioning, so --

18 Q. (BY MS. PARKS) So does your hospital only
19 track hand washing because of the Leapfrog survey?

20 MS. BLAIR: Objection to form.

21 A. It is exactly the opposite of what I've been
22 saying this whole time; right.

23 We take into consideration all relevant data,
24 pressures, and information about each of our key
25 performance indices so we can make an informed decision

1 about whether we should continue to pursue that metric
2 or not.

3 Q. (BY MS. PARKS) Do you think that fewer people
4 at your hospital would wash their hands if your hospital
5 did not participate in the Leapfrog survey?

6 A. Possibly.

7 Q. So you don't have an answer one way or the
8 other? You're not sure?

9 A. I answered with one word, as you requested. I
10 said "possibly."

11 Q. Okay. So maybe fewer people would wash their
12 hands --

13 A. Yes.

14 Q. -- but maybe not, maybe it wouldn't change at
15 all?

16 A. Right. And the reason for that is, as we were
17 discussing earlier, if you lose some of the external
18 pressures -- there are multiple pressures on why people
19 behave in this way in this environment. And so it isn't
20 one force that drives the behavior.

21 So if you have 100 different forces that are
22 acting on a particular metric, if you eliminate one of
23 them that is pushing you in a positive direction, you
24 may possibly see a reduction in the response rate to
25 that metric.

1 Q. Okay. And we've spoken a lot today about
2 external reporting, however you're interpreting that
3 phrase.

4 Would you agree that external reporting by
5 Virginia Mason is only valuable if the reports are
6 accurate?

7 A. Yes. I believe the value of reporting is
8 linked to its fidelity or accuracy.

9 Q. Okay. So in other words, the -- whoever
10 receives that reported data, if the data isn't accurate,
11 that data is of no use to them?

12 MS. BLAIR: Objection to form.

13 A. I wouldn't say no use. So it's proportional
14 to many things. So that, again, no one data element has
15 a binary response. That's why it's all dashboards, and
16 it's throttled response, and you take other elements
17 into view.

18 So you can't make a binary yes/no answer in
19 this arena.

20 Q. (BY MS. PARKS) What's the usefulness of
21 inaccurate data?

22 A. It may show you that your measurement tool is
23 not functional, and you would have to go back and work
24 through a new measurement tool.

25 Q. But that would only work if you knew the data

1 was inaccurate; right?

2 A. Well, you labeled it as "inaccurate."

3 Q. Right.

4 But let's say the data is reported to you and
5 you have no way of verifying its accuracy.

6 A. That's where the science of data fidelity
7 comes in.

8 Q. Okay. So would you agree that it's important
9 to provide data that is accurate and confirm that it is
10 accurate?

11 MS. BLAIR: Objection to form.

12 A. Yes. It is important to have accurate data,
13 and it is important to have a check on the data to make
14 sure that the data fidelity is high --

15 Q. (BY MS. PARKS) Okay.

16 A. -- so you can make good decisions.

17 In situations where you don't have
18 high-fidelity data, you should weigh it less as you're
19 making your decision for a response to the set data.

20 Q. And would it be appropriate to rely on data if
21 you didn't have a check on that data to make sure it has
22 high data fidelity?

23 MS. BLAIR: Objection to form.

24 A. Please restate that question. I missed it.

25 Q. (BY MS. PARKS) Sure.

1 So you stated it is important to have accurate
2 data and it is important to have a check on the data.

3 Would -- let's say you just had the data.

4 Would it be -- would it be appropriate to rely
5 on data if you didn't also have that check to make sure
6 that data had high fidelity?

7 MS. BLAIR: Objection to form.

8 A. Again, your statement and standalone makes
9 sense. So no, you would not rely heavily on data that
10 did not have high fidelity.

11 Q. (BY MS. PARKS) Okay.

12 Okay. And so when we think about Leapfrog and
13 CMS, and all of the other external reporting systems,
14 would you agree that sometimes the data they provide to
15 the public and to doctors can be contradictory?

16 MS. BLAIR: Objection to form.

17 A. I would need an example to agree or disagree
18 with your statement.

19 Q. (BY MS. PARKS) So, for example, it's possible
20 for a hospital to do well in Healthgrades or CMS but do
21 poorly in Leapfrog, or vice versa; is that right?

22 MS. BLAIR: Objection to form. Outside the
23 scope.

24 A. I don't know what the -- what the
25 possibilities of those equations are. I haven't studied

1 that variance in hospital reportings and how they
2 crosswalk.

3 Q. (BY MS. PARKS) Okay. And do you know whether
4 Virginia Mason Medical Center has top grades across the
5 board?

6 MS. BLAIR: Objection to form.

7 A. Again, "top grades across the board" is a
8 rather vague statement.

9 Could you be more specific as to what external
10 reporting systems you're referring to. And, again, not
11 having that data in front of me, I probably won't be
12 able to answer that question.

13 Q. (BY MS. PARKS) Okay.

14 Okay. So I want to look at page 6 of your
15 report.

16 In the second full paragraph that starts "As a
17 physician," you state that you want to work in a system
18 that places significant cultural, financial, and
19 strategic emphasis on measuring and improving the
20 product they deliver.

21 So you told me earlier you don't have any
22 awareness into the budgets at your hospital; correct?

23 A. Correct.

24 Q. So how do you know that your system places
25 significant financial emphasis on measuring and

1 improving the product they deliver?

2 A. The pieces that are visible to me are
3 resourcing the humans and the technology that help
4 collect all of this quality improvement data.

5 In incidences where we see an opportunity for
6 improvement of quality, if there is expenditure to be
7 made in that arena with equipment, education, whatever
8 the thing that has a price tag may be, my experience has
9 been that the decisions to spend the resources -- the
10 financial resources on collecting the data, making it
11 visible, giving people time to formulate responses to it
12 and improvement projects, has been prioritized at my
13 institution.

14 Q. Does your hospital provide safe care, in your
15 opinion?

16 A. Safe care or SafeCare? I think there's a
17 company called SafeCare. But are you saying safe,
18 space, care, two words?

19 Q. Yes.

20 A. Okay.

21 Q. Yes. I'm looking at the last sentence in that
22 paragraph where you say, "Safe care for patients."

23 A. Oh, yes.

24 Q. Does your hospital provide safe care for
25 patients?

1 A. I think it provides one of the safest cares
2 available. Can we be better? Absolutely.

3 Q. And what's your basis for saying that your
4 hospital provides one of the safest cares available?

5 A. Almost every piece of what we do, we try to
6 track our outcomes, measure where good outcomes have not
7 happened, and do root-cause analysis to resolve those
8 issues so they don't happen again, and benchmark
9 ourselves against externally reported measures,
10 published complication rates. And then try to do
11 research, as we've discussed earlier, to change the
12 methodology of how we do that specific task so we can do
13 it safer for the next patient.

14 Q. How do you know that your hospital is safer
15 than other hospitals?

16 A. Again, I'll reference my last paragraph, by
17 comparing ourselves and our data against any externally
18 available source.

19 So as an example, we track the complication
20 rates in our deep brain stimulation surgery patients.
21 We compare that to published complication rates at other
22 large centers that do that surgery. We do that for
23 spine care. We do that for craniotomy care.

24 So anywhere where we can see that harm is done
25 and a patient hasn't done well -- they get an infection,

1 they have a heart attack after a procedure -- we first
2 try to solve the problems that we have visibility to,
3 then we compare our data with other systems, hospitals,
4 research that's published. And then we look for other
5 improvement opportunities that are available within
6 that -- the scope of that particular event.

7 And so I think by making these point
8 improvements constantly, then we're elevating the safety
9 of our whole care system.

10 Q. Okay. So you are assessing safety by looking
11 at complication rates and outcomes in your patients?

12 Did I understand that correctly?

13 MS. BLAIR: Objection to form.

14 A. Yes. That is one of the places where we look
15 at how to make things better.

16 Q. (BY MS. PARKS) Okay. And do you assess
17 safety by looking at any other measures?

18 A. Yes. Those would be the hundreds of KPIs that
19 we've discussed in an effort to prevent harm from
20 happening. Some of those have been established, process
21 metrics, some are outcome metrics.

22 All of this is a conglomeration of a data set
23 that helps us be safer every day.

24 Q. Are you -- is it your view that Virginia Mason
25 Medical Center is safer than the five plaintiff

1 hospitals in this litigation?

2 A. I don't have data on the five plaintiff
3 hospitals in -- and so I can't comment on that.

4 Q. Okay. And so you haven't done anything to
5 benchmark your hospital against those hospitals?

6 A. I have not.

7 Q. And I believe you referred to your hospital as
8 one of the safest.

9 Are there other hospitals that you would point
10 to as among the safest?

11 A. I reference that only in saying that I believe
12 we still have an opportunity to be even better. So I
13 never can claim to be the safest because there's many
14 metrics for how to measure that.

15 Q. Okay. So do you agree that figuring out which
16 hospital is the safest, different people could reach
17 different conclusions depending on what metrics they
18 measure?

19 A. Yes.

20 Q. Do you have any information to suggest that
21 the five plaintiff hospitals are not safe?

22 A. Again, I have not delved into evaluating those
23 hospitals, so I can't comment.

24 Q. And do you have any information that the five
25 plaintiffs' hospitals don't have a desire to provide the

1 best medical care to their patients?

2 MS. BLAIR: Objection to form.

3 A. Again, I have not done any research to be able
4 to answer that question.

5 Q. (BY MS. PARKS) Okay.

6 Okay. So on page 9, you talk about patient
7 safety reporting systems, including PSNet.

8 Do you see that?

9 A. Uh-huh.

10 Q. Do you know whether or not the five plaintiff
11 hospitals implement patient safety reporting systems?

12 A. I do not.

13 Q. And you -- to summarize this paragraph, my
14 understanding is you're pointing to these patient safety
15 reporting systems as an example of how a hospital can
16 create a culture of safety; is that right?

17 MS. BLAIR: Objection to form.

18 A. Yes. That is what I was hoping to point out.

19 Q. (BY MS. PARKS) Okay. And do you have any
20 other examples of how hospitals can create a culture of
21 safety?

22 A. That is a whole arena of research in
23 healthcare improvement. I would reference the Institute
24 for Healthcare Improvement website and all their
25 publications if you want to learn about culture of

1 safety.

2 Q. Okay. And you did not point to any materials
3 from the Institute for Healthcare Improvement in your
4 report; right?

5 A. I did not.

6 Q. Okay. And the only example you chose to
7 provide here is the patient safety reporting systems;
8 right?

9 A. Correct.

10 MS. BLAIR: Objection to form.

11 Q. (BY MS. PARKS) And do -- apart from patient
12 safety reporting systems, what are other examples of
13 structures that can create the structure you need for
14 hospital safety?

15 A. You had asked me to be brief in my answers. I
16 could go on -- numerous examples in this arena. How
17 many would you like?

18 Q. What examples do you provide in your report?
19 We have the patient safety reporting systems.

20 Are there any other examples included in your
21 report?

22 A. So you asked specifically about structures
23 that provide that culture. I'll reference the
24 presurgical checklist as a key example of a ritual that
25 is locked in to every procedure, that forces the

1 function of all the humans in the space introducing
2 themselves, sharing their role. And that brings down
3 the barrier for them speaking up when they see a
4 possible safety event.

5 And so structures like that and a nonpunitive
6 patient safety reporting system, like the example shows,
7 have been shown to create that culture and have a
8 structure that helps improve safety in hospitals.

9 Q. Okay. So apart from the patient safety
10 reporting systems and the presurgical checklists, are
11 there any other examples of structures that create a
12 culture of quality in hospitals, in your report, I mean?

13 MS. BLAIR: Objection to form.

14 A. Again, I'll let the report stand on its own
15 for pulling out those elements. I think we discussed
16 the report in detail. It has multiple examples of that.

17 Q. (BY MS. PARKS) Okay.

18 And when you referred to a nonpunitive patient
19 safety reporting system, what did you mean by that?

20 A. So when our system first rolled out, the
21 patient safety report structure many of the team members
22 were afraid that reporting an event of harm or defect or
23 wrongdoing would be considered as a potential piece of
24 information on which they would be judged negatively in
25 the performance in their space.

1 So the cultural shift and the work that we
2 have done within our system, and we help other systems
3 do as well, is to neutralize that fear and anxiety of
4 reporting something that you see by showing examples
5 that when that report is made, then the system looks
6 into the details of how they can prevent that from
7 happening again and does not go towards punishing the
8 person that -- or persons involved, or the person or
9 persons that reported the event.

10 So that's been a common theme in launching
11 these reporting systems within healthcare. People are
12 afraid that you're either going to be in trouble for
13 reporting or get someone else in trouble. And that's
14 been a big cultural lift to make sure that it is -- it's
15 not the person, it's the system. And how do we make it
16 so the system doesn't allow that problem to happen
17 again.

18 Q. Okay.

19 Okay. And is it your opinion that measuring
20 KPIs on their own leads to quality improvement?

21 A. Again, you can't measure KPIs on their own.
22 They -- by the simple fact that you are going through
23 the work of measuring something, you are invoking
24 awareness about the topic, you are getting humans to
25 look into the weeds of that topic, you are reporting

1 your findings to other humans in the space who will have
2 to evaluate that information.

3 So it triggers a cascade of focus around said
4 topic, which, for many reasons, triggers improvement.

5 Q. Okay. So is it the measurement or is it the
6 focus around the topic that creates the improvement?

7 MS. BLAIR: Objection to form.

8 (Simultaneous crosstalk.)

9 (Court reporter clarification.)

10 A. All of it.

11 You can't separate them out.

12 Q. (BY MS. PARKS) Well, you -- when you're
13 discussing KPIs somewhere in your report, you refer to
14 some of them being automatically collected --

15 A. Yes.

16 Q. -- is that right?

17 So some of them -- so in this case, where the
18 KPIs are just being automatically measured, how does
19 that measurement create quality improvement?

20 A. So we have hardwired certain things like
21 breast cancer screening. In our health record, if a
22 patient comes in at a certain age, they need to have a
23 mammogram for a breast cancer screening. And if that is
24 done, it creates a database that says, "All female
25 patients over the age of 50 with these risk factors had

1 their mammogram at the scheduled reporting time."

2 If we are that -- although that data is
3 collected automatically based on software that's pulling
4 the codes for the mammogram and the age of the patient
5 and whether they had screening, that report is fed up
6 through a committee that reviews that and says, "Hey,
7 this patient population doesn't seem to be getting their
8 mammography. Let's figure out why they're not getting
9 that done."

10 And then we go to the experts who evaluate the
11 data, break it down and see which site. Is it a
12 particular provider? Is it a particular patient
13 population that's resistant? And that triggers the
14 quality improvement work.

15 So, again, it is -- it is a dashboard light
16 that makes you look under the hood and check the oil to
17 see if you're really running low on oil or if the
18 dipstick is just loose.

19 Q. Okay. And in that metaphor, the dashboard
20 light itself does not lead to greater automotive safety
21 without a human taking action after seeing the light;
22 correct?

23 A. Correct.

24 Q. So similarly, in your mammogram example, like,
25 the existence of the database doesn't lead to greater

1 safety, it's the fact that a human chooses to review
2 that data; right?

3 A. Agreed. Just like the existence of a bridge
4 doesn't allow a human to walk across it. But if it
5 weren't there, you couldn't walk across that gap.

6 So, again, it's a necessary part of a system
7 to get to the end point result, which is better
8 healthcare.

9 Q. Where is the evidence in your report that the
10 metrics themselves are necessary to get to better
11 healthcare?

12 MS. BLAIR: Objection to form.

13 A. Again, I believe that that question is equally
14 answered as to -- so one of the things we reference
15 and -- when we're trying to do research is, if the
16 answer is so obvious, you should not put the resource
17 into trying to come up with that answer.

18 Like the classic example is: Are we going to
19 do a randomized controlled trial about jumping out of
20 airplanes with parachutes or without parachutes to prove
21 the parachutes actually save lives. Or walking across a
22 river with a bridge or without a bridge to see if you
23 get wet.

24 Without measuring, you cannot improve. So
25 I -- it is such an established fact that I don't think

1 you need a particular study to prove that measuring
2 helps. But I'm certain if the question at hand -- we
3 can go back historically in research that shows that
4 measuring a healthcare problem leads to improvement in
5 it. But I did not put that specific reference into my
6 work.

7 Q. (BY MS. PARKS) Okay. And did you -- it's
8 getting late, and I can't remember if I already asked
9 you this question.

10 Did you -- strike that.

11 Are you aware of any studies that link the
12 particular metrics reported in the hospital safety
13 survey -- link the measurement of those metrics, the
14 fact that they're being measured, to better outcomes?

15 MS. BLAIR: Objection to form. And asked and
16 answered.

17 A. I think, again, I would reference what I said
18 previously as an answer to that question.

19 Q. (BY MS. PARKS) Okay. And if I remember
20 correctly, what you said previously is you did not
21 search for such studies; correct?

22 A. Correct.

23 Q. And you're not aware of any such studies;
24 correct?

25 MS. BLAIR: Objection to form.

1 A. Correct.

2 Q. (BY MS. PARKS) Do you know who Leah Binder
3 is?

4 A. I do not.

5 Q. Okay.

6 MS. PARKS: This is where my disorganization
7 is going to.

8 Q. (BY MS. PARKS) I guess before I hand this to
9 you, we spoke earlier about LinkedIn, and you said it's
10 one of the social media platforms that you're a member
11 of; correct? Or maybe the only social media platform
12 you're a member of, if I remember exactly correct.

13 A. Yes. It is a social media platform that I
14 signed up for. I think everybody in our institution got
15 an account a year or two ago. And I peruse it
16 occasionally.

17 Q. And do you have any followers on LinkedIn?

18 A. I am sure I do. Are those when you -- when
19 someone says they want to be your friend and you hit
20 "accept"?

21 Q. I think that's different on LinkedIn. I'm
22 not --

23 A. Yeah.

24 Q. -- I'm not super clear on it either, but...

25 A. Neither am I, but I am -- people have

1 commented that they have seen things about me, and I
2 have seen things about my colleagues and friends on
3 LinkedIn. So, yes, it's a platform where information is
4 exchanged.

5 Do I know who they are? What they are? How
6 they are? Do I spend any appreciable time looking at
7 LinkedIn for any relevant sources of information? I do
8 not.

9 Q. Okay. And does anyone besides you have access
10 to your LinkedIn account?

11 A. I do not know.

12 Q. Do you --

13 A. I don't think so.

14 Q. Okay. That was my next question.

15 Do you believe someone besides you is
16 accessing your LinkedIn account?

17 A. It is set up on my work email account. So --
18 I assume that all my email and work communications are
19 owned by my organization, so whether or not they have
20 access to it and are doing anything to it, I'm not
21 aware, but possible.

22 Q. Okay. And do you receive email notifications
23 from LinkedIn when someone engages with your account?

24 A. I think I do, and I think they're sorted to
25 trash --

1 Q. Same for me.

2 A. -- or promotions or whatever.

3 (Exhibit Number 7 marked for identification.)

4 Q. (BY MS. PARKS) Okay. I'm going to hand you
5 what's been marked Exhibit 7.

6 Okay. So this is another document that was
7 produced to us by Leapfrog. And, again, you can tell
8 from the bottom right corner.

9 So this appears to be a LinkedIn notification
10 email that Leah Binder received. And on the reverse
11 side of the page, the first name there, "Farrokh
12 Farrokhi, Washington, Seattle started following you."

13 Do you see that?

14 A. Yes.

15 Q. Is that -- is that your LinkedIn profile,
16 "Farrokh Farrokhi, Washington, Seattle"?

17 A. I think so. I think there are multiple
18 because they changed emails.

19 Q. Oh. So you believe you have multiple LinkedIn
20 accounts?

21 A. Yes, because LinkedIn offers to make me my own
22 friends --

23 Q. Okay.

24 A. -- which, I think, makes me think there must
25 be more than one account.

1 Q. Okay.

2 A. But I see here it says "Leah Binder (President
3 & CEO of The Leapfrog Group)."

4 Q. Yes. And --

5 A. I don't think I've ever met her.

6 Q. Do you have any recollection of following her
7 on LinkedIn?

8 A. Obviously not.

9 Q. Okay. Do you have any understanding as to why
10 you would have followed her on LinkedIn?

11 A. Again, if it has to do with -- it sends you a
12 bunch of lists of names, and you have to hit "accept" to
13 get the little icons to go away, then it may have been
14 that case.

15 Q. Okay.

16 A. I apologize. I'm really not savvy with social
17 media, so...

18 Q. Okay. So do any of the opinions -- are any of
19 the opinions you're offering in this case relevant to
20 the question of whether Leapfrog is deceptive to
21 consumers?

22 A. No, I don't believe so.

23 Q. Okay. And earlier today you made a correction
24 to one sentence in your report.

25 Do you have any other corrections to make to

1 your report today?

2 A. Not at this time.

3 Q. Okay. Have you spoken to anyone about your
4 engagement in this litigation?

5 A. To the --

6 Q. I guess apart from counsel and those of us in
7 the room today.

8 MS. BLAIR: Your wife.

9 Q. (BY MS. PARKS) Your wife.

10 A. Yeah. My wife, "What are you doing today?

11 "I have a deposition for a case about
12 Leapfrog."

13 Q. (BY MS. PARKS) So apart from, you know,
14 counsel, your wife, the folks in this deposition, have
15 you spoken to anyone else?

16 A. I don't recall having discussed the details of
17 this case with anyone outside of those mentioned.

18 Q. Okay. And have you discussed your awareness
19 of the dispute between Leapfrog and the five plaintiffs'
20 hospitals with anyone besides counsel?

21 A. I have not.

22 Q. Has your engagement in this litigation -- have
23 you spoken to anyone at work about it?

24 A. When I was preparing the statement, there was
25 a question of whether I could use some of the graphics

1 of the dashboard from our quality committee to make some
2 of the examples in my case.

3 I asked our director of quality if I could use
4 it for a legal case, and he said, "No, that's within
5 company walls." So, yes, Michael T. Anderson, I think,
6 is the person that I asked the question.

7 Whether he asked the question up -- but we did
8 not get details of case information in those email
9 chains.

10 Q. Okay. So did you just tell Michael T.
11 Anderson that you were involved in a litigation, or did
12 you provide any details regarding the litigation?

13 A. I said it was in a case where I've been asked
14 to represent my opinions about the topic in this lawsuit
15 between Leapfrog and some hospitals, and could I use
16 these as examples of how we run quality. I think that
17 was the extent of the discussion.

18 He did share that he had heard that there was
19 a lawsuit against Leapfrog from other sources. He
20 didn't reveal where or how.

21 Q. Okay. And this conversation you had with
22 Mr. Anderson, was it in person or was it by email?

23 A. I think I sent him an email.

24 I may have -- I don't know if he replied just
25 in email or we had a telephone conversation about it as

1 well.

2 Q. Okay.

3 A. I apologize.

4 Q. That's fine.

5 Do you remember approximately when you
6 contacted Mr. Anderson?

7 A. It must have been in the weeks prior to me
8 filing this report.

9 Q. Okay. And -- so if you did speak to him
10 verbally, it would have been by telephone; is that
11 right?

12 A. Probably, yeah.

13 Q. Okay.

14 A. He sits on the quality committee. He comes to
15 the quality meetings, so we converse frequently.

16 Q. Okay. And would you have taken notes during
17 that telephone meeting?

18 A. No. I'm not a notetaker.

19 Q. And would there be any recording or
20 transcription of that telephone meeting?

21 A. No.

22 Q. Okay. And apart from Mr. Anderson, is there
23 anyone else you can think of who you've spoken to about
24 this lawsuit?

25 A. No.

1 Q. When you were engaged as an expert in this
2 matter, did you have to get approval from your employer?

3 A. I did not.

4 Q. Is that standard practice?

5 A. They have changed the policies. And when we
6 do independent work, we represent ourselves and our
7 experiences, and not the organization, which I think I
8 clarified in our early discussions in sharing this, that
9 I do not represent Virginia Mason, CommonSpirit, or any
10 of my employees.

11 Q. Yeah.

12 Okay. And I see -- and you have that in the
13 third paragraph of your report, and that rang a bell.

14 So provided you make that clear in any
15 testimony, you're free to testify in any case without
16 telling your employer?

17 A. Right.

18 Q. Okay.

19 Okay. I'm just flipping randomly here.

20 Okay. What is your hourly rate for working on
21 this matter?

22 A. My hourly rate for everything is \$1,000 an
23 hour.

24 Q. Okay. And by "everything," you mean you're
25 paid the same hourly rate for all of the work you do in

1 this matter?

2 A. This work, consulting work, surgical work.

3 Q. Okay. What -- are you currently doing any
4 consulting work?

5 A. Yes, but not in anything that's relevant to
6 this discussion.

7 Q. And you're saying it's not relevant to this
8 discussion because it's --

9 A. Not relevant to this discussion. It's topics
10 that are unrelated to quality and my experience in
11 testifying on the topic of the Leapfrog survey and my
12 experience as a quality director.

13 Q. Okay. And do any of your experiences as a
14 consultant contribute to your expertise in hospital
15 quality?

16 A. No. Most of my work has been in the
17 neurosurgical space.

18 Q. Okay.

19 A. Technology.

20 Q. Yeah.

21 Is your compensation contingent on the outcome
22 of this case?

23 A. It is not.

24 Q. Is your compensation contingent on your
25 opinions in this case?

1 A. It is not.

2 Q. How many hours did you spend preparing your
3 report?

4 A. I think nine hours total.

5 Q. Okay. And that would include both drafting
6 and researching your report?

7 A. (Nodding.)

8 Q. "Yes"?

9 A. Yes, it did. Sorry.

10 Q. And how many hours have you spent since you
11 submitted your report?

12 A. Approximately three hours. And then this
13 deposition.

14 Q. Do you intend to testify at trial in this
15 matter?

16 A. If requested to do so, I would be happy to,
17 yes.

18 Q. Has counsel requested that you testify at
19 trial in this matter?

20 A. They've said it may be a possibility, yes.

21 Q. And you've agreed to show up if it comes to
22 that?

23 A. Yes.

24 Q. Okay. What did you do to prepare for today's
25 deposition?

1 A. We had a Zoom meeting earlier this week to
2 discuss the details of what this deposition would be
3 like. And then I reviewed the Leapfrog survey packet to
4 make sure I was familiar with the terminology because
5 it's not a document I read on my daily rounds.

6 Q. Did you review any particular portion of the
7 Leapfrog survey packet?

8 A. I couldn't tell you what of the 355 pages I
9 read in entirety and which I skimmed over.

10 Q. Okay.

11 A. I read the neurosurgery page.

12 Q. Did you review any materials other than the
13 Leapfrog survey packet to prepare for the deposition?

14 A. I did not.

15 Q. Okay. How long was your Zoom meeting with
16 counsel?

17 A. About one hour.

18 Q. Have any of your publications ever been
19 retracted?

20 A. No.

21 Q. Has anyone ever questioned the data in any of
22 your publications?

23 A. No.

24 MS. PARKS: Okay. Let's go off the record.

25 THE VIDEOGRAPHER: We are going off the record

1 at 5:25.

2 (Brief break taken.)

3 THE VIDEOGRAPHER: We are back on the record.

4 The time is 5:49.

5 Please proceed.

6 Q. (BY MS. PARKS) Okay. Thank you for bearing
7 with us on that break.

8 A. Of course.

9 Q. I'm going to hand you what has been marked
10 Exhibit 8.

11 (Exhibit Number 8 marked for identification.)

12 Q. (BY MS. PARKS) Okay. So I'll represent to
13 you that this is a copy of Leapfrog's methodology
14 document that we obtained from Leapfrog's website.

15 Have you seen this document before?

16 A. I don't think I've seen it in detail like
17 this. I may have seen the website at some point.

18 Q. And just to be clear, this is, like, a PDF
19 that you download from the website.

20 Have you ever seen this PDF before?

21 MS. BLAIR: And for the record, this is the
22 scoring methodology for the safety grade; correct?

23 MS. PARKS: Correct.

24 MS. BLAIR: Spring 2025.

25 A. Yeah. I'm sure it's come across my desk, but

1 I didn't study it relative to this particular case.

2 Q. (BY MS. PARKS) Okay. And do any of your
3 opinions in this case rely on this scoring methodology
4 document?

5 A. No.

6 Q. Okay. And do any of your opinions in this
7 case rely on the scoring methodology for the Leapfrog
8 safety grade at all?

9 A. No.

10 Q. And I think you mentioned earlier that your
11 entire 20-year career as a doctor has been at the
12 Virginia Mason Franciscan Health system; is that right?

13 A. Yes. We've gone to other sites as partners,
14 but I've been an employee at Virginia Mason the whole
15 time.

16 Q. Okay. And Virginia Mason has participated in
17 the Leapfrog survey for a while; right?

18 A. Yes.

19 Q. Okay. Do you have any experience working at a
20 hospital that does not participate in the Leapfrog
21 survey?

22 A. I don't think so. I mean, I've helped cover
23 other hospitals for neurosurgical work, but I don't know
24 what their Leapfrog status was.

25 Q. Okay. So to the extent you're relying on your

1 professional experience in forming your opinions, all of
2 that professional experience comes from working at a
3 hospital that participates in the Leapfrog survey; is
4 that right?

5 A. I believe so. Not knowing my experience as
6 going through Hopkins, Baylor, University of Texas,
7 University of Washington, Evergreen Hospital, Overlake
8 Hospital, all the areas -- and the hospitals in which I
9 have worked during residency and during short periods in
10 conjunction to my work here, I don't have knowledge of
11 their participation in their quality structure efforts
12 during the times that I worked there.

13 Q. Okay. And all of the ones that you just --
14 all of the hospitals that you just listed, when is the
15 most recent point in time where you worked for one of
16 those hospitals?

17 A. Probably right around 2014 to '16, when we
18 went to help set up a neurosurgery program at Evergreen
19 and Overlake.

20 Q. Okay. So it's fair to say that you don't have
21 any recent experience with how nonparticipation in the
22 Leapfrog survey impacts the culture or structure of
23 quality at a hospital; correct?

24 A. Correct.

25 Q. Okay. And so you have no way, based on your

1 personal experience, to benchmark how quality is
2 impacted between a hospital that participates and a
3 hospital that does not participate; right?

4 MS. BLAIR: Objection to form.

5 A. Yes, not based on my personal experience;
6 correct.

7 Q. (BY MS. PARKS) Okay.

8 Has counsel advised you of the legal framework
9 applicable to this dispute?

10 A. My apologies. I don't understand the
11 legalese.

12 What is a legal framework?

13 Q. Sure.

14 Has counsel advised you of the arguments that
15 Leapfrog plans to make at trial?

16 A. I don't think we've discussed the -- those
17 details, just the general understanding of -- that the
18 hospitals in question were not happy with the Leapfrog
19 grades they received when they withdrew participation in
20 submitting data.

21 Q. Okay. And what is the relevance of the
22 opinions that we've discussed today to the dispute as
23 you just described it?

24 A. I think, big picture, just that measuring
25 quality matters, and it helps contribute to a culture

1 and a structure that helps us improve care.

2 And my understanding of my role is to share an
3 example of what -- of long experience in that
4 environment looks like and the pros and cons of it.

5 Q. And when you referred to "long experience in
6 that environment," are you referring to long experience
7 participating in the Leapfrog survey or something more
8 general?

9 A. Spending my career in a hospital that
10 prioritizes quality and as an adjunct participating in
11 Leapfrog was part of that quality structure.

12 Q. Okay. And how is your personal experience at
13 a hospital that prioritizes quality relevant to the
14 dispute in this case?

15 MS. BLAIR: Objection to form.

16 A. That, I don't know if I could -- the legal
17 team thinks is relevant. My job is just to present what
18 I know.

19 Q. (BY MS. PARKS) Okay. And do you have any
20 understanding of why your opinion is relevant to the
21 dispute in this case?

22 MS. BLAIR: Objection to form.

23 A. Again, I -- they find it useful and relevant,
24 and so I'm sharing my experiences.

25 Q. (BY MS. PARKS) Has counsel told you why they

1 find it useful and relevant?

2 A. I suspect it's because I've lived my life and
3 lived my career trying to do the best thing for
4 patients. And I really believe in measuring to improve.
5 And I hope I've given a career lifetime of effort
6 towards that end. And that may make it relevant.

7 Q. Is that what counsel told you --

8 MS. BLAIR: Objection.

9 Q. (BY MS. PARKS) -- about why your opinion
10 was -- is useful and relevant to this dispute?

11 A. No.

12 MS. BLAIR: Objection to form.

13 Q. (BY MS. PARKS) Did counsel tell you any
14 information about why they find your opinion useful and
15 relevant?

16 A. They did not tell me why they find my opinion
17 useful and relevant. They said they wished to hear my
18 opinion and my experiences as a customer of the
19 healthcare system that prioritizes quality and
20 participates in Leapfrog.

21 Q. Is it your belief that the quality of care
22 provided at Virginia Mason Medical Center is relevant to
23 the dispute in this case?

24 MS. BLAIR: Objection to form.

25 A. I think it's relevant in my experiences that

1 I'm sharing because it's an open and transparent
2 environment for delivering healthcare where quality is a
3 priority.

4 Q. (BY MS. PARKS) Is it your belief that the
5 plaintiff hospitals are not an open and transparent
6 environment?

7 A. I don't have an opinion about the plaintiff
8 hospitals.

9 Q. Okay.

10 Okay. During any of the breaks today, did you
11 have any conversations with counsel about the substance
12 of your testimony?

13 A. No. Mostly dealing with teenagers.

14 MS. PARKS: All right. Well, thank you very
15 much, Dr. Farrokhi, for your time today.

16 I'll pass the witness.

17 MS. BLAIR: I have just a few follow-ups.

18

19 EXAMINATION

20 BY MS. BLAIR:

21 Q. Dr. Farrokhi, we looked at Exhibit 1, which is
22 your resume. And on your resume it says that you are
23 the medical director of quality and chairman of quality
24 council from 2015 to present; correct?

25 A. Correct.

1 Q. In your role as the medical director of
2 quality and the chairman of quality council for Virginia
3 Mason, that is not specific to neurosurgery; correct?

4 A. Correct.

5 Q. And I appreciate that you will leave it up to
6 the court to qualify you as an expert, but would you
7 agree with me that you do, in that decades-long
8 experience in your role as the medical director of
9 quality and the chairman of quality council, have
10 expertise with respect to how a hospital can improve
11 patient safety?

12 A. I do.

13 Q. And would you agree with me in that
14 decades-long experience as the medical director of
15 quality, you had expertise in measuring hospital quality
16 itself?

17 A. Yes.

18 Q. And as part of the documents that you reviewed
19 in preparation for your opinions, one was the complaint
20 in this matter; correct?

21 A. Correct.

22 Q. And do you understand that in the complaint,
23 the plaintiffs' hospitals have taken the position
24 that -- well, the plaintiffs' hospitals allege in their
25 complaint that they stopped participating in the

1 Leapfrog survey in 2021.

2 You're aware of that; correct?

3 A. I believe so, yes.

4 Q. And as we sit here today, is it your
5 understanding that the five hospitals that are
6 plaintiffs in this litigation do not participate in the
7 Leapfrog hospital survey; correct?

8 A. I believe so, yes.

9 Q. And are you aware from the complaint that
10 these hospitals assert in the complaint that the reason
11 that they stopped participating in the hospital survey
12 is because the hospital survey is not reliable and
13 generates inaccurate and misleading results?

14 Are you aware that that is an allegation in
15 the complaint?

16 A. If it was listed in the complaint, yes.

17 Q. And you talked a lot today about -- well, let
18 me ask you this.

19 Do you agree with that allegation, that the
20 Leapfrog hospital survey -- again, I'm not talking about
21 the safety grade -- the Leapfrog hospital safety
22 grade -- or survey, excuse me -- the Leapfrog hospital
23 survey is not reliable?

24 A. No. I do not agree with that statement.

25 Q. Would you agree with the statement that the

1 Leapfrog hospital survey generates inaccurate and
2 misleading results?

3 A. No.

4 Q. And in fact in the decade that you have been
5 the medical director of quality and the chairman of the
6 quality council for Virginia Mason, you've had the
7 opportunity of engaging with the Leapfrog hospital
8 survey; correct?

9 A. Correct.

10 Q. You talked a lot today about external
11 reporting; correct?

12 A. Yes.

13 Q. And would you consider the Leapfrog hospital
14 survey to be external reporting?

15 A. It's internal data coalition and learning and
16 the process of quality improvement that we do in many
17 aspects of our work, and then we report that survey data
18 out.

19 Q. And you understand that Leapfrog publicly
20 reports the survey results from each and every hospital
21 that participates in the survey; correct?

22 A. Correct.

23 MS. BLAIR: And if I could have a sticker,
24 sorry. This will be 9.

25 We'll mark this as Exhibit 9 to your

1 deposition, Dr. Farrokhi.

2 (Exhibit Number 9 marked for identification.)

3 Q. (BY MS. BLAIR) I'll submit to you that I've
4 printed out the Leapfrog -- this is a printout from
5 leapfroggroup.org. And if you could just take a look at
6 this document.

7 For the record, this is the Virginia Mason
8 Medical Center current survey results.

9 Do you have that in front of you?

10 A. I do.

11 Q. And you will see that to the -- on the
12 right-hand side of all of these pages, it has what looks
13 like cell phone bars.

14 A. Yes.

15 Q. Is it your understanding that these cell phone
16 bars are the results of how Virginia Mason Medical
17 Center did on the Leapfrog hospital survey?

18 A. I believe it is.

19 Q. And do you have any reason to believe that
20 Virginia Mason inaccurately reports its data to the
21 Leapfrog hospital survey?

22 A. I do not. Most of everything that I recognize
23 on this survey from data that I've seen through my work
24 in quality seems to reflect both the high and low
25 achievement.

1 Q. And in your ten years as the medical director
2 of quality and the chairman of the quality council for
3 Virginia Mason, have you ever heard that hospitals
4 overinflate their data as reported to The Leapfrog Group
5 on the hospital survey?

6 A. No. The data methodology is very discrete and
7 descriptive.

8 Q. And we've talked a little bit today about
9 methodology. And I want to make sure the record is
10 clear.

11 Do you understand that there is a methodology
12 that underpins each and every measure on the hospital
13 survey?

14 A. Yes.

15 Q. And do you understand that there are separate
16 expert panels either for a specific measure or a
17 specific set of measures that Leapfrog employs?

18 A. Exactly. I think that's what I was
19 referencing to earlier, that we have to trust those
20 expert panels to pull all the data and the expertise
21 together to come up with the questions on the survey
22 that then lead to this report.

23 Q. And would you agree with me that -- well,
24 strike that.

25 You testified earlier about a 355-page

1 document that is the hospital survey; correct?

2 A. Correct.

3 Q. And that 355-page document that you were
4 testifying to, is that the document that hospitals
5 report on that ultimately results in what we're now
6 seeing in Exhibit 9?

7 A. Correct. That is the instruction set of what
8 data to collect and what data to report.

9 Q. And would you agree with me, if we look at
10 Exhibit 9, these cell phone bars -- a hospital could use
11 these cell phone bars to benchmark itself against other
12 survey reported -- Leapfrog survey reported data that
13 shows on the website?

14 A. Yes.

15 Q. And would you agree with me that hospitals,
16 like Virginia Mason, use that 355-page hospital survey
17 to provide a road map of how they can improve or measure
18 hospital safety?

19 A. Absolutely.

20 Q. In your experience, the effort of gathering
21 data for the Leapfrog survey that we see in Exhibit 9,
22 or the outcome -- is it your belief that the effort of
23 gathering data for the Leapfrog survey is of no
24 consequence to a hospital that has fully integrated
25 patient safety into its culture?

1 A. Agree. It -- if you have the culture of
2 safety that is measuring all the KPIs, as we talked
3 about, you have all the people in place to fill in the
4 blanks of this particular survey as well as all the
5 other data reporting structure. And you have the
6 ability to collect and react to that data.

7 Q. And in all your expertise over the last
8 decade, as the medical director of quality and the
9 chairman of the quality council for Virginia Mason,
10 would you agree that the Leapfrog hospital survey
11 provides a structure to aid hospitals in creating an
12 environment of patient safety?

13 A. Yes. If you follow the recipe and try to
14 measure all the things that are in that survey
15 thoughtfully, you are bound to create a structure, as we
16 referenced in many discussions today, of measuring to
17 improve.

18 Q. And just to be clear, in your over-decades'
19 long in being the medical director of quality and the
20 chairman of quality control, would you agree with me
21 that the hospital survey is a reliable methodology for a
22 hospital to measure and benchmark its performance on
23 hospital safety?

24 A. Very much so, yes.

25 MS. BLAIR: I have no further questions.

1 EXAMINATION (continued)

2 BY MS. PARKS:

3 Q. Okay. Can you point me to where in your
4 report you provide an opinion regarding the reliability
5 of the Leapfrog hospital survey?

6 A. I don't think I referenced specifically the
7 reliability of the Leapfrog hospital survey in that
8 report.

9 Q. Okay. So in -- when did you form the opinion
10 you just provided to counsel, that the hospital survey
11 is reliable methodology for a hospital to measure and
12 benchmark its performance on hospital safety?

13 A. When did I form that opinion?

14 Q. Yes.

15 A. Over my career and experience with my quality
16 system.

17 Q. So you formed that opinion before you put pen
18 to paper on this report?

19 A. I think my opinion of the assessment of this
20 particular tool as part of an integrated quality system
21 has been formed over all the experiences that we talked
22 about today, yes.

23 Q. Okay. And so even though you held the opinion
24 that the Leapfrog hospital survey is reliable at the
25 time you wrote this report, you did not disclose that

1 opinion within the confines of this report; correct?

2 MS. BLAIR: Objection to form.

3 A. I was not asked that question in that
4 verbiage. And no, I didn't reflect it on that report;
5 correct.

6 Q. (BY MS. PARKS) Okay. So did counsel ask you
7 to provide an opinion on whether the Leapfrog hospital
8 survey is reliable?

9 A. I believe she just did.

10 Q. Did counsel ask you, when you were drafting
11 this report, to render that opinion?

12 A. No.

13 Q. No.

14 So when Ms. Blair asked you that question a
15 few minutes ago, that was the first time counsel ever
16 asked you --

17 A. Yes.

18 Q. -- for your view on whether the survey is
19 reliable?

20 A. I believe that was the first time that
21 question was asked in that way, yes.

22 Q. Okay. And was that also the first time
23 counsel ever asked you if you can use the hospital
24 survey to benchmark a hospital's performance on hospital
25 safety?

1 A. Yes. I believe that was the first time I've
2 been asked that specific question.

3 Q. Okay. And is it fair to say that your report
4 also does not address whether it's possible to benchmark
5 a hospital's performance using the hospital survey?

6 A. Correct. I did not include that in my report.

7 Q. Okay. Do you recall counsel asked you
8 questions about whether hospitals overinflate their
9 responses to the hospital survey?

10 A. I think we just answered that question, yes.

11 Q. Yes. I'm just orienting my question.

12 Have you reviewed the responses from other
13 hospitals to the Leapfrog hospital survey to confirm
14 whether or not they overinflate their responses to the
15 survey?

16 MS. BLAIR: Objection to form.

17 A. No. I did not claim that.

18 Q. (BY MS. PARKS) Okay. So do you have any
19 information as to whether other hospitals do or do not
20 overinflate data in response to the Leapfrog hospital
21 survey?

22 A. No. I do not have any information from other
23 hospitals to -- as to whether or not they do -- how they
24 report their hospital data.

25 Q. Okay. And do you -- or did you do anything to

1 independently validate the work of Leapfrog's expert
2 panels that Ms. Blair asked you about?

3 A. No. I have not independently validated the
4 expert panels in Leapfrog.

5 Q. Okay. And have you, in your work -- in your
6 20 years of experience, ever used the cell phone bars to
7 benchmark your hospital against another hospital?

8 A. I believe our quality committees do reference
9 this and other data when they're -- as we mentioned
10 earlier, if we come up with -- across an occasion where
11 we are not performing as we think we should, or if we
12 want to perform better, I am sure that they have reached
13 out to this data set and other data sets to understand
14 how we could do better.

15 Q. Okay. And in that response, you said you
16 believe that your quality committees used the data.

17 Do you have any specific recollection of
18 anyone from Virginia Mason Medical Center using these
19 cell phone bars to benchmark against other hospitals?

20 A. I do not.

21 Q. Okay. So you can't state with certainty one
22 way or the other whether Virginia Mason has ever used
23 these cell phone bars for benchmarking?

24 A. I cannot.

25 Q. Okay. And do you have any information about

1 whether hospitals other than Virginia Mason Medical
2 Center use the Leapfrog hospital survey as a road map to
3 improve hospital quality?

4 A. I do not.

5 Q. Okay. And you also told Ms. Blair that it's
6 your opinion that the effort of completing the Leapfrog
7 survey is of no consequence if you have the structures
8 in place already; is -- am I paraphrasing that
9 correctly?

10 MS. BLAIR: Objection to form.

11 A. Correct. If we have a structure where we are
12 following key performance indicators in many realms, and
13 you have, as we discussed all day, the pieces of that
14 puzzle, both culturally, structurally, and the people in
15 place, like the quality team members, then reporting
16 these measures becomes a clerical task of moving them
17 from the data sets you have to the data sets for
18 reporting.

19 Q. (BY MS. PARKS) Okay. Have you done any
20 analysis of the incremental burden to your hospital of
21 completing the Leapfrog hospital survey?

22 A. I have not.

23 Q. Okay. So other than your belief, as you just
24 expressed it, what is your basis for saying that the
25 burden of completing the Leapfrog survey is of no

1 consequence for your hospital?

2 A. That is my opinion after having experienced
3 the environment that I've experienced over the years
4 I've been doing this.

5 Q. Okay. Have you ever asked anyone from your
6 hospital whether there is a burden associated with
7 completing a survey?

8 A. I have not.

9 Q. Okay. Do you agree that the individuals who
10 actually complete the survey would be best placed to
11 speak to whether there's a burden in doing so?

12 A. That seems like a reasonable thing to do.

13 Q. Okay. And the opinion you've rendered to
14 Ms. Blair, that the effort for your hospital is of no
15 consequence, does that opinion appear in your report?

16 A. No, it does not.

17 Q. Okay. And is that an opinion that you formed
18 prior to drafting your report?

19 A. Again, I have a challenging time with the
20 timing of my opinions. My opinion is formed over a
21 lifetime of experience, and so I can't point to a time
22 and place where an opinion was formed.

23 Q. During the process of drafting your report,
24 did counsel ask you about the burden of completing the
25 Leapfrog survey?

1 A. I don't believe they did.

2 Q. Okay. So when Ms. Blair asked you the
3 question a few minutes ago, that was the first time
4 counsel ever asked you --

5 A. Yes.

6 Q. -- your opinion on that?

7 A. Yes.

8 Q. Okay.

9 MS. PARKS: I'll pass the witness back.

10 MS. BLAIR: Quick -- I'll just quickly note.

11

12 EXAMINATION (continued)

13 BY MS. BLAIR:

14 Q. Dr. Farrokhi, if you go to Exhibit 2, page 6.

15 I did ask you some questions about using the
16 Leapfrog hospital survey as a benchmark for quality
17 improvement and measurement.

18 Do you recall that?

19 A. Yes.

20 Q. And if we look at the first full paragraph on
21 page 6, you say, "The decision by our healthcare system
22 to participate in multiple transparent external
23 reporting systems on quality (such as The Leapfrog
24 Group, CMS, and Healthgrades), and to share the results
25 with all members of our team and our community, has been

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1 critical to developing the safest space for practicing
2 medicine."

3 Do you see that?

4 A. Correct. I do.

5 Q. Is it unfair of me to take that sentence to
6 mean that you are using the transparent external
7 reporting system of The Leapfrog Group to benchmark
8 yourself and to improve patient safety?

9 A. Yes --

10 MS. PARKS: Objection. Compound.

11 A. Yes, the fact that we are measuring leads to
12 improvement. And we measure with the purpose of
13 improving. So they -- those topics go hand in hand, as
14 I believe I've stated innumerable times today.

15 Q. (BY MS. BLAIR) And so while your opinions
16 might not specifically say, "We use the Leapfrog
17 hospital survey to benchmark our quality measurement and
18 quality improvement," would you not agree with me on
19 page 6 you clearly say that you do use The Leapfrog
20 Group, which has been critical in developing the safest
21 space for practicing medicine?

22 A. Agreed.

23 Q. And by that, do you mean benchmarking yourself
24 in terms of quality improvement measurement?

25 MS. PARKS: Objection.

1 A. Yes. We benchmark by using this data and
2 trying to make it better.

3 Q. (BY MS. BLAIR) And if we turn to page 7 of
4 your opinion, the first full paragraph, last sentence,
5 you're talking about -- well, let's talk about the first
6 sentence.

7 You say, "Much of the work of a hospital
8 quality system is to question the why and how we measure
9 success."

10 Do you see that?

11 A. I do.

12 Q. And the last sentence of that paragraph, you
13 say, "This only happens in a healthcare system when that
14 work is a priority and we partner with large national
15 organizations like the TLG" -- The Leapfrog Group --
16 "that measure and share learnings and quality and
17 safety."

18 Do you see that?

19 A. Yes.

20 Q. And, again, while your expert opinion does not
21 specifically use the words "benchmarking," does that
22 opinion not set forth that it is your opinion that the
23 Leapfrog hospital survey does provide a benchmarking
24 tool for you to measure and share learnings about
25 quality and safety?

1 A. It does.

2 Q. And last but not least, if we go to page 13,
3 the first full paragraph, first sentence there, you may
4 recall counsel asked you several questions about your
5 use of Leapfrog Group grade.

6 Do you recall that?

7 A. Yes.

8 Q. And I believe at some point you asked if you
9 could drop the word "grade" from that opinion; correct?

10 A. Yes.

11 Q. And is that because the word "grade" was
12 actually referring to how a hospital was scoring on the
13 hospital safety survey as opposed to the grade?

14 A. Correct. It was the results that we have
15 visibility to in detail. And that transparency of that
16 detail is what gives it value.

17 Q. And that first sentence says, "The Leapfrog
18 Group" -- we'll take out the word "grade" -- "offers an
19 easily visible and transparent representation of the
20 complex quality and safety evaluation system that exists
21 in US healthcare today."

22 Do you see that?

23 A. Correct.

24 Q. Is that an opinion that the Leapfrog hospital
25 survey provides a way for you to evaluate and measure

1 patient safety for your hospital?

2 A. Exactly. That's what these cell phone bars
3 do.

4 MS. BLAIR: Thank you. I have no further
5 questions.

6
7 EXAMINATION (continued)

8 BY MS. PARKS:

9 Q. Okay. Does your report ever describe using
10 Leapfrog data to compare your hospital to other
11 hospitals?

12 MS. BLAIR: Objection to form. Asked and
13 answered.

14 A. I would reference the last questions that were
15 asked and answered.

16 Q. (BY MS. PARKS) And does anywhere in your
17 report re- -- like, describe how your hospital could
18 compare itself to other hospitals?

19 MS. BLAIR: Objection to form.

20 A. Again, I think in the context that we just
21 discussed in the last few questions.

22 Q. (BY MS. PARKS) Okay. So --

23 A. I reference the record.

24 Q. So the three portions of your report that
25 Ms. Blair pointed you to in that questioning, those are

1 the places where you believe your report addresses
2 comparing your hospital to other hospitals using
3 Leapfrog scores?

4 A. Correct. The whole concept of public
5 transparent reporting is to use this data to compare
6 yourself and improve. So that's the fundamental
7 concept, so...

8 Q. Okay. And then do any of your opinions set
9 forth in this report refer to the Leapfrog hospital
10 survey?

11 MS. BLAIR: Objection to form.

12 A. My entire opinion and testimony set forth here
13 is in reference to my experience as it relates to the
14 hospital survey.

15 Q. (BY MS. PARKS) Can you point me to where in
16 your report you mention the Leapfrog hospital survey?

17 A. I don't think I use those words, "the Leapfrog
18 hospital survey." I referenced that in The Leapfrog
19 Group's work because that is the facing -- the portion
20 of The Leapfrog Group that I face in my experience, as
21 stated.

22 Q. So in reading your report, should we
23 understand each reference to The Leapfrog Group to in
24 fact be a reference to the survey itself?

25 A. The survey and the data that we get from it

1 for benchmarking, yes.

2 Q. Okay. And if you were purporting to provide
3 an opinion on how hospitals use the survey itself to
4 improve hospital quality, wouldn't it have been
5 important to describe how, in particular, a hospital
6 could do that?

7 MS. BLAIR: Objection to form.

8 A. Again, important to whom? I answered the
9 questions posed for me in sharing my experience in the
10 best way I could.

11 Q. (BY MS. PARKS) Okay.

12 MS. BLAIR: I think at this point, we're going
13 far beyond time.

14 MS. PARKS: Okay. Well, I would say that your
15 questions, many of which were out of the scope of the --
16 my questions caused us to go over time, but bear with
17 me.

18 I just have one more question.

19 MS. BLAIR: Okay.

20 Q. (BY MS. PARKS) Okay. How can you say that
21 your report is providing the basis for your opinion that
22 a hospital can use the Leapfrog hospital survey itself
23 to improve quality when your report fails to mention the
24 survey or how a hospital can use the survey?

25 MS. BLAIR: Objection to form. Asked and

1 answered.

2 A. Again, I -- I've shared my opinion about my
3 experiences in this environment with this survey.

4 Q. (BY MS. PARKS) Okay. So where in this report
5 do you provide the basis for your opinion that a
6 hospital can use the Leapfrog hospital survey itself to
7 improve quality?

8 MS. BLAIR: Objection to form. Asked and
9 answered.

10 A. I think we've answered that question multiple
11 times in multiple ways in the testimony.

12 Q. (BY MS. PARKS) And by that, you mean it's the
13 three portions that Ms. Blair pointed you to?

14 MS. BLAIR: Objection to form.

15 He's been testifying about it all day.

16 A. Yes. And the whole gist -- you're asking a
17 very general question, and I hope I have adequately
18 answered it in all the answers I provided today.

19 MS. PARKS: Okay. No further questions.

20 MS. BLAIR: Thank you.

21 We will order a rough draft and etran by
22 regular delivery. Thank you.

23 THE VIDEOGRAPHER: Okay. Thank you.

24 This concludes today's testimony of Farrokh
25 Farrokhi. The total number of media units used was

1 seven and will be retained by Veritext.

2 We are going off the record at 6:25.

3 (Deposition concluded at 6:25 p.m.)

4 (Reading and signing was not requested
5 pursuant to FRCP Rule 30(e).)

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REPORTER'S CERTIFICATE

I, TAMI LYNN VONDRAN, CCR, CSR, RMR, CRR, the undersigned Certified Court Reporter authorized to administer oaths and affirmations in and for the states of Washington (2157), Oregon (20-0477), and California (14435) do hereby certify:

That the sworn testimony and/or proceedings, a transcript of which is attached, was given before me at the time and place stated therein; that any and/or all witness(es) were duly sworn to testify to the truth; that the sworn testimony and/or proceedings were by me stenographically recorded and transcribed under my supervision. That the foregoing transcript contains a full, true, and accurate record of all the sworn testimony and/or proceedings given and occurring at the time and place stated in the transcript; that a review of which was not requested; that I am in no way related to any party to the matter, nor to any counsel, nor do I have any financial interest in the event of the cause.

WITNESS MY HAND AND DIGITAL SIGNATURE this 7th day of October, 2025.



TAMI LYNN VONDRAN, CRR, RMR
Washington CCR #2157, Expires 10/6/2026
Oregon CSR #20-0477, Expires 9/30/2027
California CSR #14435, Expires 10/31/2026

1 Good Samaritan Medical Center, Et Al. v. The Leapfrog Group
2 Dr. Farrokh Farrokhi , M.D. Job No. 7621612
3 E R R A T A S H E E T
4 PAGE_____ LINE_____ CHANGE_____
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21 REASON_____
22 _____
23 _____
24 Dr. Farrokh Farrokhi , M.D. Date
25

1 Good Samaritan Medical Center, Et Al. v. The Leapfrog Group
2 Dr. Farrokh Farrokhi , M.D. 7621612

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Dr. Farrokh Farrokhi , M.D., do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10
11 _____
12 Dr. Farrokh Farrokhi , M.D.

Date

13 *If notary is required

14 SUBSCRIBED AND SWORN TO BEFORE ME THIS

15 _____ DAY OF _____, 20____.

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[approximately - attend]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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EXHIBIT 7

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

GOOD SAMARITAN MEDICAL)
CENTER, INC., ET AL) Case No.:
Plaintiffs) 9:25-cv-80526-DMM
Vs.)
THE LEAPFROG GROUP)
Defendant)

Deposition of ANTHONY HARRIS, M.D., MPH,
was taken on Monday, September 29, 2025, commencing
at 10:12 a.m., at Wilson, Elser, Moskowitz, Edelman
& Dicker, 250 West Pratt Street, Suite 2200,
Baltimore, Maryland, before MICHELE D. LAMBIE,
Notary Public.

Reported By:

Michele D. Lambie, CSR-RPR

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10
11
12
13
14 ALSO PRESENT: Brian Mackey - Videographer

EXAMINATION INDEX

ANTHONY HARRIS, M.D., MPH

BY MR. HVIDT

7

EXHIBIT INDEX

(Attached to Transcript.)

MAR

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Defendant's Expert Anthony Harris

Exhibit 2 Expert Report of Anthony Harris 60

Exhibit 3 Document Bates Numbered 108
LEAPFROG00437361

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Exhibit 5 Transcript of Expert Safety Panel 131
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Exhibit 6 Document Bates Numbered 139
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Exhibit 7 Expert Report of Professor Sean 154
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LEAPFROG00178623

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P R O C E E D I N G S

(Whereupon, Harris Deposition Exhibit No. 1, Notice of Deposition of Defendant's Expert Anthony Harris, premarked for identification.)

THE VIDEOGRAPHER: We are going on the record at 10:12 a.m. on September 29th, 2025.

This is media unit one in the deposition of Anthony Harris, M.D., MPH in the matter of Good Samaritan Medical Center, Incorporated, et al. versus The Leapfrog Group, in the United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-CV-80526-DMM.

This deposition is taking place at the offices of Wilson Elser, 250 West Pratt Street, Baltimore, Maryland.

My name is Brian Mackey from Veritext, and I'm the videographer. The court reporter today is Michele Lambie from Veritext.

Will Counsel please state their appearances and affiliations for the record?

1 MR. HVIDT: Scott Hvidt with Gibson Dunn
2 for the Plaintiffs.

3 I'm here with my colleague, Kevin Reilly,
4 with Gibson Dunn for the Plaintiffs.

5 MS. BLAIR: Kim Blair, Wilson Elser, for
6 The Leapfrog Group.

7 THE VIDEOGRAPHER: Will reporter please
8 swear in the Witness.

9 ANTHONY HARRIS, M.D., MPH,
10 the Deponent, called for examination by the
11 Plaintiffs, being first duly sworn to tell the
12 truth, the whole truth, and nothing but the truth,
13 testified as follows:

14 MR. HVIDT: Thank you.

15 EXAMINATION

16 BY MR. HVIDT:

17 Q. Dr. Harris, can you please state your
18 full name for the record?

19 A. It's Anthony Dan Harris.

20 Q. Thank you.

21 I'm going to hand you what's been marked

1 as Exhibit 1 in this deposition.

2 Have you seen this document before,
3 Dr. Harris?

4 A. Yes, I have.

5 Q. And what is this document?

6 A. It's the date and time I'm supposed to be
7 here.

8 Q. And what's the date and time you're
9 supposed to be here?

10 A. September 29th, 2025, 9:00 a.m.

11 Q. Okay. And what time is it for the
12 record?

13 A. It's 10:12.

14 Q. Okay. Thank you.

15 And other than this document including
16 the date and time, is this also the notice of your
17 deposition?

18 A. Yes.

19 Q. And do -- do you understand that you have
20 been disclosed as an expert in this case?

21 A. Yes, I do.

1 Q. And who are you disclosed by an expert
2 by?

3 A. I'm sorry, I don't understand the
4 question.

5 Q. What party to the case disclosed you as
6 an expert?

7 A. The law firm and Leapfrog.

8 Q. And who is employing you as an expert in
9 this case?

10 A. I'm not sure. It's -- I'm not sure
11 exactly. It's -- I'm not sure whether it's a law
12 firm or Leapfrog.

13 Q. Okay. Would the law firm you're
14 referencing there be Wilson Elser?

15 A. Yes.

16 Q. And is -- and Leapfrog is -- is the
17 Defendant to this case?

18 A. Correct.

19 Q. Thank you.

20 When were you first contacted about
21 possible -- possibly being retained as the expert

1 in this case?

2 A. It was relatively recently. It was the
3 last week of August to the first week of September.

4 Q. And who contacted you?

5 A. I was contacted by Kim Blair.

6 Q. And have you ever been hired by Kim Blair
7 in another matter?

8 A. I have not.

9 Q. Have you ever been hired by Wilson Elser
10 in another matter?

11 A. I have not.

12 Q. Have you ever been hired by The Leapfrog
13 Group for any purpose?

14 A. I have not.

15 Q. What is this case about in your own
16 words?

17 A. Well, I've been asked to give my opinion
18 on specific angles which relates to basically the
19 methodology that Leapfrog uses relative to grading
20 hospitals.

21 Q. I understand that. We'll -- we'll get to

1 what your assignment was in a minute, but if
2 you -- the case in the caption before you, do
3 you -- in your own words, can you describe what you
4 believe this lawsuit is about?

5 A. There's a number of hospitals that
6 received a poor grade in 2024. They're criticizing
7 a methodology related to a subsegment of the
8 metrics that compose the overall grade and they're
9 questioning whether that is the -- whether that's a
10 fair method basically related to a certain number
11 of the metrics that are being used that led to
12 their grade.

13 Q. And then going back to the -- to your
14 assignment. What -- what did Counsel ask you to do
15 in this matter?

16 A. Well, the -- the main issue of the -- of
17 what I was asked to give my opinion on related to
18 the imputation method.

19 So the Leapfrog methodology has a number
20 of outcome and process metrics, I believe 32 in
21 total.

1 The main gist of the case that I was
2 asked to give my opinion on relates to there are
3 four outcome, four process metrics -- I stand
4 corrected -- they're process metrics, that the
5 advisory committee that serves Leapfrog, of which I
6 know some of the members, decided to impute the
7 values and change the methodology from imputing a
8 median value to imputing another value, and the
9 basic things they wanted me to comment on
10 more -- most globally was that main issue was:

11 Do I agree that that methodology is fair?

12 Do I agree that that methodology is a
13 movement towards an improvement from the prior
14 methodology?

15 And then, obviously, in trying to give my
16 opinion on that, I was forced to review Nicholson's
17 expert opinion. I was also forced to review
18 or -- the changes in the Leapfrog methodology
19 specifically related to the imputation method, and
20 those are doc- -- the main documents that I
21 reviewed when I gave my expert opinion.

1 And, I mean, one really important point,
2 obviously, is what drives a lot of this is the
3 issue of nonresponse bias and whether this
4 imputation method was an improvement to the five
5 hospitals choosing not to fill out the survey and
6 ties into the best method to deal with nonresponse
7 to certain questions.

8 Q. Thank you.

9 In there, you -- you mentioned that you
10 know some members on the Leapfrog Expert Safety
11 Grade Panel. What members do you know?

12 A. Sure. So there's -- I'd like, if
13 possible, to get the complete list of the members,
14 because I did review it, but the ones I know well
15 is Arjun Srinivasan.

16 So he is employed by the CDC, but serves
17 on that advisory board. I've worked with him for
18 25 years. He was originally at Johns Hopkins as a
19 faculty member before he went to the CDC.

20 David Bates I've seen presented at a
21 number of meetings that I go to. He's a world

1 expert in quality improvement and hospital
2 per- -- performance.

3 And David Classen is a physician and
4 informatician at the University of Utah. I think I
5 only physically talked to him once when I was at
6 Harvard getting my Master's of Public Health. He
7 came as a visiting professor, and I spoke to him,
8 but I followed his career and I have seen him
9 present at a number of meetings.

10 Those are the three that I've either had
11 direct interactions with or heard them present at
12 some national meetings.

13 Q. Understood. So when you said you know
14 them, that -- that was a pretty broad spectrum of
15 knowing, would you agree with that?

16 Like, some of -- one you've worked with
17 for 25 years and another you -- you have seen
18 speak?

19 A. Well, Srinivasan I have worked with very
20 closely because he's very high up in the CDC and
21 the DHQP, which is basically an area -- an area

1 that I've received a fair amount of CDC funding
2 with and I've interacted with him probably
3 two/three times a year for 25 years.

4 Q. And then other than Ar- --
5 Dr. Srinivasan, the other two are ones that you
6 don't know as well as you know Dr. Srinivasan; --

7 A. Correct.

8 Q. -- is that correct?

9 A. Correct. And from the academic metric
10 point of view, which I think relates to conflicts
11 in our area, I have published with Dr. Srinivasan,
12 and I've not published with anyone else on the
13 advisory board.

14 Q. Thank you.

15 In -- in your description of your
16 assignment, you mentioned that you were asked to
17 assess whether the 2024 imputation methodology
18 change was an improvement.

19 When you mentioned the word improvement,
20 what -- how are you using that word or like how
21 would a methodology improve?

1 A. Okay. So I've published extensively in
2 this area mainly related to infectious
3 disease-related outcome metrics, some of which are
4 part of the Leapfrog methodology. So things like
5 hand hygiene, methicillin-resistant staph aureus,
6 MRSA, central line-associated bloodstream infection
7 rates.

8 For years, I've been involved both as a
9 day-to-day hospital epidemiologist having to
10 decrease those rates at my hospital.

11 I've also published on the methodology
12 about how to improve it and I've been involved on
13 CDC advisory boards where the exact same type of
14 discussions that this advisory board has is you
15 review a measure. You try to understand the pros
16 and the cons of the measure. You respond to your
17 constituents, which in this case would be the
18 hospitals. You respond and you aim to -- in a
19 gradual fashion over years, and in my career
20 decades, you aim to improve that metric. So you
21 look at ways a metric may be underperforming and

1 you aim to improve it.

2 As is similar in this case, there's no
3 perfect methodology for problems sometimes.

4 Q. And -- and when you're aiming to improve
5 it, are you trying to make it more accurate?

6 A. You're trying to make it more fair.

7 So if you look at both CMS, CDC, Vizient,
8 Leapfrog, their goal is to improve patient
9 outcomes. Their goal is to improve hospital
10 quality, and they're aiming to have their metrics
11 be as close a reflection of that goal, and it's a
12 tough goal to achieve.

13 And so there's always incremental
14 improvements and incremental thoughts of advisory
15 committees of how to make that better and truer,
16 truer in this case giving the hospital a true grade
17 that reflects patient quality.

18 Q. So when you say a true grade, does that
19 mean a grade that's meant to reflect how they would
20 accurately perform on the rating?

21 MS. BLAIR: Objection to form.

1 THE WITNESS: No. I -- the goal is, of
2 whether it's Leapfrog or CMS, you want when a
3 consumer looks at a rating and they choose to go to
4 a hospital or not go to a hospital, you want them
5 to have as much transparent and accurate
6 information to help them make the right decision,
7 and I -- I think that's at the crux of the
8 imputation, was you're trying to get that
9 imputation method as close to the truth as
10 possible, even though you don't know exactly what
11 the truth on, in this case, those four process
12 measures or structural measures are.

13 BY MR. HVIDT:

14 Q. So with the Leapfrog imputation
15 methodology, it's your testimony that Leapfrog is
16 trying to have that, those imputed measures, try to
17 have those be as close as you can to how they
18 actually would have performed had they participated
19 in the survey?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: I -- I think -- can you

1 read back the question because --

2 MS. BLAIR: I didn't mean to interrupt
3 you.

4 BY MR. HVIDT:

5 Q. Yeah. So when you are saying that
6 Leapfrog is trying to with the imputation
7 methodology be transparent with how -- whether
8 their rating is accurate, with the imputation
9 methodology, are they -- is Leapfrog trying to
10 accurately measure non-participating hospitals with
11 the imputation methodology?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: Hold on. One second. You
14 said it better the first time I don't think
15 you --

16 BY MR. HVIDT:

17 Q. I understand, because we were talking
18 about your testimony --

19 A. Yes.

20 Q. -- and so now --

21 A. Yeah. Yeah. So let me -- let me

1 para- -- let me paraphrase I think what my thought
2 of closest to the truth is.

3 Yeah, the whole purpose of an imputation
4 method is to try to take the hospitals that are not
5 perform -- that are not reporting and give them a
6 value as close to the truth as if they would have
7 reported, knowing that that's a difficult task, but
8 getting close to the truth.

9 So to somewhat cut to the chase and
10 emphasize a key point, I do think the changes that
11 the advisory board suggested that Leapfrog went to
12 of changing from the mean or the median, I
13 can't -- as an epidemiologist, I should remember
14 whether it was the mean or the median, but it was
15 an ordinal scale, but -- but the point is in
16 changing from -- in 2024 from the spring to the
17 fall and changing from the mean to the lower
18 achievement category, yes, I think they got closer
19 to the truth of what the value would have been if
20 those five hospitals had reported their answers to
21 the survey, to the voluntary survey.

1 Q. And so is it your testimony that, in
2 general, like when you're looking at a clean slate
3 and you're trying to set up an imputation
4 methodology, that imputation methodology, you are
5 trying to estimate what missing data would have
6 been if it weren't missing; is that correct?

7 A. Yeah, exactly. So there's --

8 Q. Okay.

9 A. One sec. There's one principle super
10 important for us to start back at.

11 In all of epidemiology, okay, it's a
12 principle called the counterfactual which is really
13 important relative to missing an imputation, okay?

14 So counterfactual basically gets
15 at -- and it applies even to like what's randomized
16 trials. It -- it gets at the point of let's say
17 if -- if I'm a patient, right, and I'm getting Drug
18 A and it's a randomized trial and someone else is
19 supposed to get Drug B, okay, you ideally want the
20 person to get Drug A -- B to be exactly the same in
21 every possible situation as possible.

1 So the way we teach it is it's call
2 cloning machines. Counterfactual is a big term for
3 cloning, okay.

4 The imputation method -- and so when
5 we're doing non-randomized trials, which is what
6 I've published on exclusively, you know, a lot
7 through the years, you're trying to get as close to
8 that ideal design.

9 So using that analogy I think is really
10 important to answer your question, which is if you
11 could go back in time and go back to these five
12 hospitals and get them to complete the survey in an
13 honest and transparent way, the idea of imputation
14 is to get as close to what the real data they would
15 have reported is.

16 Q. And, again, is it your understanding that
17 when Leapfrog implemented the 2024 imputation
18 methodology change, that Leapfrog was trying to do
19 what you just testified to? They were trying to
20 estimate what the non-performing hospitals would
21 have performed had they participated in the survey?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: Yes, I think that they were
3 trying to get as close to what they would have
4 reported and felt that the prior methodology was
5 too far from what they would have reported.

6 And that's the basis of a lot -- I'm sure
7 we'll get to my exhibits, but that's what
8 I -- that's exactly what I tried to do. And my
9 response was do what we do all the time, which is
10 almost called like a sensitivity analysis, is you
11 run things multiple ways to see, okay, if this
12 assumption is wrong, but it's only wrong a little
13 bit, how close do we get?

14 It's efforts to try to get as close to
15 the truth as possible using different methods.

16 BY MR. HVIDT:

17 Q. Thank you.

18 Switching gears for -- for a minute, and
19 we'll come back to -- to that when we dig into
20 to -- to the report.

21 Can you say what your hourly rate was for

1 working on this matter?

2 A. Yeah. \$600 an hour, \$800 an hour for
3 the deposition for today and a thousand dollars an
4 hour if it goes to court.

5 Q. And how many hours did you spend
6 preparing your report?

7 A. Preparing the report, ten and a half
8 hours I believe.

9 Q. And how many hours have you spent since
10 preparing your report?

11 A. Three to four hours.

12 Q. And what have those three to four hours
13 been?

14 A. The last three to four hours was a
15 one-hour call on Saturday with Kim, it was an hour
16 to an hour and a half last night reviewing my
17 expert opinions, and I was also reviewing
18 the -- there were two documents. One was like
19 spring 2024 Leapfrog methodology and fall 2024
20 methodology, and I quickly, in not enough detail,
21 looked through Nicholson's deposition.

1 Q. And when you said Nicholson's deposition,
2 are you referring to Dr. Sean Nicholson?

3 A. Yes, I apologize.

4 Q. Did you receive any support in preparing
5 your expert opinion?

6 A. Yes. So I have to double-check these
7 dates for the ex- -- exact thing, but I'll be
8 pretty close on the weeks at least.

9 Within a week of them contacting me, I
10 had a series of meetings with a number of lawyers
11 from -- from the firm, and then I also had one
12 meeting with Missy Danforth from Leapfrog, where
13 she was on that meeting, and as we were talking
14 through my thoughts, in general, I -- it was
15 entirely my idea related to the main -- main
16 exhibits that are part of my expert testimony, but
17 they helped me clean them up.

18 Obviously, because I did not have access
19 to the five hospitals and all of the breakdowns of
20 all of their CMS scores, their HCAHPS scores, they
21 helped give me that data through those series of

1 meetings and they helped basically make the tables
2 and exhibits look a little nicer.

3 Q. And did anyone other than Wilson Elser
4 attorneys assist you in preparing your expert
5 opinions?

6 A. Missy Danforth was on two calls I believe
7 from Leapfrog, and that's it.

8 Q. Did she review your expert opinion and
9 provide edits to it?

10 A. I do not believe so. I did not -- I was
11 only on two calls with her. I was not on -- she
12 didn't -- I -- I -- she did not edit the document
13 or make any comments on the documents.

14 Q. Did you interact with anyone else at
15 Leapfrog as -- in preparing your expert report?

16 A. I did not.

17 Q. Have you served as an expert in a
18 litigation before?

19 A. I have done two. It was a long time ago.

20 One was -- as an expert, the answer is
21 only one. It was a medical/legal case.

1 I was deposed once in a -- my -- a
2 divorce, my own divorce in the early 2000s, and the
3 expert witness deposition was, I believe, like in
4 2010. It was a long time ago.

5 Q. And in 2010, what were you an expert in?

6 A. It was so long ago that I can't remember
7 the exact details of the case, but if I'm not
8 mistaken, it was -- I was representing the hospital
9 and the defense for a surgical site infection.

10 Q. Was it --

11 A. So it was --

12 Q. -- a medical malpractice case?

13 A. Yeah, it was a medical malpractice case.

14 Q. And you served as an expert in defense of
15 there being medical malpractice in that instance;
16 is that fair?

17 A. Exactly. Exactly.

18 Q. And did you -- was any portion of your
19 expert testimony not accepted by the court?

20 A. No.

21 Q. Do you understand that your testimony as

1 an expert in this case has to be admissible under
2 the Federal Rules of Evidence?

3 A. I -- I think so.

4 Q. Can you list for me every opinion you
5 intend to offer at trial?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: I don't completely
8 understand the question, but if there was a way of
9 me having my deposition in front of me, the
10 main -- the main gist of what my opinion is, is
11 basically, one, is it nonresponse bias is a really
12 important principle and that nonresponse bias
13 basically relates to the fact that the hospitals
14 chose not to complete the survey.

15 And when someone chooses not to complete
16 something, there's a difference between those that
17 report, complete a survey and those that do not.

18 So in this case, I plan on giving my
19 opinion on the importance of nonresponse bias. So
20 that's one thing that's really important.

21 The second I think most important thing

1 that when I read Dr. Nicholson's ex- -- expert
2 opinion was that his method of imputing the -- the
3 medians for seven of the outcome measures was
4 flawed because Leapfrog only uses four of the
5 measures.

6 So to me, to somewhat be blunt, but it's
7 kind of in some ways I think the most important
8 point of my deposition, epidemiologically that's
9 really flawed, because he's giving them higher
10 scores on three outcomes that aren't even part of
11 their grade. So you would never impute stuff
12 that's not part of a score, so those are the two
13 most important.

14 The third is that -- and it ties into
15 what I alluded to at the beginning of this, is,
16 unfortunately, this is not an exact science, and so
17 there's a goal for most outcome and process metrics
18 and rankings to improve and move forward, and so
19 what I was giving my opinion on is that I agreed
20 with the Leapfrog methodology and the transparency
21 and the goal to revise aspects to move forward.

1 And then I also was going to give my
2 opinion on that the advisory committee based on my
3 internet search of them and obviously my
4 familiarity with three of them, I'm giving my
5 opinion that that's an A plus plus plus group.

6 They are experts in quality improvement,
7 patient safety, economics. It's -- it's -- it's
8 really an outstanding group.

9 BY MR. HVIDT:

10 Q. And is there any other opinion that you
11 intend to offer?

12 MS. BLAIR: Objection to form. He's got
13 a report.

14 THE WITNESS: If you allow me to look
15 back -- as I was looking at it last night, there
16 were five things of which I think I'm missing the
17 fifth, but I do want to reiterate that in -- in my
18 opinion, which is what, obviously, you're asking
19 and the two -- the two most important ones are the
20 aspects of -- or the three most important ones are
21 the importance of nonresponse bias, the flawed

1 methodology of imputing seven outcomes that
2 Dr. Nicholson used, and the expertise of the
3 advisory committee and the process that they used
4 to make the methodology ref- -- refinement between
5 the spring of 2024 and the fall of 2024.

6 BY MR. HVIDT:

7 Q. And do you intend to offer bases and
8 reasons for each of the opinions that you intend to
9 offer in this case?

10 A. Yes.

11 Q. And will you offer any opinions not
12 disclosed in your expert report?

13 A. In general, I'd like to not give my
14 opinion on things I wasn't asked to do, but
15 obviously, I expected in this deposition there
16 would be times where I would be giving my opinion
17 on stuff that was not included.

18 Q. The -- is there any other opinions that
19 you have formed as an expert here, I mean, that you
20 intend to offer that weren't in your report?

21 A. No.

1 Q. And as part of that, you -- you had
2 mentioned that you reviewed Dr. Nicholson's report;
3 is that correct?

4 A. Yes.

5 Q. And you offer some opinions as it
6 relates -- relates to portions of his report, is
7 that fair to say?

8 A. Yes.

9 Q. Do you intend to offer any opinion as it
10 relates to the portions of Dr. Nicholson's report
11 that you do not offer any opinion on in your
12 report?

13 A. I -- I do not.

14 Q. I will did my best to pronounce this
15 correctly throughout the deposition, but you
16 are -- you are in this field, and so I'm sure
17 you'll pronounce it better than me.

18 But is it fair to say that your field of
19 expertise is in epidemiology?

20 A. Yes. So -- well, I think this gets to
21 questions related to my background, so -- but

1 I'd -- I'd like to answer that a little bit more
2 broad, if possible.

3 So, first off, I'm an infectious disease
4 physician, so I see patients as an infectious
5 disease physician. So I do think that my number
6 one expertise, hopefully for my patients, is to
7 provide high quality care to treat their infections
8 and diagnose their infections.

9 The second thing, since you asked about
10 epidemiology, not all epidemiologists are the same.
11 It's a very wide field.

12 My second area of real expertise is
13 what's called hospital epidemiology, okay.

14 So what does a hospital epidemiologist or
15 healthcare epidemiologist do?

16 They spend a large portion of their day
17 trying to decrease patients who come into the
18 hospital from getting infections, and the reason
19 that's relevant to this case is that in most
20 hospitals, the most important or some of the most
21 important metrics that a hospital epidemiologist is

1 in charge for are things that are included in the
2 Leapfrog scoring aspect. So it will be like hand
3 hygiene.

4 How do you get people to wash their hands
5 more frequently?

6 How do you measure hand hygiene?

7 How do you link hand-hygiene measurements
8 to hard-outcome measures? Because hand hygiene
9 compliance is a structural or a process metric.

10 So hospital epidemiologists, in short,
11 which I spent 25 years doing, their goal is to
12 decrease central line-associated bloodstream
13 infection rates that's in the outcome metric.
14 That's the Leapfrog methodology. It's to decrease
15 catheter-associated urinary tract infections. It's
16 to decrease surgical-site infections, but then
17 there are others that are not in the CMS metrics,
18 like clostridium difficile rates.

19 And so your efforts as a hospital
20 epidemiologist is to basically help patients stay
21 safe and ave- -- and avoid adverse events related

1 to infectious disease and infection control
2 outcomes.

3 So it can also be stuff like preventing
4 them from getting a resistant bacteria. Okay.

5 Then relative to what I am giving my
6 opinion on, I'm also a epidemiologist. Meaning as
7 part of my Master's of Public Health, I did formal
8 epidemiology training, and I teach.

9 So my main appointment is actually in the
10 Department of Epi and School of Public Health at
11 the University of Maryland, so I teach the medical
12 students epidemiology and statistics all four
13 years, the majority of which is in the first year.

14 I teach them epidemiology, including bias
15 and nonresponse bias, and I also have published in
16 infectious diseases, and particularly infection
17 control.

18 So the terms infection control and
19 hospital epidemiology for our purposes could be
20 used interchangeably, so if you have problems
21 pronouncing hospital epidemiology, I would just

1 call it infection control.

2 But basically, I take methodology that
3 other people have written about and apply it to my
4 field, so that a number of my publications and when
5 I sat on the CDC advisory board is very similar to
6 what the Leapfrog advisory board was doing, in that
7 the ultimate goal was to make the CDC's methodology
8 for infectious disease outcomes better, truer to
9 hospitals and improve patient quality by getting
10 hospitals to strive to improve those outcome and
11 process measures.

12 Sorry that was a long answer, but -- but
13 I do --

14 MS. BLAIR: So yes.

15 THE WITNESS: -- but I do think -- but I
16 do think it summarizes appropriately what I'm an
17 expert in relevant to this case.

18 BY MR. HVIDT:

19 Q. So just to pull some of those threads
20 there.

21 You mentioned within that discussion that

1 some of epidemiology and -- and what you do relates
2 to infection prevention in hospitals; is that fair?

3 A. Yeah. So --

4 Q. Is it --

5 A. Yeah, go ahead.

6 No, so for 25 years, I functioned either
7 as a hospital epidemiologist or the associate
8 hospital epidemiologist, which basically means
9 relevant to this case, I work on a day-to-day basis
10 with infection prevention nurses, quality
11 improvement people who fill out surveys like
12 Vizient, like CDC's NHS hand criteria. And, yes, I
13 was in charge of a group, who similar to the
14 hospitals, strive to impor- -- improve their
15 scores, their metrics and ultimately improve
16 patient safety.

17 Q. And if we're looking at the components of
18 what you're describing, a lot of that is, it sounds
19 like you are on the ground trying to improve the
20 outcomes that hospitals are having as it relates to
21 infection, preventing infectious diseases, is that

1 fair to say?

2 A. Yeah, exactly.

3 Q. So you are there with the hospitals and
4 you see results and you're saying, This is the
5 things we can do to make it so we don't get as many
6 infections when people have to do these procedures,
7 is that fair?

8 A. Exactly.

9 Q. And have you ever been involved in
10 developing a grading methodology for how to grade
11 any subjects?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: I have -- well, do you mean
14 for the hospital or nationally or both?

15 BY MR. HVIDT:

16 Q. For whether -- whether you are rating
17 hospitals, whether you're rating practice groups,
18 whatever, have you ever set up a methodology to
19 rate performance?

20 A. Yes. So in the hospital, as an example,
21 right, we would decide, would we have central

1 line-associated bloodstream infection rates by
2 service or floor or unit, right?

3 And we would have to provide data to
4 those units. We would have to provide how we would
5 display the data.

6 Would it be the raw data?

7 Would it be a score?

8 Would it be a color-coded system?

9 Would we put the conf- -- the statistical
10 confidence intervals around it?

11 So we talked all the time about that.

12 Would we report outcome measures?

13 Would we report process measures?

14 So, yes, I had to develop how that was,
15 data would be reported internally within a
16 hospital, but some of my publications also related
17 to like, as an example, the CDC pivoted their
18 methodology from reporting rates to reporting
19 Standardized Incidence Ratios, or the SIRs, that
20 you see in the Leapfrog thing.

21 When they made that change, similar to

1 this case, there was a lot of discussion and a lot
2 of advisory of the pros and the cons. Some people
3 thought the method was better; some people thought
4 the method was worse.

5 We published on aspects related to what's
6 better, what's worse, and then a lot of my
7 publications related to once a hospital is ranked,
8 is there better ways to do what's called risk
9 adjustment? Which basically means control for the
10 type of hospital to better make the overall rating
11 fairer and more representative again to the truth
12 of that hospital's performance.

13 So the short version is both internally
14 and mainly to the CDC. I have been -- I have
15 advised them on how to make grading schemes, how to
16 improve grading schemes, how to make them fairer
17 and how to make it closer to the truth.

18 Q. And would you consider yourself an expert
19 in evaluating hospital safety grade methodologies?

20 A. Yes.

21 Q. For what -- what's your trainings or

1 certification specific to that?

2 MS. BLAIR: Objection to form. Asked and
3 answered.

4 THE WITNESS: Well, it ties into -- so, I
5 mean, mostly related to this case. The area that I
6 am a true expert on is the infectious
7 disease-related outcomes that are part of the
8 Leapfrog methodology, I am an expert on those.

9 Am I an expert on some of the other ones?
10 No, not as much.

11 I'm an expert on the type of methodology
12 that's used because it's similar, but like I'm not
13 an expert on the bar code, you know, metric that's
14 part of that, because that was never under my
15 domain of hospital epidemiology.

16 BY MR. HVIDT:

17 Q. What is your understanding of what the
18 outcome measures, the outcome portion of the
19 Leapfrog grading methodology has -- has to do with
20 the issues in this case?

21 A. Are you ready for a long answer?

1 I mean, basically what happens is you
2 have raw data, okay. The raw data is obviously the
3 truth, right? The raw data is the truth, but the
4 raw --

5 Q. In the absence of raw data, is missing
6 data the truth?

7 MS. BLAIR: Objection to form. Let him
8 finish his answer.

9 THE WITNESS: Let me -- let me finish my
10 answer.

11 Raw data is the truth. So if you look at
12 the Leapfrog methodology, right, there's a way to
13 educate consumers in a transparent way with
14 Z-scores and what SIRs means and confidence
15 intervals. That's the way you would relay the
16 data, but there's no way people are going to
17 understand that. I mean, most of my colleagues
18 don't understand it, right?

19 So Leapfrog's idea of taking a series of
20 outcomes, weighting them based on how they think
21 that weighting relates to patient quality and

1 ultimately converting it to a grade that every
2 person has been graded from elementary school
3 through their education I think is a completely
4 fair, transparent and ideal goal.

5 Now, as I alluded to, you know, being a
6 hundred percent truthful, which I am, does the
7 grade give you all the details of what's going into
8 it? It sometimes tricky, right?

9 But Leapfrog is very transparent in the
10 weighting of all of the outcomes and how they get
11 to the grade, and in this particular case, they're
12 very transparent when a hospital doesn't report of
13 what's not reported and what was imputed.

14 So, yes, I do think this is the best you
15 can do, and to be honest, I'm often accused of
16 complicating things too much, and the SIRs and the
17 raw data does complicate things for the consumer.

18 BY MR. HVIDT:

19 Q. So just a -- my -- my question was a
20 little narrower than that.

21 A. Sorry.

1 Q. My question is on the outcome measures.

2 A. Yes.

3 Q. The outcomes are the portions that are
4 CMS data; is that correct?

5 MS. BLAIR: Objection to form.

6 BY MR. HVIDT:

7 Q. In the Leapfrog -- the Leapfrog
8 methodology, the outcome measures are -- are CMS
9 data; is that correct?

10 A. I need to double-check that, because
11 there's 32 outcome metrics, and the part that I
12 would need to like look at the exhibit, to be
13 honest, is that there are some metrics where when
14 you complete -- where in some instances, some of
15 the outcome metrics are direct reporting from the
16 survey to Leapfrog, and in some instances, the
17 outcome metrics when they're not directly reported
18 are taken from CMS, but I do think the strength of
19 the methodology is that for a lot of those 32,
20 they're using standardized CMS HCAHPS, which are
21 approved methodologies as components.

1 Q. And sitting here today, you aren't -- you
2 aren't able to identify which measures are CMS
3 reported versus which are Leapfrog safety --

4 A. I had not committed that to memory, but
5 if you showed me the Leapfrog exhibit, I did go
6 over in detail, four, five weeks ago, the -- they
7 have tables where they show the weighting of each
8 of the things, whether it's like the PSI 90 or the
9 MRSA, they show you the weighting of those and they
10 show you where it's coming from, and, I mean, most
11 importantly relevant to this case, they show when
12 there's nonresponse which of -- they show basically
13 that out of those seven outcomes, three are not
14 being given and four are being imputed.

15 Q. Understand. And do you understand those
16 are for process measures?

17 A. Yes.

18 Q. And so my question --

19 A. You're asking me about the outcome
20 metrics?

21 Q. About the outcome metrics.

1 A. Yeah, I don't where they're coming
2 from -- I'm sorry.

3 THE COURT REPORTER: Hold on. You're
4 talking over one another.

5 THE WITNESS: Oh, I'm sorry.

6 THE COURT REPORTER: Go ahead.

7 THE WITNESS: So, yes, for the outcome
8 metrics, I'm not a hundred percent certain of where
9 they're coming from, but I did look over all of the
10 outcome metrics. The majority are coming from CMS
11 or HCAHPS I believe.

12 Q. And for the outcome metrics, --

13 A. Yes.

14 Q. -- what is the relevance of the outcome
15 metrics to the issues that are in this case?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: Well, it's a little bit of
18 a -- well, okay.

19 One, the outcome metrics contribute the
20 majority of their grade. So they're very relevant
21 to this case in the sense of -- and that was one of

1 the points in one of my exhibits -- a number of my
2 exhibits.

3 So in one of my exhibits, I show on the
4 outcome metrics how poor performing the five
5 hospitals were. Then I show how poor performing
6 they were compared to other hospitals in Florida,
7 and then I show mainly related to the weighting
8 that for the process metrics, even if you changed
9 them, the outcome metrics are basically driving
10 their poor grading.

11 BY MR. HVIDT:

12 Q. We'll -- we'll get to those, but I'll
13 just note, for -- for the record, the outcome
14 metrics are not a majority of the grade?

15 MS. BLAIR: Well, I'm going to object to
16 form the way you've all have been defining them in
17 this conversation.

18 BY MR. HVIDT:

19 Q. Are you -- are you on Leapfrog's Expert
20 Safety Panel?

21 A. I am not.

1 Q. Were you ever asked to be on Leapfrog's
2 Expert Safety Panel?

3 A. I have not.

4 Q. Are you an ex- -- expert in Leapfrog's
5 hospital safety grade methodology?

6 A. Yes.

7 Q. And what qualifies you to be an expert in
8 Leapfrog's hospital safety grade methodology?

9 MS. BLAIR: Objection. Asked and
10 answered.

11 THE WITNESS: Yeah, I -- I think I
12 answered that question previously in the following
13 ways.

14 I think I'm an expert because a lot of
15 their outcome metrics are infection related and
16 hospital epidemiology related, and so I am an
17 expert in that.

18 I'm also an expert in how you convert raw
19 data to scoring because I've published on that
20 area. I'm also an expert on imputation methodology
21 and nonresponse bias, so, yes, I think I'm an

1 expert relevant to this.

2 BY MR. HVIDT:

3 Q. What makes you an expert in nonresponse
4 bias?

5 A. I have a Master's of Public Health from
6 Harvard, and one of the basics throughout the
7 classes is -- ties back to my counterfactual
8 explanation in that bias and confounding basically
9 are two key constructs that lead to flaws and
10 conclusions, okay?

11 So if you have bias and you don't account
12 for that bias, you come to faulty conclusions, and
13 so you are taught -- and some of my references get
14 to that -- in Rothman, in Szklo, in a reference
15 called Sackett or, as an example, the med students
16 literally every year in order to move on to the
17 next step, they get asked questions on common
18 biases that can affect, because bias is a key thing
19 to reading medical articles. It's a key thing to
20 fair hospital Leapfrog rankings.

21 So, yes, I've taught those components to

1 med students, master's students, Ph.D. students,
2 and I've published a lot. So in the small world of
3 hospital epidemiology or infection control, I'm an
4 expert in methodologic design of case control
5 studies and quasi-experimental studies where
6 controlling for bias and confounding is critically
7 important.

8 Q. And so -- and I just want to make sure
9 I -- I pull on this thread.

10 You said that if you have bias and you're
11 not accounting for that bias, that can lead to
12 faulty conclusions; is that correct?

13 A. Yes.

14 Q. And is -- and here if there is bias in
15 the Leapfrog safety grade methodology, is it your
16 view that Leapfrog is trying to eliminate that bias
17 as much as possible with its imputation
18 methodology?

19 A. Can you repeat that question?

20 Q. Yes. So when you -- when Leapfrog set
21 out to do its imputation methodology change in

1 2024, is it your view that they were trying to
2 eliminate or reduce as much as possible bias to
3 reach an accurate estimation of the nonreporting
4 hospitals' scores for those imputed measures?

5 A. Don't cut me off just at the yes, please.

6 So, yes, they cannot eliminate the bias,
7 but reduce the bias, and that was their goal in
8 switching their methodology, was to reduce the
9 nonresponse bias.

10 Q. And if they are trying to reduce the
11 nonresponse bias, I mean, it's -- strike that.

12 If Leapfrog Group was not trying to
13 reduce the nonresponse -- any -- any bias in their
14 methodology when they came up with the imputation
15 change, would that impact your opinion on whether
16 or not it's fair?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: I'm sorry, can you repeat
19 the question?

20 BY MR. HVIDT:

21 Q. Yeah. So if -- if with the methodology

1 change Leapfrog was not trying to reduce bias, but
2 instead didn't care if there was bias, would that
3 impact your expert opinion on whether or not the
4 2024 imputation change was fair?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: Well, if you're trying to
7 say -- okay. They were trying to reduce bias if
8 you define bias as they were trying to get as close
9 to the truth of what those five hospitals' survey
10 response would have been.

11 If you're asking me if they're not trying
12 to get to what the actual data would have shown,
13 would I have changed my opinion?

14 Yeah, but that's not consistent with
15 their whole goal of rating. The whole purpose of
16 the ratings is to get as close to the truth as
17 possible --

18 BY MR. HVIDT:

19 Q. Have you --

20 A. -- to improve patient quality.

21 Q. Have you reviewed any deposition

1 testimony in this case?

2 A. I told you that I reviewed
3 Dr. Nicholson's, but like really cursory. So like
4 for about 15 minutes.

5 Q. Have you reviewed any of the deposition
6 testimony of the Leapfrog witnesses?

7 A. I have not.

8 Q. Have you reviewed the deposition
9 testimony of Dr. Patrick Romano?

10 A. I looked at that for about five minutes.

11 Q. And have you -- what -- what documents
12 did you review in forming your opinions in this
13 case?

14 A. Okay. I'd -- I'd love to answer that
15 question after a break if I was allowed, just
16 because I have all of them, but let me tell you by
17 memory, which will give me close to the complete
18 list, but most likely not the complete list, okay?
19 And these were reviewed four, five weeks ago.

20 The first document I reviewed was the
21 Leapfrog methodology describing what they were

1 doing in the spring of 2024. I also reviewed the
2 methodology, a very similar document, other than
3 the change in the imputation method and change
4 related to going two cycles back instead of four
5 cycles back, the spring -- no, one sec. I said the
6 spring. The spring, now the fall was the
7 methodology that was most relevant. I reviewed
8 Dr. Nicholson's expert opinion. Those were
9 the, oh, three documents I started with.

10 Then I reviewed a document. I don't know
11 what it's officially called, but it was the like
12 the public disclosure notes.

13 So when they switched the imputation
14 method, there was a period of public disclosure,
15 which is similar to what I'm familiar with, with
16 the CDC, and I reviewed some of those comments, and
17 then I also reviewed an annotated transcript of
18 some of the meeting notes of the advisory board. I
19 believe that is all.

20 However, the one thing I would say is you
21 can imagine based on my expert opinion and the

1 exhibits, I was then forced to review some of the
2 raw data for the five hospitals in order to make
3 those exhibits.

4 Q. Did you -- and -- and when you wrote your
5 expert opinion, you -- you included a list,
6 an -- an exhibit of the documents you relied on in
7 forming your -- in writing your report; is that
8 correct?

9 A. They helped me with that, yes.

10 Q. And we can move --

11 A. Oh, oh, one sec. Now, that jogs my
12 memory of one thing that is important.

13 There were two references in
14 Dr. Nicholson's expert opinion, and I pulled those
15 papers and I did review those, and they're
16 referenced -- and they're referenced in my expert
17 opinion as well.

18 And by the way, to circle back to a
19 question then, that was -- I think that was the
20 fifth point that I was asked to give, to opine on,
21 was that those two articles were somewhat outdated.

1 So although they were of high quality,
2 they were not most relevant to this case because it
3 was a methodology that was old.

4 Q. And other than those two articles, did
5 you review any of the other sources in
6 Dr. Nicholson's report?

7 A. I did not.

8 Q. And Leapfrog produced hospital safety
9 grade data for the hospitals across the country in
10 this litigation for the last few years. Did you
11 review that?

12 A. I did not. I did go to their
13 website --

14 Q. Did you --

15 A. -- to try to address the aspect of how
16 easy is it to find the grades and how transparent
17 as -- is that? But that was 20 minutes, at most,
18 looking at the Leapfrog website.

19 Q. Are you offering a -- an expert in this
20 case as to the -- the -- the transparency of the
21 grade on the website as it would relate to a

1 consumers' experience?

2 A. I'm not.

3 Q. Okay. And other than the -- the
4 documents listed, did -- did you ever -- do you
5 have any understanding as to how many documents
6 Leapfrog produced in this litigation?

7 A. I have -- I do not.

8 Q. Did -- would it surprise you to know that
9 Leapfrog produced around a million documents in
10 this litigation?

11 A. That's a large number of documents.

12 Q. And did you have access to the one
13 million documents that Leapfrog produced in this
14 litigation?

15 A. I did not.

16 Q. Did you ask to have access to the
17 documents Leapfrog produced?

18 A. I did not.

19 Q. Did the documents that you did review,
20 did -- did Counsel provide you those documents?

21 A. Yes. Not at the get-go.

1 So this -- the series of events was a
2 initial call, obviously. I had no documents. It
3 was a brief discussion of the case, a brief
4 discussion of my thoughts.

5 Then what I remember is exactly what we
6 alluded to. The first couple of documents related
7 mainly to the methodology that I had to review,
8 but, yes, there were subsequent documents as we
9 were -- as basically we were running those exhibits
10 and the analysis, subsequent analyses.

11 Q. Did you ask for any documents in addition
12 to the documents Counsel provided you?

13 A. No, but the -- the expert opinion is
14 obviously entirely mine, so some of the angles of
15 where we were going, okay.

16 So meaning if we cut to the chase related
17 to the imputation method, right, which is the
18 crux -- the crux of what I'm asked to give my
19 opinion on, I specifically requested to do -- and I
20 need to look at the exhibit, but the exhibit where
21 we run the grades with them getting the lowest

1 score, but then them getting a score higher than
2 the lowest score, but less than the median, I
3 specifically asked them to give me the documents in
4 order to create that analysis.

5 In a similar way, relative to your
6 question of the outcome metrics of those five
7 hospitals, I wanted to look over what their raw
8 data was on the CMS ratings. I wanted to look over
9 what their HCAHPS scores were. I wanted to look
10 over their Z-scores and their SIRs.

11 So, yes, I requested and received that
12 data, and similarly for the exhibit where we
13 contrast their scores with other scores, at a
14 point, I got access and requested those other data
15 elements that are contained in the exhibits.

16 Q. Did you ask Counsel if the documents they
17 provided you were representative of the full story?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: I did not ask with that
20 wording.

21 BY MR. HVIDT:

1 Q. Did you ask if they had documents that
2 supported conclusions contrary to those that you
3 were offering in your report?

4 A. We had a long discussion about
5 Dr. Nicholson, and -- because, to be honest, I was
6 initially very impressed with Dr. Nicholson's CV.
7 And I asked what -- were there other expert
8 witnesses similar to that and what was angles
9 related to that aspect, but that was all that we
10 had discussions about.

11 (Whereupon, Harris Deposition Exhibit No.
12 2, Expert Report of Anthony Harris, marked for
13 identification.)

14 MS. BLAIR: Thanks.

15 BY MR. HVIDT:

16 Q. Dr. Harris, I'm handing you what's been
17 marked as Exhibit 2 to your deposition.

18 What is Exhibit 2?

19 A. Let me just look through all of the pages
20 so I can answer your question correctly.

21 Yeah, so Exhibit 2 is my expert report.

1 Q. And does Exhibit 2 appear to be the
2 report that -- that you submitted in any way? Is
3 there anything there that would cause you to think
4 that it's different than the one that you submitted
5 on September 4th?

6 MS. BLAIR: And, Scott, I'll just -- for
7 the record, this one has an electronic signature,
8 but you have a version with his wet signature as
9 well. Okay?

10 MR. HVIDT: Okay.

11 MS. BLAIR: Yeah, I'm just letting you
12 know. We had trouble transmitting it that night,
13 but you have it as well.

14 THE WITNESS: Yes, this appears correct.

15 MR. HVIDT: Understood. Momentarily, I
16 thought you were going to say there was a highlight
17 in there.

18 MS. BLAIR: No. No, no. You have one
19 with his actual signature and one with an
20 electronic signature, that's all.

21 BY MR. HVIDT:

1 Q. And you've seen this report before; is
2 that correct?

3 A. Yes.

4 Q. And you signed off on it?

5 A. Yes.

6 Q. And you agree with everything in here?

7 A. If it's -- if it's exactly what we
8 submitted in the PDF I reviewed last night, yes.

9 Q. All right. I'll direct your attention to
10 the Table of Contents on page 2.

11 A. Yeah.

12 Q. If you look at -- do you see there a II
13 and there's a III? II says, Scope of Opinions, and
14 III says Summary of Opinions, do you see that?

15 A. Yes.

16 Q. And if you look at those two sections
17 there, which -- which one would you say is -- if
18 there's anything that contradicts or is different
19 between the two? Like which way -- where should we
20 go to look at the summary of your opinions?

21 A. I like III. So III is more to the point.

1 Q. III is more to the point?

2 A. Yes.

3 Q. Okay. So to the extent there -- it does
4 not match, III should take precedence over II?

5 MS. BLAIR: I'll object to form.

6 THE WITNESS: Yeah, I -- I believe so.

7 I mean, the -- the four points in III are
8 summarized in the last paragraph of II, and then
9 the first two paragraphs of II are more legal. So,
10 yeah, I think III is the summary of the opinions
11 that I believe.

12 BY MR. HVIDT:

13 Q. Got it. Okay. Let's start with III, and
14 then we'll come back to II.

15 A. Okay.

16 Q. Okay. Looking at III a., you first write
17 no methodology is perfect, do you see that?

18 A. Yep.

19 Q. You say, Leapfrog takes great pains to
20 consult with the leading experts of the country to
21 create a methodology that is reasonable and ethical

1 in light of ever-changing landscape of healthcare
2 industry standards and available data. Do you see
3 that?

4 A. Yep.

5 Q. What do you mean by great pains?

6 A. Well, when I look at page 7 and their
7 expert panel -- and this came up the minute I was
8 contacted -- I was very impressed by that group,
9 and when I then -- some of the people I did not
10 recognize initially, such as Sara Singer and, to be
11 honest, Patrick Romano.

12 When I then looked online, I was like,
13 Oh, my God, you know, these are experts. They had
14 a couple of nurses who I didn't recognize, but they
15 were nurses that are quality experts.

16 And so when I saw that, that leads to the
17 opinion that the -- it takes great pains, they took
18 great pains to get experts to help advise them.

19 The other reason I say that is that as
20 hospital epidemiologists where our hosp- -- I'm not
21 in that capacity any more, but I was familiar when

1 I was in that capacity of how thorough Leapfrog was
2 in their methodology because I was living that
3 day-to-day. I was living what was required to
4 complete the quality improvements, and I was -- I
5 was understanding changes they were making over the
6 years, that we were submitting data to Leapfrog and
7 I was in charge of the small portion of some of the
8 outcomes.

9 Q. And so when you say great pains, are you
10 aware of the process that Leapfrog went through
11 with the expert safety panel as it relates to like
12 meetings and -- a number of meetings?

13 A. No, I'm not familiar with that.

14 So that's a fair point. I don't know the
15 frequency that that group meets. I don't know the
16 voting aspects. I don't know the rules and
17 regulations of how often they're allowed to modify,
18 and I don't even know much about the corporation in
19 the sense of, you know, for profit, not for profit.
20 I don't know any of those details.

21 Q. So do you know about the -- whether the

1 expert safety panel met to talk about the
2 methodology that Leapfrog actually implemented?

3 A. Well, I do know relative to the
4 imputation method, because that was relevant. I
5 looked over those notes, as I mentioned, and I saw
6 the discussion related to that, just the
7 dis- -- just the discussion.

8 Q. Are you referring to the April 12th, 2024
9 meeting?

10 A. I -- I would have to go back and look at
11 the date.

12 Q. And we'll -- we'll get to that
13 momentarily.

14 But other than those notes and that
15 meeting, are you aware of any other time that the
16 expert safety panel met to talk about the actual
17 imputation methodology that Leapfrog implemented?

18 A. No.

19 Q. And you continue on in this first opinion
20 to note that it is your opinion that the
21 methodology is reasonable and ethical, do you see

1 that?

2 A. Yes.

3 Q. Is that your opinion?

4 A. Yes.

5 Q. And you ref- -- you reference an
6 ever-changing landscape of the healthcare industry
7 standards, do you see that?

8 A. Yes.

9 Q. What do you mean by ever-changing
10 landscape? I believe that appears a couple of
11 times in your report.

12 A. Yeah, it's a good point.

13 It's -- it's a sentence that summarizes
14 the process that Leapfrog, Vizient, CDC have done.

15 So I'll give an example that's closer to
16 my area of expertise, but is an outcome metric that
17 is included in the Leapfrog's, so I think it's
18 relevant.

19 I'm old enough to know when hospitals
20 didn't have to pay for performance for infectious
21 disease, okay?

1 And then the first metric I believe they
2 did, or at least the one that kept us most busy,
3 was central line-associated bloodstream infections,
4 and I think using that example and carrying it
5 through, you'll understand why it's a good answer
6 to ever-changing landscape, and I'll be brief,
7 don't worry. Okay?

8 First off, we reported raw rates, okay?
9 So basically, hospitals were ranked on the raw
10 rates, no adjustment at all, nothing, okay?

11 Then over the course of the ever-changing
12 landscape, we switched from raw rates to
13 Standardized Incidence Ratios similar to what's in
14 the Leapfrog methodology.

15 Then there were rates stratified by
16 location. Then there was rates stratified by
17 location and by type of facility;
18 academic/nonacademic. Then there were additional
19 risk adjustment, and some of my work of the
20 ever-changing landscape was the idea of when we get
21 fully automated, which we're getting close to,

1 right, there needed to be better methodology and us
2 getting ready to go towards that.

3 So if you look at CLABSI of where the
4 metric is now and what we do and what we report and
5 what we risk adjust and why we have Standardized
6 Incidence Ratios and where we were, and it's only
7 like 15 or 20 years, the two metrics -- the -- the
8 two things are so different, and it's evolved
9 tremendously.

10 Q. And so back in the day, it was -- are you
11 saying that it was -- with the raw data when you
12 were trying to compare hospitals across the
13 country, it was hard to do that because there was a
14 lot of different variables among them; is that
15 correct?

16 A. Yeah.

17 MS. BLAIR: Objection to form.

18 THE WITNESS: Yeah. So basically, the
19 hospitals that took care of sicker patients or had
20 patients with more comorbid conditions or was a
21 higher acuity hospital or had a different mix of

1 patients or even had patients that required more
2 central lines than another patient, yeah, the
3 methodology was not ideal, and it's gradually moved
4 forward.

5 BY MR. HVIDT:

6 Q. And you view that gradual move forward
7 as -- as an improvement; is that correct?

8 A. Yes.

9 Q. And because you're getting better at
10 trying to compare dissimilar hospitals in one
11 comparison?

12 A. Exactly.

13 Q. Did --

14 A. And you -- and you find flaws. Like in
15 that methodology, even so -- like, this is getting
16 into the weeds.

17 But certain bacteria, right, that were
18 counted against hospitals were removed, okay?

19 So -- and then in the reverse direction,
20 bacteria that should have been counted and
21 hospitals should have been counted as a bad event

1 were not, so there's been constant evolution of all
2 of these infectious disease-related metrics, and
3 that's what I've been most involved in both as a
4 day-to-day epidemiologist and as advising the CDC,
5 on occasion, related to those metrics and where we
6 should go.

7 Q. Got it. So when -- when we're reading
8 the phrase ever-changing landscape, you're
9 referring to the progress that's been made in
10 trying to risk adjust CMS or other measures to make
11 it a better one-size-fits-all, recognizing there
12 are differences among hospitals?

13 A. It's -- it's not only --

14 MS. BLAIR: Hold on. Objection to form.
15 Mischaracterizes his testimony.

16 THE WITNESS: It's not just risk
17 adjustment.

18 It's everything from how do you define
19 the numerator?

20 How do you define the denominator?

21 How do you measure the numerator

1 accurately?

2 How do you measure the denominator
3 accurately?

4 Is the definition fair?

5 And then how do you move it forward
6 closer to the truth?

7 BY MR. HVIDT:

8 Q. And -- and the goal there is to try to
9 get closer to the truth; is that correct?

10 A. (Nodding head yes.) To give you another
11 example that relates to this. It is relev- -- no,
12 no. It is relevant. It's very relevant, okay?

13 So for central line-associated
14 bloodstream infection, my group is in charge of a
15 new metric that the CDC is thinking of adopting
16 where this new bloodstream metric would replace
17 CLABSI. So this ever-changing landscape can even
18 change to you take a metric that was fine and you
19 say now it's time to be retired even though it's
20 better than it was.

21 Q. Thank you.

1 Your second opinion listed here is that
2 nonresponse bias is real and should be accounted
3 for in a methodology evaluating hospital safety
4 grades; is that correct?

5 A. Yes.

6 Q. Is that an opinion you have?

7 A. Yes.

8 Q. Okay. Then your next opinion states,
9 These five hospitals are underperformers regardless
10 of the assigned score for the four measures at
11 issue. Do you see that?

12 A. Yes.

13 Q. Is that your opinion?

14 A. Yes.

15 Q. And then you say -- your last opinion is
16 there in III d., do you see that?

17 A. Yes.

18 Q. And does that accurately state your
19 opinion?

20 A. Yes.

21 Q. And, again, this report contains all of

1 your opinions related to this matter; is that
2 correct?

3 A. Yes.

4 Q. And let's flip back to Scope of Opinions
5 section, section II.

6 Looking over in this section, you write
7 that the -- the sentence that carries over from
8 four to five, During that time, the five Plaintiff
9 hospitals benefited from the fact that the four of
10 the 32 safety measures that make up the Leapfrog
11 hospital safety grade the Plaintiff hospitals were
12 given grades equal to the mean of similarly
13 situated participating hospitals performed on those
14 four metrics. Do you see that?

15 A. Yep.

16 Q. Okay. When you say that the -- during
17 that time, what time frame are you referring to?

18 A. Well, based on the prior sentence, it's
19 for the four years that they stopped participating.
20 But relevant to the case, I think it's most
21 relevant to their spring 2024 grade.

1 Q. They --

2 A. The spring 2024 grade, they got the mean.
3 The four 2024 grade, they did not get the mean.

4 Q. And while we're on the mean, a couple of
5 times in this report you used the word median.

6 Do you understand that -- that mean is
7 the -- the correct term there?

8 A. We can --

9 Q. Well, we can get to those.

10 A. -- get to that.

11 If it -- if it's a numerical number,
12 you're correct, mean is more right.

13 I probably used median because of
14 the -- to get assigned the least achievement, but
15 then the least achievement is converted to a
16 number. But anyway ...

17 Q. And -- and you said that the hospital
18 benefited from getting the mean. On what basis do
19 you -- did you assert that point?

20 A. Right. It -- it relates to the
21 nonresponse bias, so ...

1 Q. Other than the nonresponse bias, is there
2 any other facts or data that you can point to, to
3 support the notion that they benefited from being
4 assigned the mean?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: Well, their grades are
7 lower when they get assigned -- when they get
8 imputed the value that's most likely closer to the
9 truth. So they benefited from the mean in getting
10 a higher value based on my opinion and the advisory
11 board's opinion of what the correct imputation
12 methodology was.

13 BY MR. HVIDT:

14 Q. So when you say that the Plaintiff
15 hospitals benefited from getting the mean, are you
16 referring only to the fact that they benefited from
17 getting the mean as compared to getting the lowest
18 achievement score?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: Well, in -- one sec. In
21 Exhibit 8, I demonstrate that at least for spring

1 of 2025 if they get imputed the mean, they get a
2 higher grade, they get imputed what Leapfrog did,
3 which I think is the closest to the truth, they get
4 a low grade, and if they get imputed some
5 achievement which is between the mean, they still
6 have low ratings.

7 So, yes, based on Exhibit 8, if Exhibit 8
8 existed for the prior years, then the sentence
9 you're referring to is correct in that they
10 benefited from the mean as evidenced by Exhibit 8.
11 BY MR. HVIDT:

12 Q. So when you say they benefited from the
13 fact that they were assigned the mean, you -- do
14 you have any data of how they actually would have
15 performed had they participated in the survey in
16 those years?

17 A. I don't have data.

18 Q. Thank you.

19 And then when you -- so when you say that
20 they benefited, if you were to look at whether or
21 not they participated, you don't know whether they

1 would have performed better than the mean or not
2 had they participated in those years; is that
3 correct?

4 A. Well, that's the whole thing of
5 imputation and missing data. We never really know
6 what the truth is.

7 We are using the advisory panel and, in
8 my opinion, my expertise to say that the mean is
9 farther from the truth than the method used and
10 farther from the truth that I show in Exhibit 8,
11 which is I think closer to the truth as well.

12 Q. And on what basis do you think that the
13 lowest achievement score is closest to the truth?

14 A. It's -- it's based on two main points.

15 The first point is, as evidenced by some
16 of the other exhibits, these are poor-performing
17 hospitals on the outcome metrics. They're
18 poor-performing hospitals like both on the CMS star
19 rating, on the SIR rates, disease scores, and one
20 of the key aspects of preventing infections is hand
21 hygiene.

1 If your hand hygiene is poor, there's an
2 extremely high probability that you're going to be
3 a poor performer on infection data, such as in
4 Exhibit 3.

5 And the hospitals and exhibit -- so if
6 they're poor performing in their infection rates,
7 there's a high probability their hand hygiene is
8 not good, because hand hygiene is the cornerstone
9 of preventing infection.

10 Q. Do you have data on their hand hygiene?

11 A. No. They didn't report it.

12 Q. And -- and -- and here, you also
13 mentioned the outcome scores. Are the outcome
14 scores imputed in the Leapfrog hospital safety
15 grade?

16 A. No. I wouldn't -- they are not imputed.

17 Q. Thank you.

18 And so what I'm trying to get an
19 understanding is how -- on what basis do you say
20 that the imputation on or, excuse me, the
21 assignment of the lowest achievement score to

1 nonreporting hospitals is closer to the truth?

2 MS. BLAIR: Objection to form. Asked and
3 answered.

4 THE WITNESS: It's closer to the truth
5 because they chose not to respond, and by choosing
6 not to respond, they know what their data is. They
7 know what their rates are, so that if it was going
8 to help them, they would have responded.

9 BY MR. HVIDT:

10 Q. Aren't there many reasons why a hospital
11 might not -- might choose to respond -- not to
12 respond to a Leapfrog survey?

13 A. In my opinion, the major reason a
14 hospital would choose not to response is because
15 they know their rates are poor.

16 Q. Is there any other reason a hospital
17 might choose not to respond to the survey?

18 A. The only other reason is that the survey
19 would take them too long to report, but as someone
20 who functioned as a day-to-day hospital
21 epidemiologist, that's -- if we reported if it

1 was -- if it was going to help us.

2 Q. And that's just in your own experience?

3 A. That's in my own experience.

4 Q. Do you have any -- are you -- have you
5 ever completed individually the full survey that
6 Leapfrog --

7 A. I have not, but -- I have not.

8 Q. And are you aware that there's a whole
9 list of common objections that hospitals have to
10 completing the hospital's survey?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: I don't think I was asked
13 to give my opinion on that, but I'm not familiar
14 with objections.

15 BY MR. HVIDT:

16 Q. So the only conclusion -- the only -- the
17 only consideration you choose -- took to a decision
18 not to respond to the hospital's safety survey is
19 that they would be poor performing; --

20 MS. BLAIR: Objection.

21 BY MR. HVIDT:

1 Q. -- is that correct?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: Can you repeat the question
4 again?

5 BY MR. HVIDT:

6 Q. Yeah. So the only -- the -- you are
7 assuming that the reason that they did not complete
8 the hospital survey is because they're a
9 poor-performing hospital; is that correct?

10 A. I'm saying there's an extremely high
11 probability that that's the reason they chose not
12 to respond.

13 Q. And do you have any -- what data do you
14 have to support that?

15 MS. BLAIR: Objection. Asked and
16 answered.

17 THE WITNESS: I know how important
18 Leapfrog ratings, Vizient ratings, CDC ratings are
19 at hospitals and hospital leadership because I was
20 there, and you have a whole hospital quality team.

21 You choose not to report, generally, if

1 you think it's going to hurt, if you think it's
2 going to -- if you -- if you think reporting is
3 going to hurt you.

4 BY MR. HVIDT:

5 Q. Have you looked at any data in this case
6 to support the notion that non-participating
7 hospitals would be act- -- would actually hit the
8 low achievement score?

9 MS. BLAIR: Objection to form. Asked and
10 answered.

11 THE WITNESS: Yeah, I don't have the raw
12 data.

13 BY MR. HVIDT:

14 Q. Okay. And have you -- do you understand
15 that the lowest achievement score that they're
16 assigned is the lowest score you can get on the
17 Leapfrog grading methodology?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: I -- I don't think that's
20 correct, because the lowest achievement is the
21 score that the responders did, and I think that

1 they could have actually gotten a lower score,
2 being a zero.

3 BY MR. HVIDT:

4 Q. On what basis do you assert that?

5 A. Because -- well, I'd have to re-review,
6 but when I re- -- when I reviewed the methodology,
7 there -- they could have gotten a lower score. The
8 least achievement does not give them a zero. It
9 gives them an actual score.

10 Q. It gives them a 5, a 15, 15 or a 25; --

11 A. Yeah.

12 Q. -- is that right?

13 A. I believe so, yeah.

14 Q. And --

15 A. They could have gotten a zero.

16 Q. And you think that -- strike that.

17 Do you have an understanding that the
18 expert safety panel did not think that the
19 low -- that the lowest achievement score would be
20 an accurate reflection of the non-performing
21 hospitals?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: Can you repeat the
3 question?

4 BY MR. HVIDT:

5 Q. Do you -- do you have an understanding
6 that the expert safety panelist that's
7 been -- that's testified in this case testified to
8 the basis that the lowest achievement score does
9 not accurately reflect poor performance of
10 non-participating hospitals?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: No, I'm not aware of that.

13 BY MR. HVIDT:

14 Q. And do you have an understanding that the
15 expert safety panelist testified that, in fact,
16 that's not what they were trying to do in coming up
17 with the limited achievement score for the
18 imputation methodology?

19 MS. BLAIR: Objection to form. You keep
20 saying panelist, and there's only one that's been
21 deposed.

1 THE WITNESS: Yeah, so I -- I disagree
2 with that statement in the following ways:

3 Based on the data I reviewed, which was
4 the transcript of the advisory board and also the
5 public commentary period, based on my read of that,
6 the advisory council thought this was the best
7 methodology, and, in fact, in the public comment,
8 although there were some negative comments related
9 to the imputation method, there were an equal
10 number or greater number of positive comments
11 related to the imputation method, and I think that
12 point is missed in your recent line of questioning.

13 In that anytime something is changed,
14 you're looking for the majority, and to me in
15 reading that document both in the public comment
16 section and in the advisory board, the majority
17 felt that this method was better.

18 BY MR. HVIDT:

19 Q. Did you know that the safety grade panel
20 didn't vote on a methodology change?

21 A. I'm not familiar that they didn't vote,

1 but I would say having sat on some of these
2 advisory boards for the CDC, voting is not routine.
3 It depends on the bylaws. It's more like a public
4 comment and an expert opinion to help advise the
5 agency or group on what they should do next.

6 Q. And --

7 A. One -- one sec. I want to be very
8 concrete about that.

9 So as an example, I sat on the C. Diff
10 advisory -- advisory board to the CDC, that then
11 advised what's called HICPAC, H-I-C-P-A-C.

12 When I sat on the C. Diff advisory board,
13 which was an extremely controventional metric which
14 changed, I must have sat on five, six hours of
15 calls. There was never any voting. There was an
16 exchange of ideas.

17 Q. And do you understand that when the
18 expert safety panel met, they weren't talking about
19 the imputation change that Leapfrog actually
20 implemented?

21 A. No, I -- I don't agree with that.

1 The part I read, they were talking about
2 the imputation method. They were also talking
3 about other things, as is typical of a full --
4 full-agenda meeting. I don't agree --

5 Q. When you were --

6 A. Go ahead.

7 Q. Does nonresponse bias require you to
8 consider alternative reasons that hospitals might
9 not -- might choose not to respond to the survey?

10 A. Nonresponse bias more globally gets at
11 that people who respond are different than people
12 who do not respond, and that would definitely apply
13 in this case, okay?

14 Meaning, I would argue strongly that they
15 chose not to respond because they knew their
16 numbers were poor. Other people could say that
17 they chose not to respond for other reasons.

18 It still makes nonresponse bias a valid
19 principle, and it still makes nonresponse bias
20 something you should aim to control for
21 irrespective of the reason, because it basically

1 means that the hospitals that respond and hospitals
2 do not -- that do not respond are different.

3 Q. Did you do any data analysis in this case
4 to show that?

5 A. No, but similar to most biases, you
6 cannot.

7 If you had the data, there would no
8 nonresponse bias. It wouldn't -- it wouldn't be
9 relevant to the case if you had the data.

10 Q. We'll -- we'll get to the data that's
11 been produced in this case.

12 All right. Let's flip to the Background
13 section, section VI.

14 What is this section? What is your
15 opinion stated here?

16 MS. BLAIR: Well, objection to form.
17 It's not an opinion. It's background, as you
18 mentioned.

19 THE WITNESS: It's just giving
20 background -- background related to my
21 understanding of The Leapfrog Group, when it was

1 formed, when they started their hospital grade
2 ratings and the panel of -- of experts.

3 BY MR. HVIDT:

4 Q. So is this just a summary of what are
5 purported facts?

6 A. Yes.

7 Q. And do you apply any expertise in this
8 section to form any opinion?

9 A. What do you mean by apply expertise? I'm
10 sorry.

11 Q. You are testifying in this case as an
12 expert or as a purported expert; is that correct?

13 A. Yes.

14 Q. And I'm asking if there's any opinions in
15 this case or any particular expertise that you're
16 trying to opine to in this section?

17 A. Just on the history of Leapfrog, the
18 history of how they're forming the scores and of
19 how they're imputing the missing data, yes.

20 Q. Okay. So you're just summarizing those
21 points; is that correct?

1 A. Yep.

2 Q. Okay. And on page 7, you list the expert
3 safety panel for Leapfrog, do you see that?

4 A. Yes.

5 Q. And you mentioned earlier Patrick Romano.
6 Do you consider Patrick Romano an expert
7 in safety grade methodology?

8 A. Yeah. Based on my review of his -- his
9 publications briefly and his affiliation and
10 website, yes.

11 Q. And below the list, you say that their
12 expertise cannot and should not be questioned when
13 it comes to the area of patient safety and quality,
14 do you see that?

15 A. Yes.

16 Q. Do you agree with that?

17 A. I do, but they could have differing
18 opinions and still be experts.

19 Q. And am I allowed the question the talent
20 of the expertise of the safety panel?

21 MS. BLAIR: Objection to form.

1 Argumentative.

2 THE WITNESS: Yes.

3 BY MR. HVIDT:

4 Q. And what qualifications does one need to
5 determine who is allowed to determine whether or
6 not their expertise should be questioned?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: I think you're asking me
9 how do I -- how did I determine that these people
10 were experts?

11 I looked at what they do in their
12 day-to-day job. I looked at their publications and
13 then I tried to see whether related to Leapfrog's
14 mission and/or the mea- -- measures whether these
15 people had expertise in doing that. And so in
16 summary, most of them have published on quality.
17 Most of them have done day-to-day quality.

18 The nurses that I may not have known, as
19 an example, were experts, in my opinion, related to
20 some of the nursing-related metrics and
21 nursing-related issues, and then similarly related

1 to how long it would take to record the survey
2 data, there are people on this panel who have more
3 expertise than I do in that area. So I thought
4 based on all of that, yes, they were experts.

5 BY MR. HVIDT:

6 Q. And so did you -- is it correct that
7 you -- you just looked -- you looked at their bios
8 on the website?

9 A. Yeah.

10 MS. BLAIR: Objection to form.

11 THE WITNESS: I mean, one other
12 person, I apologize, in an earlier question that I
13 do know, I forgot. Peter Pronovost was at Johns
14 Hopkins, and so I did interact with him when he was
15 there. And he is a national leader in patient
16 quality and quality improvement.

17 So -- so the short answer to your
18 question is I knew Pronovost, Srinivasan, Bates,
19 and at one point, Classen was on the committee. I
20 knew their work from meetings and publications and
21 interactions, and the others I looked at the

1 website.

2 So, yes, I did not know Romano, Singer,
3 McDonald, McHugh, Vogus of this list. I looked on
4 their website and looked at their CVs.

5 BY MR. HVIDT:

6 Q. And you note Dr. Classen is not on this
7 list, right?

8 A. Yeah. He must have been on a prior one I
9 looked at.

10 Q. And you said you read some of their
11 publications, did I get that right?

12 A. Not the full publications, but I looked
13 up some of their abstracts and publications they
14 were on, yes, in PubMed basically.

15 Q. So you looked at kind of the title of the
16 abstract. You didn't read their publications in
17 forming your opinion in this case; is that correct?

18 A. Correct.

19 Q. Okay.

20 MR. HVIDT: I think we need to take a
21 video break, so we'll go off record.

1 MS. BLAIR: Sure.

2 THE VIDEOGRAPHER: We're going off the
3 record. The time is 11:47 a.m.

4 (Recess taken -- 11:47 a.m.)

5 (After recess -- 11:58 a.m.)

6 THE VIDEOGRAPHER: We are back on the
7 record. The time is 11:58 a.m. This is media
8 number two.

9 BY MR. HVIDT:

10 Q. Dr. Harris, before the break, we were
11 talking about your opinion that the Leapfrog Safety
12 Grade Expert Panel about their, your opinion of
13 them; is that correct?

14 A. Yes.

15 Q. And did you do any kind of scientific
16 analysis of their qualifications?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: I wouldn't call it
19 scientific analysis, but I did look up their
20 affiliation, some of their publications, some of
21 what they identified as their areas of strength

1 that would have been listed on their websites at
2 their institutions.

3 BY MR. HVIDT:

4 Q. And so you reviewed their websites
5 and -- and a few, a list of their acc- -- their
6 accolades; is that correct?

7 A. Yes. Typically, on most academic
8 websites, there's links, so some people have links
9 to their publications. Some of the people will
10 have their education qualifications capacity, so,
11 yes.

12 Q. And during break, did you have any
13 conversations with Counsel?

14 A. I did.

15 Q. Did you talk about the substance of your
16 testimony?

17 A. No.

18 Q. And if we can flip now to your
19 opinion -- back to your report looking over on page
20 11. Do you see where section VIII is?

21 A. Yep.

1 Q. And you write, The Leapfrog Methodology
2 Accurately Reflects the Nonperformance of
3 Plaintiffs. Do you see that?

4 A. Yep.

5 Q. So it's your opinion that the Leapfrog
6 methodology is trying to accurately, the word
7 accurately reflect their nonperformance; is that
8 correct?

9 MS. BLAIR: Objection to form, asked and
10 answered.

11 THE WITNESS: Yes, it's trying to get as
12 close to the truth of where their performance would
13 be.

14 BY MR. HVIDT:

15 Q. And what facts in the record do you point
16 to, to show that Leapfrog is trying to accurately
17 reflect the nonperformance -- the non-participating
18 hospitals' performance on those imputed scores?

19 A. Well, it gets at what -- what we
20 discussed earlier, which is previously they were
21 given the median values -- the mean values.

1 The mean values in many cases were the
2 highest of the scoring system, and the -- the
3 methodology accurately looked at those numbers and
4 said, we do not believe that's close to the truth.
5 And so the committee changed the methodology.

6 Q. So do you believe -- what facts do you
7 support the notion that the expert panel thought
8 that the mean was not accurate and that's why they
9 changed the methodology?

10 A. Because related to nonresponse, the fact
11 that the hospitals were not responding means they
12 were unlikely performing at the highest level.

13 Q. Is there -- are there emails in this case
14 that you can point to that support that notion?

15 A. I did not review emails.

16 Q. All right. Are there meeting summaries
17 that support that conclusion?

18 A. The meeting notes that I read supported
19 my conclusion.

20 Q. The meeting -- it's your opinion that in
21 that meeting, they talked about trying to

1 accurately assign on participating hospitals?

2 A. Yes.

3 Q. And we'll get to that.

4 In this section, how did you come
5 to -- actually, strike that.

6 Let's look over on to the -- the next
7 page. Do you see where you say at the top of the
8 page, Based on my review of the credentials of the
9 Safety Grade Expert Panel? Do you see that?

10 A. Yes.

11 Q. And so is that one of the bases of your
12 ex- --your opinion in this section? That
13 your -- your review of their -- of their
14 credentials is the rationale for your opinion; is
15 that correct?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: Review of their credentials
18 and transcripts of the expert panel meetings, which
19 is on the sentence prior.

20 BY MR. HVIDT:

21 Q. And so it's on those two that you're

1 forming your opinions in this section; is that
2 correct?

3 A. Yes.

4 Q. And is -- so is there any scientific
5 method that you're applying to form your expert
6 opinion in this section, other than your review of
7 the credentials and your review of the minutes of
8 the April 12th, 2024 expert safety panel?

9 A. I think --

10 MS. BLAIR: Objection to form.

11 THE WITNESS: I think the third paragraph
12 on page 12 is also relevant, and that's why it's
13 contained in this section, is that my day-to-day
14 involvement in hospital-associated infection
15 outcomes and my work with CDC advisory boards,
16 which are very similar to these, also led to that
17 conclusion.

18 BY MR. HVIDT:

19 Q. Okay. But is there kind of a scientific
20 method that you applied to assess the accuracy?

21 A. Not in this section, but in the

1 nonresponse bias and Exhibit 8 is formal
2 methodology that I think leads to the conclusions
3 overall in my expert opinion.

4 Q. And we'll -- we'll get to those opinions
5 there as well, but in this section, I'm trying to
6 understand, are you applying any scientific method
7 in this section to reach these opinions?

8 A. It depends how you define scientific
9 method, but there's no calculations if that's what
10 you're asking.

11 Q. Is there any -- you know, other than your
12 day-to-day life experience, your review of one
13 document and your review of the credentials of the
14 Safety Grade Expert Panel, are there any other
15 bases that form this -- the opinions in this
16 section?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: Not for section VIII.

19 BY MR. HVIDT:

20 Q. And when you say that, you know, you
21 looked at the -- the expert safety panel notes, you

1 mentioned the word transcript.

2 Was that document an actual transcript of
3 that meeting that you looked at?

4 A. I believe it was.

5 Q. It was a recorded transcript?

6 A. I believe it was.

7 Q. Okay. Why -- why was that document not
8 listed in Exhibit B to your report?

9 A. I'm not sure.

10 Q. And you mentioned their expert safety
11 panel meetings.

12 Was there more than one expert safety
13 panel meeting that you reviewed the notes for?

14 A. There was not.

15 Q. In the second paragraph on page 12, do
16 you see where you define the goal of these groups
17 is to improve hospital safety ranking systems to be
18 fair, accurate and ultimately help drive hospitals
19 to improve patient outcomes?

20 A. Yes.

21 Q. And so if you look at the prior sentence,

1 Leapfrog is included within the -- those -- the
2 term groups as used in that sentence; is that
3 right?

4 A. Yes.

5 Q. And so is it your understanding that
6 Leapfrog's goal is to accurately rank hospitals?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: I mean, this paragraph
9 is probably not using legal terms, but as a
10 hospital epidemiologist where we cared about
11 Leapfrog, CMS and Vizient, I'm looping those groups
12 together in the sense of these are groups that
13 hospitals care about what their rankings are, they
14 care about what their ratings are and they do feel
15 that those groups are aiming to improve outcomes
16 for patients, and so that's why I grouped them
17 together.

18 Although, I obviously don't know the
19 exact wording of their mission statements, vision
20 statements, but that's why I grouped those three
21 together.

1 BY MR. HVIDT:

2 Q. And so you mean hospitals expected
3 Leapfrog to try to accurately rank hospitals in
4 their grading system; is that correct?

5 MS. BLAIR: Objection to form, calls for
6 speculation.

7 THE WITNESS: They expect Leapfrog
8 to be improving their methodology to, yes, improve
9 patient outcomes and be transparent.

10 BY MR. HVIDT:

11 Q. Hospitals want Leapfrog to be transparent
12 about what they're doing with their grading
13 systems?

14 A. Yes.

15 Q. Okay. And do -- do hospitals expect
16 Leapfrog to try to accurately rank them?

17 MS. BLAIR: Objection to form, asked and
18 answered.

19 THE WITNESS: Yes. I think they're
20 trying -- I think hospitals would say they would
21 like it where their grade accurately reflects their

1 performance relative to other hospitals.

2 BY MR. HVIDT:

3 Q. And if you look down at the sentence
4 carrying over that begins, Thus. Do you see where
5 it says, Thus, it is my opinion that the assignment
6 method the Safety Grade Expert Panel chose is
7 reasonable and ethical? Do you see that?

8 A. Yep.

9 Q. Where -- on what basis do you believe
10 that the expert safety panel chose the methodology?

11 A. Yeah, I mean, you're right. That -- that
12 sentence could be improved dramatically, and
13 what -- what that sentence is trying to get at in
14 that based on my review of the Leapfrog methodology
15 related to the 32 outcomes, a combination of
16 outcome metrics and process metrics, and based on
17 what I saw related to how the Safety Grade Expert
18 Panel discussed change in methodology, that led me
19 to that sentence that, yes, I think the
20 meth- -- overall methodology is reasonable and
21 ethical.

1 And that's followed up by the next
2 sentence, which I do agree with, is saying, No
3 methodology is perfect. They take great pains to
4 consult with the leading experts in the country.

5 Q. And I'm -- I'm referring specifically to
6 the -- the -- the phrase in that sentence that the
7 Safety Grade Expert Panel chose.

8 Do you have an understanding that the
9 Safety Grade Expert Panel chose the methodology?

10 A. I think that sentence is incorrect.

11 Q. Okay. Who is -- and in your
12 understanding and in forming your expert opinion in
13 this case, who choose the methodology?

14 A. I think based on the fact the expert
15 panel does not vote, right, they're giving their
16 opinions, and then I don't know what the next step
17 is. I don't know who makes the final decision
18 related to who -- who decided to change the
19 imputation method. I don't know the -- I don't
20 know who makes that final decision.

21 So you're -- you're right that that

1 sentence is probably incorrect based on the
2 additional information, because it shouldn't be
3 chose. It should be advised or something.

4 Q. So if you don't know who chose the
5 methodology, do you know why that person who chose
6 the methodology changed the methodology?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: I don't know who chose it,
9 but based on the transcripts of the panel, it was
10 felt that the hospitals that did not respond, the
11 median value was not close to the truth of what
12 their data would have been.

13 BY MR. HVIDT:

14 Q. And if you -- if you don't know who chose
15 it, do you know that they were at the expert safety
16 panel meeting?

17 A. I do not.

18 Q. Okay. Do you know why they made the
19 change?

20 A. Who? They -- the person that I don't
21 know who chose?

1 Q. Yeah.

2 A. No, I don't know.

3 Q. Do you know for what reasons they made
4 the change?

5 A. No. I -- I -- I would -- I based on the
6 reading of the methodology in the spring, the
7 methodology in the fall and the advisory is they
8 felt that giving them the mean value was not close
9 to what their actual data would be.

10 Q. And so from those three points, that's
11 where you're driving this, the methodology as it
12 was before the change, that your notes of the
13 meeting that you reviewed and the methodology
14 afterwards; --

15 A. Correct.

16 Q. -- is that correct?

17 A. Yeah.

18 Q. Okay.

19 (Whereupon, Harris Deposition Exhibit No.
20 3, Document Bates Numbered LEAPFROG00437361, marked
21 for identification.)

1 MR. HVIDT: I'm marking this Exhibit 3 in
2 your deposition.

3 BY MR. HVIDT:

4 Q. Dr. Harris, Exhibit 3 is -- has been
5 previously introduced as an exhibit in the
6 deposition of Missy Danforth and Alexandra Campione
7 as well as I believe Dr. Austin.

8 Do you see the -- have -- have you seen
9 this document before?

10 A. I -- I don't -- I do not remember seeing
11 this document, but slide whatever -- the --
12 the -- THE page labeled Current Imputation Model
13 does seem very similar to something I reviewed.

14 Q. IF -- if you flip to the third page of
15 the document ending in 363, is that -- No. Sorry,
16 flip back, sir.

17 The cover of this presentation, does
18 that -- looking at it from the presentation
19 standpoint, is this a document that looks familiar?

20 A. It's possible that I saw this, but I'm
21 getting confused as to whether this was part of the

1 transcript or whether this was a separate document
2 that I received.

3 Q. Okay. And so flipping back to the front
4 page of the document, do you see where this is a
5 Zoom invite from a Matt Austin?

6 A. Yes.

7 Q. Do you know Matt Austin?

8 A. I do not.

9 Q. And do you see there in the list of To
10 line, does that look to be the Leapfrog Safety
11 Grade Expert Panel?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: Yes. But with additional
14 people on the To line, yes.

15 BY MR. HVIDT:

16 Q. And so you see --

17 A. Like I see Missy Danforth and I see some
18 Leapfrog emails that are not part of the committee.

19 Q. But you see that there's --

20 A. Peter Pronovost --

21 Q. -- Peter Pronovost on there?

1 A. -- Arjun Srinivasan, and -- yeah. Kathy
2 McDonald. Those are all members of the -- of the
3 group.

4 Q. Right. And do you see a Dr. Classen on
5 there?

6 A. I do not.

7 Q. And if we could flip to the page that you
8 were looking at, Current Imputation Methodology --
9 Current Imputation Model. It's on slide 7.
10 Actually, strike that.

11 Back -- back to the cover of the
12 presentation for a second, which is -- ends on 363,
13 do you -- the third page of the document. Right
14 there.

15 What's the title of this document?

16 A. Leapfrog Hospital Safety Grade Expert
17 Panel Meeting.

18 Q. Is it dated?

19 A. April 12th, 2024.

20 Q. Okay. And so if you flip to -- back to
21 page 7, Current Imputation Model --

1 MS. BLAIR: Which Bates number?

2 MR. HVIDT: On page 7. It ends in Bates
3 number 369. It's a littler stamp. It looks like
4 this (indicating).

5 THE WITNESS: 369, Current Imputation
6 Model?

7 BY MR. HVIDT:

8 Q. Yes.

9 A. Yes.

10 Q. Is it your understanding that this is a
11 summary of the approach that Leapfrog had for
12 imputing measures for the CPOE, BCMA, hand hygiene
13 and IPS scores prior to fall of 2024?

14 (Whereupon, there was a pause for
15 document examination.)

16 THE WITNESS: Yes.

17 BY MR. HVIDT:

18 Q. Okay. And if you'd flip to page 12,
19 which is ending in 374. Okay. Let me know when
20 you're there.

21 A. Yes, I'm here.

1 Q. Okay. Can you read the second sentence
2 of that slide titled Hospitals Eligible for
3 Imputation into the record, please?

4 A. Oh.

5 Q. Beginning A.

6 A. A slight dip in survey participation
7 occurred this past year as hospitals opted to use
8 past survey results in step 1 imputation.

9 Q. Okay. Do you have any understanding that
10 a drop in survey participation was one of the
11 reasons that Leapfrog was considering changing its
12 imputation methodology in 2024?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: It looks like I'm having
15 problems understanding the visual, because the X
16 axis is years, the Y axis is number of facilities,
17 but I don't understand what the color coding scheme
18 is.

19 BY MR. HVIDT:

20 Q. I understand that, but I'm -- I'm -- if
21 you'd focus on my question here.

1 Do you understand that a slight dip in
2 survey participation from 2023 -- in 2023 was one
3 of the reasons for Leapfrog's looking at whether to
4 change its imputation methodology in 2024?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: I wasn't asked to give an
7 opinion on this document, and to be honest with
8 you, without understanding what the colors are, I
9 can't understand that sentence. Because one of the
10 bars is higher, so I can't interpret that sentence,
11 and one of the bars shows no dip. So I can't
12 understand what the slight dip is referring to.

13 BY MR. HVIDT:

14 Q. So to give the expert opinions you're
15 giving in this case, did you consider the -- is it
16 your view that the reasons why Leapfrog was making
17 its methodology change were not relevant to your
18 expert opinions?

19 A. I can't comment on that.

20 Q. Do you not think assessing whether
21 reasonableness of Leapfrog's -- excuse me.

1 Do you not think that assessing the
2 reasonableness of Leapfrog's methodology requires
3 one to look at the reasons why it changed its
4 methodology?

5 A. Yeah, but I don't have data to -- to
6 offer an opinion on why they changed -- how this
7 affects their change in methodology. I mean, I
8 don't understand this figure.

9 Q. Did you ask Leapfrog why it changed its
10 meth- -- imputation methodology in 2024 in
11 preparing your expert report?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: No. I -- if -- I -- I
14 viewed the advisory committee notes and I reviewed
15 the scoring, and that's what led to my opinion.

16 BY MR. HVIDT:

17 Q. And did you review any of the testimony
18 in this case as to the reasons why --

19 A. No.

20 Q. -- Leapfrog may have changed?

21 A. I did not.

1 Q. And if you knew the reasons why Leapfrog
2 testified to why it made the change, would that
3 impact your opinions?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: I mean, it's -- it's hard
6 to say because I don't know why they changed their
7 methodology, so I wouldn't just say if I knew the
8 reasons, I would change my opinion. I'd need to
9 review what their reasons were.

10 BY MR. HVIDT:

11 Q. So how are -- did you apply -- well,
12 strike that.

13 Okay. If you could flip to the next page
14 there ending in 375. Do you see where it says
15 Proposed Future Imputation Methodology?

16 A. Yes.

17 Q. Okay. In reviewing this slide, is this
18 the imputation methodology that Leapfrog
19 implemented in 2024?

20 (Whereupon, there was a pause for
21 document examination.)

1 THE WITNESS: The step -- the -- the
2 bullet point says hospitals assigned the mean for
3 their cohort. This implies to me that this is the
4 methodology they used for spring of 2024.

5 BY MR. HVIDT:

6 Q. Have you -- you haven't seen this
7 document before; is that correct?

8 A. I don't believe so.

9 Q. And the -- do you have an understanding
10 that this is the document -- the presentation that
11 was shown to the Safety Grade Expert Panel at the
12 April 12th, 2024 expert safety panel meeting?

13 MS. BLAIR: Objection to form, lacks
14 foundation.

15 THE WITNESS: I haven't seen this
16 document, so it's hard for me.

17 Based on the first page, yes, it appears
18 that it was circulated to the -- to the panel, but
19 I can't say anything -- I mean, I don't know what
20 else happened.

21 BY MR. HVIDT:

1 Q. And so you -- you don't have any
2 understanding that this was the presentation that
3 was discussed at the meeting that -- the notes you
4 looked at in forming your opinion? You have
5 no -- you have no understanding whether this was
6 shown to them or not at that meeting that
7 you -- for the notes that you looked at; is that
8 correct?

9 A. Yeah, I don't remember the details of the
10 transcript carefully enough to know whether it
11 refers to this exact apparent slide deck.

12 Q. Okay. And if this was the methodology
13 that Leapfrog was proposing to its Safety Grade
14 Expert Panel at the April 12th, 2024 expert safety
15 panel meeting, do you understand that this page
16 does not represent what Leapfrog's current approach
17 is to impu- -- imputing scores for those four
18 measures?

19 MS. BLAIR: Objection to form, lacks
20 foundation.

21 THE WITNESS: I would agree that this

1 specific slide and titled Proposed Future
2 Imputation Methodology is not clear what the spring
3 2024 imputation method is.

4 BY MR. HVIDT:

5 Q. And if this was the methodology that was
6 discussed at the expert safety panel meeting from
7 the notes that you reviewed, would that change your
8 opinion as to whether the expert safety panel
9 discussed the imputation methodology that Leapfrog
10 implemented?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: I -- I don't -- I don't
13 think that question is really fair in that you're
14 giving me this, a set of slides. You're asking me
15 to comment on one specific slide, but like as an
16 example, you haven't alluded to the slide 363 that
17 says problem that we're working to solve.

18 So unless I reviewed slide 363, reviewed
19 slide 369, I mean, I -- I can't comment on whether
20 my opinion would change.

21 BY MR. HVIDT:

1 Q. So without -- setting aside this slide,
2 this presentation, if the Leapfrog safety expert
3 panel was discussing a proposed methodology at that
4 meeting and that was the only meeting they had,
5 does that change your opinion whether the expert
6 safety panel advised on the Leapfrog methodology
7 change?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: I think -- I think my
10 opinion would only change if I had a video of
11 exactly what went on in that meeting and exactly
12 the slides and I was able to go back and see
13 exactly what they had and I had time to literally
14 have been a member there, which would have been
15 like two hours probably, then, yes, theoretically,
16 my opinion could have changed. But it's -- it's
17 impossible with looking at one slide.

18 The -- the slide does not reflect the
19 slide plus the discussion. The slide does not
20 reflect the emails. I -- I have not had access to
21 any of that, so it's impossible for me to tell you

1 with any confidence and understanding of what went
2 on at that meeting.

3 BY MR. HVIDT:

4 Q. Feel free to look at this presentation
5 and see if the words limited achievement are -- are
6 in there as to a methodology change being proposed
7 to the expert safety panel.

8 (Whereupon, there was a pause for
9 document examination.)

10 MS. BLAIR: I'll just object to form.
11 Lacks foundation.

12 (Whereupon, there was a pause for
13 document examination.)

14 THE WITNESS: Can you repeat your
15 question, specific -- specifically the section
16 related to limited achievement?

17 BY MR. HVIDT:

18 Q. Yes. In this presentation, does The
19 Leapfrog Group mention or recommend that the
20 imputation methodology could change to assigning
21 non-participating hospitals a score of limited

1 achievement?

2 A. I think this ties to my point prior. So
3 there's slide 372, which is titled Spring 2024
4 Cohort Means for Step 2 Imputation.

5 The discussion around this slide is
6 really important because these appear to be the
7 mean scores, so I would assume the discussion was
8 related to in this thing what the current method
9 was, which was the means scores.

10 And then the next slide is called Spring
11 2024 Measure Scores of which the term limited
12 achievement is on there. So without being at the
13 meeting and mirroring the transcript with this
14 slide, you don't really know what was discussed
15 related to the limited achievement term on this
16 slide.

17 Q. I'm going -- we'll -- we'll get to that,
18 and -- and on this slide, do you see limited
19 achievement? Is that the lowest-score level there
20 listed in that chart?

21 A. That's the lowest level.

1 Q. Thank you. And then --

2 A. No. One second. I -- I do want to say
3 that you're asking me to interpret this data, which
4 I haven't had a chance to review, but if you'll
5 notice, if you look at the slide before and you
6 look at the slide next, it supports what I stated
7 previously, that the mean scores for some of these
8 are in the high 80s and then the limited
9 achievement. So the mean scores that they were
10 getting imputed appears to be like 89, 88, so I
11 just want to point out -- that out.

12 Q. Absolutely. And on that point,
13 Dr. Nicholson testified and -- and it's been his
14 opinion as it relates to the increased mean scores,
15 do you recall that?

16 MS. BLAIR: Objection to form, lacks
17 foundation.

18 THE WITNESS: I'd need to see the exact
19 section you're referring to.

20 BY MR. HVIDT:

21 Q. You -- you read the Nicholson report; is

1 that correct?

2 A. I did.

3 Q. And you offer some opinions related to
4 some of the items in Nicholson's report; is that
5 correct?

6 A. Yes.

7 Q. And earlier you testified that you didn't
8 criticize any of the portions of his report that
9 aren't referenced in your -- your own report?

10 A. Correct.

11 Q. Okay. And one of those opinions is that
12 the mean scores are increased because hospitals who
13 participate inflate their answers when they
14 participate, do you recall that?

15 A. I -- I do not.

16 Q. Okay. So before you sat here today, you
17 had not seen this presentation; is that correct?

18 A. I don't -- I don't believe I did.

19 Q. Okay.

20 MR. HVIDT: And I'm going to --

21 (Whereupon, Harris Deposition Exhibit No.

1 4, Document Bates Numbered LEAPFROG00258530, marked
2 for identification.)

3 MR. HVIDT: I'll mark this as Exhibit 4,
4 a document that was produced in this litigation by
5 Leapfrog.

6 BY MR. HVIDT:

7 Q. And if you see how on that first page,
8 there's a reference to -- in -- in the attachment,
9 there's a reference to Leapfrog Hospital Safety
10 Grade Expert Panel Meeting Notes?

11 A. Yeah.

12 Q. Okay.

13 MR. HVIDT: And -- and just for the
14 record, this is a document produced as
15 LEAPFROG00258530.

16 BY MR. HVIDT:

17 Q. If you flip to the third page of this
18 document, Dr. Harris, do you see where it says
19 Meeting Notes, Leapfrog Hospital Safety Grade
20 Expert Panel Call, Friday, April 12, 2024?

21 A. Yes.

1 Q. And looking at this document, have you
2 seen this document before?

3 A. I'm not certain. If -- if I had seen it,
4 I do not remember it. I do not believe I have seen
5 this, but I am not certain.

6 Q. Have --

7 A. I --

8 Q. When you mentioned that you saw a
9 transcript from the April 12, 2024 --

10 A. Yeah.

11 Q. -- expert safety panel call --

12 A. No, this was not this document.

13 Q. -- was this -- was it a document like
14 this?

15 It's not like this?

16 A. No. The transcript document I saw was
17 like 50, 60 pages, almost similar to this where
18 it's a verbatim transcript, which is why this does
19 not seem familiar to me.

20 Q. And when did you see that?

21 A. That was like -- if my thing was

1 September 4th, the week prior to that.

2 Q. And is that document -- is that
3 transcript listed in Exhibit B to your report in
4 there -- in Exhibit 2 to your deposition?

5 So Exhibit B to your expert report lists
6 the documents relied upon, correct?

7 A. So what page is that?

8 Q. Your -- your finger is on it right now,
9 your other finger, your index finger. Right there,
10 that's part of Exhibit B.

11 A. Oh, sorry. Sorry.

12 (Whereupon, there was a pause for
13 document examination.)

14 THE WITNESS: It's not 1, 2 or 3.
15 You're -- you're correct, but I don't understand
16 what this section entitled Documents Produced
17 means.

18 BY MR. HVIDT:

19 Q. So Leapfrog produced documents in this
20 litigation, do you understand that?

21 A. Yes.

1 Q. Plaintiffs produced documents in this
2 litigation, do you understand that?

3 A. Yes.

4 Q. And together, there's over a million
5 documents produced in this case, do you understand
6 that?

7 A. I do now, yes.

8 Q. Okay. And do you see there that you have
9 three documents listed there?

10 A. Yes, and none of those three is the
11 transcript based on what I see.

12 Q. Do you have an understanding
13 that -- that -- whether the transcript was produced
14 by Leapfrog in this case?

15 A. Yes, I guess it -- it was.

16 Q. Okay. We'll flip now -- so you've never
17 seen Exhibit 4 before sitting here today; is that
18 correct?

19 A. I -- I don't believe so.
20 I -- it's -- it's hard for me to tell, to be
21 honest. It -- I do not remember this document.

1 Q. Do you -- do you believe that reviewing
2 the meeting notes for the meeting that played a
3 role in you forming your expert opinions would have
4 been important to applying your expert analysis to
5 the facts of this case?

6 A. Yeah. In an ideal world, I would have
7 reviewed the million documents, and the meeting
8 notes would have been helpful.

9 Q. Do you --

10 A. I -- I mean, I do agree with you that
11 point 2 -- if you're saying should proposed changes
12 to the imputation model notes, is that relevant
13 to -- would it have been relevant to my opinion?
14 Yes.

15 Q. And --

16 A. One thing that does jog that's similar to
17 the transcript though, so if you look at the last
18 page, I do remember this thing where like it says,
19 Peter liked that idea, said hospitals could offer
20 help with delivering this message. I do remember
21 that section of the transcript. So, yes, it is

1 referring to documents that I did read, but ...

2 Q. Up above, do you see where it says, Peter
3 noted that Leapfrog's message on this change will
4 be critical?

5 A. Yes.

6 Q. And then do you see where it says --

7 A. Yeah, I --

8 Q. -- has the potential to backfire?

9 A. Yeah.

10 MS. BLAIR: Well, objection to form.
11 That's not the whole sentence, but fine.

12 BY MR. HVIDT:

13 Q. Do you see that?

14 A. Yes, I see that.

15 Q. And in your expert opinion, what do you
16 believe could backfire depending on Leapfrog's
17 messaging of this -- of a change?

18 MS. BLAIR: Objection to form, outside
19 the scope and lacks foundation.

20 THE WITNESS: Yeah, I mean, I -- I don't
21 have an opinion on this. I haven't reviewed it

1 enough.

2 I would tell you that when I was
3 president of the Society of Healthcare Epidemiology
4 of America, you have endless times where you draft
5 documents and you make changes and members are
6 either happy or unhappy and any policy change has
7 potential angry members responding.

8 BY MR. HVIDT:

9 Q. And you can set that document to the
10 side.

11 (Whereupon, Harris Deposition Exhibit No.
12 5, Transcript of Expert Safety Panel Meeting dated
13 April 12, 2024, marked for identification.)

14 BY MR. HVIDT:

15 Q. All right. I am handing you as Exhibit 5
16 to your deposition what is a transcript of the
17 April 12th, 2024 expert safety panel meeting.

18 If you -- this document was used during
19 the Matt Austin deposition last week, and this
20 document was extracted from a live link that
21 Leapfrog produced in this litigation for the Zoom

1 meeting.

2 And Veritext -- a court reporter on page
3 47 certified that the document was a transcript, is
4 a true and accurate record of the video Zoom link.

5 Have you seen this document before,
6 Dr. Harris?

7 A. Yeah, this -- this appears to be exactly
8 the document I had, I think, in that it's a full
9 transcript of the meeting.

10 Q. Do you see where it says on page 47 that
11 this was recorded on September 11th?

12 MS. BLAIR: 2025.

13 BY MR. HVIDT:

14 Q. 2025?

15 A. Oh. I guess this is not what I saw. I
16 apologize.

17 Q. And so do you have any understanding if
18 the transcript that you reviewed was produced in
19 this litigation in the form that you reviewed it?

20 A. I -- I don't -- I am not sure.

21 Q. Do you have any understanding why it

1 wasn't listed in your documents cited?

2 A. I do not.

3 Q. And we're going to look through this
4 transcript to do the exercise that you mentioned.

5 If you flip through the transcript to
6 page 13, if you look on line 18, do you see where
7 the speaker is Matt Austin?

8 A. Yep. Line 18?

9 Q. Line 18. Do you see the paragraph from
10 line 18 forward where he says, What we want to
11 spend the majority of the time talking about?

12 A. Yes.

13 Q. Okay. And so from this section forward,
14 is this similar to what you looked at when you said
15 you looked at a transcript of the meeting?

16 MS. BLAIR: Can he take a second to read
17 it?

18 MR. HVIDT: Absolutely.

19 THE WITNESS: So what pages am I reading?

20 BY MR. HVIDT:

21 Q. So it's page 13 of the document to page

1 31 is the section where the -- the meeting where
2 they were talking about the imputation methodology
3 change.

4 A. I'm sorry. So since you've correctly
5 pointed out that I haven't seen this version of the
6 document, you want me to read page 13 to 31 now?

7 Q. I -- for -- for -- I had asked a question
8 about whether this -- looking at the test- --
9 looking at the words reminded you of the document
10 that you looked at.

11 I -- for the purposes of the time since
12 we were -- started over an hour late, I'd prefer
13 that you not read it fully -- fully right now.
14 I'll direct you to a few places, and we'll allow
15 you to have context surrounding those, okay?

16 MS. BLAIR: And for the record though,
17 are you asking him is this what he -- when he keeps
18 referring to a transcript, is this what he's
19 referring to?

20 MR. HVIDT: I'm -- I'm asking if it's
21 similar to what he looked at when he said he's

1 referring -- referring to a transcript.

2 MS. BLAIR: Yeah. So if you just want to
3 just skim 13 through 31 --

4 MR. HVDIT: Yes.

5 THE WITNESS: Okay.

6 MS. BLAIR: -- just to see if anything
7 sticks out as, Oh, yes, this is it.

8 (Whereupon, there was a pause for
9 document examination.)

10 THE WITNESS: This is not similar to what
11 I reviewed in the sense that there's a lot more
12 details.

13 BY MR. HVIDT:

14 Q. Okay.

15 MR. HVIDT: We'll just put a note on the
16 record that we're requesting that Defendant produce
17 the document that --

18 MS. BLAIR: I'll figure it out.

19 MR. HVIDT: -- that he's referring to.

20 BY MR. HVIDT:

21 Q. Okay. I'll direct your attention to page

1 18, and first, do you see there on line 8 where it
2 says, So what we're going to propose to you all?

3 A. Yes.

4 MS. BLAIR: And again, for the record,
5 this is Matt Austin talking.

6 MR. HVIDT: And for the record, this is
7 Matt Austin talking.

8 MS. BLAIR: Got it.

9 BY MR. HVIDT:

10 Q. And if you pull back out Exhibit 3, which
11 was the presentation --

12 A. Yeah.

13 Q. -- and you flip back to the page that
14 read proposed methodology -- Proposed Future
15 Imputation Methodology, which is slide 13, Bates
16 ending in 375, do you have those two documents out
17 together?

18 So -- and so do you see where Matt Austin
19 says, So, what we are going to propose to you is
20 for a refinement to the imputation model is, one is
21 to retire step 1, which is where we use the recent

1 historical data from hospitals to calculate a
2 score, so that would be -- would be do away with
3 step 1, and within step 2, we would specifically
4 focus on hospitals and how they did on their first
5 year of reporting on the current standard, so we
6 would still group the hospitals into cohorts. Do
7 you see that?

8 A. Yeah.

9 Q. So does it appear from looking at that
10 presentation slide and what Matt Austin said
11 is -- in this document before you that what was
12 being proposed by Leapfrog to the expert safety
13 panel on April 12th, 2024 was not the imputation
14 change that Leapfrog ended up implementing?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: I -- I can't comment on
17 that without reading the whole -- this whole
18 document like more slowly. I mean, the -- the
19 details really matter.

20 BY MR. HVIDT:

21 Q. Would it have been beneficial to have

1 reviewed them before the deposition?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: I mean, you're asking me a
4 very specific question mirroring -- trying to merge
5 two documents. I -- I mean, I can't answer that.

6 BY MR. HVIDT:

7 Q. Do you understand that Dr. Austin
8 testified that the actual solution that Leapfrog
9 implemented was not explicitly proposed --

10 A. No.

11 Q. -- to the expert panel?

12 MS. BLAIR: Objection to form, lacks
13 foundation.

14 THE WITNESS: No, I'm not aware of that.

15 BY MR. HVIDT:

16 Q. You can set those documents to the side.

17 Beyond the transcripts, did you review
18 the feedback that any of the experts on the safety
19 grade panel provided to Leapfrog in any form?

20 A. I reviewed a document where there was an
21 open discussion, and that included some emails from

1 constituents.

2 Q. Are you referring to the comments to the
3 proposed change?

4 A. Yes.

5 Q. Have you reviewed any emails that
6 Dr. Romano produced -- I mean that Dr. Romano wrote
7 that were produced in this litigation?

8 A. I have not.

9 (Whereupon, Harris Deposition Exhibit No.
10 6, Document Bates Numbered ARMSTRONG_0008450,
11 marked for identification.)

12 BY MR. HVIDT:

13 Q. I am handing you what has been produced
14 in this litigation as ARMSTRONG_0008450, which is
15 an email from Patrick Romano to Matt Austin dated
16 May 15, 2024, with copy to Missy Danforth and
17 Alexandra Campione, regarding Leapfrog proposed
18 text for imputation change, and an attachment, HSG
19 Proposed Imputation Change for Fall 2024 PSR. Do
20 you see that, Dr. Harris?

21 A. I see it, yes.

1 Q. And if you flip to the attachment to this
2 email that I referenced, it's on the third page
3 ending in 452. Let me know when you're there.

4 A. One sec. I have --

5 Q. Here, I gave you two.

6 A. I think you gave me two. So which page
7 are you asking? The third page?

8 Q. Correct, ending in 452.

9 A. Okay.

10 Q. Looking there at the -- the language
11 there in this exhibit, does this seem -- does this
12 language seem like a draft or -- of a -- of what
13 went into the document that you looked at relating
14 to the responses to the comments and release of the
15 imputation methodology?

16 MS. BLAIR: Objection to form, lacks
17 foundation.

18 THE WITNESS: One sec. Can you repeat
19 the question?

20 BY MR. HVIDT:

21 Q. Yes.

1 A. does this seem like a --

2 Q. Before the -- before I handed you this
3 document, you said one of the documents you had
4 reviewed and -- in preparing your opinion was a
5 document that announced the release of the
6 imputation change and responded to public comments,
7 do you recall that?

8 A. Yes.

9 Q. And so I'm asking if this language is
10 similar to the -- what you reviewed in that
11 document?

12 A. I haven't reviewed that document for four
13 or five weeks, but the bottom portion of this page
14 452 where it says, Leapfrog is proposing the
15 following changes, yeah, this seems similar.

16 Q. Okay. And then if you look up in the
17 redline or the -- it looks like a gray line on
18 our -- in front of us, the second paragraph, do you
19 see where in the last sentence of that paragraph
20 there's an edit there that adds, encourage survey
21 participation?

1 A. Yes.

2 Q. And do you see where there's an edit
3 there to add, kind of adjust the language to say,
4 to improve user's confidence in the data. Do you
5 see that?

6 A. Yeah.

7 Q. Okay. We'll come back do that later, but
8 I just wanted to direct your attention to that now.

9 If you could flip to the email that
10 starts this chain on the second page, 451. On the
11 second page, sir.

12 There's an email from Matt Austin dated
13 May 7th, do you see that?

14 A. Yes.

15 Q. And it's directed to Dr. Romano, do you
16 see that?

17 A. Yes.

18 Q. And do you see where he references that
19 they met with the expert panel?

20 A. Yes.

21 Q. And then he references later that they

1 drafted the attached language to share with
2 hospitals about the proposed change, do you see
3 that?

4 A. Yeah.

5 Q. And he -- he asks for Dr. Romano's input,
6 do you see that?

7 A. Yeah.

8 Q. Okay. And if you flip to the email
9 response from Dr. Romano, have you ever seen this
10 email before?

11 A. I don't remember reading it.

12 Q. Okay. And do you see where he says, I
13 like the simpler and more direct approach here? If
14 the goal is to penalize nonparticipants, you might
15 as well do so in a clear and unmistakable manner,
16 do you see that?

17 A. I see that sentence, yeah.

18 Q. And do you see where he references, the
19 goal is to penalize nonparticipants?

20 A. I see --

21 MS. BLAIR: Objection to form.

1 THE WITNESS: I see that sentence, yes.

2 BY MR. HVIDT:

3 Q. Have you reviewed any of the facts or
4 testimony in this case relating to whether or not
5 Leapfrog had a goal of trying to penalize
6 nonparticipants in --

7 MS. BLAIR: Objection.

8 BY MR. HVIDT:

9 Q. -- in its methodology change?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: I -- I don't agree -- I
12 mean, I don't agree with that because I haven't
13 seen any documents to support that sentence.

14 BY MR. HVIDT:

15 Q. Have you reviewed the Dr. Romano
16 transcript from his deposition?

17 A. I haven't. I -- I spent five minutes on
18 that, so, no, not enough to comment related to this
19 sentence.

20 Q. Okay. And have -- if there were facts
21 and testimony in this case that one of Leapfrog's

1 goals in its methodology change was to penalize
2 non-participating hospitals to encourage them to
3 participate in the survey, would that change any of
4 your opinions in this case?

5 MS. BLAIR: Objection to form, outside
6 the scope.

7 THE WITNESS: If -- I mean, let me just
8 make one thing. Leapfrog gains for transparent
9 presentation, so their goal is to have every
10 hospital in the country participate in a
11 transparent fashion, which I think is a totally
12 appropriate goal.

13 If you're saying that -- so I think that
14 that goal is fair, and that wouldn't change my
15 opinion.

16 If you provide me with data that says
17 they're actively trying to penalize
18 nonparticipants, yes, that would change my opinion.

19 BY MR. HVIDT:

20 Q. And how would it change your opinion?

21 A. Well, it's all ties into the whole thing

1 of if the imputation method is getting closer to
2 the truth, then it's fair.

3 If it's getting closer to the truth and
4 then it encourages more hospitals to report their
5 data, then that's fine, because that's the truth.
6 So I think that's a laudable goal.

7 If the imputation method is flawed and
8 it's penalizing people, which I don't believe is
9 the case, then, yes, I would change my opinion.

10 If the imputation method was flawed and
11 got us farther from the truth and you provided
12 documents that said they did it specifically to
13 penalize, yeah, that would change my opinion, but I
14 don't think that's the case.

15 Q. Okay. Let's keep reading.

16 Dr. Romano continues to say, While
17 allowing for hospitals to manage their burden, do
18 you see that?

19 A. Which paragraph is that?

20 Q. We're -- we're continuing on that same
21 sentence. Dr. Romano's reference to the hospitals

1 are needing to manage their burden, do you see
2 that?

3 A. Yes.

4 Q. Do you have any -- any understanding that
5 the burden of completing the Leapfrog hospital
6 survey is one reason why a hospital might choose
7 not to respond to the Leapfrog hospital survey?

8 MS. BLAIR: Objection. Asked and
9 answered.

10 THE WITNESS: I answered it earlier.

11 I don't think -- I disagree with
12 Dr. Romano on this. I don't think it's a burden.

13 I think that -- I think that to spend the
14 time to report your true data is the right way to
15 go, so I -- I -- I disagree with this sentence. I
16 just -- I don't think it's a burden. It takes
17 time, but I would not say it's a burden.

18 BY MR. HVIDT:

19 Q. But it does take time to complete the
20 survey, right?

21 A. Yes, it takes time.

1 Q. And hospitals have to manage the
2 resources that they have; is that correct?

3 A. Yes.

4 Q. Okay. And hospitals have a lot of
5 mandatory obligation -- reporting obligations; is
6 that correct?

7 A. Yes.

8 Q. Okay. And Leapfrog is voluntary; is that
9 right?

10 A. I believe so.

11 Q. Okay. So moving on to the large
12 paragraph there in his email, do you see where it
13 says, your step 2b proposal would have led to lower
14 imputed scores, but not more accurate imputation?
15 Do you see that?

16 A. I see that sentence.

17 Q. Okay. And --

18 A. I don't agree with that sentence. I
19 think that the imputation does lead to more
20 accurate -- I -- I disagree with Dr. Romano on that
21 sentence.

1 Q. Have you reviewed data to support your
2 disagreement?

3 A. Yeah. I have reviewed nonresponse bias,
4 and I reviewed -- I recalculated in Exhibit 8 what
5 I think is more accurate results.

6 Q. Okay.

7 MS. BLAIR: And I want to go back and
8 just object to form. He's referring to step 2b.

9 MR. HVIDT: Thank you. I was --

10 MS. BLAIR: I thought you said just step
11 2, sorry.

12 MR. HVIDT: Yes, step 2b, which is the
13 step 2b proposal in the presentation --

14 MS. BLAIR: Correct.

15 MR. HVIDT: -- that Dr. Austin had sent,
16 which that -- I was going to clarify that that's --

17 MS. BLAIR: Okay.

18 MR. HVIDT: He's not referring to step 2b
19 there to what Leapfrog ultimately ended up doing.
20 He was referring to their initial proposal that we
21 just walked through.

1 BY MR. HVIDT:

2 Q. Okay. And then we move on to in the
3 middle of that sentence -- in the middle of that
4 paragraph, Dr. Romano addresses what your
5 hypothesis is.

6 He says, The underlying hypothesis behind
7 your proposed step 2b approach was that hospitals
8 stop reporting because their true performance
9 deteriorated relative to the cohort. Do you see
10 that?

11 A. Yes.

12 Q. Okay. Then he continues, My hypothesis,
13 by comparison, was that most hospitals stop
14 reporting because it's too burdensome and because
15 they only find market value in A, which
16 improves -- which proves impossible to attain or
17 maintain, do you see that?

18 A. Yeah.

19 Q. And he says, If my hos- -- hypothesis is
20 correct, then the current step 2 approach would
21 yield more accurate imputations. Do you see that?

1 A. Yeah.

2 Q. And then he says, but it doesn't achieve
3 your strategic objective of penalizing
4 nonparticipants, do you see that?

5 A. Yes.

6 Q. And so the your there, do you have an
7 understanding that Dr. Romano was referring to
8 Leapfrog?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: Yeah, I agree
11 your -- your -- well, now, your could refer to the
12 committee and/or Leapfrog.

13 BY MR. HVIDT:

14 Q. Okay. But it's either the expert safety
15 panel or Leapfrog; is that correct?

16 A. Yeah, that would be my interpretation of
17 that sentence.

18 Q. Okay. And then he says, I wasn't keen on
19 back-door approach to penalizing nonparticipation.
20 Do you see that?

21 A. Yes.

1 Q. He says, If you want to penalize
2 nonparticipants, then don't pretend that you are
3 imputing missing values in a statistically optimal
4 way. Just be honest about your goal. Do you see
5 that?

6 A. Yes.

7 Q. So you were asking if there's any
8 evidence in the record that supports the notion
9 that Leapfrog was trying to penalize
10 non-participating hospitals through its imputation
11 change.

12 MS. BLAIR: Objection to form.

13 BY MR. HVIDT:

14 Q. Does seeing this email change any of your
15 opinions?

16 MS. BLAIR: Objection to form,
17 mischaracterizes Mr. Romano's email and lacks
18 foundation.

19 THE WITNESS: I wish I had read -- had
20 read Dr. Romano's deposition, because I would
21 hazard a guess it has a lot more valuable

1 information to supplement this email.

2 If you're asking if I'm just reading this
3 email in isolation, I don't think I was asked to
4 opine on this email.

5 BY MR. HVIDT:

6 Q. Were you asked to opine on Leapfrog's
7 safety grade methodology?

8 A. I was.

9 Q. Were you asked to opine on whether their
10 imputation methodology is reasonable?

11 A. Yes.

12 Q. Were you asked to -- does -- do you think
13 that the reason for the methodology change is
14 relevant to whether the methodology change is
15 reasonable?

16 A. No. I think that -- I think that what I
17 reviewed, which I reviewed, you know, thoroughly, I
18 think the imputation method is fine and -- and as
19 close to optimal as they could deal with.

20 Q. And if Leapfrog was trying to penalize
21 nonparticipants with its methodology change, does

1 that impact your opinion on whether or not
2 Leapfrog's methodology change was ethical?

3 MS. BLAIR: Objection. Asked and
4 answered.

5 THE WITNESS: In the documents I
6 reviewed, it had no evidence that Leapfrog or the
7 committee was trying to penalize nonparticipants.

8 If that's truly the case, if that's what
9 you're saying, the hypothetical, yes, that would
10 affect my opinion.

11 BY MR. HVIDT:

12 Q. And the number of documents you reviewed
13 in preparing your report was three, correct?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: Yes.

16 BY MR. HVIDT:

17 Q. If we could pull back Exhibit 2 which is
18 your -- actually, strike that.

19 (Whereupon, Harris Deposition Exhibit No.
20 7, Expert Report of Professor Sean Nicholson,
21 marked for identification.)

1 MS. BLAIR: Thank you.

2 BY MR. HVIDT:

3 Q. I'm handing you what's been marked as
4 Exhibit 7 in your deposition which is the expert
5 report of Professor Sean Nicholson which is dated
6 August 7th, 2025.

7 Dr. Harris, have you seen this document
8 before?

9 A. Yes.

10 Q. We'll cover more aspects of this, but can
11 we work towards Workpaper 2, which is towards the
12 back of the document in Appendix E. It is page 6
13 to 7 of Appendix E Workpaper 2. It will look like
14 this (indicating).

15 A. Six to 7?

16 Q. Um-hum. Let me know when you are there.

17 A. Yeah, I'm there.

18 Q. Okay. In your report, you talk about
19 your experience with other boards, do you recall
20 that?

21 A. Yes.

1 Q. Okay. And how did you apply your
2 experience with other boards in reaching your
3 expert opinions in this case?

4 A. Well, my experience in other boards
5 related to looking at the methodology,
6 assign -- looking at the change in methodology and
7 trying to figure out, especially after I read
8 Dr. Nicholson's report, what -- where was the truth
9 related to where these hospitals were from a
10 quality perspective and what potential impact the
11 change in imputation methodology would have.

12 Q. And you -- one of those boards you're
13 familiar with is the CDC advisory board; is that
14 correct?

15 A. Yes.

16 Q. And CMS metrics are something that you
17 look at in relation to your work on that board,
18 would that be fair to say?

19 A. Yes. So if -- since you're at Appendix
20 E, of the metrics in Appendix E, the one that I
21 have a lot of expertise on, to be frank more than

1 Dr. Nicholson, is CLABSI, CAUTI, SSI colon, MRSA,
2 C. Diff.

3 As a day-to-day hospital epidemiologist,
4 I also have had familiarity with pretty much every
5 single other one on -- on this as well.

6 Q. And each of those that you just
7 referenced are in the Outcome portion of the --

8 A. Well, it's --

9 Q. --leapfrog weight breakdown, do you see
10 that?

11 A. Yeah, but that's not completely correct
12 because there's all the HCAHPS.

13 Q. And do you -- do you see those under
14 Process Structural?

15 A. Yeah. Which -- that's H -- H-COMP-1,
16 H-COMP-2, 3, 5, 6, right?

17 Q. Yes. Do you see that?

18 A. I believe so, yeah.

19 Q. Okay. Do you see that TLG, the measures
20 collected from CMS account for less than half of
21 the numerical score Leapfrog calculates for

1 participating hospitals in the spring of 2025? Do
2 you see that down at the bottom, Total Weight By
3 Data Source?

4 A. Yeah, but what the -- the survey --
5 what's in the survey category? I think the details
6 are really important, because I think the
7 HCPSS -- the HCAHPS scores are part of the survey,
8 and I would deal -- I would say that those are
9 objective as well.

10 Q. So if you look at the second column, do
11 you see where it says Primary Data Source?

12 A. Yeah.

13 Q. Okay. And then do you see where it says
14 Surveyor, CMS?

15 A. Yeah.

16 Q. Okay. And do you see for the H-COMP,
17 there's the CMS there?

18 A. Yeah.

19 Q. And then for the -- there's six outcome
20 measures or, excuse me, five outcome measures where
21 it says CMS there in Primary, do you see that?

1 A. Yes. Right. So my -- the point I'm
2 trying to clarifying is that in the earlier
3 portion, I -- I would consider the H-COMP-1, 2, 3,
4 5, 6 not so much process and structural, as it's an
5 objective -- if -- if those are the questions that
6 are part of the HCAHPS score, it's really important
7 to clarify that those are objective questions, and
8 so they're outcome -- they're outcome generated.

9 So depending upon how you rolled them up
10 into the total weight by data source, that's really
11 important.

12 Q. And do you understand this is how
13 Leapfrog has delineated the measures in its survey,
14 in its grading methodology?

15 A. Yes.

16 Q. Okay. And do you see where it says Total
17 Weight By Data Source?

18 A. Yeah.

19 Q. Do you see where it says CMS is 43
20 percent?

21 MS. BLAIR: Objection to form.

1 THE WITNESS: Right, but the -- but,
2 look, I'm not positive I completely understand
3 Appendix E, and this is why the devil is in the
4 details.

5 But I think it's really, really important
6 to make the following point: You're focusing on
7 the wrong aspect of the Appendix -- no, no. This
8 is important. This is really important.

9 You're focusing on the wrong aspect of
10 Appendix E, okay?

11 The imputation method accounts for only
12 24 percent, and that imputation method includes all
13 seven questions, okay?

14 And so that if someone nonresponds I
15 believe, even when you reweight everything, the
16 imputation of the four questions amounts for an
17 incredibly small percentage of the overall grade,
18 and that's the most important point. And -- and
19 just -- No, this is really important.

20 So when you get a 55-page deposition,
21 that's the key weakness of this document. That's

1 the key weakness of Nicholson's deposition.
2 Everything else is irrelevant.

3 BY MR. HVIDT:

4 Q. Doctor, --

5 A. Yeah.

6 Q. -- when I ask a question, --

7 A. Go ahead, I'm sorry.

8 Q. -- I'd just ask that you answer the
9 question --

10 A. Okay. I'm sorry. Yeah.

11 Q. -- and then we can -- and we're going to
12 get to that point.

13 A. Okay.

14 Q. Okay?

15 A. Okay.

16 Q. But like let's focus -- we're -- we're
17 going to be here -- it's going to be shorter if we
18 focus on the questions --

19 A. Right.

20 Q. -- that we're talking about.

21 A. But I just feel -- I just feel like -- I

1 just feel like you're trying to trap me on minor
2 details of a long deposition of an expert report.

3 MS. BLAIR: Right.

4 BY MR. HVIDT:

5 Q. Dr. Harris, all I'm simply trying to ask
6 you in this moment --

7 A. Yeah.

8 Q. -- is whether the survey percentage for
9 participating, whether -- when Leapfrog grades
10 participating hospitals, so hospitals that
11 participate in its survey, whether the CMS score,
12 CMS data or the survey data makes up a greater
13 percentage of that grade?

14 MS. BLAIR: And I'm going to object to
15 form to the extent this is inaccurately
16 representing where this data comes from.

17 THE WITNESS: Yeah, I -- I -- look,
18 here's my short answer. I don't think Appendix E
19 is -- I don't think this is correct.

20 I think the survey -- based on what I
21 reviewed, the survey does not account for 56.6

1 percent of the overall thing. I just think that's
2 factually incorrect.

3 BY MR. HVIDT:

4 Q. Okay.

5 A. I -- I don't think --

6 Q. Do you see the source there is the
7 website that Leapfrog has for the 20- -- spring
8 2025 methodology?

9 A. I know, but you're asking me for my
10 honest opinion. The other documents I reviewed did
11 not have -- this -- this does not seem correct. It
12 just does not seem correct. That's -- that's all
13 I'm saying.

14 Q. And all I'm trying to ask and understand
15 is if you have any understanding that as a matter
16 of Leapfrog's methodology whether the survey data
17 or the CMS data accounts for a greater percentage
18 for the grade for a participating hospital?

19 MS. BLAIR: Objection to form, asked and
20 answered, and this Appendix E mischaracterizes
21 where this information comes from.

1 THE WITNESS: I'll -- I'll tell you, I
2 figured it out now. The reason this
3 mischaracterizes it is because if you fill out the
4 survey, some of the data comes from the survey. So
5 that's how you get to 56.6 percent.

6 If you don't fill out the survey, there's
7 data that comes from the HCAHPS score or the -- or
8 the CMS, so then that second line would be
9 redistributed and then you'd have a much larger
10 percent from CMS or secondary data objective
11 sources.

12 BY MR. HVIDT:

13 Q. Correct. If you are not a participating
14 hospital, the CMS percentage is higher than 43.6
15 percent; is that correct?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: Yes, it's correct, and it's
18 based on objective data.

19 BY MR. HVIDT:

20 Q. Okay. And you mentioned that 24
21 per- -- it's your opinion that 24 percent of weight

1 of a grade is small?

2 A. Yeah, 24 percent is small. It's -- it's
3 small in the appropriate context of what my expert
4 report says, which is they're poor performing on 75
5 percent.

6 Q. Now, what we're -- if -- is it -- would
7 you agree with me that if I am taking a test in
8 your class and I get a zero for 2024 -- 24 percent,
9 that the highest number that I can get is a 76?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: First, they're not getting
12 a zero. They're getting a 15, okay? But that's
13 why the devil is in the details. That's why
14 Exhibit 8 shows that no matter how you deal with
15 things, they're poor-performing hospitals in my
16 opinion.

17 BY MR. HVIDT:

18 Q. That's not -- so listen to my question.

19 A. Yes.

20 Q. If I'm in your class and I get -- there's
21 a hundred points possible and you give me a zero on

1 24, the highest I can get is 76; is that correct?

2 A. Yes.

3 MS. BLAIR: Objection to form.

4 THE WITNESS: Yes, I agree with that.

5 BY MR. HVIDT:

6 Q. Thank you. Do you see where in
7 exhibit -- Workpaper 2 in Exhibit E where it says,
8 Secondary Data Source?

9 A. Yes.

10 Q. Do you see for CPOE, BCMA, IPS and HHS
11 the secondary data source is listed as imputation?

12 A. Yes, for those four -- four lines.

13 Q. Okay. So is it your understanding that
14 if a hospital doesn't participate in the survey
15 that the only source that Leapfrog uses to give
16 them a score for those measures is its methodology,
17 imputation methodology?

18 A. Yes, for those four scores. That's
19 correct.

20 Q. And do you believe that in coming up with
21 the 2024 methodology that the Leapfrog and its

1 Safety Grade Expert Panel applied the Leapfrog
2 Safety Grade Expert Panel's guiding principles in
3 trying to determine what the methodology should be?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: You'd have to re-read for
6 me the guiding principles, but, yes, I think they
7 applied the guiding principles.

8 BY MR. HVIDT:

9 Q. If you could go to your report, which is
10 Exhibit 2 on page 8 and 9. Did you copy and paste
11 the safety grade -- the expert panel's Guiding
12 Principles on the Development of the Composite
13 Leapfrog Hospital Safety Grade for U.S. Hospitals
14 into your report?

15 A. With the help of my legal team, yes.

16 Q. And did you review those principles
17 before copying them into your report?

18 A. I did.

19 Q. And at the beginning of the paragraph on
20 page 7, do you see where it says, According to its
21 website?

1 A. Page 7, I'm sorry?

2 Q. Yes.

3 A. Yes.

4 Q. Okay. So is it correct that you found
5 these principles on Leapfrog's website?

6 A. With the assistance of my legal team,
7 yes.

8 Q. Okay. And so in your opinion, is it fair
9 to say that Leapfrog is publicly representing to
10 those who visit its website that these are the
11 guiding principles that form -- underlie its
12 methodology?

13 A. Yes.

14 MS. BLAIR: Objection to form.

15 THE WITNESS: Yes.

16 BY MR. HVIDT:

17 Q. And do you see where on page 9 of your
18 report, there's a section Imputing Missing Data?

19 A. Yes.

20 Q. And do you see in that first sentence
21 where they say, When a hospital is missing data for

1 a particular performance measure, we recommend
2 ignoring the measure and recalibrating the weights
3 within the domain so that hospitals are scored only
4 on the measures for which their performance data
5 are available? Do you see that?

6 A. Yeah, one sec. Yes, I see that.

7 Q. Okay. And does that sentence simply mean
8 that like if they don't have a hospital's data,
9 they recommend that the best move is to not give
10 any weight or any grade to that measure, but just
11 assign the weights to all of the places where they
12 actually have data; is that correct?

13 MS. BLAIR: Objection to form, calls for
14 speculation.

15 THE WITNESS: Look, I think you're asking
16 me to look at one sentence of a two-page mission
17 statement and you're identifying the one thing
18 that's not a hundred percent consistent, but, yes.
19 If you're asking me to just interpret that one
20 sentence in isolation, it says, We recommend
21 ignoring the measure and recalibrating the weights

1 within the domain, yes, that portion of the
2 sentence alone in isolation means you would ignore
3 the measure.

4 BY MR. HVIDT:

5 Q. And so would you agree that they
6 don't -- leapfrog doesn't have data for hospitals
7 that don't participate in the Leapfrog score for
8 the four measures that they impute data for?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: Yes, I agree with that, but
11 it's -- the rest of their mission is consistent
12 with having transparent data so that the patients
13 can look.

14 If you look at what's most important in a
15 mission statement, it's the first sentence, and if
16 you have a bunch of hospitals with incomplete data,
17 okay, and you have a bunch of -- so because
18 in -- in at least what I read, if they don't
19 impute -- if they're missing a certain number of
20 outcomes, they don't get a score, which then means
21 that the consumer would be going to a website with

1 a bunch of hospitals missing scores, which then is
2 of no value to their overall mission.

3 BY MR. HVIDT:

4 Q. Is that of greater value than assigning a
5 score that does not accurately reflect the
6 hospital's performance?

7 A. No, but that's the -- the whole crux of
8 my expert opinion is you have nonresponse bias.
9 You're trying to deal with that, so you're trying
10 to get -- you're better off with a score within an
11 imputed value than no score for a ton of hospitals.

12 You're -- you're better off scrapping
13 Leapfrog if you're going to have no scores for a
14 ton of hospitals, which is what would happen if
15 you're being rig- -- rigid and just focusing on
16 this sentence related to imputing missing data
17 in -- in my opinion.

18 Q. Do you think -- so you pointed out that
19 Leapfrog doesn't grade hospitals if it's missing
20 more than six process measures, do you -- do you
21 understand that?

1 A. I -- I cannot remember the exact number,
2 but I do remember in my review of the documents if
3 they're missing a certain number, there's no score
4 assigned.

5 Q. And do you understand that if the
6 hospitals that don't participate in the survey,
7 Leapfrog is missing data for the four measures that
8 are imputed and the three process measures for
9 which no score is provided?

10 MS. BLAIR: Objection to form,
11 mischaracterizes his testimony.

12 THE WITNESS: Right. So what you're
13 saying is if I look at the details, if these five
14 hospitals didn't have the four data points imputed,
15 they would have seven missing data points and they
16 would not get a score, I would say overall that
17 you're doing the patient a disservice by not having
18 those hospitals have any grade at all, because
19 these hospitals on all of the other outcome metrics
20 were poor performers, and the patient has the right
21 to see that data. And they would not see that data

1 on the Leapfrog. It would be blank.

2 BY MR. HVIDT:

3 Q. Can a patient go to CMS and see a star
4 rating?

5 A. Yes.

6 Q. Can a patient go to a number of other
7 sources, like Google reviews, and see what people
8 say?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: Yes, they could, and if
11 they went to the CMS star rating as in my thing,
12 they would see poor -- poor performing
13 hos- -- those five hospitals with scores of 1s and
14 2s on the 5-star rating.

15 BY MR. HVIDT:

16 Q. And when you -- CMS measures
17 different -- when it comes up with a star rating,
18 it measures different categories than Leapfrog; is
19 that correct?

20 A. I'm not sure. I was not asked to opine
21 on the exact details of CMS, and in the state of

1 Maryland, we have a different reimbursement system.
2 So we're like the one state that the CMS scoring
3 system is less relevant.

4 Q. If you look down to the last sentence of
5 that paragraph that we're looking at, Imputing
6 Missing Data, do you see where it says, If data are
7 used from a secondary source? Do you see that
8 sentence?

9 A. Sorry, the sentence?

10 Q. The last sentence of that paragraph.

11 A. Oh, the -- if data are used, in the first
12 paragraph; yes.

13 Q. And then it goes on to say, Attempts
14 should be made to provide a grade that is equitable
15 to what the hospital would have earned had the data
16 been available from the primary data source, do you
17 see that?

18 A. Yep.

19 Q. Do you have any understanding whether
20 Leapfrog is still applying that principle today?

21 MS. BLAIR: Objection to form.

1 THE WITNESS: Yeah, I think that sentence
2 actually is really true relative to the imputation
3 method.

4 It's saying -- it's saying that you're
5 trying to go to a secondary data source and you're
6 trying to give it equitable to what the hospital
7 would have earned, and based on nonresponse bias,
8 that's exactly what the committee tried to do.

9 They're trying to give them a score
10 equitable to what they would have -- would have
11 reported.

12 BY MR. HVIDT:

13 Q. But on what facts are you basing your
14 view that the expert panel was trying to be
15 equitable in the 2024 methodology change? What
16 facts?

17 MS. BLAIR: Objection to form, asked and
18 answered.

19 THE WITNESS: Well, it's based on the
20 transcript that I reviewed.

21 BY MR. HVIDT:

1 Q. Okay. The transcript that you reviewed
2 that hasn't been produced to us, is that what
3 you're saying?

4 A. That's correct.

5 Q. Okay. And are you aware that Dr. Romano
6 testified that Leapfrog with the imputation
7 methodology change is not trying to be equitable
8 with the grade that it's trying to assign for the
9 imputation methodology?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: No. I'm not -- I am
12 not -- I did not review his deposition or his
13 emails or --

14 BY MR. HVIDT:

15 Q. Okay.

16 A. -- that statement.

17 Q. Okay. And so are you aware that Missy
18 Danforth, the Leapfrog 30(b)(6) witness, testified
19 that these guiding principles are no longer
20 applicable?

21 A. I'm -- no, I'm not familiar with that.

1 Q. Do you think that reviewing the record in
2 this case would have been helpful to forming your
3 expert opinions in this case?

4 MS. BLAIR: Objection to form, asked and
5 answered.

6 THE WITNESS: If you're asking me whether
7 additional documents are useful in forming my
8 opinions, yes. More data is always better.

9 BY MR. HVIDT:

10 Q. And do you think that reviewing testimony
11 in this case as to whether Leapfrog is applying or
12 still relying on these guiding principles would be
13 useful to the Court in determining whether to look
14 at the principles in assessing the issues before
15 it?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: I really think that's
18 outside what I was asked to form an opinion, but if
19 you're saying that if I was sitting on the advisory
20 board, right, is my understanding -- is it relevant
21 for me to know what their mission is and their

1 guiding principles when I sit on that board? Yes,
2 I agree with that statement.

3 BY MR. HVIDT:

4 Q. Okay.

5 MR. HVIDT: I think we're going to take a
6 break. The videographer needs a few minutes.

7 MS. BLAIR: Okay.

8 THE VIDEOGRAPHER: We are going off the
9 record. The time is 1:28 p.m.

10 (Recess taken -- 1:28 p.m.)

11 (After recess -- 2:04 p.m.)

12 THE VIDEOGRAPHER: We are back on the
13 record. The time is 2:04 p.m. This is media
14 number three.

15 (Whereupon, Harris Deposition Exhibit No.
16 8, Document Bates Numbered LEAPFROG00178623, marked
17 for identification.)

18 BY MR. HVIDT:

19 Q. I'm handing you what's been marked as
20 Exhibit 8 to your deposition.

21 Exhibit 8 is a -- what's been

1 produced -- part of it was produced as
2 LEAPFROG00178623, and it was used as an exhibit in
3 the Alexandra Campione deposition.

4 Part of the attachments to it are -- were
5 produced to us in black-and-white form, and so
6 we've included a color copy that Leapfrog provided
7 to us for -- for that as well as the color version
8 of the fall 2024 hospital safety grade final
9 methodology changes.

10 Doctor --

11 MS. BLAIR: So these yellow highlights
12 were yellow?

13 MR HVIDT: The yellow highlights are
14 the --

15 MS. BLAIR: I don't remember that.

16 MR HVIDT: If you look to the stapled
17 first item --

18 MS. BLAIR: Yeah.

19 MR HVIDT: -- they're grayed and a
20 hard-to-read, darker coloring, and that was
21 the -- the native version that you all provided.

1 MS. BLAIR: Yes. I just didn't remember.

2 Thank you.

3 BY MR HVIDT:

4 Q. Turning to the -- the last document
5 there, which is color --

6 A. Okay.

7 Q. -- would you unclip it?

8 A. Yeah, that would be great.

9 Q. That might be easier for your management.

10 A. I do remember the annoying highlighting
11 on the version I saw, so I appreciate the
12 attachment.

13 Q. Okay. So the -- your -- your -- that
14 information helps to answer the question that I was
15 about to ask, which was, one of the documents you
16 relied on you had mentioned being comments to the
17 methodology and that change announcement, is
18 it -- is that --

19 A. Yes.

20 Q. -- document what you reviewed if you look
21 at those two documents that are attached to this

1 email?

2 A. Yes, exactly. The -- the
3 comments -- the -- the fall public comments, and,
4 yeah, exactly there were two documents similar to
5 this color which was the fall and the spring
6 methodology.

7 Q. Okay. And then if you look at the
8 comments attachment in the color-copy version, let
9 me know when you're there.

10 A. Yep.

11 Q. Okay. How many comments are there as
12 proponents to the fall 2024 proposed changes listed
13 there on that first page?

14 A. The proponents. Oh, there's -- yeah,
15 good point. There appears to be four.

16 Q. Okay. And then if you flip to the next
17 page, do you see where the top of it says Against
18 Themes and Color Coding?

19 A. Yeah.

20 Q. And then how many comments are included
21 underneath that heading Against Themes and Color

1 Coding?

2 MS. BLAIR: Like by hospital?

3 THE WITNESS: Six I believe.

4 MS. BLAIR: Okay.

5 BY MR HVIDT:

6 Q. And if you could keep that document with
7 you, but then also pull out your expert report,
8 which is Exhibit 2, and go to page 14 of your
9 report, please.

10 On page 14 of your report, do you see in
11 the middle of the page in that second paragraph you
12 said, I reviewed the public comments on the
13 proposed changes and many were favorable?

14 A. Yep.

15 Q. Okay. And so this -- this is the
16 document you reviewed when making that conclusion?

17 A. Yeah. Yes.

18 Q. Okay. And so were you -- did you also
19 review the comments that were not favorable in
20 forming your opinion?

21 A. I definitely did, because I remember the

1 Piedmont Healthcare comments which were the ones
2 that were most critical of the imputation itself.

3 Q. And did you reference that there were
4 comments that were unfavorable in your expert
5 report?

6 A. Can you point me back to the sentence on
7 page 14 or which paragraph it is?

8 Q. Absolutely. If you look between footnote
9 where like the part of the second paragraph where
10 there's footnote 18 and footnote 19, do you see
11 that, I reviewed?

12 A. Yeah. You're -- you're -- no, that
13 sentence does not mention that there were some
14 against. That's correct.

15 Q. Okay. Do you -- did you consider the
16 public comments that were against the change in
17 forming your opinion?

18 A. I did. I did read them.

19 Q. Okay.

20 A. I think --

21 Q. And is it fair to say that the against

1 commentators did not reference that the reason
2 they're not participating in the Leapfrog survey is
3 that they're poor-performing hospitals?

4 A. Say that again, please.

5 Q. In the against -- in the against themes'
6 comments in this document, do any of them say
7 they're not participating in the Leapfrog survey
8 because they're poor-performing hospitals?

9 A. I'd -- I'd have to read it again, but I
10 don't -- I do not remember that.

11 Q. And instead, did some of these hospitals
12 comment or representatives from hospitals comment
13 with criticisms of the proposed change?

14 A. Say that again, please.

15 Q. Did some of the hospitals, the members,
16 these individuals who are with hospitals who
17 commented against the proposed methodology change,
18 did they reference criticisms to the change?

19 A. Yeah, they did. Although, the one thing
20 I would say that ties into this, which is why I
21 remember the Piedmont Healthcare, is like if you

1 look at the first one by Allina Health, I didn't
2 take that comment as against.

3 It says like the public will not
4 understand nor dig into the methodology of these
5 grades. I didn't see -- I didn't think that was an
6 accurate -- I mean, it's -- it's probably true, but
7 I think it was comments like this that led them to
8 explain what they were doing. But I do agree that
9 of these six comments, there -- there were some
10 that were critical --

11 Q. Okay.

12 A. -- of the imputation methodology, but not
13 all six.

14 Q. Going -- going to that Allina Health
15 comment, you think it's true that the public would
16 not understand or dig into the methodology of these
17 grades and hospitals may be falsely represented
18 with a lower grade because they chose not to
19 complete a survey?

20 A. I don't agree with the second part. I
21 agree with the first part.

1 Q. Okay. So can you clar- -- clarify which
2 part you agree with?

3 A. Public will -- well, I wouldn't say will,
4 but a lot of the public may not understand nor dig
5 into the methodology of these grades.

6 Q. And do you see before that sentence where
7 Allina Health, Becky Wenthold says, These changes
8 will penalize hospitals that do not submit a
9 survey?

10 A. Yes.

11 Q. Would you consider that a criticism of
12 the methodology?

13 A. Yeah, you're right. That sentence is a
14 criticism, so my statement just prior is incorrect.

15 Q. Okay. And then do you see where she
16 continues to describe how the survey is extremely
17 time intensive and in a time when hospitals are
18 barely breaking even financially, they do not have
19 the resources to commit to this survey?

20 A. Yes, I see that sentence.

21 Q. Okay. And then do you see in the last

1 sentence where it says, A hospital with excellent
2 outcomes will no longer be able to receive an A
3 grade because limited achievement is assigned to
4 process measures that actually may be in place? Do
5 you see that?

6 A. Yeah. Well --

7 Q. Do you agree with that?

8 A. -- that sentence, I -- I mean, that
9 sentence I don't agree with, because, I mean, that
10 sentence is a completely separate argument.

11 Is it saying that the Leapfrog
12 methodology should consider other process measures
13 that may be in place that they're not collecting?
14 Which is -- it's a valid point, but it's -- it's in
15 opposition to her prior sentences in that those
16 process measures would also require completion of a
17 survey.

18 Q. Isn't her point there though that she's
19 saying that a hospital with excellent outcomes
20 won't get an A because it's assigned limited
21 achievement for scores when it might actually have

1 that achievement, but just being assigned the
2 limited achievement because it didn't participate
3 in the survey?

4 A. Right. I --

5 MS. BLAIR: Objection to form, calls for
6 speculation.

7 THE WITNESS: Right. I -- I -- so I
8 think that's a -- a really important point and
9 that's exactly why I urged us to do Exhibit 8,
10 which was to recap -- I'm sure one of your
11 economists or someone is going to say, it's
12 something called a sensitivity analysis, okay.

13 It's incredibly important when you're
14 imputing just in general and/or when there's any
15 confounding or any bias hypothesis, and it gets at
16 the idea of, okay, we're never going to get to the
17 real data, but we want to get to as close as
18 possible, okay?

19 And very similar to the gist of this
20 case, you could have two or three people that say,
21 Well, I think method A is the best, I think method

1 B is the best, I think method C is the best and
2 then you have an argument and a disagreement over
3 which method.

4 Well, the best way to try to get an idea
5 of how much those different things would impact
6 things is you look at a sensitivity analysis where
7 you see how would those three methods play out.

8 In my opinion, the beauty -- the beauty
9 of this case lies in exactly that, in that you have
10 Nicholson's method of seven, which I think is
11 completely wrong. You have four ascribed to the
12 median -- mean and then you have the Leapfrog
13 method and then you have something in between, and
14 what -- what Allina Health is asking is exactly
15 that analysis that we did in Exhibit 8 and
16 disproves her arg- -- their argument, because
17 basically, these hospitals would not have received
18 an A grade based on Exhibit 8.

19 BY MR. HVIDT:

20 Q. So you mentioned sensitivity analysis.
21 That's important before you implement an imputation

1 methodology; is that correct?

2 A. It's important to help understand what
3 the implications would be.

4 Q. And did you -- is it your understanding
5 that Leapfrog performed the sensitivity analysis
6 before it made the 2024 imp- -- imputation
7 methodology change?

8 A. I'm not aware that they did.

9 Q. Okay. Do you know that they previously
10 did a sensitivity analysis and establishing an
11 imputation methodology in 2020 and 2021?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: I was not familiar with
14 that.

15 BY MR. HVIDT:

16 Q. Were you familiar with Leapfrog hiring a
17 consultant, Mathematica, to help it come up with
18 the imputation methodology that it used between
19 2020 and 2024?

20 A. I heard the term Mathematica at some
21 point in the documents I reviewed, and I saw that

1 it was a statistical consulting company, but I was
2 not aware of exactly what role they played.

3 Q. And so you didn't -- you're not aware of
4 any of the documents relating to how Leapfrog came
5 up with the imputation methodology that they had in
6 place before 2024; is that correct?

7 A. Correct.

8 Q. And turning back to these comments here,
9 if you look down to, you know, these comments, they
10 have -- they include reasons, other reasons that a
11 hospital might choose not to participate in the
12 Leapfrog hospital survey other than nonresponse
13 bias; is that correct?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: Can -- can you repeat that?

16 BY MR HVIDT:

17 Q. Yeah. So Allina Health referenced that
18 the survey is extremely time intensive, do you
19 recall that?

20 A. Yes.

21 Q. And if you look down to Mount Sinai

1 Health, do you see that --

2 A. Yeah.

3 Q. -- where it says, This survey is very
4 resource intensive outside of existing regulatory
5 quality operations and quality improvement efforts?

6 A. So I think these points are very valid,
7 but I was not asked to give my opinion on it. And
8 once I, fortunately or unfortunately -- as a
9 hospital epidemiologist, when I do talk about what
10 my expertise is, typically, my expertise was never
11 to understand how long it took for these type of
12 surveys or data collection and maybe I was
13 fortunate enough to be at a facility that never
14 really complained about how much time it was going
15 to take for the data to be accumulated. But, yes,
16 these people are objecting to the potential amount
17 of time it takes to collect the data based on their
18 statements.

19 Q. And so is it correct that you were not
20 asked to give your opinion on reasons hospitals
21 might not participate in the hospital survey, other

1 than nonresponse bias?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: All I'm trying to say is,
4 is there's reasons why people don't fill stuff out,
5 and I do not -- I am not an expert on how long it
6 takes to fill out the Leapfrog survey.
7 That's -- that's my point.

8 BY MR HVIDT:

9 Q. If you look to the comment that you said
10 you recalled from Piedmont Healthcare, Zubin Momin,
11 do you see that?

12 A. Yes.

13 Q. And do you see in the last paragraph of
14 his -- apologies, I'm assuming Zubin is a -- is a
15 male. I don't know.

16 But do you see that in the last paragraph
17 where it says, We feel like?

18 A. Yeah.

19 Q. And it says, We feel like this model is
20 unnecessarily punitive. We often skip survey
21 submission because the responses provided for IPS,

1 hand hygiene BC -- BMCA and CPOE are largely
2 unchanged in the two-year period that was allotted
3 before negatively impacting grades. Do you see
4 that?

5 A. Yes.

6 Q. And then it says, The FTE resource
7 committed to complete the survey is already
8 significant. There's no value added by completing
9 a survey every year or every other year when
10 practices in our hospital have not changed. Do you
11 see that?

12 A. Yes.

13 Q. And is it fair to say that
14 there's -- there's more than one of these hospitals
15 commentators that felt that the imputation
16 methodology change would be punitive to
17 non-participating hospitals?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: Yes, I agree with that, but
20 they were asking my expert opinion whether I
21 thought the imputation method was punitive. And

1 so, yes, I agree with you that some of these people
2 felt as if it was punitive, but I did not.

3 BY MR HVIDT:

4 Q. Okay. So when you say -- it's your
5 opinion that it's not punitive; is that correct?

6 A. Yes.

7 Q. And when you say that, are you basing
8 that on facts that Leapfrog didn't intend for it to
9 be punitive?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: No. It's based on -- it's
12 based on punitive -- punitive to me implies that
13 their grade would go from a good grade to a poor
14 grade, and so the whole reason I re- -- tried to
15 rerun all of those calculations in the sensitivity
16 and dig into the details and look at the weighting
17 is to see how much of an impact those four scores
18 would have, because to me, that's what would be
19 punitive.

20 Punitive is that you're giving people
21 those four scores unfairly and that it affects

1 their overall grade. I just did not come to either
2 conclusion.

3 I don't think the four scores were given
4 unfairly, and I don't think that errors in those
5 four scores led -- would lead to a change in the
6 overall grade.

7 BY MR HVIDT:

8 Q. And no, we'll get to more than Exhibit 8
9 in a -- in a minute.

10 But with your own Exhibit 8, three of the
11 five hospital grades changed; is that correct?

12 A. They -- if you look at Exhibit 8 -- I
13 think the detail is really important in this
14 response. So one hospital --

15 Q. My question is straightforward.

16 A. Yes. Yes, they changed from like Fs to
17 Ds --

18 Q. Thank you.

19 A. -- and Ds to Cs.

20 Q. When -- you've talked about the goal of
21 transparency a little bit today, do you -- do you

1 recall that?

2 A. Yes.

3 Q. Okay. And do you think that Leapfrog
4 should be transparent with the public as well?

5 A. Yes.

6 Q. So when Leapfrog is making a change with
7 it's imputation methodology that it should be
8 transparent with the reasons why?

9 A. Yes.

10 (Whereupon, Harris Deposition Exhibit No.
11 9, Document Bates Numbered LEAPFROG00209811, marked
12 for identification.)

13 BY MR HVIDT:

14 Q. I'm handing you what's been marked as
15 Exhibit 9, which was previously introduced in
16 depositions for Alexandra Campione and Leah Binder.
17 The Bates number is LEAPFROG00209811.

18 Dr. Harris, have you seen this document
19 before?

20 A. I definitely have not seen the top email
21 from Leah Binder.

1 Q. And if you look to the attachment, it's a
2 Request For Public Comments beginning on 813.

3 Have you seen this document, whether in
4 this redlined form or the -- a clean version
5 of -- of that?

6 A. I believe -- I'm almost certain I have
7 seen a clean -- yeah, I have seen a clean version
8 of the -- one sec. I definitely saw a clean
9 version of the methodology for fall 2024.

10 What's throwing me off a little bit is
11 I'm a little confused as to whether I saw the
12 request for comments.

13 I'm -- I'm not positive just because the
14 format of some of this thing looks so similar to
15 the final methodology --

16 Q. Um-hmm.

17 A. -- that I don't know like, as an example,
18 if I saw something that said, summary of the
19 changes and instructions of how to submit a public
20 comment. I believe I may not have seen that page
21 813.

1 Yeah, I -- I have feeling I did not see
2 page 813 or 814, but yet, page 815, 16 and 17 to me
3 look very, very familiar with the format of the
4 documents that I did review.

5 Q. Okay. If you go to 814 with me, do you
6 see that there's track changes in this?

7 A. Yes. I did not see a track-changes
8 version, definitely.

9 Q. Okay. And then do you see if you go to
10 the -- to the first page of the whole document --

11 A. The email? The first page --

12 Q. Yes.

13 A. -- of the whole exhibit?

14 Q. Yes.

15 A. Okay.

16 Q. Okay. Do you see where Leah Binder says,
17 Hi, Alex, Here it is with some tweaks?

18 A. Yes.

19 Q. Okay. And then if you look down to the
20 second paragraph, do you see where she says, I
21 don't think we need the sentence about influencing

1 survey participation --

2 A. Yes.

3 Q. -- and giving people confidence in
4 validity? Do you see that?

5 A. Yes.

6 Q. And then she says, It sounds defensive
7 like nobody participates in the survey and our own
8 TEP questions our validity. Do you see that?

9 A. Yeah. I'm not sure what T -- T -- what's
10 TEP refer to? I apologize.

11 Q. You know, I -- I believe it's technical
12 expert panel, --

13 A. Okay.

14 Q. -- but I won't -- that was just my own
15 understanding.

16 If you go down to the -- the last
17 paragraph, it says, I think when we respond to the
18 public comments, we can be more pointed and
19 specific about the survey and imputation reasoning,
20 if necessary. Do you see that?

21 A. Yes.

1 Q. Okay. So with that last note, is it your
2 understanding that the recommended revisions here
3 are trying to take out the reasoning for the
4 proposed change from the public disclosure?

5 MS. BLAIR: Objection to form, calls for
6 speculation and lacks foundation as to this
7 document.

8 THE WITNESS: Can you repeat the
9 question, please?

10 BY MR HVIDT:

11 Q. Absolutely. Is the comment here that the
12 public disclosure opening the comment period for
13 the proposed change methodology from the CEO of The
14 Leapfrog Group recommends deleting the reason for
15 the proposed change from the public disclosure?

16 MS. BLAIR: Objection to form,
17 mischaracterizes the document.

18 THE WITNESS: So I'm really confused.
19 What's the -- what -- the question is?
20 Ask the question one -- one last time, please.

21 BY MR HVIDT:

1 Q. Absolutely. In his email and with these
2 revisions, --

3 A. Yes. Yes.

4 Q. -- the CEO of The Leapfrog Group is
5 asking -- is -- is saying edits should be made --

6 A. Yeah.

7 Q. -- to the disclosure to remove the
8 reasoning for the methodology change; is that
9 correct?

10 MS. BLAIR: Objection to form,
11 mischaracterizes the document.

12 THE WITNESS: Just one sec. I haven't
13 seen this document. Again, I want to -- I want
14 to --

15 (Whereupon, there was a pause for
16 document examination.)

17 THE WITNESS: I see your point, but
18 I -- I think you're not -- look at the sentence
19 that's key in this. It says it's enough that the
20 expert panel advised us to do the imputation in a
21 different way and not treat older better data in an

1 equivalent way to new data.

2 BY MR HVIDT:

3 Q. Going to that point there --

4 A. That's a really important part.

5 Q. -- the expert panel --

6 A. One sec. One second. And then it says,
7 The comments will give us a good gauge on the
8 extent to which we need to reveal all our reasoning
9 and whether the expert panelists will truly stand
10 up for it when push comes to shove.

11 To me, in contrast to the email you
12 showed me previously from Dr. Romano, I -- I
13 would -- I mean, I have not had a chance to review
14 this, but I think when you're getting at what the
15 president is saying here, that's pretty good.
16 That's saying that she's trusting the expert panel.
17 She's deferring advice to the expert panel, and
18 she's going to be responsive to the comments.
19 I -- I think this email is really great overall.

20 Q. So going back there to the point though,
21 the expert panel advises to do the imputation in a

1 different way.

2 Have you been able to identify where the
3 expert panel advised that Leapfrog take the
4 imputation methodology change they ultimately
5 implemented?

6 MS. BLAIR: Objection. Asked and
7 answered.

8 THE WITNESS: Right. So that's a really
9 good point, and that ties into the previous
10 discussion we had, okay?

11 I really like the expert panel's
12 expertise. I reviewed the expert panel where they
13 had time to comment on things, the transcript,
14 which, by the way, I want to clarify one thing.

15 The document you gave me, which was
16 Exhibit -- Exhibit 5, it actually is the same
17 transcript that I received, but the date that threw
18 me off is your date is after, because apparently it
19 was transcribed from a video, so this does appear
20 to be the same document. So I wanted to clarify
21 that related to the prior thing.

1 But your question is, is do I know
2 exactly what the expert panel recommended?

3 No, not based on the transcript, but
4 based on this email, this confirms to me that it
5 was a very fair assumption that they discussed it.
6 They had people comment on it and that the process
7 they do, the -- the expert panel did recommend to
8 go ahead with the change in methodology.

9 BY MR HVIDT:

10 Q. Where are you finding that's where the
11 record -- where the expert panel recommended to go
12 ahead with the change in the methodology?

13 A. Well, you're right -- I'm -- I'm --
14 I'm -- well, I was assuming that based on the
15 documents I reviewed, but now I am thinking that
16 this email implies that based on the sentence I
17 read.

18 It says it's -- it's -- we'll see whether
19 the expert panelists will stand up for it when push
20 comes to shove. To -- to me, that implies they're
21 going to defer to the expert panel.

1 Q. And what do you interpret push comes to
2 shove means? What's a push?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: Wait. So a new terminology
5 I use -- learned, that I still don't understand, is
6 someone was asking me whether a job change is
7 push-pull.

8 Push -- push comes to shove to me is
9 implying that Binder thinks that some of the
10 comments will be negative related to the
11 imputation, which is a fair assumption, because
12 anytime you make an alt -- I mean, this was
13 definitely my experience as president of the
14 Society of Healthcare Epi of America.

15 At 2,000 members, when we made changes,
16 even changes that we thought were overall like 95
17 percent beneficial, we got 10 negative comments for
18 each one positive comment.

19 People speak out negatively more than
20 they speak out positively, and I -- I think that's
21 really important, which is why we would defer to

1 our expert panel at that point, not irrespective,
2 but we would take the comments -- but we would take
3 the comments to identify things we may have missed,
4 but then we would circle back to the expert panel.

5 BY MR. HVIDT:

6 Q. And here the negative comments exceeded
7 the number of positive comments?

8 A. Yeah, which you correctly -- yeah, you
9 correctly pointed out, which is something I missed.
10 The negative comments exceeded the positive
11 comments.

12 (Whereupon, Harris Deposition Exhibit No.
13 10, Document Bates Numbered LEAPFROG00602404,
14 marked for identification.)

15 THE WITNESS: Thank you.

16 BY MR HVIDT:

17 Q. I'm handing you what is Exhibit 10 to
18 your deposition, which has previously been used in
19 depositions including in the Alexandra Campione
20 deposition produced as LEAPFROG00602404.

21 If you look at the email on the first

1 page, do you see at the bottom where it says Leah
2 Binder sent the email? If you look to the next
3 page, the top there, is that the same email that we
4 were just looking at in Exhibit 9?

5 A. It looks like it. Let me just make sure.

6 Q. Right.

7 A. You're saying is the email on the bottom
8 of 404 and -- and the top of 405 the same email you
9 just showed me in the previous exhibit?

10 Yes, that's correct.

11 Q. Okay. And then if you look up top on the
12 first page, Missy Danforth sends an email to Matt
13 Austin, with a copy to Alexandra Campione, do you
14 see that?

15 A. Yes.

16 Q. Do you see where she says, Since she
17 mostly updated the parts Pete -- Peter and Patrick
18 helped with, you can take a look and let us know if
19 you have any concerns? Do you see that?

20 A. Yeah, I'm not sure who she refers to.

21 Q. Missy Danforth, do you see that?

1 A. Yes.

2 Q. And do you think that she refers to Leah
3 Binder?

4 MS. BLAIR: Objection to form, calls for
5 speculation. He's not seen this email before.

6 THE WITNESS: To be honest with you, this
7 is -- it's really hard, because her email doesn't
8 say she's updating any -- I -- I can't -- I can't
9 say who she refers to.

10 BY MR HVIDT:

11 Q. Leah Binder in Exhibit 9 and at the
12 bottom of page 40, 2404 to 405 says, Hi Alex, Here
13 it is with some tweaks. Do you see that?

14 A. Oh, yeah, yeah. Yes.

15 Q. And Missy Danforth forwards that
16 email, --

17 A. Yeah.

18 Q. -- correct?

19 A. Yes, you're -- yeah, you're correct based
20 on those two sentences.

21 I haven't seen this, so I wasn't asked to

1 give my opinion on this, but she does likely refer
2 to Leah Binder.

3 Q. And do you see Missy Danforth references,
4 she mostly updated the parts Peter and Patrick
5 helped with? Do you see that?

6 A. Yes.

7 Q. If you pull out Exhibit 6, which I think
8 you're already looking for --

9 A. I'm looking for who -- peter refers to
10 Peter Pronovost. I'm trying to figure out who
11 Patrick is referring to. Patrick Romano. Okay.
12 Yeah.

13 Q. Okay. And if we look back to Exhibit 6,
14 we looked at some track changes that they had edits
15 to --

16 MS. BLAIR: Exhibit 6.

17 THE WITNESS: Okay. Yes.

18 BY MR. HVIDT:

19 Q. If you look at the attachment
20 there, --

21 A. Yes.

1 Q. -- there's track changes to the
2 same --

3 A. Yeah.

4 Q. -- section, do you see that?

5 A. Yeah.

6 Q. And if you go back to the cover email
7 there from Dr. Romano, you'll see he references
8 that he corrected some typos in Peter Pronovost's
9 recommendations, do you see that?

10 A. Yeah.

11 Q. Okay. And then if you go back to Exhibit
12 10, the top email, it's from Matt Austin. Let me
13 know when you're there.

14 A. Yeah.

15 Q. Matt Austin says, My only note is the why
16 has been edited out of the explanation. Do you see
17 that?

18 A. Yeah.

19 Q. Okay. Is it your understanding that The
20 Leapfrog Group was transparent with the public why
21 it was making the imputation methodology change in

1 2024?

2 MS. BLAIR: Objection to form, outside
3 the scope of his opinion, calls for speculation,
4 lacks foundation.

5 THE WITNESS: Well, I have a couple of
6 comments. I'd have to read the finalized version
7 to see whether I agree with Matt's comment the why
8 has been edited out. That's the first point.

9 But the second point that I think is
10 really important that you seem to have glossed
11 over -- and remember, this is an email chain I
12 hadn't seen before. To me, the really important
13 sentence in Missy Danforth's is, since she mostly
14 updated the parts Peter and Patrick helped with,
15 this implies that Peter and Patrick were the major
16 drivers of this email.

17 So this ties into our prior discussion of
18 what input did the safety committee have?

19 BY MR. HVIDT:

20 Q. Okay.

21 A. The safety committee signed off on the

1 changes and, in fact, two of the members drafted
2 the letter.

3 Q. And if you look -- they -- they drafted
4 the redline in the letter that's in Exhibit 6, if
5 you look back at that right in front of you, and if
6 you look at Exhibit 9, you'll see that Missy --
7 that Leah Binder proposed deleting and revising the
8 only things they added to the -- the notation --

9 MS. BLAIR: Objection to form.

10 BY MR HVIDT:

11 Q. -- is that correct?

12 A. I -- I would have to -- I would need a
13 lot more time to look at who did what in the track
14 changes, who drafted the original email, what
15 Dr. Romano and Dr. Pronovost added or deleted, and
16 it -- and the Dr. Romano additions and deletions
17 are really relevant to any opinion I have.

18 Q. And -- and is it correct that before
19 today, you hadn't reviewed any of those documents?

20 A. That's correct.

21 Q. And is it correct that before today, you

1 hadn't reviewed the testimony of the witnesses that
2 we're talking about?

3 A. Correct.

4 Q. Okay.

5 A. Well -- well, one sec. To clarify
6 something I did -- I did say earlier.

7 I got Dr. Romano's transcription probably
8 a week -- no. Friday night or something or
9 Saturday evening, and so I looked at it for three
10 to four minutes, and I looked for a Control F on
11 Harris. I wanted to see where I was quoted in his,
12 and I found very little to nothing. So I spent
13 less than five minutes on Romano's transcript.

14 Q. So the only thing you looked at in
15 Romano's transcript is whether your name was
16 brought up?

17 A. I was looking for sections. I'm -- I'm
18 getting a little confused, because I looked at that
19 and then I looked at -- I think it was in
20 Dr. Nicholson's, I was looking for four and seven
21 because I thought that was the key aspect and for

1 my name as well. But, yes, I have not seen any of
2 these emails until today, and I have not read in
3 any detail Dr. Romano's transcript deposition to
4 make any real strong opinion without further
5 reviewing it.

6 Q. So it's my understanding you -- you have
7 an opinion that nonresponse bias played a role
8 here; is that correct?

9 A. Yes.

10 Q. And have you applied that opinion to the
11 facts of this case?

12 A. Yes, I believe I did in Exhibit 8.

13 Q. Is it --

14 A. And -- one sec. And the other thing, I
15 think we're going to get to that, but what I tried
16 to do in looking at all of the raw data, right, was
17 to see how these hospitals were performing on the
18 objective measures.

19 So there's an exhibit where I look at
20 their star rating. There's an exhibit where I look
21 at their SIRs, their Z-scores and that's how I then

1 led to what likely is going to happen in this
2 nonresponse bias.

3 Q. Now, that's only as it relates to the
4 Plaintiff hospitals that you looked at that data;
5 is that correct?

6 A. That only relates to what?

7 Q. The Plaintiff hospitals.

8 A. Correct. Well, in -- in addition in one
9 exhibit, there were I believe five other hospitals
10 in the Florida cohort.

11 Q. But the -- the aspects of the imputation
12 methodology change that Leapfrog implemented, you
13 did not do any analysis as to whether the --
14 applying your nonresponse bias principles --

15 A. Yeah.

16 Q. -- was appropriate as it relates to how
17 Leapfrog made the change back in 2024; is that
18 correct?

19 A. That's correct.

20 Q. Okay. So --

21 A. And one thing --

1 Q. -- at that time, the data that you --
2 that -- for the five Plaintiff hospitals
3 specifically that you are referring to, did
4 that -- do you have any basis to say that that data
5 relates at all to the methodology change that
6 Leapfrog had in 2024?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: Right, I think what you're
9 asking was just to clarify what I'm responding to.

10 Have I looked at what imputation would do
11 to any of the wider scope of hospitals? No.

12 BY MR HVIDT:

13 Q. And the data that you mentioned you've
14 looked at as it relates to Plaintiff hospitals,
15 those are not the data related to the imputed
16 measures, right? They're not related to BCMA or
17 CPOE or hand hygiene or IPS; is that correct?

18 A. No. They are related. They're directly
19 related. That's where I took the -- that's exactly
20 where I created the categories of -- I took what
21 Nicholson did, which was ascribe the median to the

1 seven things. Then I took what the -- what their
2 spring -- what their -- the Leapfrog methodology
3 was, so the scores they did, and then I took the
4 sensitivity analysis of what if you had given them
5 some achievement? And that -- that was the basis
6 of Exhibit 8.

7 Q. But earlier you mentioned that you looked
8 at the CLABSI and those CMS measures of how the
9 outcome was?

10 A. Right.

11 Q. Those are not imputed measures; is that
12 correct?

13 A. That's correct.

14 Q. Okay. And then so as it relates those
15 four, the CPOE, BCMA, IPS and hand hygiene
16 measures, you don't have the actual data from the
17 hospitals. You haven't looked at that; is that
18 correct?

19 A. Correct.

20 Q. Did you ask for that?

21 A. They didn't provide the data.

1 No, I didn't ask the hospitals for the
2 data on those four, but I --

3 Q. Would that have been relevant to your
4 opinion?

5 A. Yeah, more data would have been great,
6 but I --

7 Q. Do you understand that that was produced
8 in this case?

9 MS. BLAIR: Objection. That was produced
10 last week in this case.

11 THE WITNESS: So that's -- that's really
12 important, because I did ask or Kim -- that was
13 like the first discussion point we had the last
14 week of August, was she told me that they had
15 requested that data on the prior years and the year
16 of 2024, and she had yet to receive that data. And
17 so I could not -- when I produced my expert
18 opinion, I didn't have access to that data.

19 BY MR. HVIDT:

20 Q. But you've had -- do you have an
21 understanding that it was produced before today's

1 deposition?

2 A. No.

3 Q. Did you ask to receive it when it was
4 produced or received?

5 A. No.

6 Q. Okay.

7 MS. BLAIR: It was produced last week.

8 THE WITNESS: That data would be useful.

9 MR HVIDT: We'll object to the time
10 component because I think it's been much earlier
11 than last week, but ...

12 MS. BLAIR: No, it wasn't.

13 BY MR HVIDT:

14 Q. The --

15 A. One sec. That's a really important part.
16 Yes, that data would be very important for my
17 opinion.

18 Q. Thank you.

19 And we're going to stick with the
20 nonresponse point. Do you understand that Leapfrog
21 produced grading data for hospitals across the

1 country in this litigation? Is that correct?

2 A. Do I understand that they?

3 Q. They produced their grading data, all
4 the --

5 A. Yeah.

6 Q. Yeah. And have you looked at that?

7 A. For -- for which hospital?

8 Q. For the hospitals in the -- in the United
9 States that are -- that are graded by Leapfrog's
10 hospitals specifically.

11 A. Yes. So when I went to the website, in
12 addition to looking at the methodology, of course I
13 was curious about what the local hospitals in my
14 area scores were. So I looked at the University of
15 Maryland Medical Center and some of our system
16 hospitals and I also looked at Johns Hopkins, and
17 so one of the ideas was -- I obviously have a
18 gestalt of where we fall, and I looked at that and
19 it allowed me to get a better sense of if I was a
20 consumer, right, what would the data look like if I
21 was trying to choose a hospital in the area.

1 Q. Okay. And then -- but in this case, you
2 understand that the -- the raw data for all of the
3 measures that go into the Leapfrog score was
4 produced?

5 MS. BLAIR: Objection to form. It was
6 not.

7 THE WITNESS: So you're saying
8 that -- could you say that again?

9 BY MR HVIDT:

10 Q. Okay. So Leapfrog produced --

11 A. Oh, in this case?

12 Q. -- in this case data for the hospitals
13 that it grades, their CMS data that went to the
14 scores that they get, the --

15 A. Yeah.

16 Q. -- imputed measures, the survey data.
17 That was all produced, do you --

18 MS. BLAIR: To the extent available.

19 BY MR HVIDT:

20 Q. To the extent available. Do you have an
21 understanding as to that?

1 A. I -- I do now, yes.

2 Q. Do you -- did you ever ask for data to
3 perform any of your analysis in your case?

4 A. Yeah. So the reason I drove our -- our
5 lawyers crazy is if you look at Exhibit 3, I was
6 looking at the actual Z-scores, right, or as an
7 example for the area I'm really familiar with, I
8 was looking at the Standardized Incidence Ratios of
9 CLABSI, CAUTI, SSI. I was looking at the raw data
10 of the PSI 90, especially when I heard about how
11 much weighting that was, so that's --

12 Q. Sir, I want to --

13 A. Yeah.

14 Q. My question is focused on the measures
15 for the -- for the survey responses for the imputed
16 measures, okay.

17 Did you ask for any data on how hospitals
18 respond as it relates to the CPOE, BCMA, IPS or
19 hand hygiene?

20 A. Yeah. So we -- we got into that
21 discussion related to the median imputation, right.

1 So one --

2 Q. Do you understand they don't do median
3 imputation?

4 A. Mean -- mean imputation, okay.

5 So what I looked at was in detail, you
6 have what's called an ordinal scale. I'm going to
7 get this exact terminology wrong, I apologize, but
8 it's -- because the wording I found is hard to
9 memorize. It's least achievement, some achievement
10 and I cannot remember what the other categories
11 are. One sec. No, this is important.

12 Q. I understand. I'm just trying to focus
13 the question on my -- my question --

14 A. No, I'm --

15 Q. -- because it's not answering my
16 question.

17 A. No. I am answering your question.

18 MS. BLAIR: He is answering your
19 question.

20 THE WITNESS: I am totally answering it.
21 I'm getting to it.

1 I looked over the methodology of least
2 achievement, some achievement and then there's two
3 other categories. Then they take that -- they take
4 that ordinal scale and they convert it to numbers,
5 okay, of which as an example for most of the four
6 metrics you're talking about, they were getting 15s
7 or 25s, if I believe correctly.

8 Then I looked at the mean score that the
9 other places were getting, which as you showed me
10 this morning is like 80 or 85 and I was trying to
11 figure out exactly what you alluded to was what
12 were those five hospitals' potential scores if I
13 had had the data? And that's exactly -- and so,
14 yes, I did request, Do you have any data on least
15 achievement, some achievement, high achievement for
16 those five hospitals?

17 Do you have the data on what they scored
18 previously and/or what their imputed values were?

19 And I think that is what led to the fact
20 that we did not have data at the time I drafted the
21 report and led to the calculations we ran.

1 BY MR HVIDT:

2 Q. Have you looked at how Leapfrog has
3 scored hospitals that perform versus don't perform
4 on the CPOE, BCMA, IPS, hand hygiene, safe
5 practices, nursing care measures?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: I looked at the mean values
8 of the responders because that was the data we had.

9 BY MR HVIDT:

10 Q. Okay. And do you cite to any data in
11 section IX of your report in Exhibit 2?

12 A. Do I do what in section IX?

13 Q. Cite to any data analysis to support any
14 of your opinions in section IX of your report.

15 A. Section IX. I do in section X.

16 Q. I'm asking about section IX.

17 A. I -- I don't cite any data in IX. IX
18 builds the epidemiologic definition of nonresponse
19 bias that then leads to the data in X.

20 Q. Okay. And did you do any data analysis
21 to show that nonresponse bias is accurate here?

1 MS. BLAIR: Objection to form, asked and
2 answered.

3 THE WITNESS: Well, did I -- yes, I would
4 say I did do data analysis, because I did the data
5 analysis in section X. Section X supports the
6 arguments made in section IX.

7 BY MR. HVIDT:

8 Q. Section X references only the CMS data
9 measures. It does not reference any imputed
10 measures; is that correct?

11 A. No. Section X -- section X, Exhibit --
12 okay. Section -- no, you're correct.

13 Section XI deals with the imputed
14 measures and is a data analysis to support section
15 IX.

16 Q. We'll get to section XI, but --

17 A. But -- but section X --

18 Q. Doctor, there's no pending question.
19 There's no pending question.

20 A. Okay.

21 MR HVIDT: I'm going to mark what's been

1 produced in this litigation as Exhibit 11.

2 (Whereupon, Harris Deposition Exhibit No.
3 11, Non-Participants in TLG's Survey Would Likely
4 Score Substantively Higher than the Limited
5 Achievement TLG Assumes, marked for
6 identification.)

7 BY MR. HVIDT:

8 Q. Exhibit 11 is a document, a demonstrative
9 that was prepared using the Leapfrog hospital
10 safety grade data that Leapfrog produced in this
11 litigation.

12 MS. BLAIR: For the record, who prepared
13 this?

14 MR HVIDT: For the record, we did.

15 MS. BLAIR: The lawyers in the case?

16 MR HVIDT: For the record, the --
17 the -- Dr. Nicholson, and The Cornerstone Group
18 facilitated in the preparation of this document
19 using the data that was produced in this
20 litigation.

21 MS. BLAIR: Is Dr. Nicholson

1 supplementing his opinion with this document?

2 MR HVIDT: He has not supplemented his
3 opinion in an official capacity in this document.
4 We are producing this as it relates to a
5 demonstrative for the ease of discussion over
6 the -- with Dr. Harris in preparing for his
7 deposition to respond to --

8 MS. BLAIR: Well, I object to the use of
9 this only to the extent that Dr. Harris obviously
10 has not seen this and you're going to ask him to
11 opine on numbers that he's not seen and a document
12 that has no ability to show how it was -- how these
13 numbers or lines or whatever this is came to be
14 resulted in, but to the extent Dr. Harris can read
15 this, he'll discuss it. But I'm objecting to the
16 use of it going forward.

17 MR HVIDT: Okay.

18 BY MR HVIDT:

19 Q. Dr. Harris, if you look to the red dotted
20 lines on this -- on each of the four columns, do
21 you see that that red dotted line lines up with the

1 limited achievement score on the Leapfrog safety
2 grade methodology?

3 A. Yeah, so the dotted red lines are
4 consistent with one of my prior answers in that the
5 scores look like they're 15, 5 and 25 for these
6 four metrics, so, yes.

7 Q. Okay. And I'll represent to you that the
8 blue bar graphs are the actual answers that --
9 measures that were given to hospitals on the
10 Leapfrog spring 2025 hospital safety grade for
11 hospitals that in 2024 when Leapfrog made the
12 imputation methodology change had not participated
13 in the prior year.

14 Looking at that and understanding that
15 point, do you see that the hospitals that were
16 non-participating at the time of the methodology
17 change for CPOE when they began reporting after the
18 methodology change got a 91.7 on average? Do you
19 see that?

20 MS. BLAIR: I'll object to form as to the
21 use of the document and the foundation for it and

1 whether or not these numbers are even accurate and
2 whether Dr. Harris can even interpret this.

3 THE WITNESS: So -- so one thing I think
4 is really important, so when you get a piece of
5 data like this, you really need -- you need sample
6 size, okay? And you need -- you need like pages of
7 data to understand this.

8 BY MR. HVIDT:

9 Q. Do you see there were 315 hospitals in
10 that category that are in blue looking at the note
11 there?

12 A. No. Where does it say that? Oh, right
13 here.

14 Q. The blue bar shows the average
15 self-reported score in 2025 for hospitals that did
16 not participate in the survey in 2024, but did
17 participate in '25, 315. Do you see that?

18 A. Yeah, but what -- I don't understand what
19 the green bar represents.

20 Q. The green bar represents hospitals that
21 didn't participate in the most recent year, but

1 were -- but did previously participate. And so
2 what this shows is in the last two years, hospitals
3 that were -- did not participate in the Leapfrog
4 survey have scores much higher than the limited
5 achievement score that Leapfrog assigns
6 non-participating hospitals?

7 MS. BLAIR: Objection to form and the use
8 of this document.

9 THE WITNESS: This -- this document is
10 flawed for the following reason: One, you haven't
11 given me enough time to look at it.

12 Two, a one-line definition of the number
13 of hospitals doesn't give you an idea of what
14 category they would fall into, and;

15 Three, you're introducing a potential
16 other large bias.

17 Okay. So if you're -- if, you're looking
18 at the blue bars -- you're asking me to comment on
19 the blue bars. So the blue bar shows the average
20 self-reported score in 2025 for hospitals that did
21 not participate in the survey in 2024.

1 Okay. So you're taking hospitals -- this
2 exactly proves my nonresponse bias point
3 potentially, okay? It could prove alternative
4 hypothesis, but you're taking hospitals that didn't
5 report probably because their scores were poor,
6 okay? Then their scores are better because they've
7 been making efforts, okay? And they don't want to
8 be ascribed a low value, so there's tremendous
9 motivation for them to improve and get their scores
10 better, which is exactly what you're showing, which
11 is exactly what Leapfrog -- why Leapfrog wants
12 people to produce.

13 So now you're saying that, okay, the blue
14 bars are showing hospitals that reported and
15 they're scoring high. Yeah, they're scoring high
16 because they've made efforts to improve.

17 So you're then going to say, Well, these
18 are the scores my five hospitals would have gotten?

19 No, absolutely not because they chose not
20 to participate. If they had scores in the 90s,
21 they would have filled out the survey. I think

1 this is -- this is --

2 BY MR. HVIDT:

3 Q. I --

4 A. This can easily be interpreted as
5 consistent with the main point of my argument, that
6 you report when you have a good score, and if your
7 score stinks, you're not going to report.

8 Q. On what basis do you say that the hospitals
9 that are in blue all improved dramatically in the
10 year where they didn't participate versus when they
11 did participate?

12 A. I'm -- I'm saying -- that's my
13 hypothesis, and the only way this data would be
14 interesting is if you showed what the scores of
15 those blue hospitals were in the prior years that
16 they didn't report and showed me that in the years
17 they didn't report, their scores were equally high.

18 Q. But if you look at the green, you will
19 see that the hospitals who aren't reporting now
20 were previously reporting high scores and then
21 chose to not participate in the survey anyway?

1 A. Right, but that's temporal change. You
2 can't make conclusions of temporal change. That's
3 exactly why the imputation method was trying not to
4 impute in prior years.

5 Because, look -- look, I -- I can tell
6 you as a -- a day-to-day hospital epidemiologist,
7 my scores could be great one year and then I can
8 absolutely stink, okay? Especially like during the
9 pandemic, we had massive turnover, okay? And we
10 could be a high-performing hospital with great
11 policies and all of a sudden we're stinking, okay?
12 That happens routinely.

13 And so a green bar score -- again, there
14 are different ways of -- unless you have data of
15 I -- I didn't report and here's my scores and I
16 reported and here's my scores for the same
17 hospitals, this is cherry picking data in my
18 opinion.

19 Q. This -- this is selecting all the data
20 that there is for hospitals who were not
21 participating in 2024 when they made the

1 methodology change and then made the -- and then
2 participated the following year and you'll see that
3 there are very large differences in their actual
4 performance versus the limited achievement
5 performance. And so had they not made the decision
6 to -- to participate, they would have been assigned
7 a measure dramatically lower than their actual
8 performance, do you see that?

9 MS. BLAIR: Objection to form,
10 mischaracterizes this document, and I object to
11 this document in its entirety.

12 THE WITNESS: The -- the only thing you
13 can say with this is that when hospitals report
14 scores, which is the hospitals in blue in 2025 and
15 the green hospitals, which is when they reported in
16 2023 or 2024, that when they report scores, they
17 are significantly higher than the limited
18 achievement. I completely agree with that.

19 You cannot make a statement about what
20 the counterfactual is, which is what you're aiming
21 to say, which is that the scores that averaged 91.7

1 on a CPOE, if they chose not to respond, they would
2 be 91.7. I mean, that's -- that is not what this
3 document supports.

4 BY MR HVIDT:

5 Q. Did you conduct any data analysis to
6 support your hypothesis -- hypothesis that
7 assigning non-participating hospitals limited
8 achievement achieves a proximity to the casual
9 truth?

10 A. To the causal truth?

11 MS. BLAIR: Causal.

12 BY MR. HVIDT:

13 Q. Causal truth?

14 MS. BLAIR: Objection. Asked and
15 answered multiple times today.

16 THE WITNESS: Yes, that's exactly what I
17 tried to do in the last exhibit, which is do a
18 sensitivity analysis of the limited achievement,
19 which is the redline, the some achievement, right,
20 and -- and the methodology that Dr. Nicholson did,
21 which is the mean, and I tried to basically look at

1 what would happen to their grades in those three
2 scenarios.

3 BY MR. HVIDT:

4 Q. And -- and we'll -- we'll get to those
5 shortly, but other than that analysis, did you do
6 any -- any other analysis when looking at
7 the -- reaching your -- supporting your nonresponse
8 bias opinion?

9 A. Yeah, in that the ones we have not looked
10 at, at all is Exhibit 3, Exhibit 4, Exhibit 6,
11 which is both the raw data analysis and their
12 color-coded analysis in terms of how they were
13 performing in the other metrics, which is a data
14 analysis to get at how they likely would have
15 performed on the ones they're choosing not to
16 respond to.

17 If you're -- hold one sec. This is an
18 important point.

19 If you're a poor-performing hospital and
20 you were performing well on the process metrics,
21 why would you not report that? Because it would

1 raise your grade.

2 Q. There's a -- we have walked through a
3 number of comments today about the reasons why
4 hospitals don't report to -- choose not to respond
5 to a hospital safety survey; is that correct?

6 A. That's correct, because they're likely
7 higher-performing hospital.

8 Q. On what basis do you make that statement?

9 A. Because they're making a conscious
10 decision not to invest the time to fill out
11 the -- the survey, and if you're a high-performing
12 hospital and you think it's only going to get you
13 from a B to a C, it's not going to matter.

14 If you're a poor-performing hospital and
15 you're at an F and you're performing high on
16 the -- on the survey, it's totally worth your time
17 to fill out the survey to raise your score, okay?

18 Wait. There's one -- there's one point
19 that's super important.

20 Q. Sir, there's no pending question, okay?

21 A. Fine, but ...

1 (Whereupon, Harris Deposition Exhibit No.
2 12, Document Bates Numbered LFROG_CP009_000000006,
3 marked for identification.)

4 Q. Okay. What's your point?

5 A. The hospital epidemiologist and the
6 quality people in my day-to-day job, okay, you have
7 endless meetings with the C-suite, the CMO, CEO,
8 the finance people. They ask you over and over and
9 over, look at this quantitative outcome, look at
10 this qualitative outcome, look at this process, and
11 they go through all these calculations of if you
12 improve your score by this, it's going to get our
13 grade to this. It's going to drive our
14 reimbursement by this, and they come and tell you.
15 These discussions happen all the time.

16 I would be absolutely shocked if I was
17 one of those five hospitals that there weren't
18 those discussions related to if we choose not to
19 report, here's what it's going to do.

20 If we choose to report, here's what our
21 scores show. How much time is it going to take?

1 Those discussions have to have happened,
2 which leads to a nonresponse bias. That's my
3 opinion.

4 BY MR HVIDT:

5 Q. Did your nonresponse bias opinion look at
6 any data of other than the hospital, Plaintiff
7 hospitals at issue? Did you apply that to the
8 national set of hospitals at all?

9 A. I did not.

10 Q. Okay. Thank you.

11 I'm handing you what's been marked as
12 Exhibit 12 to your deposition. This document was
13 produced by Plaintiffs in this litigation.

14 Have you seen this before?

15 A. No.

16 Q. Okay. So if you look -- and we'll focus
17 on Good Samaritan first, which is listed there on
18 the second page for 2024, do you see that?

19 A. Page 1, Good Samaritan?

20 Q. Yes.

21 A. Yeah, I -- I see it.

1 Q. Okay. Do you see where it says the group
2 score for CPOE in patient medications?

3 A. Yeah, 88 you mean?

4 Q. Yes. Okay. And then do you see where it
5 says Inpatient BCMA?

6 A. Group score, 98 Tenet Target, 95?

7 Q. Yeah. Okay. Do you have any
8 understanding if those -- I'll represent to you
9 that those are the -- what has been produced in
10 this litigation as the representations that
11 these -- these hospitals did at -- at the request
12 of Defendant to go through the exercise of what
13 they would have earned had they participated in the
14 survey and that was the results for those measures,
15 do you see that?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: Yeah, I have not seen these
18 data before, but if you're saying that this is
19 saying that in 2024, Good Samaritan would have had
20 a CPOE of 88 or 98, a BCMA of 98, I have not seen
21 this data before.

1 BY MR. HVIDT:

2 Q. And -- and Good Samaritan was assigned a
3 15; is that correct? Or was assigned a score of
4 limited achievement?

5 A. It was.

6 Q. Do you have an understanding of that?

7 A. Yes. I -- I understand that they were
8 assigned a limited achievement.

9 Q. Okay. Does seeing the actual data for
10 the hospitals that what their score would have been
11 for those measures affect your opinion at all
12 whether the nonresponse bias was fairly and
13 adequately applied to non-participating hospitals
14 here?

15 MS. BLAIR: Objection to form,
16 categorizing this as the actual data.

17 THE WITNESS: If this is the actual data,
18 it would affect my opinion.

19 BY MR HVIDT:

20 Q. Okay. So if -- if these hospitals scored
21 the measures that are reported here, how would

1 that --

2 A. Well, you just asked me to do Good
3 Samaritan.

4 Q. Okay. Well, let's -- let's focus on Good
5 Samaritan. Let's also look at Good Samaritan for
6 2025. On the third page, 10234, okay? Do you see
7 it there?

8 A. Yes.

9 Q. And do you see their score for CPOE?

10 A. Yeah, 92.

11 Q. Do you see their score for BCMA?

12 A. Yeah, 98.

13 Q. Okay. For Good Samaritan, does the
14 actual data affect your opinion as it relates
15 to --

16 A. Yeah, as I -- as I --

17 MS. BLAIR: Objection to form to
18 the -- that this is the actual data or that it
19 would be the answers to the Leapfrog survey.

20 THE WITNESS: Yeah, I think this -- like
21 I said if this is the actual data and this data is

1 valid, yes, it would affect my opinion.

2 BY MR HVIDT:

3 Q. Okay. Let's do the same with -- thank
4 you.

5 If you'd look -- take a minute and look
6 through for the other five hospitals and let me
7 know if there's anything in other -- other --

8 A. Can you just explain --

9 Q. -- the summary chart --

10 A. Yeah, can you explain to me the second
11 chart in each thing is the raw data? Because
12 you're having me focus on the first chart of each
13 thing.

14 Q. What do you mean by the first chart of
15 each thing?

16 A. Okay. So if you look at -- we just did
17 Good Samaritan 2024, okay?

18 Q. Yeah.

19 A. The first box that's -- has a group
20 score, but then below it, there's like raw data
21 that has like 172,400. There's a numerator, a

1 denominator. Then there's a score I can't really
2 see. I mean, it's a little bit hard to know
3 whether that second data is the raw data that feeds
4 up to the top thing. I just don't understand the
5 details of this exhibit.

6 Q. Understanding you're looking at it for
7 the first time, but in looking at that, the raw
8 data feeds in from the bottom --

9 A. Yeah. If you're --

10 Q. -- to the top.

11 A. -- if you're telling me that I'm focusing
12 on -- I'm assuming that all of the data is correct,
13 I'm assuming -- and you're telling me that the
14 group scores represent the actual score and then
15 I'm disregarding the Tenet Target, which is
16 irrelevant to your point, then, yes, this data
17 would affect my interpretation of -- of -- of my
18 expert opinion.

19 Q. And how would it affect your opinion?

20 A. Well, it would affect it in the following
21 way: It would infect it to say -- it would affect

1 it, not infect it, to say that for these hospitals
2 if this data is legitimate that the limited
3 achievement for these hospitals may have been an
4 underestimate of the truth.

5 However, when we get to Exhibit 10 -- 8,
6 I'm sorry, it still would most likely not affect
7 the poor grade that the five hospitals would have
8 received due to Nicholson's flaw of you would not
9 be impute -- so Nicholson's score gives them a C
10 imputing seven measures.

11 You would just be imputing four measures,
12 so best-case scenario, those hospitals would have
13 gotten a C, and more likely they would have gotten
14 a lower grade.

15 Q. Now, we -- we keep going over to that
16 exhibit, so let's -- let's look at that exhibit
17 for -- for a minute because I think it's important
18 to deal with this testimony here.

19 What is the counterfactual that underlies
20 Exhibit 8 for your -- for your -- your portion of
21 it?

1 A. Yeah, that's a good question.

2 The counterfactual of Exhibit 8 is what
3 we talked about early on. You're trying to get as
4 close to what their scores accurately were.

5 You don't know exactly what those scores
6 were, because they chose not to respond.

7 What this is trying to get at is
8 different scenarios. By far, the weakest to the
9 counterfactual is Nicholson's calculation because
10 it's imputing three metrics that aren't even
11 included. I mean, that is completely flawed.

12 Q. We're going to get to that aspect.

13 A. Okay.

14 Q. I'm asking directly, what is the
15 counterfactual you envisioned? What -- what
16 scenario unlies your change? What -- what did the
17 hospital does in the world you're looking at?

18 A. Well, exhibit -- the exhibit is getting
19 at the assumption that there may be a
20 counterfactual where the limited achievement is too
21 harsh and the middle category is trying to get at a

1 plausible scenario of what their data really looks
2 like.

3 Q. And why did you limit that change to just
4 those four measures?

5 A. Because those are the only ones that were
6 imputed.

7 Q. Do you understand that -- what scenario
8 would a hospital only answer, complete the survey
9 and only answer those four and not answer the other
10 three?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: Well, yeah, but -- I
13 understand your question, but you're -- you're
14 having -- it's trying to get close -- yeah, but
15 that's -- that's like saying, they chose not to
16 participate, okay? And then they voluntarily chose
17 not to participate. They voluntarily know their
18 data most likely across the seven measures, okay?
19 And based on the fact they produced the data, like
20 why couldn't they have produced the data to
21 Leapfrog?

1 And then you're saying, Well, Nicholson's
2 is closer to the counterfactual because they would
3 have performed at the median across seven measures.
4 That's far from the counterfactual in my -- in my
5 opinion.

6 I still -- I still believe that the first
7 column is closest to counterfactual because the
8 advisory committee, which I'm an expert, but
9 they're more experts, that's where they went, and I
10 think that my second column is definitely closer to
11 the counterfactual than imputing the median -- the
12 mean for seven measures.

13 BY MR. HVIDT:

14 Q. When you say that's where the expert
15 panel went, on what facts are you supporting that?

16 MS. BLAIR: Objection. Asked and
17 answered.

18 THE WITNESS: Yeah, I have -- I answered
19 that before.

20 That's based on the fact that they --
21 they reviewed the methodology. They signed off on

1 the methodology. They gave their opinion. They
2 drafted the email you provided to me.

3 BY MR HVIDT:

4 Q. What basis do they have to draft an email
5 that -- that -- strike that. Okay.

6 A. It's the exhibits that you provided to
7 me. To me, they had a say in that email.

8 Q. On what -- when -- when hospitals
9 complete the survey, do you think that they
10 complete the whole survey?

11 A. I -- I don't know the details, but, yes,
12 I would assume that they -- well, that they
13 complete a -- they complete -- they probably
14 complete the survey that -- the portion of the
15 survey that's directly related to them getting
16 scores.

17 I mean, one thing that was clear that I
18 should have clarified previously is some of what
19 they're agreeing to is allowing Leapfrog to access
20 their healthcare-associated infection data directly
21 from CMS.

1 Q. Okay. And then when they -- you -- you
2 said that they answered the questions for the
3 survey for which they're graded for, and so if a
4 hospital was previously not participating and then
5 chose to participate, is it a fair counterfactual
6 to assume they're going to answer the questions for
7 the -- that go into the scores for those seven
8 measures?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: Look, I think this is an
11 area where I'm not an expert for the following
12 reasons: I have never filled out the survey. I
13 have not seen the 2024 version of the survey
14 because I stopped being a hospital epidemiologist
15 in -- I have to double-check this, but I believe it
16 was January 2023, but it may have been January
17 2024. So I'm not familiar with the present version
18 of this survey nor the amount of time it takes nor
19 exactly whether you can answer certain questions,
20 but not others.

21 BY MR HVIDT:

1 Q. Okay. Do you understand that Nicholson's
2 analy- -- Nicholson's counterfactual was what would
3 happen if a non-participant participated in the
4 survey?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: Yes. Nicholson's
7 counterfactual is saying that the -- yes, and I
8 think that's the wrong counterfactual.

9 BY MR HVIDT:

10 Q. Okay. And how -- so in your response to
11 Nicholson's counterfactual is a par- -- a
12 non-participating hospital participates in the
13 survey for four measures, but doesn't for the other
14 three?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: No, that's not -- that's
17 not what I'm saying.

18 I'm saying that if a hospital chooses not
19 to participate, right, their grade, which is the
20 basis of the cases, is how much worse is their
21 grade than it would have been?

1 How much worse is based on the four
2 metrics that were imputed. It's not based on seven
3 metrics that would have been imputed based on them
4 participating.

5 They didn't participate, so their grade
6 wasn't calculated based on seven metrics. It was
7 calculated based on four.

8 BY MR HVIDT:

9 Q. Do you understand that the case is bigger
10 than just the four imputed measures?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: Right, but that's exactly
13 what the rest of my deposition gets.

14 These are poor-performing hospitals
15 across the objective CMS measures, across the
16 HCAHPS measures, across their CMS rating --

17 Q. Do you --

18 A. -- their Z-scores, their SIR scores,
19 their PS 90 scores.

20 Q. Do you understand that Nicholson had an
21 opinion that taking the three measures that

1 participating hospitals get credit for and
2 giving -- and deleting them for the
3 non-participating hospitals and reassigning the
4 weights is one of the ways that the Leapfrog
5 methodology is unfair as to non-participating
6 hospitals?

7 A. I'm sorry, can you say that again?

8 Q. Nicholson's expert report included an
9 opinion that deleting the three measures for
10 non-participating hospitals and reassigning those
11 weights was one of the ways that the Leapfrog
12 methodology is unfair as to non-participating
13 hospitals, do you understand that?

14 A. Well, I would need --

15 MS. BLAIR: Objection to form.

16 THE WITNESS: I would need to read it in
17 more detail, but here is why I disagree with what
18 you just verbalized: If you have seven metrics
19 that a hospital chooses not to respond to, okay,
20 and you eliminate three and you reweight the
21 objective outcomes that they have reported, you're

1 placing more emphasis on data that is measured,
2 which to me is the right thing to do and closer to
3 the counterfactual.

4 You -- you -- Nicholson's argument is
5 saying, I don't like imputed data, and then the
6 next breath he's saying, but I'm going to impute
7 data across seven metrics.

8 Well, you just said you didn't like
9 imputed data. So why would you impute it across
10 seven metrics?

11 I mean, that -- that just to me is, by
12 far, the biggest flaw in -- in his reasoning.

13 (Whereupon, Harris Deposition Exhibit No.
14 13, Share of Participating Hospital That Respond to
15 TLG's Survey for Measures That are Excluded for
16 Non-Participating Hospitals, marked for
17 identification.)

18 BY MR HVIDT:

19 Q. I'm handing you what's been --

20 MS. BLAIR: Thank you.

21 BY MR HVIDT:

1 Q. -- marked as Exhibit 13, which, again, is
2 a chart that looks at Leapfrog hospital safety
3 grade data that they produced in this litigation,
4 and the document -- the demonstrative shows at the
5 top the share of participating hospitals that
6 respond to the Leapfrog survey for measures that
7 are excluded for non-participating hospitals. Do
8 you see that, Dr. Harris?

9 MS. BLAIR: I'm going to object to form.
10 And for the record, again, has this been produced
11 in this litigation? Who prepared it?

12 MR HVIDT: It's a demonstrative that we
13 prepared.

14 MS. BLAIR: You prepared it, the lawyers
15 in this case?

16 MR HVIDT: Yes, with the assistance
17 of --

18 THE WITNESS: I'm sorry, can you explain
19 the title to me? I don't understand it.

20 BY MR. HVIDT:

21 Q. Okay. So share of participating

1 hospitals that responded to the Leapfrog
2 sur- -- survey for measures that are excluded from
3 non-participating hospitals.

4 Do you understand that there are three
5 measures in the Leapfrog methodology that are not
6 graded --

7 A. Yeah. Yeah.

8 Q. -- for non-participating hospitals?

9 A. Yeah. These are the -- yeah.

10 Q. And do you understand that there are
11 questions on the Leapfrog safety -- the Leapfrog
12 hospital survey that go into calculating the score
13 for a hospital that participates in the Leapfrog
14 survey?

15 A. Say the last sentence again.

16 Q. Do you understand that there are
17 questions on the Leapfrog hospital survey that go
18 to the -- the answers for which go into the
19 grade -- the measure that they're assigned, the
20 hospitals are assigned for those three measures?

21 MS. BLAIR: Objection to form.

1 THE WITNESS: Yes.

2 BY MR HVIDT:

3 Q. Okay. And what this shows is that of the
4 hospitals that participated in the Leapfrog
5 hospital survey, the hospitals that participated, a
6 hundred percent of them answered all of the
7 questions for -- that went into the score for safe
8 practices: Safe Practice 1: Culture of Leadership
9 Structures and Systems, and Safe Practice 2:
10 Culture Measurement, Feedback and Intervention. Do
11 you see that?

12 A. Yes.

13 Q. And do you see that 99.55 percent of
14 hospitals responded to the questions relating to
15 nurse- -- total nursing care hours per patient day?

16 A. Yep.

17 MS. BLAIR: And, again, objection to form
18 and the use of this exhibit.

19 BY MR HVIDT:

20 Q. And looking at this and understanding
21 that hospitals that participate in the survey

1 answer the questions as it relates to those three
2 measures, does that change or affect your opinion
3 at all as to whether it was reasonable for
4 Nicholson to assume in his counterfactual that had
5 the Plaintiff hospitals participated in the survey,
6 they would have participated in the survey as it
7 relates to these measures?

8 MS. BLAIR: Objection to form,
9 mischaracterizes this document, and I object to the
10 use of this document.

11 THE WITNESS: So, yes, the hospitals that
12 chose to participate answer these three questions,
13 but that then gets at these questions must not
14 require too much effort to respond to, which means
15 I bet if you showed a graph of how they responded
16 to all seven, you would be close to a hundred
17 percent, which means that the people -- the groups
18 that choose to respond answer all seven questions,
19 which means that it can't be too labor intensive to
20 respond if you're responding to all seven. Because
21 if some were particularly labor intensive, you

1 wouldn't have a hundred percent in my opinion.

2 BY MR HVIDT:

3 Q. But setting aside the burden component of
4 answering them or not, do you agree that if a -- it
5 is fair that if a -- you're going to assume in a
6 counterfactual that a hospital is participating in
7 the survey that you assume that they participate in
8 all seven of the measures that -- for the process
9 score?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: It's -- it's --

12 MS. BLAIR: Calls for speculation.

13 THE WITNESS: It's -- it's saying that if
14 you choose, the hospital -- I mean, it
15 depends -- yes, but it also means that the
16 hospitals that choose to participate are very
17 different than the hospitals that choose not to
18 participate, because the hospitals who choose to
19 participate answer all of the questions, and the
20 hospitals that choose not to participate are
21 choosing not to answer the questions, which makes

1 them different.

2 BY MR. HVIDT:

3 Q. Isn't it also fair that the data that
4 Leapfrog has for the hospitals that choose not to
5 participate is entirely different than the data it
6 has for the hospitals that choose to participate?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: No, not on the -- the
9 hospitals they -- they have -- no, that's
10 completely incorrect.

11 BY MR. HVIDT:

12 Q. The --

13 A. The -- the data that they get
14 from -- from CMS is the same most likely, which is
15 exactly the whole point of my prior exhibits, is
16 that these five hospitals were underperforming on
17 the same calculations, the same methodology for the
18 outcomes that they choose not to participate.

19 Q. For the imputed measures, what actual
20 data from non-participating hospitals does Leapfrog
21 have?

1 A. For non-participating hospitals, they
2 don't have data.

3 Q. Thank you.

4 And for participating hospitals, they
5 have data --

6 A. Yes.

7 Q. -- for those measures, correct?

8 A. Yes.

9 Q. And so the data they have for
10 non-participating hospitals for those imputed
11 measures is dramatically different than the data
12 they have for participating hospitals; is that
13 correct?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: Yeah, they have data for
16 the participating hospitals. They do not have data
17 for the non-participating hospitals. They have
18 data for both hospitals on the other out- -- on
19 some of the other outcomes collected in the
20 identical fashion.

21 BY MR HVIDT:

1 Q. Do you understand that in spring 2025,
2 the only hospitals that received a -- strike that.

3 Do you understand that in spring 2025
4 hospital safety grade, no non-participating
5 hospital that was given a step 2 imputation method
6 where they were assigned a limited achievement that
7 had an ICU got an A on the Leapfrog hospital
8 survey -- on the Leapfrog hospital safety grade?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: One second. I haven't -- I
11 mean, I haven't reviewed that data. I haven't seen
12 that data.

13 And is it spring 2025 or spring 2024?

14 MS. BLAIR: He's saying 2025.

15 THE WITNESS: Fall? I thought the only
16 data I was talking about was fall 2024 and now
17 you're talking about spring 2025?

18 BY MR HVIDT:

19 Q. Yes. Also, for fall 2024, do you
20 understand that no non-participating hospital that
21 has an ICU got an A when it was assigned a step 2

1 imputation methodology?

2 A. Yeah, but that's not the relevant point.
3 It's how many got Fs and Ds?

4 Q. Do you understand that no participating
5 hospital in the 2025 -- spring 2025 hospital safety
6 grade got an F?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: Say that again.

9 BY MR HVIDT:

10 Q. Do you understand that no participating
11 hospital in the Leapfrog spring 2025 hospital
12 safety grade got an F?

13 A. No, I'm not aware of that.

14 Q. Okay. Do you understand that in -- for
15 spring 2025, no non-participating hospital with an
16 ICU received an A grade when it also had step 2
17 imputation applied to it?

18 MS. BLAIR: Objection. Asked and
19 answered.

20 THE WITNESS: Yeah, I just answered that
21 question I thought.

1 MS. BLAIR: You can answer it again.

2 THE WITNESS: No, I haven't seen that
3 data, but you're telling me that yeah -- no. I did
4 not -- I was not aware of that.

5 BY MR HVIDT:

6 Q. So in performing -- reaching your
7 opinions in this case, you did not look at the
8 grade distribution data as it relates to
9 participating versus non-participating hospitals;
10 is that correct?

11 A. Other than exhibit -- well, somewhat
12 Exhibit 6 gets at that in that it looks at the data
13 of performance of CMS and HCAHPS measures to other
14 non-participating hospitals in Florida, so it
15 compares the five hospitals to five other hospitals
16 that also chose to not participate, which is
17 relevant to the line of questioning that you just
18 gave me.

19 Q. And those relate to the CMS measures,
20 correct?

21 A. And the HCAHPS measures.

1 Q. Those do not relate to the imputed
2 measures; is that correct?

3 A. That's correct.

4 Q. Okay. Did you make a causal analysis of
5 how a non-participating hospital is likely to score
6 on the imputed metrics had they participated based
7 on how they scored on CMS data?

8 A. Say that again.

9 Q. Did you make a causal analysis of how a
10 non-participating hospital is likely to score on
11 the imputed metrics had they participated based on
12 how they scored on CMS measures?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: Yes, in some ways because
15 hand hygiene is the cornerstone of infection
16 control. So that -- poor-performing hospitals in
17 CLABSI rates, MRSA rates, the intermediate variable
18 that leads to those causal outcomes includes hand
19 hygiene performance, which is one of the process
20 measurements.

21 BY MR HVIDT:

1 Q. Did you perform any causal analysis that
2 appeared in your report connecting those
3 line -- those items?

4 MS. BLAIR: Objection to form, other than
5 what he's testified to.

6 THE WITNESS: It depends on how you
7 define causal analysis, but, yes, that's the basis
8 of the exhibits, which is that they were
9 underperforming on a number of the outcome metrics
10 and, thus, their hand hygiene data was probably
11 going to be poor.

12 BY MR HVIDT:

13 Q. Probably on what basis? What --
14 what -- why?

15 A. Because hand hygiene -- okay. If we're
16 talking about the most important infection control
17 process measure, it's hand hygiene compliance,
18 okay?

19 If you're washing your hands when you're
20 going into a patient room and when you're exiting,
21 there's a good probability that you're going to

1 help prevent surgical site infections, CLABSI
2 infections, CAUTI infections. It's -- it's just
3 one of the -- one of the intermediate variables
4 that is -- is the cornerstone of infection control.

5 So in Exhibit 6 and Exhibit 3, yeah, 3,
6 these hospitals' Z-scores, SIR scores are poor.
7 And so, yes, I think there's a very plausible
8 hypothesis that their hand hygiene data, which is
9 one of the four metrics, would likely be poor.

10 Q. And where is that opinion stated in your
11 report and where is that analysis?

12 A. It's -- it doesn't -- it does not say
13 hand hygiene, but it's -- it's implied in the
14 nonresponse bias section.

15 Q. All right.

16 MR HVIDT: Let's take a brief break.

17 Let's go off record.

18 THE VIDEOGRAPHER: We're going off
19 record. The time is 3:35 p.m.

20 (Recess taken -- 3:35 p.m.)

21 (After recess -- 3:49 p.m.)

1 THE VIDEOGRAPHER: We are back on the
2 record. The time is 3:49 p.m. This is media
3 number four.

4 BY MR. HVIDT:

5 Q. Dr. Romano (sic), can you pull out your
6 report, which is Exhibit 2? And can you turn to
7 page 15, section X?

8 In section X, what -- what is your
9 opinion stated here?

10 A. In section X?

11 Q. Correct.

12 A. Five Plaintiff hospitals are
13 underperforming in the areas of patient safety and
14 quality regardless of the Leapfrog hospital safety
15 grades.

16 Q. How did you come to that opinion?

17 A. I came to that opinion -- and just a
18 clarification, legal referred to me as Dr. Romano
19 in that correction -- in that question. It needs
20 to be changed.

21 MS. BLAIR: Oh, he did.

1 THE WITNESS: Yeah.

2 BY MR. HVIDT:

3 Q. I'm sorry. Dr. Harris --

4 MS. BLAIR: I didn't even notice.

5 THE WITNESS: That's okay.

6 MS. BLAIR: I think that's true though.

7 THE WITNESS: Maybe -- yeah, so --

8 BY MR. HVIDT:

9 Q. Dr. Harris, how did you come to your
10 opinion in exhibit -- in section X?

11 A. So it's -- it's -- it's a number of the
12 exhibits.

13 So Exhibit -- Exhibit 2 shows a CMS star
14 rating for the five Plaintiff hospitals. So the
15 first column represents each of the
16 hospitals -- the -- the column represents the
17 hospitals with each row being an individual
18 hospital. The second column is their overall
19 rating, which of the two columns I think is the
20 most important, and then the third column
21 represents a patient survey rating which ties into

1 the importance of the HCAHPS score.

2 The CMS ratings are on a scoring system
3 with lower numbers of poor performers, and you see
4 that the average rating of these five hospitals was
5 1.2, with a 5 star rating, meaning 5 stars is the
6 highest.

7 Exhibit 3 gets into a lot of the raw
8 data, which I think is really important, and it has
9 columns representing each hospital. It tries to
10 show -- it has then their overall Leapfrog grade.
11 As an example if you look at Palm Beach, it's a
12 grade of F.

13 It then has each row representing one of
14 the outcome metrics that are part of the 32 that
15 led to that grade, and so I think it's important to
16 walk through, as an example, and have nurse
17 communication, doctor communication, staff
18 responsiveness -- I'm going to skip some rows for
19 brevity sake, but it then has the areas I'm most
20 familiar with, CLABSI, CAUTI, SSI and then it has
21 one that led to a fair amount of the weighting,

1 which is the PSI 90.

2 So if we take Palm Beach as an example,
3 okay. Just if you look at -- if you -- if
4 you -- if you take -- I'm sorry, if you take
5 Delray, which is an F, and you look at their
6 CLABSI, CAUTI, SSI, a negative Z-score means
7 they're underperforming, and then that's also
8 relayed basically in the bar graph below in that
9 the red represents the national average and then
10 their score. So that the Y axis is their scores,
11 which are all less than the national average.

12 If you move away from the raw data, what
13 I then did in Exhibit 4 was I color coded it. I
14 took the scores basically for each of these
15 outcomes on the Y axis, and red was poor
16 performance, yellow average performance and green
17 is above, because it gives you basically a visual,
18 very similar to a grading scheme. And what you're
19 struck by is that there's a lot of red, a lot of
20 yellow and very little green. That's the basis of
21 my opinion that these hospitals were

1 underperforming.

2 Q. So in section X, is there any method,
3 scientific method that you used in creating section
4 X?

5 A. Yeah. I think, one, Exhibit 2 is
6 deferring to the scientific method of CMS, which
7 likely has an advisory panel as well, and it's
8 saying that the CMS method, which is another method
9 of evaluating hospitals, is saying that these are
10 poor-performing hospitals.

11 Q. So --

12 A. Exhibit 3, which has all of the raw data,
13 many of which is the methodology that CDC uses for
14 CLABSI, CAUTI and SSI is also saying that these are
15 underperforming hospital.

16 Q. So we'll just take these one at a -- one
17 at a time.

18 So two, you mentioned you're deferring to
19 CMS.

20 So did you copy what CMS' star ratings
21 were for that and paste that into that chart?

1 A. Yes, that's what me and the legal counsel
2 did.

3 Q. Okay. Did you do anything other than
4 copy and paste the -- the information as it relates
5 to coming up with Exhibit 2?

6 A. No.

7 Q. Okay. Looking over at Exhibit 3, did you
8 copy and paste that information from the CDC?

9 A. So what I -- what I did was I looked at
10 the raw data, which included Z-scores and SIRs.

11 The SIR is what's called a Standard
12 Incidence Ratio. Less than 1 is better than
13 greater than 1. Because it's so hard to
14 understand, we chose not to include that in this
15 summary table, but, in essence, a negative Z-score
16 corresponds with an SIR greater than 1, which
17 corresponds to hospitals poor performing.

18 I looked over that data, and, yes, I
19 requested that the lawyer legal team make this into
20 this type of table where you see the overall grade
21 and you see poor performance across the individual

1 rows, which encompasses some of the outcomes that
2 contribute to the 32.

3 Q. Okay. And then in Exhibit 3, it includes
4 the title Summary, correct?

5 A. Yes.

6 Q. Is it fair to say this is a summary of
7 data?

8 A. Yeah. It doesn't -- well, it doesn't
9 include all 32 outcomes or the formula towards
10 them, but --

11 Q. Okay. But --

12 A. -- but the PSI 90 -- we will have to
13 double-check the details, but the PSI 90 has I
14 believe a dozen individual components. So by using
15 the PSI 90, you could easily have just added 12
16 additional rows that would have shown the same data
17 as that row, which then would get you really closer
18 to the total. So it would not be a sum- --
19 it's -- it's a summary, but it's not really a
20 summary.

21 Q. Okay. So -- but did you do anything

1 other than summarize the data that's included here?

2 A. No. Well, no, that's incorrect. Let
3 me -- let me -- I looked over all of the components
4 as an example of the PSI 90.

5 So I looked over every single outcome I
6 believe for these five hospitals. This is a
7 summary, but I looked over -- yeah, I definitely
8 did this, because there -- there were -- of the
9 30 -- yeah, I looked over every single row of the
10 32 outcomes for all five hospitals. I'm -- I'm 99
11 percent certain of that.

12 Q. Okay. And so you took the data that was
13 present in a source and you applied that here and
14 put it into Exhibit 3; is that correct?

15 A. Yes, with -- with legal help.

16 Q. Okay. And then did you apply any
17 scientific method to that dataset in Exhibit 3?

18 A. No, because I deferred the strong
19 scientific methodology of what CMS does and what
20 CDC did, which is already done.

21 So as an example, the Standardized

1 Incidence Ratio that the CDC applies, it already
2 has risk adjustment. It already has a number of
3 variables. It's not the raw data. It's applying
4 the approved methodology to fairly rate those
5 hospitals.

6 Q. And so -- but you took what CDC did and
7 put that here?

8 A. Correct.

9 Q. Okay.

10 A. And similarly, I took what -- the PSI
11 90 -- talk about something that's very confusing to
12 completely understand. I took the methodology that
13 CMS debates endlessly related to the PSI 90 and I
14 just put that data into this table.

15 Q. And looking over to Exhibit 5 and 6,
16 let's start with -- sorry, let's start with Exhibit
17 4.

18 Exhibit 4, this here, did you just -- you
19 color coded the CMS scores that the Plaintiff
20 hospitals received; is that correct?

21 A. Yes. So let me just give a tiny bit of

1 background of what Exhibit 4 does, because you are
2 asking on the prior exhibits did I apply any of my
3 own scientific methodology? The short answer to
4 the other exhibits is no.

5 Did I apply my own methodology to Exhibit
6 4? Absolutely.

7 Am I open to criticism for Exhibit 4's
8 methodology? Absolutely, but let me give you the
9 background of why I did it this way.

10 What Leapfrog does, which, again, I think
11 is open to criticism, but I know why they do it,
12 they take all of these raw metrics and they convert
13 it to a single grade, okay.

14 Now, that can be problematic, right?
15 Because in some ways, it's great. It's easy to

16 understand. You got an F. You got an A. You got
17 a B. In other ways, it's overly simplistic, right?
18 It leads to the obvious questions, Why did I get an
19 A? Why did I get an F? Okay?

20 What I tried to do applying my
21 methodology to Exhibit 4 is the following: Often

1 in hospital quality, there's stuff called
2 dashboards, right? And there's dashboard science
3 that's been shown that frontline providers want
4 something simpler than the Z-scores and the SIRs.

5 They want a green is good, yellow is
6 pretty good, and red isn't good. And so what I
7 tried to do is -- like, as an example, a lot of
8 companies make a fair amount of money taking your
9 data and creating dashboards which are based on a
10 red, yellow, green system. So I tried to apply
11 that technique that I think is generally well
12 described in hospital quality and probably familiar
13 to the hospitals that participate, and I tried to
14 apply that methodology to the data so that you can
15 quickly look at Exhibit 4 and see that.

16 On a positive note, Palm Beach Gardens is
17 performing well on MRSA. They're not performing so
18 well on H-COMP-1, H-COMP-2, H-COMP-3, H-COMP-5,
19 H-COMP-6 and PSI 90. It's an easy, quick visual
20 way to try to summarize data that I think provides
21 more granularity than a grade, but is more easily

1 interpretable than like Exhibit 3. That was the
2 goal of Exhibit 4.

3 Q. What methodology did you apply to the
4 color assignment?

5 A. Yeah. I have to look back, and I just
6 realized on page 17, it's not -- I have criticized
7 stuff for having not enough data to explain things.
8 We need a footnote.

9 I believe we split them into a third, a
10 third, a third. So green would represent the top
11 third performing hospitals for each outcome.
12 Yellow would represent the next third, and red
13 would -- but I would -- I need to double-check that
14 and clarify that.

15 Q. And you -- that's not -- that methodology
16 is not stated in your report; is that correct?

17 A. Correct. That's a mistake on my behalf.
18 I would state though that the methodology in
19 Exhibit 4 and Exhibit 6 is the same.

20 Q. Is there an Exhibit 5?

21 A. I was just looking, and it appears as if

1 we're missing an Exhibit 5.

2 Q. And -- but you -- so sitting here today,
3 you -- you believe it's a third, a third, a third;
4 is that correct?

5 A. Yeah.

6 Q. Okay.

7 A. This -- this is an important
8 clarification that I need to go back, and I
9 apologize. It's obviously an error in my --
10 it's -- it's an error in my -- in my expert
11 opinion.

12 Q. And is there any support for that
13 methodology?

14 A. Well --

15 MS. BLAIR: Objection to form, asked and
16 answered, but you can answer again.

17 THE WITNESS: If I used a third, a third,
18 a third, it's a fair way -- it's a fair way of
19 statistically dividing data.

20 BY MR. HVIDT:

21 Q. Is there any published academic

1 principles that relates to analyzing CMS data that
2 that's an appropriate way to divide them?

3 A. No. I would say the principle I used was
4 basically like when you have data, right, you aim
5 not to eliminate any data? Right?

6 So if you're not eliminating, let's say,
7 the top performers or the lowest performers or
8 outliers, you got to -- you got to summarize the
9 data in some way.

10 So if you're using a three -- a
11 three-color system, which we are, and you're aiming
12 to include all the data, that's kind of what I
13 think we did, and to me, that would make sense.

14 Q. Okay. So you're summarizing the data
15 while putting the data into a third, a third, a
16 third buckets?

17 A. I believe.

18 Q. And for these infectious disease -- I'm
19 sorry, strike that.

20 For the measures that relate to
21 infections, it communicates that one-off instances

1 can dramatically alter the scores; is that correct?

2 A. Yeah, that's an excellent point. It's
3 something we haven't gotten to today.

4 Q. Okay.

5 A. One sec.

6 Q. Oh, sorry.

7 A. I need to finish.

8 Q. There was -- there was a pregnant pause.
9 I thought that you were done with that.

10 MS. BLAIR: So close.

11 BY MR. HVIDT:

12 Q. That was the question that was asked, so
13 I was hopeful that we were going to move on.

14 MS. BLAIR: No, go ahead.

15 THE WITNESS: I apologize, but in the
16 spirit of more data, it is generally valued by
17 epidemiologists. It's the following: When you
18 have an SIR for the stuff I know, okay, and you're
19 an individual hospital, it is really important to
20 look at the numerators and the denominators, and
21 your point is a hundred percent clear -- correct,

1 in that when outcomes are rare, single events or
2 slight changes can make a difference.

3 And just to tie into something that I did
4 not explain clearly before -- and don't -- don't
5 worry, it will be very brief -- as CLABSI rates
6 have plummeted, okay, the numerators have gone
7 down, which on the CDC advisory committee I sit on,
8 that's the exact point of why there was discussion
9 of retiring that metric and replacing it with the
10 metric that I've published on, hospital-onset
11 bacteremia, because that event occurs more
12 frequently and, hence, exactly like your point
13 made, it's nothing wrong with CLABSI. But by
14 retiring that, you then have an outcome that occurs
15 more frequently, so it bounces around less. So an
16 individual hospital would not go from great to
17 lousy to average based on just rare events.

18 So your point is absolutely right, that
19 for most of these outcomes if you're getting into
20 the details, having numerators and denominators and
21 looking at how much it's affected would be

1 important.

2 BY MR. HVIDT:

3 Q. And while you're working on an effort to
4 place CLABSI in the way you're talking about
5 presently and in the Leapfrog grading methodology,
6 the CLABSI score is still included; is that
7 correct?

8 A. CLABSI, CAUTI, SSI Colon, MRSA and C.
9 Diff.

10 Q. And so for all of those, are -- is
11 your -- what you are describing -- what you were
12 just describing, is that applicable to all of those
13 measures?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: If you're asking me whether
16 in the infection outcomes these are rare events,
17 the answer is yes. Although, they're more common
18 than the never events that are also in Leapfrog.

19 So this is -- but yet, this is why I
20 actually like some of the Leapfrog changes.
21 Obviously, the process measure of hand hygiene is a

1 very frequent event, so that that -- in short, yes.

2 For CLABSI, CAUTI, SSI, these are
3 outcomes that occur infrequently and more
4 frequently though than some of the other never
5 events.

6 BY MR. HVIDT:

7 Q. And when you say they occur infrequently,
8 does the -- do characteristics of the hospital also
9 impact the likelihood that those events might occur
10 at that hospital?

11 A. Ab- --

12 MS. BLAIR: Objection to form.

13 THE WITNESS: Absolutely. So let
14 me -- let me put it in numbers matter that would be
15 easier to understand and then you can backtrack the
16 denominators, okay?

17 So I can't remember what -- take colons,
18 okay? The rate of infection of a colon surgery is
19 about five percent in an average hospital.

20 If you took hips and knees, it's about .5
21 percent to one percent, so those are infrequent

1 events. It depends upon how many procedures a
2 hospital does, right?

3 For a lot of surgical procedures, the
4 hospitals are not doing more than a hundred or 200
5 surgeries a year, okay?

6 If you do a hundred colons a year, you're
7 only going to have five infected, okay?

8 If you're a poor-performing hospital, you
9 may be poor performing getting to eight or nine
10 versus five, okay?

11 Similarly to what you just alluded to,
12 the type of patient that's going for the colon
13 surgery greatly affects the potential outcome in
14 terms of what their comorbid conditions are.

15 So the majority of my research was on the
16 idea that if you're an acting counterfactual, since
17 you like that term, if I have two cloned hospitals
18 outside our window, right, they're doing the same
19 hundred colon surgery procedures, right, I take the
20 identical patients, and in a hundred, it's one
21 patient -- it's a hundred patients. And let's say

1 the rate of diabetes in those hundred patients is
2 five percent, okay, and in the other hospital, it's
3 the exact identical patients except it's 60 percent
4 of them are diabetic. The rate of colon surgical
5 site infection in the second hospital that has a
6 higher rate of diabetes is going to be higher.

7 And so if you do not risk adjust for the
8 prevalence of diabetes and take in further other
9 comorbid conditions, you could end up looking as a
10 worse hospital in the hospitals that are operating
11 on more diabetics. That's the principle of risk
12 adjustment and that's what the CDC tries to do in
13 their SIR as they have modified their terminology
14 and definitions.

15 BY MR. HVIDT:

16 Q. And does -- do the CMS measures that are
17 included in the Leapfrog hospital safety grade
18 methodology, are those risk adjusted?

19 A. Yes. Now, I don't know all of them,
20 right, but I do know, as an example, the CMS ones
21 for the ones I know, which is the infections,

1 similar to what we discussed prior, the CDC is
2 routinely modifying their methodology and modifying
3 their risk adjustment. So, yes, over the decades
4 I've been doing this.

5 Initially, as an example, they had
6 hospital size and academic, non-academic, but then
7 they started to -- they added additional variables
8 for each of these procedures to better risk adjust.

9 Q. Are they perfectly risk adjusted?

10 A. No, they're not perfectly risk adjusted.

11 Q. Are they still trying to improve the risk
12 adjustment?

13 A. Yes.

14 Q. Would the fact that a hospital is a
15 trauma center be an impact in how it might perform
16 on these measures?

17 A. Yes, absolutely. It's an excellent
18 question. It's especially relevant to the colon
19 SSI.

20 Q. And so a hospital that's a trauma center
21 might see more likely occurrence of the -- of that

1 issue; is that correct?

2 A. Yes. Now, I have to look into -- I
3 should know what this is called, but I do not
4 remember.

5 So the CDC and CMS, right, adjust by the
6 type of -- in certain of their measures -- like as
7 an example for CLABSI, they adjust based on the
8 type of location, so you get a different ICU and
9 non-ICU. I'm almost certain they have a
10 distinction for trauma, but I do not know whether
11 they do.

12 I -- I don't under- -- I don't know all
13 of the adjustment methodology for each of these
14 individual metrics, but literally, there's
15 a -- there's a website.

16 If you, unfortunately, look up CDC and
17 HSM, there is transparent public availability of
18 exactly what the risk adjustment is for each of
19 these, and the problem is it's different. It's
20 different for each of these infection outcomes.

21 Q. And so would a Level 3 trauma center see

1 even more of a -- like -- like having an incident
2 occur as it relates to those -- those issues?

3 A. So, I mean, the more -- the more correct
4 answer -- in -- in short, yes, most likely, but you
5 need to look at each one.

6 So like, as an example, if you look at
7 MRSA, right, it's the rate of MRSA bloodstream
8 infection that occurs.

9 But what's the biggest driver of that?
10 The biggest driver is what's your like prevalence
11 of MRSA in your community?

12 Different communities have different
13 rates, so if I'm not mistaken, they adjust based on
14 that.

15 As an example for C. Diff, okay, and this
16 is the panel I sat on, and the biggest controversy
17 they made is they had different calculations based
18 on the type of testing you used and that became so
19 controversial.

20 So in short, there's some things that
21 they adjust pretty standardly across the ones that

1 are in the CMS, like academic, non-academic and
2 size of facility, but then there are some where
3 there's individual features for each. And
4 basically, the goal of an infection prevention
5 nurse or infection preventionist, they know these
6 definitions cold. And when you send it to the CDC
7 through their portal, they have fixed fields that
8 you have to enter in and you have to collect.

9 But, yes, in general, a trauma center
10 could perform worse on these things, and I do not
11 know for each of these things what adjustment is
12 done for that or not.

13 Q. How about a cancer specialist center, a
14 center that focuses on -- that sees a lot of cancer
15 patients have -- have any impact on how it might
16 perform on some of these measures?

17 A. Yes, I agree with that as well, and,
18 again, I would need to look over each one of them,
19 but there -- this has been -- there is adjustment
20 for -- definitely for CLABSI, you're judged against
21 other cancer-center populations, and it -- in fact,

1 that's been a whole matter of debate, because
2 cancer patients get different organisms that cause
3 bloodstream infections, and there's been a series
4 of changes to the definitions of which char- --
5 which counts and which doesn't count over the
6 years.

7 Q. Would an elderly patient population have
8 an impact on the scores you could get as a hospital
9 for these measures?

10 A. Yes, in my opinion. I do not -- I'd have
11 to double-check whether the CDC adjusts for that or
12 not.

13 Q. Sticking with Exhibit 4 and also looking
14 at Exhibit 6, because it's -- it looks like Exhibit
15 6 takes Exhibit 4 and then adds rows; is that
16 correct?

17 A. Yeah, exactly. The upper part is exactly
18 the same, and the lower part is other
19 non-participating hospitals in Florida. And I -- I
20 believe based on the discussions I had with counsel
21 that it's -- because we had some back and forths on

1 this, I believe it's all -- it's all of the
2 non-participating hospitals in Florida. Meaning
3 those are not just five hospitals. It's all the
4 other non-participating hospitals.

5 Q. That was exactly where I was going to go
6 with my next question, which was how -- how -- and
7 so I'll just get that clear on the record.

8 How did you select those five hospitals?

9 A. Well, so I asked counsel, and I believe
10 they asked Leapfrog to give them the five other
11 non-participating hospitals either in all of
12 Florida, which I believe is correct, or in the same
13 region that their cohort like scores had been
14 imputed in the old methodology or the new
15 methodology.

16 Q. You gave a couple options there with an
17 or, and so I just want to make sure.

18 A. Well, we -- we --

19 Q. Do you know which one of those it is?

20 A. I -- I -- I believe it's all the other
21 hospitals in Florida that non-participated, but I

1 would need to double-check that.

2 Q. And there's no footnotes here to indicate
3 that; is that correct?

4 A. Yes. Again, yes, I apologize. There
5 should have been a footnote to clarify that.

6 Q. And -- and why did you believe that this
7 is the appropriate comparison?

8 A. Well, in the spirit of more data rather
9 than less, I wanted to see how the other
10 non-participating hospitals were doing related to
11 the metrics that were standardly collected and I
12 wanted to see whether they were performing the
13 same, better or worse than the five hospitals to
14 try to give me some insight as to what -- what
15 happened on the nonresponse bias.

16 Meaning if the comparator hospitals are
17 performing better, then that indicates that these
18 five hospitals were poor-performing hospitals
19 independent of how they answered those seven or
20 four questions, and I -- I think that's what
21 Exhibit 6 shows.

1 Q. So do these five hospitals, was it
2 appropriate to -- to label them poor performers and
3 impute the lowest achievement score for the
4 five -- for the four imputed measures?

5 A. I --

6 MS. BLAIR: Objection to form. I don't
7 know who said they were poor performers.

8 THE WITNESS: Well, I actually think if
9 you look at Exhibit 6, there's a lot of green and
10 yellow and very little red, so I would argue that
11 those on the outcome metrics are doing well. But,
12 yes, I do think if they chose not to respond, they
13 may be underperforming on the bar code computer
14 physician order entry. Meaning there's a reason
15 they chose not to answer those questions.

16 BY MR. HVIDT:

17 Q. Could the reason they chose not to answer
18 those questions be unrelated from whether -- how
19 they would have performed on them?

20 MS. BLAIR: Objection to form, asked and
21 answered.

1 THE WITNESS: Yes. There -- it -- it
2 could tie to your prior argument. It could be due
3 to the fact that they're poor performing or it
4 could be driven by other hypotheses. Like it may
5 be a take -- they did not feel the juice was worth
6 the squeeze to report.

7 BY MR. HVIDT:

8 Q. So -- so here, these five hospitals are
9 non-participating hospitals and they have some
10 green and some yellow in the HCAHPS category and
11 PSI categories, and what you're saying is when
12 looking at that, you still think that they didn't
13 participate in the Leapfrog hospital survey because
14 they might be poor performers on the imputed
15 scores; is that correct?

16 A. That's correct.

17 Q. And you also looked at Plaintiffs' CMS
18 scores and said, Looking at their data where you
19 say, in your opinion, there's more red, the
20 reason -- the reason they didn't answer the imputed
21 scores and didn't participate in the survey is

1 because they were poor-performing hospitals and I
2 can make that determination looking at their CMS
3 measures; is that correct?

4 MS. BLAIR: Objection to form,
5 mischaracterizes his testimony.

6 THE WITNESS: I think what ties together
7 my testimony is that if a place chooses not
8 to -- to report, there's a higher probability that
9 they're not reporting because they're poor on that
10 measure than that they're not reporting because
11 it's too labor intensive for them to report or for
12 some other reason.

13 BY MR. HVIDT:

14 Q. When I asked that last question, you
15 responded, What ties my testimony together, and so
16 what I want to understand is how is it the case
17 that both sets of five hospitals here you can reach
18 the same conclusion from when they have differing
19 CMS scores?

20 MS. BLAIR: Objection to form,
21 mischaracterizes testimony.

1 THE WITNESS: So I'm saying that if I'm
2 one of the top -- if I'm one of the hospitals at
3 the top of Exhibit 6 that's poor performing, I know
4 I'm poor performing, and if I'm performing well on
5 the seven outcome -- seven process metrics, I would
6 want to report them because I know it's going to
7 get my score from an F and a D to, hopefully, a
8 better score.

9 Similarly, if I'm on the bottom and I'm a
10 high-performing hospital, if I know that I'm going
11 to be imputed a lower score and my scores are
12 better based on the green and yellow, I would say,
13 Well, I'll fill out the process metric so that then
14 I get an A or a B. If I don't fill out the process
15 metric, there's a chance -- and I don't know the --
16 I don't know the overall grades of the bottom five
17 hospitals, they had a C -- no, one sec. It says
18 they had a C grade or better.

19 So, yeah, if I'm a bottom hospital with a
20 B and I know my process metrics are better than the
21 mean, why wouldn't I report them? I would get up

1 to an A.

2 BY MR. HVIDT:

3 Q. So in both scenarios, you're saying that
4 if they had participated and they were better than
5 a lower achievement, their grades would change; is
6 that correct?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: I'm saying that they know
9 their data, they know how much time it takes them
10 to report the data, and if the data was going to
11 help them, whether you're a low-performing or a
12 high-performing hospital, you know what -- if the
13 data is going to help you, you'd report the data.

14 BY MR. HVIDT:

15 Q. How do you know the data? How are you
16 making that assessment that you know that the
17 hospitals will know how to answer the imputed
18 measures?

19 A. Well, because -- I mean, as a perfect
20 example, I have to look at the exact details, but
21 the hand hygiene metric relates to how many

1 observations you're making and what your compliance
2 is. So you already -- you -- you know whether you
3 have made an effort to collect that data and
4 whether you're focusing in on hand hygiene, and
5 then in a somewhat similar way -- and, again, I
6 think there's other experts like Dr. Classen who
7 understand this better, but you know whether you
8 meet the criteria of CPOE or bar code,
9 especially -- are you using bar code?

10 So as an example in one of the things,
11 they expanded the bar code to, oh, the
12 post-anesthesia unit. Well, you know whether
13 you're using a bar code or not. You know whether
14 you're going to make the investment to do that or
15 not, so you know whether you're going to score well
16 on that type of bar code or CPOE is -- is my
17 understanding.

18 Q. But do you under- -- do you have any
19 basis to know that the Plaintiff hospitals knew
20 what their data were for those measures?

21 A. Not that I reviewed.

1 Q. Okay. Looking at these exhibits lower in
2 your -- in your report and, in particular, Exhibit
3 6, do you see where it says not applicable for the
4 five other hospitals for several of the
5 infection-related measures?

6 A. Yeah.

7 Q. Do you have an understanding of why it
8 says not applicable?

9 A. Yeah, I'd have to double-check, but my
10 hypothesis would be that they do not have enough
11 denominator data for -- so as an example for
12 surgical site infection, they probably do not do
13 enough colon surgeries.

14 Q. Okay. So if these hospitals don't do
15 enough, see enough volume to have answers to those
16 measures, do you think that they're appropriate
17 comparators to the Plaintiff hospitals?

18 A. They're not -- if you're asking me for
19 the not applicable categories, are they -- should
20 they be compared across those categories? No.

21 The hospitals that have not applicable

1 should not be visually compared.

2 So what you're saying -- as an example, I
3 am not stating in Exhibit 6 that DeSoto Memorial
4 performs better on CLABSI than Delray Medical
5 Center. I would never say that, because their data
6 is not applicable, not available and not relevant.

7 However, I would say it's -- it's fair to
8 compare on like H-COMP-1 where DeSoto is in the
9 green and Palm Beach is in the red.

10 Q. Would -- are H-COMP scores impacted by
11 the number of patient volume that the hospitals
12 see?

13 A. Yeah. So I would need to triple-check
14 this, but H-COMP-1, H-COMP-2, H-COMP-3, H-COMP-4,
15 H-COMP -- no, H-COMP -- strike 4 -- 5 and 6 relate
16 to an HCAHPS survey.

17 The HCAHPS survey was designed by HRQ
18 originally. It's been used at least a decade.
19 It's a methodology -- I believe they're up to 29
20 questions now, but it's -- it's a methodology where
21 patients are randomly chosen to fill out a survey,

1 and -- and their responses to the survey yield
2 those scores.

3 And similar to what we've been talking
4 about today, those questions are revised. Those
5 questions are modified based on advisory panels,
6 and, yes, I think those questions are objective.

7 And, again, I don't -- not -- I
8 don't -- I'm sorry, the ques- -- your question was
9 basically, Does the denominator of people who fill
10 out those questions affect the validity of the
11 data? Yes, but my understanding is that the
12 HCAHPS' methodology requires a certain number of
13 people to answer it. So I think that if it's
14 reported in both groups, they've determined that
15 the methodology can be compared across different
16 sized hospitals.

17 Q. Are there studies that talk about how
18 HCAHPS scores are affected by -- clearly affected
19 by room sharing, that that can lead to negative
20 HCAHPS scores?

21 MS. BLAIR: Objection to form.

1 THE WITNESS: I'm not familiar -- I mean,
2 I was not asked to form my opinion on the HCAHPS
3 scores, because it's a little bit outside of my
4 expertise, but I do know the 29 questions. And I
5 would say that, yes, room sharing could affect a
6 patient's perception of their satisfaction on some
7 of these questions.

8 BY MR. HVIDT:

9 Q. And in this section in your report, other
10 than the copying of the CMS and CDC information
11 into these measures, did you do any other like
12 assessment of the Plaintiff hospitals?

13 MS. BLAIR: Objection to form,
14 mischaracterizes testimony.

15 THE WITNESS: If -- you're saying what
16 assessment did I do of the Plaintiff hospitals?
17 I --

18 BY MR. HVIDT:

19 Q. Yeah. Did you?

20 A. -- I think it's described in my
21 deposition what data I looked at and what I -- I

1 mean, it's all contained in here.

2 Q. Okay. So did you look at -- did you
3 visit the hospitals?

4 A. No, I did not.

5 Q. Did you look at the documents and the
6 data that they produced in this litigation?

7 A. I did not look at any additional data
8 than what I think I described today. I did not
9 look at the hospitals' websites. I -- I did not do
10 any of that in contrast to what I did for the
11 advisory group.

12 Q. Did you look at their patient population?

13 A. I did not look at the case mix of their
14 patient population.

15 Q. Did you look at their specialties or
16 accreditations?

17 A. I did not.

18 Q. Did you do any statistical analysis to
19 support your conclusion that Plaintiffs performed
20 worse than the national average?

21 MS. BLAIR: Objection to form.

1 THE WITNESS: Well, I -- I did not do
2 statistical analysis, but I deferred to statistical
3 analysis that was part of the HCAHPS score, the CMS
4 scores, the CDC scores.

5 BY MR. HVIDT:

6 Q. Looking at Exhibit 4 and 6, in the -- if
7 you look to the sixth columns on the right-hand
8 side, is it fair to say that the Plaintiff
9 hospitals did perform better than the hospital
10 average on some measures?

11 A. So there's --

12 MS. BLAIR: The six?

13 THE WITNESS: There's eight.

14 BY MR. HVIDT:

15 Q. The six far-right columns.

16 A. Oh, the far right.

17 Q. Starting with CLABSI and going over to
18 PSI 90, is it fair to say that there are measures
19 for each of the five Plaintiff hospitals on which
20 they performed better than the national average?

21 A. Yes. It's reflected by the green.

1 Q. And just quickly, CMS' star ratings are
2 different than Leapfrog grades; is that correct?

3 MS. BLAIR: Objection. Asked and
4 answered.

5 THE WITNESS: Yes. I mean, I have not
6 spent as much time looking at how CMS rolls up all
7 of their stuff into the star rating, but, yes, the
8 star rating is different than the grade rating.

9 BY MR. HVIDT:

10 Q. Setting aside Plaintiff hospitals, you
11 include here in your report on page 19 that -- or
12 strike that.

13 I would say that your -- your -- let's
14 read your last sentence on page 19, the beginning
15 of that -- of that full paragraph beginning, Thus.

16 A. Sorry, page 19?

17 Q. So --

18 A. Thus?

19 Q. Thus. Um-hum.

20 A. Thus, even if the assignment?

21 Q. And so is your opinion here that because

1 the four imputed measures account for 24 percent of
2 the overall rating, you say less than 25 percent,
3 that even if the assignment method was different,
4 that would not really affect the overall grades
5 that the Leapfrog group uses; is that correct?

6 A. Yes.

7 Q. And flipping now to your Exhibit 8 in the
8 next section, do you see your what if in the middle
9 column of grades?

10 A. Yes.

11 Q. And in your Exhibit 8, you assumed the
12 counterfactual where the Plaintiff hospitals
13 received the mean or some achievement on the
14 Leapfrog safety grade for the four imputed
15 measures; is that correct?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: Now, say that again because
18 I -- I don't think it's correct.

19 BY MR. HVIDT:

20 Q. Okay. So for your counterfactual, you
21 assigned Plaintiff hospitals the some achievement

1 score for the four imputed measures; is that
2 correct?

3 A. Not completely. I would say the
4 following: I still think that the advisory panel
5 experts are much more knowledgeable than me on
6 this, okay?

7 So the true counterfactual is the second
8 column, which is their current grade. The point of
9 this exhibit is to say, let's say the safety
10 committee is wrong, which is not what I say in --
11 in my expert testimony. I say, let's say they're
12 wrong. Let's try to adopt something where if
13 they're wrong, how much would it change the grade,
14 okay? And that's what that's getting at.

15 It's saying, look, I think nonresponse
16 bias leads to them underreporting and being poor
17 performance. I think the Leapfrog methodology is
18 correct and they should be assigned the least
19 achievement, but let's give them the benefit of the
20 doubt. Let's do a scenario that's probably the
21 upper-upper level of plausibility. That's the some

1 achievement, and let's see how much that impacts
2 the grade.

3 And to me when you compare the second
4 column to the third column, me personally, if I'm
5 in charge of the hospital, an F to a D, an F to an
6 F, a D to a D, an F -- an F to a D, assuming what's
7 not probably the counterfactual means that these
8 are underperforming hospitals. That's my
9 conclusion.

10 Q. In the exercise that you did in Exhibit
11 8, for the middle column, you gave the hospitals
12 the some achievement score for the imputed
13 measures; is that correct?

14 A. Yes.

15 Q. And when you did that, the grade for Palm
16 Beach Gardens from what it currently received to
17 what it received under that counterfactual became a
18 D instead of an F; is that correct?

19 A. That's correct.

20 Q. And when you did that for West Boca, it
21 became a D instead of an F, correct?

1 A. Correct.

2 Q. And when you did that for St. Mary's, it
3 became a C instead of a D; is that correct?

4 A. Correct.

5 Q. So for a majority of the five hospitals
6 that are in this case, when you -- in your
7 counterfactual when you changed the limited
8 achievement score for the imputed methodology to
9 some achievement for imputed methodology, it
10 changed the grade for the hospital; is that
11 correct?

12 A. Yes, that's correct.

13 Q. So seeing how a majority of the
14 hospitals' grades changed by one letter grade in
15 your exercise in Exhibit 8, how does that impact
16 your opinion at the end of section X where you say
17 that because they only account for 24 percent of
18 the overall rating, you wouldn't expect a
19 change -- an -- an effect in the overall grades if
20 there was a -- not a limited achievement
21 assignment?

1 A. Which sentence are you referring to?

2 Q. So the last sentence of that full, big
3 paragraph.

4 A. On what page?

5 Q. On page 19. You refer up to the fact
6 that --

7 A. Yeah, the non- --

8 Q. -- the four assignment -- the four
9 assigned struc- -- the four assigned structural
10 measures at issue in this litigation account for
11 less than 25 percent of the overall rating, do you
12 see that?

13 A. Yeah. Yeah.

14 Q. And then you say in the following
15 sentence, Even if the assignment method for these
16 four measures was not optimal, which I do not
17 believe to be the case -- excuse me, which I do not
18 believe is the case -- I just wanted to make sure I
19 got that right -- they would not really affect the
20 overall grades and conclusions due to the weighting
21 systems use by The Leapfrog Group?

1 A. Yeah, I still stand by that statement
2 because it doesn't says grades. It says grades and
3 conclusions, okay?

4 Q. But do you --

5 A. Palm Beach going from an F to a D changes
6 the grade. That doesn't change the conclusion that
7 it's a poor-performing hospital.

8 It's not like they're going from an F to
9 an A. It's not like they're going from an F to a
10 B. They're going from an F to the last -- to --
11 to -- to -- the -- another performing,
12 underperforming grade.

13 Q. You're a professor; is that correct?

14 A. Yes.

15 Q. What happens when a student gets an F?

16 A. Not many of my students get an F because
17 they're good students and I teach them properly and
18 they know -- have clear instructions of how not to
19 get an F.

20 Q. Under the rules of your institution, what
21 happens when a student gets an F?

1 A. They have to take the class again.

2 Q. What happens when a student gets a D?

3 A. I -- I don't know, to be honest, the
4 specific rules at the University of Maryland just
5 because we give grade-grades and there are
6 different bars, but if what you're getting at is
7 there's a difference -- in some criteria, there's a
8 difference again an F and D whether you need to
9 take a class again, yes, there's a difference.

10 Q. Okay. Do you understand that a consumer
11 of the general public might look at an F as meaning
12 I didn't pass the class?

13 MS. BLAIR: Objection to form.

14 BY MR. HVIDT:

15 Q. And might look at D as, passed. Didn't
16 do great, but passed?

17 MS. BLAIR: Objection to form, calls for
18 speculation.

19 THE WITNESS: Look, if you're going to
20 use the student analogy and my kid comes home with
21 a D and an F, they're not doing well. And I'm not

1 praising them for getting a D, and I'm probably
2 punishing them the same amount for a D or an F.

3 And I would say as a hospital
4 epidemiologist, if my hospital scored a D grade on
5 a Leapfrog, we're improving. And if they scored an
6 F, we're improving, and the amount of effort we're
7 doing to get out of a D or F category is the same
8 amount of effort.

9 And if I'm CMO or chief quality officer,
10 which is positions I chose not to take, I would
11 have that same advice, that if we're a D or an F,
12 we should be spending the same amount of time to
13 improve. That's just my thoughts.

14 BY MR. HVIDT:

15 Q. Hospitals can be trying to improve in
16 ways other than just participating in a Leapfrog
17 survey; is that correct?

18 A. That's absolutely correct, and, in fact,
19 that's exactly the advice I gave occasionally.

20 Meaning there are outcomes that mattered
21 as much or more to me and my hospital that were not

1 on Leapfrog, Vizient or CMS and we focused efforts
2 towards those because we thought they were
3 critically important.

4 So like as a prime example, right, tying
5 in your trauma orthopedic, right, at my hospital is
6 a trauma center. The surgical site infection rate
7 for open and closed fractures is not reportable.
8 It does not drive report cards. We focus efforts
9 on that because the infection rate in that is ten
10 and a half percent.

11 If you have an infection that's ten and a
12 half percent and it's not reportable and you're
13 doing a lot of volume, you should focus your
14 efforts on that instead of a hip or knee, which
15 would be .5 percent, but is reportable.

16 So, yes, you target things where you hope
17 you can improve patient outcomes the most whether
18 it's reportable or not.

19 Q. And focusing on the aspect of the point
20 here in your report, what we're trying to
21 understand is you -- you -- strike that.

1 You carved out conclusions when I asked
2 my prior -- prior question, and I just want to get
3 a clear point on the record.

4 Do you agree that because Exhibit 8 shows
5 that the grade changed for the majority of the five
6 Plaintiff hospitals when you assigned them some
7 achievement for the imputed measures, that even
8 though there's only a 25-percent impact on their
9 overall grade, that the assignment of value that
10 they get for those imputed measures affects their
11 overall grade?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: I agree that even though
14 it's 25 percent, the assignment of value can affect
15 their grade as defined by a letter change, a single
16 letter change.

17 BY MR. HVIDT:

18 Q. And a single letter change is when you
19 raise it from limited achievement to some
20 achievement, correct?

21 A. Yes.

1 Q. And that amount could be different if you
2 assign them something different, something higher
3 than some achievement; is that correct?

4 A. Yeah, that's what the last column aims to
5 represent.

6 Remember, we could have added a column,
7 right, that theoretically it could have been done
8 where you'd assign them zero, right. It could have
9 been a column even more extreme from a sensitivity
10 analysis point of view.

11 You could have added multiple columns,
12 right, as you broaden your sensitivity analysis?

13 Q. As it relates to assigning them zero, are
14 you aware whether any hospital that participated in
15 the Leapfrog hospital survey got a zero in 2025 or
16 2024?

17 A. That participated? I'm not familiar with
18 that data.

19 Q. Would it surprise you to know that no
20 hospitals have gotten below the limited achievement
21 scores that are assigned to hospitals that don't

1 participate in the Leapfrog hospital survey?

2 A. None got less than like 15 or 5? None
3 got any -- any numeric?

4 Q. Correct.

5 A. Well, I'd need to look at that data, but
6 it would be interesting data to look at.

7 Q. Do you understand that that data was
8 produced in this litigation?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: No, I -- I do not. I was
11 not or I am not or all variants.

12 BY MR. HVIDT:

13 Q. Do you think it's clear on Leapfrog's
14 website that whether a hospital participates or not
15 in the survey can impact their grade?

16 MS. BLAIR: Objection to form, outside
17 the scope.

18 THE WITNESS: Yeah, I -- I don't think I
19 can comment on that.

20 What I did look at was I looked whether
21 it was clear whether the value -- where the data

1 point came from and whether the data point was
2 imputed, and I cannot remember the exact
3 terminology they used, but it was clear to me that
4 there were data points where it was -- the -- the
5 data was clearly explained that it had not been
6 collected and was not provided by the hospital.

7 BY MR. HVIDT:

8 Q. Which website did you look at?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: I went on -- I went to -- I
11 went to Google, typed in Leapfrog initially and
12 just started spinning into all of their subsections
13 basically.

14 BY MR. HVIDT:

15 Q. Do you know if you were looking on the
16 Leapfrog hospital safety grade website or the
17 Leapfrog group website?

18 A. I'm not sure.

19 Q. Okay. Well, did you know that on the
20 Leapfrog website it's clear -- or strike that.

21 Do you know the Leapfrog website for each

1 hospital, it lists on there what the lowest score
2 assigned to a hospital in the country is for each
3 of the measures?

4 MS. BLAIR: Objection to form, outside
5 the scope.

6 THE WITNESS: Can you ask that question
7 again?

8 BY MR. HVIDT:

9 Q. Yeah. So on the Leapfrog
10 safety -- hospital safety grade website when you
11 type in a particular hospital, it goes to a page
12 and it has a breakdown of their scores, and when it
13 shows the score, it also shows what the
14 lowest-performing hospital got on an individual
15 measure?

16 MS. BLAIR: Objection to form. I don't
17 know what a performing hospital is. You keep
18 saying that.

19 BY MR. HVIDT:

20 Q. The lowest score that a hospital received
21 on an individual measure, it shows what that is.

1 Do you have any understanding as to that?

2 A. I understand, but I don't remember seeing
3 that.

4 Q. Okay. In -- in the section VII on page
5 22, you write that in your expert opinion -- I'm
6 sorry, strike that.

7 It is my expert opinion based on a
8 reasonable degree of professional certainty the
9 Leapfrog methodology is the closest to the truth.
10 Second column, do you see that?

11 A. Yes.

12 Q. And just so the record is clean, on what
13 basis do you make that opinion?

14 MS. BLAIR: Objection. Asked and
15 answered.

16 THE WITNESS: Yeah. I mean, it's -- it's
17 based on the advisory committee chose to do the
18 second column in contrast to the third column, and
19 it's based on the sentence that follows it, is that
20 the last column is the Nicholson method is flawed
21 based on assigning seven values instead of four

1 values and based on assignment to the mean.

2 So it's saying that the Nicholson column
3 is the poorest. The advisory panel had a lot of
4 expertise and access to a lot more data than I had.
5 They chose the least achievement, so I think that
6 is the closest to the truth.

7 The second column and the third column,
8 which is mine, is an effort at sensitivity
9 analysis.

10 BY MR. HVIDT:

11 Q. And is it your understanding that the
12 Leapfrog Safety Expert Panel in Leapfrog was trying
13 to assign non-participating hospitals a measure
14 closest to the truth when it assigned them the
15 limited achievement score?

16 A. Yes. I think that they were trying to
17 assign it closest to the truth of what it would be
18 if they had reported on the survey.

19 Q. And have you reviewed testimony or
20 evidence in the record that factually supports your
21 conclusion that that is what they were trying to

1 do?

2 A. As I mentioned previously, I reviewed why
3 they thought the mean was an incorrect method. I
4 reviewed what the classification was of those three
5 categories, and I reviewed the transcript of their
6 meetings.

7 Q. Did you review the Dr. Romano testimony?

8 MS. BLAIR: Objection. Asked and
9 answered.

10 THE WITNESS: I did not.

11 (Whereupon, Harris Deposition Exhibit No.
12 14, Rough Draft of Dr. Romano's Deposition, marked
13 for identification.)

14 BY MR. HVIDT:

15 Q. I am handing you, with the benefit of
16 some Post-It notes for guidance because there are
17 not page numbers on this, what is a rough
18 transcript of the deposition of Dr. Romano for ease
19 of coordination because that's all that is
20 available at this time.

21 MS. BLAIR: And I'll object to the use of

1 this document as it is a rough draft and not the
2 final, in addition to no foundation. He's never
3 seen it or read it, and he's not here to offer
4 opinions about Dr. Romano.

5 BY MR. HVIDT:

6 Q. Are you here to offer opinions about the
7 facts in the record, Dr. Harris?

8 A. The facts in which record? This?

9 MS. BLAIR: Yeah, that you have never
10 seen.

11 THE WITNESS: I need clarification on
12 that.

13 I -- I have not seen Dr. Romano's
14 deposition until now. I mean, other -- yeah.

15 BY MR. HVIDT:

16 Q. You were -- you mentioned that you
17 searched through Dr. Romano's deposition to look
18 for your name; is that correct?

19 A. Yes.

20 Q. Okay. Were you sent this document?

21 A. I sent it. I would have to check, but it

1 was Friday or Saturday night.

2 Q. Okay. If you could go to the Post-It tab
3 that's farther into the document?

4 A. One sec. Just to clarify the timeline.
5 It's important.

6 On Saturday, I was seeing patients all
7 day at the VA, as was I on Sunday. So that if the
8 document arrived Saturday -- I mean, the limited
9 work I've done this weekend on this was a one-hour
10 call with legal counsel and a one- to two-hour
11 call, as I stated, reviewing my expert opinion. So
12 the last --

13 Q. So if you look at that tab --

14 A. Yeah.

15 Q. -- there, do you see at the top where the
16 question says, and they are assigned values the
17 lowest amount?

18 A. No. It says -- I'm sorry, it says -- and
19 how -- oh, sorry. It's the next page. Are they
20 assigned values at the lowest amount? Yes.

21 Q. And then it says, Is that correct?

1 And the answer says, Correct?

2 A. Yes.

3 Q. And then the question says, And when
4 you're imputing measures, you're trying to estimate
5 what the missing data would have been had it not
6 been missing, is that fair?

7 And the answer is, Generally, yes.

8 Do you see that?

9 A. Yes.

10 Q. And then it goes -- says, But when you
11 were assigning data, you're no longer trying to
12 estimate what the value would have been, is that
13 fair?

14 Yes.

15 Do you see that?

16 A. I don't understand the difference between
17 those two questions, why Dr. Romano would have
18 answered them differently.

19 Q. And what do you mean by that?

20 A. It says, And when you're imputing
21 measures, you're trying to estimate what the

1 missing data would have been had it not been
2 missing, is that fair?

3 He answers, Generally, yes.

4 I would have answered generally -- I
5 would have answer, yes, to that as well.

6 Then the next question is, When you're
7 assigning data, you're no longer trying -- you're
8 no longer trying to estimate what the value would
9 have been?

10 He says, Yes.

11 No, that -- that answer contradicts what
12 he just said above. Assigning or imputing data is,
13 in essence, the same thing. Both -- both you're
14 trying to estimate what the value would have been
15 if it was missing, but both are the same.

16 Q. If you'd flip to the prior page with me?

17 A. Yeah.

18 MS. BLAIR: Like the prior marked page or
19 the prior --

20 BY MR. HVIDT:

21 Q. The -- just the same where you are, but

1 just flip it back. So --

2 A. How is that different than imputing? But
3 the page before.

4 Q. There -- there you go. Right there. And
5 then you look at the question there halfway down?

6 A. What's the difference --

7 Q. It says, What's the difference between
8 assigning and imputing?

9 Do you see that?

10 And then Dr. Romano answers on this
11 document, the rough,

12 It says, Well, assigning makes it clear
13 that the same decision, the same value is being
14 assigned to all facilities in that situation. The
15 same numerical score values.

16 So all -- the question, So all steps to
17 non-participating hospitals are assigned the same
18 values?

19 Correct.

20 And then he -- then the next question
21 says, And how is that different than imputing a

1 value?

2 And he -- and the answer says, Well, in
3 most imputation approaches, different missing data
4 points would be replaced with different values, not
5 all -- not necessarily all the same value.

6 So, again, as we described earlier that
7 imputation would -- could incorporate data on the
8 same measure from previous reporting cycles.

9 The -- it could use data other -- on
10 other measures from the same reporting cycle or
11 could use data on the same measure for other
12 hospitals. And then --

13 A. So -- oh, yeah. Okay.

14 Q. And so then he goes on to say, Is it fair
15 to say that post-2024 methodology for Leapfrog,
16 that the values assigned for those four measures
17 CPOE, BCMA, IPS and hand hygiene, are not imputed
18 measures?

19 And then Dr. Romano says, They're not
20 imputed value, no. They are assigned value.

21 And so after reviewing the testimony

1 that's portrayed here in the rough transcript, do
2 you have any understanding of whether Dr. Romano
3 considered Leapfrog to trying to be estimate --
4 trying to estimate the value that non-performing
5 hospitals would get by assigning them the lowest
6 possible score?

7 MS. BLAIR: Objection to form, calls for
8 speculation.

9 THE WITNESS: Can you repeat the
10 question?

11 BY MR. HVIDT:

12 Q. Dr. Romano, in response to a question
13 asking whether you're trying to estimate the value
14 of a score by assigning them the lowest achievement
15 score answered that they're no longer trying to do
16 that --

17 A. Well, where is that?

18 MS. BLAIR: Yeah.

19 BY MR. HVIDT:

20 Q. If you look over onto the assigning on
21 that page right there, the first question we went

1 over where you asked to reframe as to the
2 difference between assigning and imputing.

3 Do you see where it says, But when you
4 are assigning data, you're no longer trying to
5 estimate what the value would have been, is that
6 fair? Do you see that?

7 A. No, I don't, I'm sorry. I'm at the top
8 of a page that says, How is that different than
9 imputing a value? Where do you want me to go?

10 Q. If you look to the page over there --

11 A. Yeah.

12 Q. -- in the middle of the page it says:
13 'Question. But when you are assigning
14 data?

15 Do you see that?

16 A. Yeah. Yeah. Okay. So, yeah, this is
17 easy to answer.

18 I disagree -- well, first off, I want to
19 point out -- it's really important -- if you notice
20 the flow of questions, it has me reading something
21 two page back, commenting on it, two -- two page

1 ahead, then going back, then going forward. I've
2 never seen this document. It's nine-tenths into a
3 deposition. It's impossible -- my opinion is worth
4 nothing on this without reading it.

5 Q. If --

6 A. However, if you're asking me to say,
7 would I answer these questions about imputing and
8 assigning the way Dr. Romano did? Absolutely not.
9 Absolutely not.

10 Imputing and assigning is, to me, the
11 exact same thing. It's -- you're -- and -- and so
12 that the way -- that's why I objected early on to
13 say that the way he answers those two questions, in
14 my opinion, is wrong.

15 When you're imputing measures, here's how
16 would I answer: Where is the page where he's
17 saying imputing and assigning is different?

18 No. It's the same, and when you're
19 imputing measures, you're trying to estimate what
20 the missing data would have been had it not been
21 missing. I would say yes.

1 When you're assigning data, you're no
2 longer trying to estimate what the value would have
3 been? No, I don't agree with that.

4 Assigning and imputing data in this
5 scenario, you're trying to get at what the data
6 would have been had it not been missing.

7 His answer in the previous page relates
8 to the fact that he's correct in that
9 traditionally, you would not impute -- in most
10 imputations, you're not imputing the exact same
11 value for every single group, but that's true in
12 this method as well. They're not imputing 15 for
13 every single one. In some, they decided to impute
14 25. In some, they decided to impute five. That's
15 not the same imputation or assignment.

16 Q. But each hospital who is a
17 non-participant gets a 15 for one measure; is that
18 correct?

19 A. That's correct.

20 Q. And are you -- are you saying that you
21 think that the -- the representation that Leapfrog

1 is saying when it says it's assigning limited
2 achievement, it's not clear what the difference
3 would be between assigning of a limited achievement
4 versus imputation --

5 A. Yes.

6 Q. -- of it; is that correct?

7 A. That's correct. I'm -- I'm saying the
8 following: It's really important relevant to this
9 question, and it's pretty clear in my expert
10 opinion.

11 You're striving to get exactly as your
12 line of questioning alluded to. You're trying to
13 estimate what the missing data would have been had
14 it not been missing. That is absolutely correct.

15 And what you're saying is in the spring
16 of 2024, the method of them giving the mean values,
17 okay, is trying to get at what the missing data
18 would have been had it not been missing, and the
19 advisory panel comes to the conclusion that that's
20 not where it would have been and that it's flawed
21 and they need to revise the method to, using your

1 exact terminology, estimate what the missing data
2 would have been.

3 They come to the conclusion that the
4 closest to that missing data is least achievement.
5 Whether you call it imputing, whether you call it
6 assigning, they're trying to get as close to the
7 missing data.

8 Q. Do you understand that Dr. Romano
9 testified that they're not trying to get to the
10 estimated value?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: No. How would I? I
13 haven't read this.

14 BY MR. HVIDT:

15 Q. Okay. Do you understand that you are
16 being asked to apply your expert opinion to the
17 facts in this case?

18 A. Right, but that's exactly --

19 MS. BLAIR: Objection to form.

20 THE WITNESS: Yes.

21 MS. BLAIR: He's given limited opinions.

1 They're in his report.

2 You're asking him to give an opinion on
3 what Dr. Romano may or may not have said.
4 We're -- we're going far afield here.

5 THE WITNESS: Yes, based on what I'm
6 asked to give my opinion on, I'm saying that the
7 fall -- the spring 2024 old mean methodology is
8 flawed. It's far from the truth and that the
9 revised methodology is closest or closer definitely
10 to the data if it would have not been missing, and
11 whether you want to call that imputation or
12 assignment, it doesn't really change my opinion.

13 BY MR. HVIDT:

14 Q. And were you involved in the events that
15 led to the methodology change?

16 A. Was I involved?

17 Q. Yes.

18 A. No. I reviewed this data way -- I
19 reviewed this data for the first time in the last
20 week of August 2025.

21 Q. And the documents that are -- go into

1 your opinion are -- are listed in your report; is
2 that correct?

3 A. That's correct.

4 Q. Okay. So is there a specific document
5 that you can point me to that supports the notion
6 that the experts came to the conclusion that the
7 limited achievement score was selected because that
8 would be the one that would most accurately
9 represent the non-participating hospitals?

10 MS. BLAIR: Objection to form, asked and
11 answered.

12 THE WITNESS: I think what I've been
13 somewhat consistent with -- I mean, I wish I had
14 spent more time on this document in the -- in the
15 weekend before this, as I believe that was
16 reflected in the transcript, and based on my
17 experience of why hospitals would choose not to
18 respond to the survey.

19 Having done -- you know, having been at
20 hospitals that fill out surveys, yes, I have strong
21 feelings, which I think are accurate, about why a

1 hospital would not fill out the survey.

2 BY MR. HVIDT:

3 Q. And if you look -- if you want to look at
4 the transcript -- strike that.

5 If it's not in the transcript that you
6 looked at, is there any other document that you can
7 point to, to support the basis for your conclusion
8 that you think that the expert safety panel was
9 trying to come up with the accurate estimation of
10 what non-participating hospitals would have
11 received for the imputed measures by assigning them
12 the limited achievement scores?

13 A. Well, I think the commentary document
14 that we looked at as well tries to get at what does
15 the public think of the proposed measures and what
16 are the pros and cons of it and -- and taken -- if
17 you take the as -- the comments out that related to
18 length of time it takes, I personally, when I
19 reviewed those comments, saw very little criticism
20 of the imputation method other than the time that
21 it was going to spend, which is why I wrote that

1 section that said there were favorable comments.
2 Because I was asked to give my opinion mainly on
3 the imputation method because I think that's the
4 key to the case.

5 MR. HVIDT: Why don't we take a brief
6 break?

7 THE WITNESS: Thank you.

8 THE VIDEOGRAPHER: We are going off the
9 record. The time is 5:07 p.m.

10 (Recess taken -- 5:07 p.m.)

11 (After recess -- 5:29 p.m.)

12 THE VIDEOGRAPHER: We are back on the
13 record. The time is 5:29 p.m. This is media unit
14 number five.

15 MR. HVIDT: Thank you.

16 BY MR. HVIDT:

17 Q. Dr. Harris, if I could direct your
18 attention to Exhibit 2, which is your report, and
19 page 13, do you see that?

20 A. Yes.

21 Q. Okay. Do you see footnote 14?

1 A. Yes.

2 Q. Okay. Can you look up to the sentence
3 that precedes for the -- for which footnote 14 is
4 the citation? Do you see where it says, If these?

5 A. Yeah, I'm not sure what 14 is though.
6 It's like PBHN -- okay. Yeah, If these
7 non-participating hospitals.

8 Q. You -- you write, If these
9 non-participating hospitals believed they were
10 median or high performers, they would have spent
11 the required time to complete the survey. Do you
12 see that?

13 A. Yes.

14 Q. And you cite one document for that
15 support; is that correct?

16 A. Yes.

17 Q. And it's Bates labeled PBHN000002103, do
18 you see that?

19 A. Yeah.

20 (Whereupon, Harris Deposition Exhibit No.
21 15, Email dated January 28, 2025, marked for

1 identification.)

2 BY MR. HVIDT:

3 Q. I'm handing you a document that's been
4 produced in this litigation as PBHN000002103 as
5 Exhibit 15 in this deposition.

6 Have you seen this document before,
7 Dr. Harris?

8 MS. BLAIR: This -- this -- this document
9 is not Bates labeled that we're looking at?

10 MR. HVIDT: The copy that was printed
11 here does not include this Bates label.

12 BY MR. HVIDT:

13 Q. But are you comfortable proceeding with
14 this document? Dr. Harris, have you seen this
15 email before?

16 A. One second.

17 (Whereupon, there was a pause for
18 document examination.)

19 THE WITNESS: One sec. Are you saying
20 that this document should be labeled the same PBHN
21 number as reference 14? Because I -- I don't see

1 that parallel, and I'm really having problems
2 remembering what reference 14, PBHN2103 is.

3 BY MR. HVIDT:

4 Q. So the document in front of you as
5 Exhibit 15 you say --

6 A. Exhibit 15?

7 Q. Exhibit 15.

8 A. You just talked about exhibit -- oh, no.
9 Exhibit 15 is what, I'm sorry?

10 Q. Exhibit 15 is the email in front of you,
11 sir. Do you see that?

12 A. Yeah.

13 Q. Okay. And are you saying that Exhibit
14 15, as you just read it, does not support the
15 sentence for which it's cited in your report if
16 that is the right Bates number?

17 A. I'm asking for clarification to the
18 question. I have Exhibit 15 here.

19 MS. BLAIR: Um-hum.

20 THE WITNESS: Fifteen is not labeled the
21 same number as reference 14 or reference 15.

1 MS. BLAIR: Right.

2 THE WITNESS: So what's the question?

3 I don't know exactly what reference 14
4 and reference 15 is by the code number, because I
5 did that six weeks ago, and I'm not certain what
6 Exhibit 15 is.

7 BY MR. HVIDT:

8 Q. Okay. And so looking at the document in
9 front of you, does the document in front of you
10 support the statement in your report, If these
11 non-participating hospitals believe they are median
12 or high performers, they would have spent the
13 time -- the required time to complete the survey?

14 A. The sentence that I think does support
15 that statement is it says, I think we would need to
16 work on the CPOE and bar coding. Those are two of
17 the self-reported metrics, it says. I do believe
18 we could increase to a C, maybe a B -- implying
19 they were a D or an F -- if we resurveyed by June.
20 I think we would need to work on the CPOE and bar
21 coding. Patient experience brings us down

1 significantly.

2 Q. Okay. So --

3 A. So they are saying that -- yeah, they're
4 saying that they can move -- if they work on
5 things, implying that they're low performers, they
6 could bring their grade up.

7 So then if this email predates when they
8 then didn't report, yeah. Then it says, If these
9 non-participating hospitals believed they were
10 median or high performers, they would have spent
11 the required time to complete the survey, because
12 this email is implying they're not a high performer
13 in CPOE and bar coding, that they need to work to
14 bring it up.

15 If they brought it up and they report it,
16 maybe they could bring their grade up. So, yes, I
17 think it's this email, which I do not know whether
18 it's reference 14 or 15, does support the
19 statements I'm making at the age -- at the end of
20 page 13 of my expert opinion.

21 Q. Okay. Dr. Harris, let's point you to

1 where -- do you see this email is from And- -- an
2 Andrea Nunes?

3 A. Yes.

4 Q. Okay. And do you have -- understand that
5 through her signature you can see that she is at
6 West Boca Medical Center? Do you see that?

7 A. Yes.

8 Q. Do you have an understanding that West
9 Boca Medical Center is one of the Plaintiffs in
10 this case?

11 A. Yes.

12 Q. Okay. And then do you see that this
13 document is dated January 28, 2025?

14 A. Yes.

15 Q. Dr. -- Dr. Harris, you can look at the
16 document.

17 A. Yes.

18 Q. Okay. Thank you.

19 And do you see where Ms. Nunes says that,
20 I said, yes, we really received a D. Do you see
21 that in the third paragraph.

1 A. Yes.

2 Q. Okay. And then she says, I explained we
3 do not participate in the surveys and do not have
4 the benefit of adding additional information. Do
5 you see that?

6 A. Yeah.

7 Q. Okay. And then if you go down to the
8 last sentence where she says, I do believe we could
9 increase to a C, maybe a B if we resurveyed by
10 June, do you see that?

11 A. Yes.

12 Q. Is Ms. Nunes saying that the score was
13 negatively affected because West Boca Medical
14 Center did not participate?

15 MS. BLAIR: Objection to form, calls for
16 speculation, mischaracterizes the document.

17 THE WITNESS: No. I'd -- I'd like to
18 respond to this.

19 MS. BLAIR: Go ahead.

20 THE WITNESS: I would like to respond to
21 this, actually.

1 MS. BLAIR: It was just my objection.

2 THE WITNESS: Let me repeat exactly what
3 she said. She says, I do believe -- okay. So
4 first off, I've never seen this document before,
5 but I appreciate you giving me the context.

6 This is a person who's director of
7 clinical quality improvement. Meaning part of her
8 job is to have the hospital perform well, improve
9 patient outcomes, exactly consistent with the
10 mission of Leapfrog.

11 Her job -- I think her job also is to
12 know what the methodology is and to just follow it,
13 okay, which she clearly seems to based on her
14 understanding.

15 She then says, and I quote, "I do believe
16 we could increase to a C, maybe a B if we
17 resurveyed by June. I think we would need to work
18 on the CPOE and bar coding."

19 The conclusion of what she's saying in
20 those two sentences are, we are underperforming.
21 We need to raise our CPOE and bar coding score,

1 which we can improve, and that would lead to an
2 increase in our grade.

3 So I strongly object to your question,
4 which if you re-read it, implies that she's saying
5 that they got a bad grade because they didn't
6 respond. That's not what she's saying.

7 That's -- she's saying, We need to work
8 on things. We have a bad -- we would have a bad
9 score on CPOE and bar coding. We need to work to
10 get it up. And that makes perfect sense because
11 CPOE and bar coding is black and white. She knows
12 whether they have it or not, and so this strongly
13 supports exactly what I said. They chose not to
14 respond because they knew they were going to get a
15 bad score on CPOE and bar coding.

16 BY MR. HVIDT:

17 Q. Do you -- do you have any understanding
18 whether she was the one who made the decision
19 whether to participate in the survey or not?

20 A. No, not from this email.

21 Q. Is there anything in this email that says

1 that West Boca believes that it couldn't achieve a
2 C or a B if they participated in the survey?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: Yeah. They -- yes. It's
5 saying that at the level they're performing now,
6 they would get a D, that they have to make efforts
7 to get up to a C or B.

8 So it's saying that -- to -- to me, it's
9 pretty clearly saying the D was deserved and they
10 need to make an effort to get up to a C or B, not
11 that their not response to the survey gave them a
12 D. And that's reiterated in the last sentence,
13 Patient experience brings us down significantly.
14 That has nothing to do with nonresponse. That has
15 to do with why they're scoring so poorly on another
16 metric as well.

17 BY MR. HVIDT:

18 Q. And so you are not interpreting that
19 sentence to mean that she -- they could get from a
20 C to a B if they worked on those measures?

21 MS. BLAIR: Objection. Asked and

1 answered.

2 THE WITNESS: No, that's exactly what I'm
3 saying. They need to improve the metrics
4 dramatically between the email date of January
5 28th, 2025 and June of that year.

6 It's not giving any implication of
7 how they -- I mean, it's not saying that they were
8 wrong by not nonresponse survey.

9 (Whereupon, Harris Deposition Exhibit No.
10 16, Document Bates Numbered PBHN000002103, marked
11 for identification.)

12 MS. BLAIR: Are you going to mark this?

13 MR. HVIDT: I'm --

14 BY MR. HVIDT:

15 Q. I'm handing this to you as Exhibit 16 to
16 your deposition.

17 Do you see that document in front of you,
18 Dr. Harris, that's marked as PBHN000002103?

19 A. Sorry, where is that number?

20 MS. BLAIR: Way at the bottom here on the
21 bottom right (indicating).

1 THE WITNESS: Yeah.

2 BY MR. HVIDT:

3 Q. Is that the same number as the footnote
4 14?

5 A. Yes.

6 Q. And is -- and you just testified that you
7 hadn't seen this document before; is that correct?

8 MS. BLAIR: Objection to form. He didn't
9 say that.

10 THE WITNESS: No, that's not what I said.

11 I said that I was looking for
12 clarification of whether this document was
13 reference 14, because I don't remember six weeks
14 later what PBHN000002103 is. I mean, I do not have
15 an encyclopedic, binary code memory.

16 This document is sent one minute apart it
17 looks like. Exhibit 16 says --

18 MS. BLAIR: Oh, yeah.

19 THE WITNESS: -- 11:34:10 p.m. Exhibit
20 15 says 11:34:11 p.m.

21 MS. BLAIR: Weird.

1 THE WITNESS: The substance is very
2 similar, the format is different, which is exactly
3 why I'm asking for that specific clarification,
4 because you now have two emails sent one minute
5 apart and you're asking me which document was 14.
6 But irrespective of that --

7 BY MR. HVIDT:

8 Q. The substance --

9 A. -- the substance is the same and exactly
10 supports what I wrote based on my answer to the
11 prior question.

12 Q. And that's the only document you cite for
13 that statement; is that correct?

14 A. Well, I still don't understand what 15
15 is, because we're talking about two sentences. I
16 would like to see LEAPFROG00178624 to -- to refresh
17 my memory as to what led to that other sentence.

18 Q. Footnote 15 is at -- at the end of a
19 different sentence; is that correct?

20 A. Yes.

21 Q. Okay. And to clarify, that's a

1 one-second difference in the tab, the coloring
2 thing. It's the same document; is that correct?

3 MS. BLAIR: Yeah.

4 BY MR. HVIDT:

5 Q. It's not meant to be a --

6 A. Yeah, it appears --

7 Q. -- maybe the printing left off the
8 document.

9 A. Yeah, it appears to be the same
10 document, --

11 Q. Okay.

12 A. -- but -- but if this is reference 14, it
13 supports on page 13 the last -- this email
14 completely supports, in my opinion, the last three
15 sentences of my expert testimony.

16 Q. And you recognize that she believed in
17 writing that -- strike that.

18 You recognize in her email she references
19 the notion that they could improve their grade if
20 they participate in the hospital in that email; is
21 that correct?

1 MS. BLAIR: Objection to form, asked and
2 answered.

3 THE WITNESS: No.

4 MS. BLAIR: Mischaracterizes testimony.

5 THE WITNESS: That's -- yeah,
6 that's -- that's incorrect. She's acknowledging
7 exactly what I said.

8 If these non-participating hospitals
9 believed they were median or high performers, they
10 would have spent the entire time to complete the
11 survey. It was advantageous for the
12 poor-performing hospitals to decline reporting so
13 they would be assigned the cohort median values
14 that are higher than their likely actual values.
15 This would falsely favorably bias their scores on
16 these structural measures.

17 The two sentences you asked me to comment
18 on and in this email pretty much says that exact
19 same thing.

20 It says, I do believe we could increase
21 to a C, maybe a B if we resurveyed. We would need

1 to work on the CPOE and bar coding.

2 Well, if they need to work on a CPOE and
3 bar coding, they're not performing at the median
4 level. They wouldn't need to would work on
5 anything if their scores were higher. Hence, they
6 knew their scores were poor and chose not to
7 report. That's exactly what this email implies,
8 exactly.

9 BY MR. HVIDT:

10 Q. Is it possible that she was referring
11 there to the answer we would need to work on those
12 scores because they are being imputed at a
13 low-performing measure?

14 MS. BLAIR: Objection to form, calls for
15 speculation, mischaracterizes the document, asked
16 and answered.

17 THE WITNESS: I -- I wouldn't -- no,
18 I -- I don't -- I don't agree with that conclusion.

19 BY MR. HVIDT:

20 Q. Okay. Let's put that to the side and go
21 to Exhibit 7. Exhibit 7 is --

1 A. My CV.

2 MS. BLAIR: No, hang on.

3 THE WITNESS: No, not.

4 BY MR. HVIDT:

5 Q. Exhibit 7 is the expert report of
6 Professor Sean Nicholson, do you see that?

7 A. Oh, I'm sorry. Yes, you're correct.

8 Q. Okay. And earlier you testified that all
9 your -- that you had reviewed the -- this report;
10 is that correct?

11 A. Yes, I reviewed portions of this.

12 Q. You did not review the entire report?

13 A. I read the entire report. It was very
14 lengthy.

15 As I indicated in a prior response, I
16 spent ten and a half hours on all of the documents
17 that were provided, so I do not know the exact
18 amount of time I spent on this document, but it
19 was -- it was not exhaustive.

20 Q. And does your report include all of your
21 opinions as it relates to the Nicholson report?

1 A. Well, the -- the main point I was making
2 relates to once I saw the imputation of seven
3 outcome metrics, it seemed like a low priority for
4 me to focus on other aspects of his expert opinion.

5 Q. My question is slightly different.

6 Is there anything in your report -- is
7 there anything that you are offering an opinion on
8 in this case, other than what's in your report, as
9 it relates to the Nicholson report?

10 A. Just give me one minute, please.

11 (Whereupon, there was a pause for
12 document examination.)

13 THE WITNESS: No. I am just commenting
14 on what I put in my opinion, my expert opinion
15 relative to 11, Nicholson's recalculation. I'm not
16 commenting on any other aspect of his expert
17 report.

18 BY MR. HVIDT:

19 Q. Okay. So if you flip in Exhibit 7 to the
20 section Foundational Principles for Measuring
21 Hospital Quality, do you see that on page 11?

1 A. Yep.

2 Q. Is it fair to say that in your report,
3 you don't offer any opinions as it relates to
4 Professor Nicholson's report in this section?

5 A. That's correct.

6 Q. And if you look at -- if you look
7 at -- on page 15, section VIII, Hospital ratings
8 Influence Patient Decisions About Medical --
9 Medical Care and Misleading Hospital Grades Can
10 Distort Patient Choices, Causing Substantial Harm.
11 It carries forward all of the way on to -- ending
12 on the top of page 21. Do you offer any opinions
13 in response to this section?

14 A. Opinions now?

15 Q. In your report.

16 A. In my report relative to section VIII?

17 Well, I -- I don't know the section where
18 he has the two references that I do offer an
19 opinion on, and I guess in a somewhat -- so, no,
20 I -- I do not believe I -- I do not believe I offer
21 an opinion on section VIII on page 15 through 21.

1 Q. Then if you flip to section X B -- so
2 section X begins on 27, and then 10 B begins on
3 page 30. Let me know when you're there.

4 A. I'm -- I'm at page 27, section X. Do you
5 want me to go to page 30?

6 Q. Yes.

7 A. Yeah.

8 Q. Do you see TLG's Rating System Results in
9 Inappropriately Inflated Grades for Hospitals
10 That -- That Choose to Participate in Its Survey
11 and Inappropriately Deflated Grades for Hospitals
12 That Choose Not Participate? Do you see that?

13 A. Yes.

14 Q. Okay. If you look at Exhibit 1 in this
15 section, do you offer any opinions as it relates to
16 Exhibit 1?

17 A. Well, yes, I do, because on page 35,
18 that's the Hwang article, and then --

19 Q. So Exhibit 1 is on page 31. Do you see?

20 A. No. I -- what?

21 Q. Exhibit 30 --

1 A. Oh, Exhibit 1 specifically?

2 Q. Yes.

3 A. Okay. I'm sorry.

4 (Whereupon, there was a pause for
5 document examination.)

6 THE WITNESS: I did not in my expert
7 opinion specifically offer an opinion on Exhibit 1.
8 BY MR. HVIDT:

9 Q. If you flip to Exhibit 2 on the next
10 page, --

11 A. Exhibit 2.

12 Q. -- do you offer any expert opinion in
13 your report as it relates to Exhibit 2?

14 A. I did not.

15 Q. If you look at Exhibit 3 on the next
16 page, did you offer any expert opinion as it
17 relates to Exhibit 3?

18 A. Well, yes, in that the title says, TLG
19 Assigns Non-Participating Hospitals the Lowest
20 Possible Scores on Four Process Measures. I do
21 offer an opinion on those -- those scores, and I

1 agree with those green scores of what's done.

2 I did not offer an opinion on the latter
3 half of that exhibit related to while participating
4 hospitals self-report very high scores, I didn't
5 have the data to comment on that.

6 Q. And you -- you referenced how your report
7 refers to two articles. Do you want to flip
8 to -- back to your report, Exhibit 2, for a moment?
9 And I believe it's on the last -- the second to the
10 last page of the -- of Exhibit 2's -- your report
11 substance, so page 23. Let me know when you're
12 there.

13 A. I'm at the page.

14 Q. And you were referencing the Hwang
15 and -- and Smith articles; is that correct?

16 A. Yep.

17 Q. And you -- you -- you reference that
18 these papers have scientific merit, do you see
19 that?

20 A. Yep.

21 Q. And so do you agree that the context

1 where they were -- where they had scientific merit?

2 A. Can you repeat the question?

3 Q. Like do you agree with what you write
4 here that those papers have scientific merit and
5 that they were peer -- they went through a
6 peer-review process, those undertaken before they
7 were accepted?

8 A. Yes. The -- yes, I'm familiar with both
9 journals, and they both require the peer-review
10 process. Both journals are well respected.

11 I also know in the Shawna Smith article
12 the last author, I believe, is Jennifer Meddings,
13 and I have -- I believe I may even have published
14 with her, and her work is of high quality.

15 Q. And you -- the -- the only criticism you
16 reference of those in your report is that
17 they -- they relate to a methodology Leapfrog no
18 longer uses; is that correct?

19 A. Yes. So the -- the -- the -- like I
20 said, I have the utmost of respect for Jennifer
21 Meddings, and so that article is published in

1 Medical Care. I spent about 30 minutes reviewing
2 the paper.

3 Just so you know to review a paper
4 properly, like if there's going to be a series of
5 lines of questions related to that, it requires
6 like four or five hours, okay? Because she
7 actually ran a ton of sensitivity analyses.

8 Like I alluded to, I think she published
9 with me other stuff. Her work is of high quality,
10 so I'm -- I'm fairly confident to say that that
11 2017 article was of high quality.

12 The Journal of Hospital Medicine I'm
13 familiar with as well, and so I'm -- I spent only
14 about 10 or 15 minutes on that paper, but it seemed
15 fine.

16 As -- as we alluded to in one of my -- in
17 one of my key points, the -- the field of
18 methodology evolves a lot over a seven- or
19 eight-year period, and definitely over an 11-year
20 period, which is why the statement, The field of
21 hostile outcomes, metrics and risk adjustment has

1 evolved tremendously since the time of these
2 publications were authored, and so I -- I agree
3 that these were good manuscripts at the time they
4 were done, but they're not relevant to the case at
5 this point in time.

6 And it says, Therefore, Dr. Nicholson's
7 reliance on this outdated meth- -- methodology was
8 inappropriate for attempting to assess the current
9 Leapfrog methodology; I agree with that.

10 Q. Is there anywhere in the Nicholson report
11 where Nicholson cites those papers as if they
12 are -- in -- in a manner that is citing them as if
13 they are -- their data or analysis is applying to
14 the current methodology?

15 So to say it differently, like, does
16 Dr. -- does Professor Nicholson cite them for
17 points for which those papers do not support the
18 point he is citing them for?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: Yeah. Yeah, I do.

21 I think that the statement on page 40, it

1 says, It is also contradicted by both Hwang and
2 Smith as thus dis- -- as thus discussed above.
3 Smith found no statistically significant
4 differences between hospitals that chose to
5 participate in TLG's hospital survey and those that
6 did not in terms of sev- -- several patient
7 outcomes measured by CMS.

8 I think that statement is strongly
9 implying and building his case that that -- that is
10 still relevant to today, and it's not.

11 BY MR. HVIDT:

12 Q. Do you have any basis to say that there
13 is not any updated study that has assessed whether
14 there is statistically significant differences
15 between the hospitals that choose to participate in
16 Leapfrog's hospital survey and those that do not?

17 A. Can you repeat that question?

18 Q. Yeah. Is there any significant data
19 analysis since 2017 that could be -- that relates
20 to whether there's -- there's a
21 statis- -- statistically significant difference

1 between hospitals that choose to participate in
2 Leapfrog's hospital survey and those that do not?

3 A. No, but her methodology of papers is
4 completely different. The outcomes are different.
5 The risk adjustment is different.

6 I can definitively say that the
7 methodology used for risk adjustment in 2017 for
8 some of these CMS outcome metrics is dramatically
9 different than in 2024.

10 Q. And would the -- there's -- there's also
11 differences as it relates to the imputation
12 methodology since then; is that correct?

13 A. Correct.

14 Q. And the imputation methodology since
15 then, back -- back then, there was -- there was use
16 of a different data source for those measures if
17 the hospital didn't participate in the Leapfrog
18 hospital survey, do you understand that?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: I mean, at some point in
21 the documents I reviewed today, there's a thing

1 related to, I think, the American Hospital
2 Association, but that supports my point, which is
3 basically, the -- these papers are using a
4 completely different methodology, which is why
5 I -- I don't think they support or are against.

6 I'm asked to comment on the methodology
7 that's being used in 2024 and 2025, and that's what
8 I commented on.

9 BY MR. HVIDT:

10 Q. And in that sentence, there does -- does
11 Dr. -- does Professor Nicholson say that that
12 study, you know, was applied in 2024 or does he
13 cite it as a -- with its date that -- that it was
14 applied in 2017?

15 MS. BLAIR: Objection to form, asked and
16 answered.

17 THE WITNESS: No, he doesn't -- he
18 doesn't state that he applied it to 2024 data.

19 BY MR. HVIDT:

20 Q. Do you offer any opinion in your expert
21 report whether Leapfrog's methodology disadvantaged

1 non-participating hospitals even before the 2024
2 imputation change?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: Can you say --
5 disadvantage, like can you clarify that part of the
6 sentence, please?

7 BY MR. HVIDT:

8 Q. Yes. So in Professor Nicholson's report,
9 one of his opinions relates to how, in his expert
10 opinion, he believes that Leapfrog's methodology
11 disadvantaged non-participating hospitals even
12 before the fall 2024 imputation methodology change.

13 Does your expert report offer any opinion
14 as it relates to that opinion of Dr. -- of
15 Professor Nicholson?

16 MS. BLAIR: Objection to form and can you
17 point to what page of Exhibit 7 you're referring
18 to?

19 MR. HVIDT: If you look beginning on page
20 34, paragraph 63, carrying forward.

21 THE WITNESS: Thrity-four?

1 BY MR. HVIDT:

2 Q. Yes, through Exhibit 4 on page 36.

3 MS. BLAIR: I'm just going to object to
4 form then, because he's -- this is talking about
5 two methodologies ago and you said in the spring of
6 2024 previously.

7 THE WITNESS: One sec. Your question was
8 about the methodology before the change, but page
9 34 is referring to the methodology of imputing the
10 lower number. So where is this sentence referring
11 to --

12 BY MR. HVIDT:

13 Q. So beginning on page 63 -- I mean,
14 beginning on page 34, paragraph 63.

15 A. Oh, even prior to adopted.

16 Q. Yeah. And so what my question was aimed
17 at doing was not referring to a specific
18 methodology, but was that -- I was trying to
19 understand if you offered in your report an opinion
20 that was responding to or disagreeing with or
21 supportive of Professor Nicholson's report, expert

1 opinion that even before the methodology change in
2 fall -- in 2024, the methodology -- the Leapfrog
3 methodology penalized non-participating hospitals?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: Yeah, so point 63, which
6 talks about the HA survey, I did not give an
7 opinion on.

8 Point 64 talks about the Hwang study,
9 which I just commented on that I thought was
10 outdated methodology and not apple- -- applicable.

11 The direct question is, Do I think that
12 the prior methodology penalized the hospitals?

13 No. I state the exact opposite. I said
14 the Leapfrog Safety Grade Expert Panel correctly
15 concluded that assigning the median to these four
16 measures would be incorrect. Thus, it is my
17 opinion to a reasonable degree of professional
18 certainty that the methods of assignment were
19 correct, and that's basically saying not only do I
20 not agree with Nicholson that they were formally
21 penalized, I think they were formally -- form,

1 formerly given too high a score by the medians. I
2 don't think they were penalized. I think they were
3 unduly praised.

4 BY MR. HVIDT:

5 Q. And did -- does your report include any
6 data analysis or scientific method that you applied
7 to reaching that conclusion?

8 A. No. It's the non -- non -- the
9 scientific method is based on the nonresponse bias
10 and the direction -- the direction that the
11 nonresponse bias would likely lead.

12 So the scientific method when you have a
13 bias is you hypothesize what direction the true
14 data lies and then you come to conclusions of where
15 it's going to go.

16 So, yes, I used the scientific method
17 that the nonresponse bias probably led to the
18 median score -- mean scores being too high and that
19 the direction of change would have been lower. So
20 related to your question, they were not penalized.
21 They were overly valued, given too high of scores.

1 Q. Just to reiterate, are there any opinions
2 that you intend to offer in this litigation as it
3 relates to the Professor Nicholson report that
4 aren't stated in your report?

5 A. No.

6 (Whereupon, Harris Deposition Exhibit No.
7 17, Publication - A Survey on Handwashing Practices
8 and Opinions of Healthcare Workers, marked for
9 identification.)

10 BY MR. HVIDT:

11 Q. I'm handing you what's been marked as
12 Exhibit 17 to this litigation.

13 A. Whoa, this one is old.

14 Q. Dr. Harris -- Dr. Harris, is Exhibit 17 a
15 publication in the Journal of Hospital Infection
16 from 2000 that you participated in -- in preparing
17 titled A Survey on Handwashing Practices and
18 Opinions of Healthcare Workers?

19 A. Yes. I was a first author, so I was
20 responsible for survey design, survey analysis and
21 manuscript writing under the direction of Dr. Yuda

1 Carmeli, who was a collaborator of mine when I was
2 doing an infectious disease fellowship at the Beth
3 Israel Deaconess of Harvard.

4 Q. And do you agree -- as it relates to when
5 this was published in 2000, did you disagree with
6 anything in it at that time?

7 A. No. At the time I published it -- it's
8 been a while, it's 25 years -- no, the -- I stand
9 by the authenticity of the data, the analysis and
10 the conclusions.

11 Q. And if you flip to the Discussion
12 section, do you see under the Discussion section
13 where it -- there's a paragraph at the end that
14 says, This survey demonstrates?

15 MS. BLAIR: I don't think he's there yet.

16 BY MR. HVIDT:

17 Q. Oh, I'm sorry.

18 A. One sec. If you'll just give me a quick
19 sec. I mean, this was -- this is one study. I
20 have 370 studies now. This one was 25 years ago.

21 I -- I do remember this one because it

1 was one of my first 20, but I just want to
2 refamiliarize myself.

3 (Whereupon, there was a pause for
4 document examination.)

5 THE WITNESS: Yes, okay. Discussion.

6 BY MR. HVIDT:

7 Q. Do you see the paragraph that
8 says -- that starts, This survey demonstrates?

9 A. Yes.

10 Q. Okay. If you look down to the sentence
11 that carries forward on the next page, do you see
12 where it says, Only 2 percent of respondents
13 reported that they washed their hands less often
14 than peers and only 3 percent reported washing
15 their hands less than 75 percent of the time? Do
16 you see that?

17 A. Yep.

18 Q. And then if you go two sentences forward,
19 it says, One ex- -- one possible explanation, do
20 you see that?

21 A. Yeah.

1 Q. And then the second sentence after that
2 says, Another explanation is that healthcare
3 workers are likely to overestimate their compliance
4 with handwashing. Do you see that?

5 A. Yeah.

6 Q. You can set that to the side for the
7 moment.

8 (Whereupon, Harris Deposition Exhibit No.
9 18, Publication - Automated Hand Hygiene Count
10 Devices May Better Measure Compliance Than Human
11 Observation, marked for identification.)

12 BY MR. HVIDT:

13 Q. I'm handing you what's being marked as
14 Exhibit 18 to your deposition Dr. Harris.

15 Does Exhibit 18 appear to be an article
16 in the American Journal of Infection Control --

17 A. Yes.

18 Q. -- from 2012 titled Automated Hand
19 Hygiene Count Devices May Better Measure Compliance
20 Than Human Observation?

21 A. Yep.

1 Q. Are you one of the authors of this?

2 A. Yes, I am.

3 Q. And if you -- do you see in the paragraph
4 that begins on the first column, but then moves
5 over to the second on the first page where there's
6 a sentence that starts, The widely accepted?

7 A. I'm sorry, which?

8 MS. BLAIR: Where?

9 THE WITNESS: Oh, yes, Widely accepted
10 gold standard.

11 BY MR. HVIDT:

12 Q. Can you read that aloud, please?

13 A. The widely -- the widely accepted gold
14 standard for hand hygiene compliance measurement is
15 direct observation, although the Joint Commission
16 and other groups recognize electronic monitoring as
17 an acceptable method for estimating hand hygiene
18 compliance.

19 Q. Does The Leapfrog Group conduct any
20 direct observation of hand hygiene measures that go
21 into the Leapfrog safety grade score?

1 MS. BLAIR: Objection to form, outside
2 the scope, but if he knows.

3 THE WITNESS: Yeah, I'd have to review
4 the Leapfrog definition of their hand hygiene
5 structural and process metric.

6 I -- I do want to comment on a couple
7 points there.

8 BY MR. HVIDT:

9 Q. There's no -- there's no question
10 pending, Doctor.

11 A. This is an article from -- okay. But
12 this is an article from 2012.

13 So for the same reasons that I
14 object -- I mean, I've got to be consistent here to
15 feel this has evolved a lot in automated hand
16 hygiene and the field has evolved a fair amount as
17 well about, you know, healthcare workers'
18 attitudes, so I think it establishes the importance
19 of hand hygiene, but these articles are fairly old.

20 Q. Do you have any understanding whether The
21 Leapfrog Group does any electronic monitoring of

1 hand hygiene?

2 A. I -- as I answered the last question, to
3 be consistent, I am not familiar with the exact
4 definition, and I was not provided that in the
5 documents that I reviewed.

6 Q. It's an article that you wrote; is that
7 correct?

8 A. Which?

9 MS. BLAIR: Wait.

10 BY MR. HVIDT:

11 Q. The one before you.

12 A. No. I'm talking about --

13 Q. Strike that. Strike that. I'm sorry, I
14 understand now what you're saying. Okay.

15 MR. HVIDT: Can we get 34, please?

16 (Whereupon, Harris Deposition Exhibit No.
17 19, Publication - Is there a Correlation Between
18 Infection Control Performance and Other Hospital
19 Quality Measures, marked for identification.)

20 BY MR. HVIDT:

21 Q. I'm handing you what's been marked as

1 Exhibit 19 in this deposition.

2 Do you see Exhibit 19 as a 2017
3 publication in Infect -- is that Infectious Control
4 Hospital --

5 A. Infection Control in Hospital Epi.

6 Q. Okay. And the title is, Is There a
7 Correlation Between Infection Control Performance
8 and Other Hospital Quality Measures? Do you see
9 that?

10 A. Yes.

11 Q. And are you one of the authors to this?

12 A. Yes, I'm the last author.

13 Q. Okay. In the Abstract, do you see where
14 it says, Quality measures are increasingly reported
15 by hospitals to the Centers for Medicaid &
16 Medi- -- Medicare & Medicaid Services, CMS, yet
17 there may be trade-offs in performance between
18 infection control and other quality measures? Do
19 you see that?

20 A. Can you repeat the question, the exact
21 sentences?

1 Q. Yes. Under Abstract on the first
2 page, --

3 A. Yeah.

4 Q. -- do you see the language that's listed
5 above the line there?

6 A. Yeah.

7 Q. And then it goes on to say, Hospitals
8 that perform best on --

9 A. Yeah.

10 Q. -- infection control measures do not
11 perform well on most CMS non-infection control
12 quality measures. Do you see that?

13 A. Yes.

14 Q. Okay. And so is that -- in an Abstract,
15 are you trying to -- that's a -- something you
16 observe, folks observe and you're trying to get an
17 understanding as to why that is; is that correct?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: I -- I think -- I think the
20 correct points is the following: And this is
21 consistent with the last ten minutes of

1 questioning.

2 This article in 2017 is correct. I stand
3 by the conclusions. I stand by the analysis. I
4 stand by the internal validity of the data and
5 analysis.

6 However, as I alluded to in the Hwang and
7 Smith articles, for the same reason that I stand by
8 those articles, but say that they are not
9 applicable to the current situation, I say the
10 exact same thing, that this paper involved
11 different calculations of infection control
12 measures, different calculations of the other
13 quality measures, and conclusions of what was true
14 in 2017 in this paper may not be true in 2025. And
15 this does not involve the Leapfrog methodology.

16 BY MR. HVIDT:

17 Q. And if you go to page 3 under Results, do
18 you see where it says, Hospitals that perform best
19 on infection control measures did not perform well
20 on most CMS non-infection control quality measures?
21 Do you see that?

1 A. Yes.

2 Q. Okay. And then if you flip to the last
3 page, do you see where the first sentence there on
4 the first full sentence on that page is?

5 A. Which last page?

6 Q. On page 4 of the document.

7 A. Yeah.

8 Q. Okay. Do you see where it says, The
9 reasons for lack of observed correlations are
10 likely multifactorial and may include the
11 following:

12 1. Hospitals have insufficient resources
13 to tackle multiple hospital quality measures and
14 thus focus only on a few.

15 2. Some hospital quality measures should
16 be re-evaluated regarding their causal relationship
17 to quality.

18 3. Better risk adjustment must be done
19 for quality measures to ensure that hospitals with
20 complex patient populations are not inappropriately
21 penalized for metrics, such as infection rates.

1 Do you see that?

2 A. Yes.

3 Q. Did you agree with that in 2017?

4 A. Yeah. I still agree with that today.
5 That's consistent with the first main-opinion point
6 I make, which is that while no methodology is
7 perfect, Leapfrog takes great pains to consult with
8 the leading experts in the country to create a
9 methodology that is reasonable and ethical in light
10 of the ever-changing landscape of the health
11 industry standards and available data.

12 This is exactly what I told the legal
13 counsel and I told Leapfrog when they first hired
14 me.

15 I have a number of publications like this
16 that criticize risk adjustment methodology used by
17 the CDC and CMS and I chose to do that stuff as a
18 goal of continuing to move the landscape forward,
19 and that's why if they wanted my opinion on whether
20 I thought Leapfrog was moving the landscape
21 forward, that's the crux of the angle.

1 Is the new methodology better than the
2 old methodology? Yes.

3 Is it applied transparently? Yes.

4 Is the method perfect? No.

5 My point in this paper in 2017 is, still
6 holds true related to those discussion points that
7 I say. We need better risk adjustment, and some
8 hospitals may perform well on some metrics and not
9 on others.

10 Q. We were looking at one of the -- we were
11 talking a moment ago about hand hygiene.

12 You -- you referenced that you weren't
13 aware whether Leapfrog -- what goes into Leapfrog's
14 hand hygiene survey as it relates to observational
15 or machine-oriented observation for compliance; is
16 that --

17 A. That's correct.

18 Q. Okay. And so if you're not familiar with
19 what goes into Leapfrog's survey answers as it
20 relates to hand hygiene, on what basis are you
21 opining on as it relates to the -- to the burden of

1 completing the survey and whether or not a hospital
2 is not completing a survey is doing so because it
3 wouldn't perform well as opposed to that it was too
4 burdensome?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: Well, I didn't provide my
7 opinion on how burdensome the survey was because I
8 didn't know, and specifically related to the hand
9 hygiene, I just testified that I don't know -- I
10 have not functioned as a hospital or associate
11 hospital epidemiologist since January 1st, 2024 I
12 believe and I was not as the associate hospital
13 epidemiologist in the period of 2024 and 2023 in
14 charge of infection control aspects related to hand
15 hygiene compliance.

16 The areas I focused mainly on was outcome
17 metrics in a medical intensive care unit and
18 outcome metrics in Shock Trauma. So I focused
19 almost exclusively on CLABSI rates, SSI rates, so
20 that if the methodology of Leapfrog, which my
21 hospital I believe was participating in, in both

1 2024 and 2025, I did not know what they were
2 reporting or how many observations they needed or
3 what method of definition, because we had three to
4 four hospital epidemiologists and we divide and
5 conquer, and the hand hygiene angle was not under
6 my purview during that time period.

7 BY MR. HVIDT:

8 Q. And so when you represented -- strike
9 that.

10 So without knowing the aspects of the
11 hand hygiene survey component of the Leapfrog
12 survey, on what basis did you perform a causal
13 analysis that the answers to or the decision not to
14 participate in that survey might -- relates in any
15 way to low CMS measures on infection control?
16 Meaning they're a poor performer on hand hygiene?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: Well, I'd state the
19 following: I know a lot of hospital
20 epidemiologists in this country, okay? And I know
21 a lot of chief quality officers, because a large

1 chunk of them were hospital epidemiologists before
2 they became chief quality officers.

3 I had never heard of these hospitals,
4 which I consider to be generally hospitals that
5 strive to improve patient quality, not responding
6 to the survey.

7 So as an example at my institution,
8 right, I never had heard of us even discussing not
9 responding to the survey.

10 So my opinion of where nonresponse bias
11 would have led is based on the fact that the
12 hospitals that I know the hospital epidemiologist
13 and the chief quality officers, they always
14 reported their data, and if their data was poor,
15 they made efforts to improve their data. And that
16 then leads to the idea that if you're not hiding
17 something and your data is poor, you make an effort
18 to improve your data.

19 BY MR. HVIDT:

20 Q. Did you perform a causal analysis looking
21 at the CMS outcome -- the CMS scores for the

1 Plaintiff hospitals for the infection control
2 measures and tie it to the hand hygiene -- the
3 decision not to participate in the hand hygiene
4 survey?

5 A. No.

6 Q. Looking back at Exhibit 7 momentarily, if
7 we could flip to page 36, which is the Nicholson
8 report.

9 In paragraph 66, do you see where he
10 says, Using data produced by TLG in this matter, I
11 conducted a similar rescoring exercise for all
12 non-participating hospitals in spring 2025
13 presented in Exhibit 5? Do you see that sentence?

14 A. Yeah.

15 Q. Okay. And then the next sentence, do you
16 see where Nicholson presents the counterfactual
17 that he is estimating? Can you read that sentence
18 for me, please?

19 A. Which sentence?

20 Q. The one beginning, Assuming.

21 A. Assuming that these hospitals chose to

1 participate in TLG's survey and assign themselves
2 the average score the participating hospital did
3 for each of the seven self-reported measures in the
4 survey, their performance would have improved
5 substan- -- substantially.

6 Q. Okay. And do you understand from reading
7 that sentence that what Nicholson did was his
8 counterfactual was what would happen had the
9 Plaintiff hospitals chose to participate in the
10 survey and assign themselves an average score that
11 the participating hospitals do?

12 A. Can you repeat the question, please?

13 Q. Yes. So in Nicholson's regrading
14 analysis, does paragraph 66 show that Nicholson's
15 counterfactual that he was looking at was what
16 would happen if the hospitals chose to participate
17 in the Leapfrog hospital survey and assign
18 themselves the average score that participating
19 hospitals did for each of the seven self-reported
20 measures in the survey?

21 A. Yeah. I -- it -- it ties -- but his

1 counterfactual is incorrect in my opinion.

2 Q. I'm asking you what his counterfactual
3 was. Is that a correct statement of what his
4 counterfactual was?

5 A. His counterfactual is he takes the seven
6 reported measures and he assigns them the average
7 score.

8 Q. And he does that because he assumes that
9 they participated in the survey and answered the
10 questions in the survey for those seven measures;
11 is that correct?

12 MS. BLAIR: Objection to form,
13 mischaracterizes what that states.

14 THE WITNESS: It's a false assumption.
15 He's -- he is -- he's in- -- he's incorrectly
16 imputing those scores in my opinion.

17 BY MR. HVIDT:

18 Q. I'm asking this question in this instance
19 not whether -- what your opinion is of what he did.

20 I'm asking if you could confirm for me
21 your understanding of what he, in fact, did?

1 MS. BLAIR: Objection to form, asked and
2 answered.

3 BY MR. HVIDT:

4 Q. And is Professor Nicholson's rescoring
5 analysis one where he -- his counterfactual is what
6 would happen if the non-participating hospitals
7 participated in the survey and answered the
8 questions for the seven self-reported measures in
9 the survey --

10 MS. BLAIR: Objection.

11 BY MR. HVIDT:

12 Q. -- and assigned themselves the average
13 score for those measures?

14 A. I'm just saying that based on that one
15 paragraph in Exhibit 5, it's almost impossible to
16 tell exactly what he did.

17 It just does not have the level of detail
18 that a scientific re-analysis requires, in my
19 opinion, to have given my opinion on it, which is
20 why I chose not to do it. It's exactly why I chose
21 to recalculate only on the five hospitals.

1 Q. Did you look at the appendixes to
2 Professor Nicholson's report before opining on his?

3 A. I skimmed some of them, yes.

4 Q. And are there notes below each of the
5 exhibits in Exhibit 5 and Exhibit 6?

6 A. There's notes, yes.

7 Q. And if you look at Exhibit 6, I just want
8 to get -- make sure we're talking about the same
9 thing.

10 Did Nicholson regrade the Plaintiff
11 hospitals assuming they participated in the survey
12 and assign themselves the average score for the
13 seven self-reported survey scores, the average of
14 the participating hospitals?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: It says, I conservatively
17 rescore each of the seven measures to be the
18 average score.

19 BY MR. HVIDT:

20 Q. Thank you. And he says he conservatively
21 measure -- rescored them to the average score is,

1 in his view, he could have scored them higher than
2 the average score?

3 A. Yeah, but I -- I disagree with that,
4 because it's -- the sentence before is talking
5 about two outdated studies. That's why he uses the
6 term conservatively.

7 I would say, and I do say, it's not only
8 conservative, it's the reverse.

9 Q. Looking at the exhibit from earlier today
10 that showed the Plaintiffs' CPOE and BCMA reported
11 data as produced in this litigation, would those
12 figures that we were looking at have been higher
13 than the limited achievement score that the
14 Plaintiffs were assigned?

15 A. I -- I can't comment on that. I did not
16 have proper time to review those documents, and
17 there was a lot of new data that was presented that
18 I would need more time in order to give my opinion
19 on.

20 Q. You'll agree that there was -- strike
21 that.

1 MR. HVIDT: We -- the Plaintiffs at this
2 time will -- will rest with the reserving rights if
3 there's anything added, amended or changed or as it
4 relates to the document that was referenced that
5 was not cited in the expert report as a document
6 relied on or provided, and to the extent there's
7 anything that is updated, we'll reserve.

8 MS. BLAIR: Sounds good. I have no
9 questions.

10 I will order the rough draft and regular
11 delivery of the final.

12 THE COURT REPORTER: Got it.

13 MS. BLAIR: AND I don't need a video yet.

14 MR. HVIDT: Same. Thank you.

15 THE VIDEOGRAPHER: We are going off the
16 record. The time is 6:31 p.m.

17 (Whereupon, the deposition of Anthony
18 Harris, M.D., MPH was concluded at 6:31 p.m., and
19 the reading and signing was not waived.)
20
21

1 State of Maryland

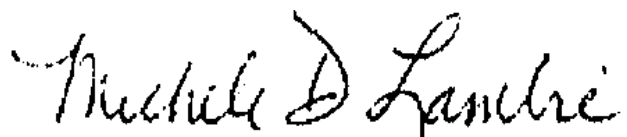
2 County of Baltimore, to wit:

3 I, Michele D. Lambie, a Notary Public of
4 the State of Maryland, County of Baltimore, do
5 hereby certify that the within-named witness
6 personally appeared before me at the time and place
7 herein set out, and after having been duly sworn by
8 me, according to law, was examined by counsel.

9 I further certify that the examination
10 was recorded stenographically by me and this
11 transcript is a true record of the proceedings.

12 I further certify that I am not of
13 counsel to any of the parties, nor related to any
14 of the parties, nor in any way interested in the
15 outcome of this action.

16 As witness my hand and notarial seal this
17 13th day of October 2025.

18 
19
20
21

1 Kimberly Blair

2 kimberly.blair@wilsonelser.com

3 October 13, 2025

4 RE: Good Samaritan Medical Center Inc, v. The Leapfrog Group

5 9/29/2025, Dr. Anthony Harris (#7621543)

6 The above-referenced transcript is available for
7 review.

8 Within the applicable timeframe, the witness should
9 read the testimony to verify its accuracy. If there are
10 any changes, the witness should note those with the
11 reason, on the attached Errata Sheet.

12 The witness should sign the Acknowledgment of
13 Deponent and Errata and return to the deposing attorney.
14 Copies should be sent to all counsel, and to Veritext at
15 errata-tx@veritext.com.

16 Return completed errata within 30 days from
17 receipt of testimony.

18 If the witness fails to do so within the time
19 allotted, the transcript may be used as if signed.

20
21
22 Yours,

23 Veritext Legal Solutions
24
25

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Dr. Anthony Harris (#7621543)

E R R A T A S H E E T

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REASON _____

Dr. Anthony Harris

Date

1 Good Samaritan Medical Center Inc, v. The Leapfrog Group
2 Dr. Anthony Harris (#7621543)

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Dr. Anthony Harris, do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10
11 _____
12 Dr. Anthony Harris

Date

13 *If notary is required

14 SUBSCRIBED AND SWORN TO BEFORE ME THIS

15 _____ DAY OF _____, 20____.

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17
18 _____
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[& - 2000]

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[ago - answer]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted

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EXHIBIT 8

1 APPEARANCES:

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19 appeared on behalf of the Defendant.

20 ALSO PRESENT:

21 Gabriel Martin, videographer

22 * * * * *

23 (appearing remotely)

24 Reported By: Valerie M. Calabria, CSR, RPR

25 License No.: 084-003928

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25		

1 THE VIDEOGRAPHER: Good morning. We are going
2 on the record at 9:15 a.m. on September 29, 2025.

3 This is Media No. 1 of the
4 video-recorded deposition of Mark Rule in the
5 matter of Good Samaritan Medical Center, Inc.,
6 et al., versus The Leapfrog Group, filed in the
7 United States District Court for the Southern
8 District of Florida.

9 The location of this deposition is
10 161 North Clark Street, Chicago, Illinois. My name
11 is Gabriel Martin, representing Veritext, and I am
12 the videographer. The court reporter is
13 Valerie Calabria, also from Veritext.

14 For the record, will counsel please
15 voice-identify themselves and who they represent,
16 starting with the taking attorney.

17 MR. TAKAGAKI: Marc Aaron Takagaki on behalf
18 of the plaintiffs.

19 MS. OTOO: Mary Otoo on behalf of Plaintiffs.

20 MS. WOOD: Courtney Wood, Wilson Elser, on
21 behalf of the defendant, The Leapfrog Group.

22 MR. MODI: Kavi Modi, Wilson Elser, attorney
23 for the defendant, Leapfrog Group.

24 THE VIDEOGRAPHER: Thank you, counsels.

25 Now the court reporter will swear in

1 the witness.

2 (Witness duly sworn.)

3 THE VIDEOGRAPHER: Counsel, you may proceed.

4 MR. TAKAGAKI: Thank you.

5 MARK RULE,

6 called as a witness herein, having been first duly
7 sworn, was examined and testified as follows:

8 EXAMINATION

9 BY MR. TAKAGAKI:

10 Q. Good morning.

11 A. Good morning.

12 Q. Could you please start by stating your
13 name for the record.

14 A. Mark Rule.

15 Q. Have you gone by any other names in the
16 past?

17 A. No.

18 Q. And have you been deposed before?

19 A. Yes.

20 Q. About how many times?

21 A. Dozens.

22 Q. And were some of those in federal court?

23 A. Yes.

24 MR. TAKAGAKI: And actually, before we
25 continue -- sorry. I should note for the record

1 that we found out this morning that Veritext
2 wouldn't be able to send an in-person court
3 reporter, so we have a virtual reporter, who is
4 appearing today on the Zoom.

5 And I've discussed with opposing
6 counsel, and I believe we're in agreement. Do you
7 have any objections, opposing counsel?

8 MS. WOOD: No objection.

9 MR. TAKAGAKI: I just wanted to note that for
10 the record. I'll continue.

11 BY MR. TAKAGAKI:

12 Q. So I believe you said that you think
13 that some of your depositions were in federal court
14 before; is that right?

15 A. I believe so, yeah.

16 Q. So you're -- we're in federal court in
17 this case, so you probably are familiar with most
18 of the ground rules for depositions, but I'll go through
19 them again, as I'm sure this happened with you many
20 times.

21 So, first, we should try not to speak
22 at the same time because we have a court reporter
23 who is watching the -- the session today, taking
24 everything down, and it's -- it's difficult for her
25 to capture what we're saying if we talk over each

1 other.

2 So I'll try to wait for you to finish
3 your answer before I ask the next question, and I
4 guess that you -- I ask that you finish -- let me
5 finish asking my question before you give an answer
6 so we minimize talking over each other.

7 Does that work for you?

8 A. Understood.

9 Q. Great. And, similarly, please try to
10 avoid giving nonaudible answers -- you know, shrugs
11 or nodding or words like "uh-huh" -- because it's
12 difficult to have those show up on the record.

13 Does that make sense?

14 A. Yes.

15 Q. Okay. And do you understand that you
16 are under oath today and testifying under oath?

17 A. Yes.

18 Q. Okay. And that today you're promising
19 to answer any questions that I have based on your
20 true recollection; is that right?

21 A. Yes.

22 Q. Okay. Are you taking anything today,
23 medications or something else, that might impair
24 your ability to testify truthfully today?

25 A. I'm on some cold medicine, but it

1 shouldn't impact my ability to testify.

2 Q. Okay. Got it. Sorry to hear that. Let
3 us know if you need a break or --

4 A. Appreciate that.

5 Q. -- or anything. We're, you know, happy
6 to do that at any time. And, also, let us know if
7 the cold medicine starts to kick in and cause a
8 problem. Okay?

9 A. Understood.

10 Q. All right. Please, today, if you can,
11 if you don't understand one of my questions,
12 clarify -- ask me to clarify. I can repeat a
13 question. Or if you're not -- unsure what
14 something means, please don't hesitate to speak up.

15 Does that work?

16 A. Yes.

17 Q. Great.

18 From time to time, your attorney will
19 have objections. Unless your attorney instructs
20 you not to answer, I will ask that you still answer
21 my question even if there is an objection.

22 Does that make sense?

23 A. Yes.

24 Q. Okay. And I -- we'll take breaks today,
25 especially, you know, in case you need one, but

1 I'll ask that we don't take one if there's a
2 question pending.

3 Does that make sense?

4 A. Yes.

5 Q. Okay. So can you provide me just a -- a
6 brief description of your educational background.

7 A. Sure. I have a BBA from the University
8 of Notre Dame with concentrations in finance and
9 computer applications. After Notre Dame, I have an
10 MBA from University of Chicago with many
11 concentrations, but primary economics, accounting,
12 and finance, amongst others.

13 I also have some professional
14 credentials. I am a CFA, a Chartered Financial
15 Analyst. I'm also an ABV, which is Accredited in
16 Business Valuation, which is awarded by the AICPA.

17 Q. Okay. And so going back to the BBA, I
18 believe you testified that you have a BBA in
19 finance and computer applications. Just briefly,
20 what does a BBA in finance cover?

21 A. That's a bachelor's of -- of business
22 administration, generally. The concentration would
23 be in finance, so it would be traditional finance
24 topics; you know, corporate finance, finance 101,
25 that type of stuff.

1 And then the computer applications,
2 the way I would describe it is it's not quite a
3 computer science degree, but it's -- it's somewhere
4 close. It's -- it's more geared for computer
5 science for business majors, if you will.

6 Q. Okay. And so how would business majors
7 use computer science? What's an example of how
8 that would apply in the real world?

9 A. Making a -- a web page, as -- is an
10 example.

11 Q. Got it. And would it be, like, a web
12 page for -- for a business like, you know,
13 nike.com's website?

14 A. It -- it potentially could be, yes.

15 Q. Got it. And would it also be -- have,
16 like, financial features to the web page?

17 A. It -- it depends on the scope of the web
18 page, but generally speaking, my recollection, a
19 lot of that coursework was focused on the
20 development of web pages.

21 Q. And have you used that computer
22 applications background in your professional work?

23 A. I mean, I -- I maintain a general
24 knowledge of it, but am I making web pages? No, I
25 am not.

1 Q. That was my next question: Do you make
2 web wages or -- for your -- for your job? It
3 sounds like no.

4 A. No.

5 Q. The -- okay. So moving on to the MBA, I
6 believe you said you had a concentration in
7 economics, accounting and finance; is that right?

8 A. Those are ones that are listed, yes, but
9 I had concentrations beyond that, as well.

10 Q. Okay. What were those other
11 concentrations?

12 A. I also had an entrepreneurship, was one
13 of them. Economics entrepreneurship, finance,
14 accounting. Strategy was one, as well.

15 Q. Okay. And so what -- what is a
16 concentration in -- in an MBA?

17 What does it mean to have a
18 concentration in one of those things?

19 A. It -- it's -- it's basically your focus.
20 It's what classes were you focused on; you know,
21 kind of subcomponents, if you will, of the overall
22 MBA from the University of Chicago. So not
23 everybody obviously took the same classes.

24 And so I was more focused on those
25 concentrations versus other offerings that other

1 students might have been pursuing.

2 Q. And did you not pursue any computer
3 science in -- in -- in MB -- in the MBA?

4 A. No.

5 Q. All right. Was that offered in the MBA?
6 Were there computer applications --

7 A. No.

8 Q. -- concentrations or courses?

9 A. No, I -- I don't have a specific
10 recollection as I sit here right now.

11 Q. Okay. And so for the -- going back to
12 the BBA, I believe that was at the University of
13 Notre Dame?

14 A. That's correct.

15 Q. During your time taking -- getting that
16 BBA, did you study -- did your studies include
17 quantifying economic harm?

18 A. Well, the -- the tools one would use or
19 I would use to quantify economic harm, in part, are
20 rooted based on my education at the University of
21 Notre Dame, yes. But was I specifically taking
22 courses or doing coursework to quantify economic
23 harm at that point, I -- I don't have that specific
24 recollection.

25 Q. So there weren't any legal or litigation

1 courses that you took at BBA --

2 A. There was some business --

3 Q. -- or getting the BBA?

4 A. Sorry. There -- there was a business
5 law class. I don't have a specific recollection as
6 to -- you know, it's been 25 years now. But
7 there -- there was a business law class that was
8 part of their curriculum that I took while I was at
9 Notre Dame.

10 Q. Do you recall if it touched on
11 calculating or quantifying damages or --

12 A. I -- I don't have a specific
13 recollection. It's been 25 years.

14 Q. Understood.

15 And then for the MBA at the
16 University of Chicago, did you learn how to
17 quantify economic harm?

18 A. I already knew how to do it at that
19 point because I had been working. So it wasn't --
20 it wasn't specific to an MBA. That was already
21 part of my professional education, if you will.

22 Q. Yeah. I was going to ask about your --
23 your professional work, which I believe started in
24 between.

25 So I guess just focusing on just the

1 MBA, so did you -- I take it that was not covered
2 at University of Chicago in the MBA in any of your
3 concentrations, how to quantify --

4 A. I -- I can't say it wasn't covered. I
5 don't have a specific recollection, again, because
6 I was -- that was my job at the -- at that point in
7 time, quantifying economic harm. So...

8 Q. Understood.

9 Do you -- I take it you didn't take
10 any legal or litigation classes while you were at
11 University of Chicago?

12 A. I -- I believe there was another
13 business law class that would have been part of
14 the -- the 20, 22 classes I took, or 25 classes I
15 took to receive my MBA.

16 Q. And do you recall whether that class
17 taught how to calculate economic harm?

18 A. Yeah. And I don't have a specific
19 recollection because that's what I was doing, you
20 know, every day at work.

21 Q. And -- and going back to the -- the BBA
22 at Notre Dame, did your studies cover ratings or
23 gradings, the grading systems?

24 A. Could you be more specific? Because,
25 obviously, I got grades.

1 Q. Did -- did your studies include
2 instruction from a professor or -- or a TA on how
3 to -- on how grading or rating systems works in the
4 context of grading or rating a business like a
5 hospital or a law firm or a restaurant?

6 A. I -- I don't have a specific
7 recollection one way or the other.

8 Q. Okay. Do you recall whether any of your
9 classes at University of Notre Dame covered ratings
10 methodologies?

11 A. Well, I -- I know part of the curriculum
12 would have covered, you know, credit ratings; those
13 that are offered, for example, by a Moody's or S&P.
14 I have a recollection of that.

15 Q. And would they have covered how to
16 assign those credit ratings?

17 A. There would have been an understanding
18 of how the rating agencies went about assigning
19 those for sure.

20 Q. And how do -- what's your understanding
21 of how ratings agencies assign those credit
22 ratings?

23 A. Well, they publish materials how they do
24 it, so you can look that up. But, generally, they
25 have a bunch of factors. They're not identical

1 between the three major ratings agencies, but they
2 take into account a bunch of things. But at the
3 end of the day, they're looking at credit
4 worthiness.

5 So a lot of it has to do with cash
6 flow and assets and stuff like that that they
7 consider when they're assigning a rating.

8 Q. Did you, when you were at the University
9 of Notre Dame, actually look at the, let's call it,
10 inputs into those ratings that the credit ratings
11 agencies used?

12 A. I want to be clear. I was talking about
13 the University of Chicago.

14 Q. Ah.

15 A. It was part of my -- my MBA.

16 Q. Got it.

17 A. I have that recollection. But, yes, it
18 would have been part of, you know, finance classes.
19 When you're looking at credit worthiness of a
20 corporation, you would look at what the rating
21 agencies are looking at and what they're taking
22 into account when they're assigning a grade, if you
23 will.

24 Q. Okay. So just to be clear, so when you
25 were at the University of Notre Dame getting your

1 BBA, you did not, to your recollection, study
2 credit rating agencies?

3 A. I -- I can't say either way. I have a
4 specific recollection at the University of Chicago
5 that that was part of the coursework.

6 Q. Okay. When you were at the University
7 of Chicago doing the coursework that was related to
8 the credit ratings agencies, did you consider
9 different methodologies that might have been used
10 for those credit ratings?

11 A. Can you be more specific.

12 Q. Well, I don't -- I'm not -- I don't even
13 know. I mean, are there -- is there more than one
14 methodology that could be used for credit ratings?

15 A. By definition, considering there are
16 three different credit rating agencies, so they all
17 do it a little bit different.

18 Q. Okay. So each credit rating agency has
19 their own methodology for how they assign their
20 ratings?

21 A. There are similarities, for sure, but
22 there are some differences, as well.

23 Q. And did you study the differences
24 between each credit rating agency's methodologies?

25 A. At the -- at University of Chicago?

1 Q. Yes.

2 A. I -- I have a recollection that when we
3 were analyzing companies we would look at credit
4 ratings. As part of analyzing the credit ratings,
5 we would read the credit rating reports and give
6 consideration to what the rating agencies were
7 discussing in said reports.

8 Q. And did those reports that you were
9 reading list the methodology or algorithm that they
10 used?

11 A. I'm not sure that they were using
12 algorithms, to be honest. But, again, they would
13 provide the base ratings within the reports
14 themselves. So that is what we read, or that's
15 what I read and analyzed as part of the coursework
16 when we're looking at a particular company as part
17 of a class.

18 Q. And did you ever analyze whether one
19 credit -- credit rating agency's methodology was
20 better than another credit rating agency's
21 methodology?

22 A. I'll go back to an answer. We did -- or
23 I did note that there were differences in the
24 methodologies, but it wasn't necessarily saying one
25 was better than the other.

1 Q. Did you ever analyze whether one was
2 more accurate than the other?

3 A. I mean, it's a credit rating -- it's a
4 credit rating. It's not -- there's not necessarily
5 an accuracy in it. It's an opinion, at the end of
6 the day. And so you can't necessarily prove that
7 one's better than the other at the time you're
8 analyzing it because it's an -- it's an assessment.
9 In some regards, it's kind of like a projection, if
10 you will.

11 Q. I guess my question is, maybe, did
12 your -- the professors assign you to, say, you
13 know, analyze this rating at -- from one agency
14 versus this rating from another and compare the
15 two?

16 A. I don't have a specific recollection of
17 that.

18 Q. Going back to your time, now, at
19 Notre Dame -- sorry to keep jumping back and
20 forth -- did any of your studies cover health care
21 or hospitals?

22 A. I don't have a recollection either way.
23 Again, it's been 25 years.

24 Q. Did they quantify -- or sorry. Excuse
25 me. Strike that.

1 Did they -- at University of
2 Notre Dame, did your studies cover how to quantify
3 damage to a hospital?

4 A. Again, I think I've answered this
5 question. I don't have a specific recollection
6 of -- of doing damage-related work at Notre Dame.

7 Q. Okay. And same for University of
8 Chicago. When you were there, did any of your
9 courses cover how to quantify damage at a hospital
10 or to a hospital?

11 A. Again, I don't have a specific
12 recollection. But what I can tell you is, during
13 my time at the University of Chicago, I was also
14 doing damage analyses, and some of them related to
15 hospitals or health care.

16 Q. Okay. So, yeah, we can move on to your
17 employment background now, which I think before you
18 touched on a bit already.

19 Could you briefly just describe your
20 employment history after finishing your BBA at
21 Notre Dame.

22 A. Sure. After I graduated from Notre
23 Dame, I began working for a company called Peterson
24 Consulting, which became part of Navigant
25 Consulting. So I worked there for a couple years.

1 Then I left for a company called
2 LECG, The Law and Economics Consulting Group. Was
3 there for about two years before I joined
4 AlixPartners in August of 2004.

5 Q. Okay. And just going back -- sorry --
6 to your educational history, were you at the
7 University of Notre Dame from 1995 to 1999?

8 A. Through January of 2000.

9 Q. So you graduated in January of 2000?

10 A. That's correct.

11 Q. And then -- and you were at the
12 University of Chicago from 2006 to 2009; is that
13 right?

14 A. Sounds about right.

15 Q. And I believe you said you started at
16 Peterson Consulting.

17 When did you start?

18 A. It would have been upon graduation in
19 January of 2000. So whether it was February of
20 2000, thereabouts, I moved from Notre Dame to
21 Chicago and began work.

22 Q. And then you said it became -- Peterson
23 Consulting became a company called Navigant.

24 Is that --

25 A. It was acquired by a company called

1 Navigant Consulting.

2 Q. Do you remember roughly when that was?

3 A. Probably within a year or so of
4 beginning work at Peterson.

5 Q. So around 2001?

6 A. Give or take.

7 Q. And then -- I believe you said then you
8 went to the LECG Law and Economics Group?

9 A. Law and Economics Consulting Group.

10 Q. Consulting Group.

11 And what year was that?

12 A. I don't have -- it would have been -- I
13 think I was there for about a year or so before I
14 joined AlixPartners, so it would have been probably
15 somewhere in 2002, 2003.

16 Q. And you've been at AlixPartners ever
17 since August of 2004; is that right?

18 A. That's correct.

19 Q. So going to Peterson, and I -- we'll --
20 we'll say for Peterson Consulting first, so not
21 when it was -- before it was acquired by Navigant,
22 so just when it was Peterson Consulting.

23 What was -- what were your job --
24 what were you doing for your job?

25 A. I was vice president in their disputes

1 group, so doing the same type of work I am doing
2 now.

3 Q. And what type of work were you doing?

4 A. Valuation, economic damages, solvency,
5 forensic accounting, alter ego. Those would be
6 the -- the main types of work that I started doing
7 when I graduated from Notre Dame and I continue to
8 do today.

9 Q. And were those generally in the context
10 of litigation or -- or strike that.

11 Were they generally in the context of
12 a legal dispute of some kind?

13 A. Not always, but often.

14 Q. When they weren't part of a legal
15 dispute, what would they have been related to?

16 A. For example, oftentimes -- like, I'll
17 give you an example.

18 When a hospital merges with another
19 hospital, I would get involved to do basically a
20 pro forma analysis to show that they would be in a
21 financially better position by merging than if they
22 were to remain two independent hospitals.

23 So part of that included valuation
24 and kind of solvency analysis, but not really. And
25 so that wouldn't have been in the context of a

1 litigation. That would be in the context of a
2 regulatory approval as part of the -- the
3 government or the -- the regulatory body to approve
4 the merger. And there's a series of analyses that
5 I and my team would put together for the benefit of
6 the regulator.

7 Q. And then I believe you said some of the
8 matters you worked on at Peterson were related to
9 legal disputes?

10 A. Sure.

11 Q. Would that -- would that have been the
12 majority of what you did at -- when you were at
13 Peterson?

14 A. It -- it -- more than 50 percent, yes.

15 Q. And would that have included calculating
16 damages for a -- a lawsuit?

17 A. For sure. I mean, I -- an example of,
18 you know, early days at Peterson, I remember there
19 were a series of failed ERP implementations,
20 particularly at some hospitals, where we would
21 quantify the damages associated with the failure of
22 that enter- -- Enterprise Resource Planning system
23 not being fully functional and the impact that it
24 would have on the hospital.

25 Q. Got it. And was Peterson -- you've

1 mentioned hospitals a couple times in your
2 examples.

3 Was Peterson focused on
4 hospital-related consulting?

5 A. Not necessarily, but there was a fair
6 amount of health-care-related, hospital-related
7 work starting with Peterson all the way through
8 until today.

9 Q. Yeah. What other types of matters did
10 you do when you were at Peterson?

11 A. Can you be more specific.

12 Q. Well, yeah. Sorry. You were talking
13 about what you did as the VP in the disputes group.
14 You said some of the -- the work you did related to
15 legal disputes. Others related to, I think,
16 mergers or acquisitions.

17 And I was just asking if there were
18 other types of, I guess, clients that you worked
19 for other than hospitals or health care related?

20 A. It would range industries. And so it
21 would -- health care and hospitals were obviously
22 an industry that I was focused on, but there was
23 other industries that, you know, required, you
24 know, the same types of analyses, whether it's
25 valuation, economic damages.

1 So it would span a lot of different
2 industries, but definitely health care and
3 hospitals were one of them.

4 Q. What were some other industries?

5 A. Chemical, oil and gas, airline, retail.

6 It -- it could span a number of
7 different industries.

8 Q. Any others?

9 A. It -- construction. I mean, it -- I
10 have a wide experience across industries. But
11 beyond just hospitals and health care, so, you
12 know, crypto. So it -- it's a large span of the
13 types of industries I've touched beyond just health
14 care and hospitals.

15 Q. Got it. And I was -- sorry. It's my
16 fault. I was just focusing on when you were at
17 Peterson in -- starting in, I think, January and
18 February of 2000.

19 I just wanted to know what were the
20 industries that you worked on while you were there.

21 A. So obviously not crypto. Again, it's --
22 it's been a while, but it's -- it's probably the
23 same types of industries that I continue to work on
24 to this day.

25 Q. Okay. So I have, I believe you said,

1 chemical, oil and gas, airline, retail, health
2 care, construction, and then crypto later in time.

3 Were there any others that you think
4 you might have worked -- or you remember working on
5 when you were at Peterson?

6 A. A lot of industries. I'd have to go
7 back and look at my CV.

8 Q. That's fair.

9 Any, like, banking? Would you have
10 worked for any banks?

11 A. Sure. There was banking in there, too,
12 particularly around the financial crisis, although
13 that would have been post-Peterson. But, yes,
14 banking would have been one of them, as well.
15 Insurance, as well.

16 Q. Any tech -- tech work back then?

17 A. Yeah.

18 Q. Would you say that when you were at
19 Peterson only, the -- that's the question I'm
20 asking now.

21 When you were at Peterson, would you
22 say that the majority of your work was not related
23 to hospitals?

24 A. It's been a while. I -- I -- there was
25 hospitals and health care was definitely a primary

1 focus of mine. Whether or not it was the majority
2 or not, I can't speak to that. It probably wasn't
3 just because -- given the variety of types of cases
4 that I'd be, you know, calculating economic damages
5 or providing valuation analyses.

6 But, again, hospitals and health care
7 have always been a focus.

8 Q. Okay. You said it was a primary focus.

9 What were some of your primary
10 focuses?

11 A. Again, I think I just list -- listed
12 them off.

13 Q. Oh, each of the ones we were just going
14 through? Okay.

15 Is that right? Each of the ones we
16 did --

17 A. Those would be examples of other
18 industries where I would apply the same
19 fundamentals from an economic damages or valuation
20 perspective.

21 Q. Okay. And I think, yeah, you just said
22 where you would apply the fundamentals. Where
23 would you have learned those fundamentals?

24 Would you have learned those in -- at
25 the University of Notre Dame?

1 A. I think we've already addressed that. I
2 don't have a specific recollection of it. It was
3 part of my work education. I -- I've worked with
4 some very senior people who have been doing those
5 type of analyses a long time, and so that's how I
6 would learn.

7 Q. You're referring to Peterson, working
8 with Peterson?

9 A. Correct.

10 Q. So you learned some of the fundamentals
11 while you were at Peterson?

12 A. For sure.

13 Q. Okay. And then moving on now to when
14 Peterson was, I believe you said, acquired by
15 Navigant in around 2001, what did you do -- what
16 was your job title then?

17 A. I -- I don't have a specific
18 recollection. It was the same group. Let's put it
19 that way. We were acquired. The group was
20 acquired, and nothing really changed other than a
21 group was signing my checks.

22 Q. Okay. And then I believe after that you
23 said you went to LECG, Law -- Law and Economic
24 Consulting Group.

25 What was your position then?

1 A. It was the same group. So we -- we all
2 moved over together. What my specific title was
3 back then, I don't recall without looking at an old
4 CV.

5 Q. Okay. So I think I'm understanding this
6 better now. So you started at Peterson as a VP in
7 the disputes group, and then that same group was
8 acquired by Navigant; is that right?

9 A. As part of the acquisition of Peterson,
10 correct.

11 Q. Okay. And then Navigant was acquired by
12 LECG?

13 A. No.

14 Q. Okay.

15 A. That group left to go to LECG.

16 Q. I see. So the group you were in at
17 Navigant left around 2002 or 2003 to go to LECG?

18 A. That is my general recollection of
19 timing, yes.

20 Q. And aside from the name of the company,
21 your role and -- and job was essentially the same
22 at each of those three stops?

23 A. Well, it -- as my career progressed, you
24 know, I'd get more responsibility and have, you
25 know, more -- more to do. But, yes, it -- it was

1 still the same -- functionally the same type of
2 work, if that makes sense. I've been doing this
3 for 25 years.

4 Q. Yeah, no, that does make sense. And so
5 the industries we were talking about before, would
6 those apply -- those answers that you gave for
7 Peterson apply also to Navigant and LECG?

8 A. Yes. And, again, it depended on the --
9 the point in time and what was going on in the
10 economy and what industries were, you know, more en
11 vogue, if you will, than others.

12 But, yeah, generally speaking, it
13 would be the same types of industries, doing the
14 same type of analyses.

15 Q. I guess my question was is -- did you,
16 at some point, sort of change your focus
17 intentionally? Not just for the winds of the
18 economy, but did you ever kind of pivot in your
19 career at those three stops?

20 A. Nothing intentional, no.

21 Q. And -- and when you were at Peterson --
22 or I'll phrase it this way: When you were in the
23 group we've been referring to that was at Peterson
24 and then Navigant and LECG, at -- can we refer to
25 that as sort of one single group that you were at

1 that moved from --

2 A. Sure.

3 Q. Okay. When you were at that group, were
4 your -- is -- is it clients? Is that the phrase
5 you would use for the people you worked for?

6 Did you have clients?

7 A. I think we all have clients. Who -- who
8 are you specifically asking me about?

9 Q. But we don't -- I mean, teachers don't
10 have clients. They have students. So I'm trying
11 to understand who -- does somebody hire you? Are
12 you a consultant and you're their client? I'm
13 trying to understand who were your clients or
14 customers or students or patients or whatever
15 phrase you use.

16 A. It depends on the case.

17 Q. Okay.

18 A. If it's a litigation, we typically get
19 engaged by attorneys on behalf of their client.

20 Q. Right. That's what I was trying to get
21 at. Was that the majority of what you did at those
22 three stops -- Peterson, Navigant, and LECG --
23 working for attorneys who engaged you on behalf of
24 their clients?

25 A. I think that's a fair assessment, yes.

1 Q. When you were at Peterson, Navigant, or
2 LECG, did you ever have to create a ratings
3 methodology?

4 A. Can you be more specific.

5 Q. Yeah. Did you ever have to create a
6 formula or an algorithm or a methodology that was
7 used to rate something?

8 A. I think the answer is yes, but we can go
9 back to the, like, credit ratings analysis.

10 Q. Well, I didn't realize you created the
11 credit ratings.

12 A. We would often, when valuating, for
13 example, like a bond -- right? -- I would do my own
14 rating analysis to be able to determine, you know,
15 whatever appropriate rate or yield would be on the
16 bond to be able to value it.

17 And so, yes, there would be instances
18 in that regard where I was developing my own
19 ratings analysis to be able to try to value a bond.

20 Q. Aside from financial instruments, did
21 you ever create any ratings methodologies during
22 your time at Peterson, Navigant, or LECG?

23 A. I -- I don't have a specific
24 recollection one way or the other as I sit here.
25 It's been 25 years. Obviously, a lot of cases over

1 those years. But the -- the example that I had
2 previously given you is something that I regularly
3 do, so that's why it was top of the mind.

4 Q. Did you ever create any grading systems
5 when you were at Peterson, Navigant, or LECG where
6 you were assigning a letter grade to something?

7 A. I -- I mean, in -- in the context of a
8 credit rating, yes.

9 Q. Aside from the credit rating, did you
10 ever create a grading system where you assigned --
11 and I won't limit it to A, B, C, D grades -- but
12 just any type of a grade?

13 A. You know, that's the example that comes
14 to mind because it's something I regularly do. You
15 know, if you're asking something different than
16 that, I -- I'd probably give you the same answer.
17 I may have.

18 It's just been a lot of casework, and
19 I just don't have a specific recollection, putting
20 the credit ratings aside, of -- of doing so as I
21 sit -- sit here. It's quite possible, to be
22 honest.

23 Q. Okay. I don't think I saw a reference
24 to that in your report or your CV.

25 Does that sound accurate to you, that

1 there wouldn't have been a reference in there?

2 A. I wouldn't imagine I would have that
3 reference in there because, again, my report is
4 focused on responding to the plaintiffs' experts.
5 So it's more of a rebuttal report.

6 Q. Got it. Yeah. I just wanted to make
7 sure I didn't miss anything. So I don't recall it
8 in there.

9 It sounds like you also don't?

10 A. Again, given the scope, I was responding
11 to the plaintiffs' experts.

12 Q. All right. I'd like to move on now to
13 your time at AlixPartners, which I believe you
14 joined around August 2004?

15 A. That's correct.

16 Q. And so could you -- was that part of the
17 same group that we've been discussing moving over?

18 A. No.

19 Q. Was it just you who went to AlixPartners
20 from LECG?

21 A. Yes.

22 Q. And why did you leave LECG to go to
23 AlixPartners in 2004?

24 A. It was a better opportunity, access to
25 doing some more bankruptcy-related work, and

1 significant increase in pay.

2 Q. Okay. And did your -- were you a VP --
3 I guess going back to when you were at Peterson,
4 Navigant, and LECG, was your title always VP?

5 A. It might have been VP, SVP -- senior
6 vice president -- something along those lines.

7 Q. Yeah, I guess I should have clarified.
8 VP stands for vice president?

9 A. Correct.

10 Q. And what was your title when you went --
11 when you started at AlixPartners in 2004?

12 A. I think it was probably SVP, senior vice
13 president.

14 Q. And were you in a -- a group when you
15 were at AlixPartners, similar to -- well, I'll
16 leave that there.

17 Were you in a group at AlixPartners?

18 A. Yes.

19 Q. And what group was that?

20 A. It -- it would have been the same group
21 I'm in now. It's our disputes -- investigation and
22 disputes practice.

23 Q. And that's been the group that you've
24 been in essentially for your whole career since you
25 started at Peterson, some type of a disputes group?

1 A. Yeah. It's the same group that I help
2 run to this day. But, yes, that's where it would
3 have been -- it might have been called something
4 different over the years, but generally speaking,
5 that's where I sat at AlixPartners.

6 Q. Yeah. Yeah. As you can probably tell,
7 I'm just trying to understand if anything changed
8 sort of substance-wise from these different stops;
9 if your career changed in terms of your job duties
10 or the substance -- the substance of your work.

11 It sounds like it was about the same;
12 obviously, becoming more senior?

13 A. Once I became more senior, I started to
14 testify. Yes, that -- that's a little bit
15 different.

16 But from a substance perspective as
17 to, you know, core competencies and, you know,
18 damage analyses, valuation solvency, forensic
19 accounting, alter ego, those have always been
20 things I do on a regular basis throughout my
21 career.

22 Q. Is it fair to say that when you refer to
23 your career, your career has been -- you've had the
24 same career since you started at Peterson until
25 today?

1 A. Correct.

2 Q. That's what I was getting at.

3 And at AlixPartners, do you still
4 have -- I believe you testified that when you were
5 at Peterson, Navigant, and LECG, you were typically
6 retained by counsel on behalf of their clients.

7 Is that also the case at
8 AlixPartners?

9 A. Typically, yes, if it's, again, a
10 litigation-related dispute. Not always. Sometimes
11 the retention is directly with the -- the end
12 client, if you will. But oftentimes it's
13 structured with counsel retaining on behalf of
14 their client.

15 Q. And the end client -- you said sometimes
16 you're retained by the end client. That could just
17 be a business who would hire you to get your help
18 with something?

19 A. That's correct. And -- and, again, that
20 would have been the normal -- more of the normal
21 course if it's outside of litigation, if it's M&A
22 related or something like that.

23 Q. And was the majority of your work in --
24 in the context of litigation?

25 A. Yes.

1 Q. Do you have a rough sense of the split
2 of litigation versus non-litigation work?

3 A. It -- it -- it depends on -- on the
4 year. But most years it's the majority of my time
5 for sure, is litigation oriented disputes.

6 Q. Okay. I believe earlier we talked about
7 sort of the industries that you worked in. I'll
8 list the ones that I've got down. Chemical, oil
9 and gas, airline, retail, health care,
10 construction, banks, insurance, tech, crypto
11 eventually at one point.

12 Would those industries be industries
13 you were working in at AlixPartners, as well?

14 A. Yeah, generally speaking.

15 Q. Were there any others that come to mind?

16 A. I've done cannabis work, too. But as
17 it's noted on my CV, you know, I think I have
18 experience performing economic damages, valuations,
19 solvency, forensic accounting, or alter ego in
20 probably over 30 industries with, obviously, health
21 care and hospitals being a primary one.

22 Q. And when you say it was a primary one,
23 meaning it stood out more than the others that
24 we've been discussing?

25 A. No, not necessarily. But, again, that's

1 in part what we're here to discuss today. I'm just
2 noting it, that hospitals and health care have
3 always been -- dating back to Peterson, have always
4 been part of my practice.

5 Q. Yeah, yeah. I'm just trying to
6 understand. You said it was primary, and you said
7 you've worked on 30.

8 Would it have stood out more than the
9 other 29? Is that your testimony -- strike that.

10 If I were to go back and look at
11 every matter you've worked on, would -- if you were
12 to say each 30 had their own, you know, equal
13 weighting, would it have a larger percentage than
14 the others?

15 A. It -- it would be -- hospitals and
16 health care would probably be -- you know, if I had
17 to stratify the industries, it would probably be in
18 the top, you know, five to seven for sure.

19 Q. Five to seven out of the ones we've been
20 discussing? Or five to seven industries in the
21 world?

22 A. Of the 30-plus industries that I've told
23 you over the course of my career. I've -- I've
24 consistently done hospitals and health care work
25 since day one.

1 Q. Got it. So I think -- strike that.

2 And I believe you said that when you
3 switched over to AlixPartners, part of it was a
4 more -- a better title or more senior title; is
5 that right?

6 A. That was part of it.

7 Q. I -- I have, I believe, listed that you
8 were -- your title was partner and managing
9 director at AlixPartners when you started.

10 Does that sound right?

11 A. That's my current title.

12 Q. I see. So it's changed since you
13 started in 2004?

14 A. Correct.

15 Q. Not surprising.

16 Do you recall what it was when you
17 started in 2004?

18 A. Again, I think it was SVP.

19 Q. SVP. Okay.

20 And I believe you testified earlier
21 that some of your work at these different companies
22 was testifying in court.

23 Do you recall when that started, your
24 first time testifying?

25 A. No. The first time testifying would

1 have been -- I don't know -- 10, 12 years ago.

2 Q. So around 2013, 2014?

3 A. I don't have a specific recollection. I
4 remember the case. It was -- Energy Future
5 Holdings was the first case where I was asked to
6 testify.

7 Q. Did you enjoy it?

8 A. Did I enjoy what?

9 Q. Testifying in that case.

10 A. Sure.

11 Q. And then have you been testifying in
12 cases sort of regularly since then?

13 A. Yes.

14 Q. I guess my question is there wasn't sort
15 of like a drop-off where like maybe one year, one
16 quarter or something, you were like, "I'm not a
17 testifying person anymore." It's kind of just
18 stayed the same?

19 A. Yes.

20 Q. And at AlixPartners do you -- does
21 AlixPartners, as a company, typically work for
22 plaintiffs or defendants?

23 MS. WOOD: Objection to form.

24 THE WITNESS: Neither. We're agnostic. We
25 don't specialize in one over the other.

1 BY MR. TAKAGAKI:

2 Q. But you do work for plaintiffs at times?

3 A. I have -- I work probably equally for
4 plaintiffs and defendants.

5 MR. TAKAGAKI: Okay. Are there any -- --
6 strike that.

7 So I guess we can show our first
8 exhibit. Do tab 1.

9 (Rule Deposition Exhibit 1 was
10 marked for identification.)

11 BY MR. TAKAGAKI:

12 Q. Handing you what's been marked as
13 Exhibit 1.

14 Have you seen this document before?

15 A. It looks like it's a printout from my
16 LinkedIn page.

17 Q. Have you seen this document before?

18 A. I've seen the website before, yes.

19 Q. Have you seen this document before?

20 A. This particular document? This is my
21 LinkedIn page. I've seen it before.

22 Q. Okay. And did you draft this LinkedIn
23 page?

24 A. At some point in time, yes.

25 Q. Do you recall when you last updated it?

1 A. Well, it -- it probably was -- I'm not
2 very active on LinkedIn. I probably last updated
3 it, probably, when I got promoted to partner and
4 managing director.

5 Q. And when were you promoted to partner
6 and managing director?

7 A. I believe 2021. Maybe 2020. 2021, I
8 think.

9 Q. Prior to that, were you SVP?

10 A. No.

11 Q. What were your -- what was your position
12 prior to that?

13 A. I was a director.

14 Q. Do you recall when you were promoted to
15 director?

16 A. Probably 2007, 2008, somewhere along
17 those lines.

18 Q. And do you recall what your position was
19 before you were director at AlixPartners?

20 A. I think I've answered. It was SVP.

21 Q. Oh, sorry. I didn't realize it was
22 straight up until then it was SVP. You said when
23 you started, you were SVP. I don't know if you
24 ever testified that that was the last one you had
25 before you were director, but I might have missed

1 that.

2 Okay. So when you started in 2004,
3 you were SVP, and that lasted until about 2007,
4 '08, when you were promoted to director?

5 A. I was an SVP for a couple years before I
6 was promoted to director, and then I was eventually
7 promoted to partner and managing director.

8 Q. Got it. And what's the difference
9 job-duty-wise between SVP and director?

10 A. Just more responsibility, effectively,
11 more experience, so more is expected.

12 Q. At AlixPartners do you -- when you work
13 on a -- on a matter, which I -- I'm using that
14 phrase to mean, you know, a client engages you for
15 a specific project. When you work on a matter, do
16 you work as an individual or do you have a team?

17 A. I have a team.

18 Q. And was that the case when you started
19 in 2004 as SVP?

20 A. Well, at that point I would be part of a
21 team, and so I would have people that were working
22 for me, and -- but I also was reporting to
23 people --

24 Q. So is it --

25 A. -- above me.

1 Q. Sorry. I cut you off.

2 Did you have more?

3 A. No.

4 Q. My apologies.

5 So is it at -- does AlixPartners
6 typically have teams who are assigned to a given
7 matter as opposed to a given person?

8 A. Again, it depends on the case, but
9 generally speaking, we work in teams.

10 Q. Okay. So when you were an SVP, you
11 would have been a member of the teams for any of
12 the matters you were on?

13 A. Correct.

14 Q. Okay. And then when you were a
15 director, you were also just a member of teams for
16 different matters --

17 A. When I'm at the director level, I was
18 basically running the teams in support of a partner
19 and managing director.

20 Q. Got it. So you were still -- my
21 question is more just, you were still sort of in a
22 team framework. It sounds like now, as a director,
23 you would have been leading each team; is that
24 fair?

25 A. That's correct.

1 Q. Okay. And then when you were promoted
2 to partner and managing director around 2021, were
3 you still on teams, or were you sort of removed
4 from the team aspect of things?

5 A. At that point I'm at the top of the --
6 the team, if you will. It's --

7 Q. Got it.

8 A. -- it's my team.

9 Q. Your team. Got it. You're running the
10 team. Got it.

11 Looking on -- if I can direct your
12 attention to just sort of page 1 of Exhibit 1, it
13 says here -- underneath your name, it says "Partner
14 and Managing Director at AlixPartners."

15 Do you see that?

16 A. I'm sorry. Could you repeat that. I
17 was looking elsewhere.

18 Q. Yeah, no problem. Underneath your --
19 well, do you see there's a picture of someone?

20 A. There -- there is a picture of someone,
21 yes.

22 Q. Yeah, a good-looking man.

23 Is that you?

24 A. A little bit different-looking than I
25 look today, but yes, that is me -- that is me

1 without a beard.

2 Q. Okay. And then underneath that it says
3 "Mark Rule" and then it says "Partner and Managing
4 Director at AlixPartners." That's what I was
5 directing you to.

6 Do you see that now?

7 A. Yes.

8 Q. Okay. And then beneath that it says
9 "AlixPartners," with a bullet "University of
10 Chicago" and then beneath that, there's an "About"
11 section.

12 Do you see that?

13 A. I do.

14 Q. Okay. And it says "Specialties:
15 Restructurings, workouts, distressed companies,
16 valuation, financial advisory, litigation
17 consulting and expert testimony."

18 Do you see that?

19 A. I do.

20 Q. Do you -- did you write that?

21 A. Many years ago, I did.

22 Q. Okay. Is it accurate?

23 A. Generally speaking, it is, yes.

24 Q. Okay. And do these -- I assume these
25 refer to sort of your specialties in a professional

1 setting?

2 A. It's examples of the type of work I've
3 done over the course of my career.

4 Q. And "restructuring" is the first item
5 there.

6 What are restructurings?

7 A. Think about a corporate bankruptcy, as
8 an example.

9 Q. So when a company goes bankrupt, do they
10 go through a restructuring?

11 A. Often, yes.

12 Q. And you would -- do you have a specialty
13 in that?

14 A. Oftentimes I would get involved in
15 either the financial advisory to help guide a
16 company through it, or quite honestly, often would
17 be retained to opine on something that's at dispute
18 because often, as part of the bankruptcies or the
19 restructurings, there are embedded litigations.

20 Q. And for your work with the
21 restructurings, if you could just very briefly sort
22 of tell me, what does that work entail?

23 A. I think I just touched on it.
24 Oftentimes it's -- it's testimony. It's --

25 Q. Okay.

1 A. -- damages analyses. It's valuation
2 analyses. It's solvency analyses. Oftentimes
3 there's a forensic accounting piece to it.

4 Again, that could be, as part of a
5 restructuring, very similar to a typical commercial
6 litigation.

7 Q. When you say "damages analyses,
8 valuation analyses," what's the analysis?

9 A. Can you be more specific?

10 Q. Well --

11 A. Because oftentimes it's
12 facts-and-circumstances dependent.

13 Q. Yeah. No, I -- I actually can't, but
14 mainly because I don't understand these things. So
15 I'm kind of asking you to sort of explain --

16 A. Yeah.

17 Q. -- you know, what is a valuation
18 analyses -- or analysis for a restructure?

19 Like, what is that thing?

20 A. It's to put a value on the company.

21 Q. Got it.

22 A. To --

23 Q. That makes sense, to put a value on a
24 company. So if a company is in bankruptcy, I would
25 assume their value is relevant; is that right?

1 A. Yes, because you have different
2 constituencies that are -- are going to reorganize
3 the company, and you need to know what that value
4 is to the individual stakeholders then.

5 Q. Right. Okay.

6 And so you and your team would work
7 on creating a valuation for -- of that company,
8 right?

9 A. If it's a valuation assignment, yes.

10 Q. And is -- what is the final output
11 there?

12 Is it, like, a dollar figure?

13 A. Oftentimes it's a dollar figure.
14 Sometimes it's a range.

15 Q. And at -- at a very high level, because
16 I don't want to have you going on for -- on and on,
17 but just how did -- how does -- how do you do that?

18 How does one create a dollar value
19 figure for --

20 A. There are standard valuation
21 methodologies that one applies. So take any
22 methodology, like a discounted cash flow analysis;
23 standard valuation technique across to all
24 companies, right? But you apply it to the company
25 at issue, the facts and circumstances related to

1 that company, to come up with a valuation.

2 That is one example of a generally
3 accepted valuation standard that I have applied for
4 25-plus years.

5 Q. And forgive me. This is, like, a dumb
6 way of phrasing it.

7 But does that involve large
8 spreadsheets?

9 A. I mean, it -- it can.

10 Q. Does it typically?

11 A. I mean, oftentimes one of the tools we
12 use is a spreadsheet.

13 Q. Right. I'm envisioning, like, a -- a
14 pretty large spreadsheet that lists a bunch of
15 inputs for a company and does some math to help
16 calculate what the dollar value of that company is.

17 Is that -- am I imagining correctly?

18 A. It -- it could be. Other times it could
19 be very simple where you have an EBITDA figure and
20 you apply a multiple to it. So you don't
21 necessarily need a large spreadsheet to be able to
22 do that.

23 Q. You must get paid less for those.
24 Strike that. Strike that. It sounds easier.
25 Okay.

1 And these -- and, well, we'll stick
2 to, I guess, sort of the -- say, the discounted
3 cash flow analysis. That's typically done with
4 sort of like a large spreadsheet or chart of inputs
5 of -- of many different figures; is that right?

6 A. I -- it's -- it's
7 facts-and-circumstances dependent.

8 Q. All right. Fair enough. When you're
9 doing the -- the restructuring work for -- for a
10 company that's in bankruptcy, where do you get the
11 information to -- to calculate what the final --
12 what your final valuation is?

13 A. It depends.

14 Q. Okay. Does it sometimes come from the
15 company itself?

16 A. Sometimes it comes from the company.
17 Sometimes it comes from other third-party sources.
18 Again, it's facts-and-circumstances driven.

19 Q. And what types of information are you
20 typically seeking to get for, let's say, just a
21 discount cash flow analysis?

22 Is there -- is there revenue or --

23 A. Well, I mean --

24 Q. -- everything is lost profit? I --

25 A. -- as the name would suggest, we want to

1 get down to cash flows, and so you could start at
2 revenues. Oftentimes you do.

3 But at the end of the day, you're --
4 you're looking to get to free cash flows, so cash
5 flows that could go to the equity owners, if you
6 will. And so you tabulate those up, and you
7 discount them back to a present value to get a
8 single number or a range as of the valuation date.

9 Q. Got it. And then just the next one on
10 this list is "workouts." What's a workout in this
11 context? A workout in this --

12 A. A workout in this context would be maybe
13 something short of a formal restructuring or
14 bankruptcy. So you might have a troubled company,
15 and there might be some analyses or plans to
16 basically work out the issue, if you will, before a
17 formal, you know, Chapter 11 or Chapter 7 filing.

18 Q. So is the -- the work that's done there
19 similar to the restructurings work that we've just
20 been discussing?

21 A. It can be. Again, it's
22 facts-and-circumstances dependent.

23 Q. Sure. And then the next item on here is
24 "distressed companies." What's -- you list here,
25 one of your specialties is distressed companies.

1 What does that mean?

2 A. It's -- it's -- the restructuring,
3 workouts, and distressed companies are all kind of
4 linked together. It's really a different stage of
5 where the company is and what's required, right?

6 Oftentimes it could be part of, you
7 know, a sales process or a valuation would have
8 come in. It could be also be part of a -- a
9 dispute where the company is distressed because
10 there's been a breach of contract, and there needs
11 to be an economic damage quantification.

12 Q. Got it. So for each of these so far
13 that we've been talking about -- restructurings,
14 workouts, and distressed companies -- the work that
15 you're typically doing is valuation work?

16 A. Not necessarily. There could be damages
17 pieces in there, as well. There could be forensic
18 accounting pieces. There could be solvency pieces,
19 as well.

20 The distinction from my perspective
21 is oftentimes it's maybe not a formal commercial
22 litigation, the setting for those -- for those
23 types of work, but it's oftentimes the very same
24 type of work I would be doing regardless if it's in
25 a formal commercial litigation setting or -- or

1 not.

2 Q. I guess my question was -- maybe
3 "valuation" was the wrong term. But is -- for each
4 of these three so far -- restructuring, workouts,
5 distressed companies -- is the output of your work
6 typically a dollar figure?

7 A. Not necessarily.

8 Q. Not necessarily.

9 Well, is it ever a dollar figure?

10 A. It could be if -- if part of the scope
11 is to place a dollar figure on the value of a
12 company or the value of a security or the value of
13 the position in the company, it could be, but not
14 all the time.

15 Q. It could be a dollar range?

16 A. It could be a range. Sometimes it's not
17 a valuation exercise.

18 Q. Got it. I'm just trying to ask just --
19 the majority of the time. I'm not asking for,
20 like, the -- the weird outlier specifics.

21 But the majority of the time, is the
22 work a dollar figure or dollar range?

23 A. No, not necessarily. Again, it's --
24 it -- it -- it's -- it's not necessarily just a
25 valuation exercise where you're putting a value on

1 a company. I -- I do much more than just the
2 valuation work.

3 Q. Sorry. And I'm not trying to, like,
4 minimize what you're doing. I'm just trying to
5 understand.

6 So what else -- what else do you do
7 for these -- for these three examples, aside from
8 valuation? You've talked about forensic
9 accounting. What's forensic accounting in this
10 context?

11 A. It's -- it's basically an investigation
12 of -- from an accounting perspective to -- you
13 know, let -- let me give you an example on forensic
14 accounting.

15 So as part of the Purdue Pharma
16 bankruptcy, the maker of OxyContin, I was asked by
17 the special committee of the board of directors to
18 perform a financial -- or a forensic accounting
19 analysis for a period of ten years preceding the
20 bankruptcy day to make a determination of,
21 effectively, where all the money went.

22 So I -- there's a 420-page expert
23 report that one can go find on the bankruptcy
24 docket that delineates, I think, 26 different types
25 of transactions between Purdue Pharma and the

1 Sackler family that owned Purdue Pharma at that
2 time. It was for the benefit of the court and the
3 stakeholders to understand where all the money
4 went.

5 So that would be an example of a
6 forensic accounting analysis. It's not a valuation
7 analysis. It's not an economic damages analysis.

8 Q. That's very helpful. Thank you. That
9 probably saved us many more questions that I was
10 going to ask. That's helpful.

11 So -- so we talked about valuation
12 and forensic accounting. I think you listed a
13 couple others.

14 Can you just remind me, what are sort
15 of the other tasks or outputs you would have done
16 for -- for restructuring, workouts, distressed
17 companies?

18 A. Again, it's facts-and-circumstances
19 driven. It could be valuation. It could be
20 forensic accounting. It could be economic damages
21 that we talked about. It's the same -- as I said,
22 I think more than once, it's the same kind of five
23 core competencies -- economic damages, valuation,
24 solvency, forensic accounting, and alter-ego-type
25 analyses -- that might be applicable to a

1 bankruptcy setting or a commercial litigation
2 setting.

3 Q. Got it. For economic damages, how does
4 that differ from -- I think I understand how it
5 probably differs from -- strike that.

6 How does economic damages, the final
7 output, differ from the final output to valuation?

8 A. Well, it's a different scope. The
9 economic damages, you're trying to quantify the
10 harm --

11 Q. Okay.

12 A. -- stemming from whatever the issue is,
13 whether it's a breach of contract or what have you,
14 right? It's a different-type analysis than a
15 valuation analysis.

16 So said differently, a valuation
17 analysis might be ascribing a value to the company
18 overall, right? Whereas, economic damages might be
19 ascribing a -- a missed opportunity, if you will,
20 that could affect the overall valuation, but it's
21 not a valuation exercise. It's -- it's simply
22 quantifying harm.

23 Q. And then I believe the other two -- I
24 don't remember if you said, like, sections or
25 pillars. But the other of the five you listed, the

1 other two were solvency and alter ego.

2 Could you just tell me very briefly
3 sort of what solvency is in this setting.

4 A. Sure. Solvency, again, is a very
5 specific prescribed methodology to be able to
6 determine if a company is either balance sheet
7 solvent or insolvent. Are the assets more or less
8 than the liabilities? That's balance sheet
9 solvency, or, typically, cash flow solvent. Do
10 they have enough cash flow to be able to pay their
11 debts as they come due?

12 So there are prescribed methodologies
13 to be able to do those analyses. So that's the
14 type of solvency work that I do.

15 Q. And for that solvency work, where do you
16 get the, I guess, inputs for that? Is that from
17 the company itself?

18 A. Oftentimes it's from the company,
19 particularly when you have cash flow projections or
20 historical financials. But also it could be inputs
21 from third-party sources.

22 Q. And what's an example of a third-party
23 source here?

24 A. It could be, for example, to go back to
25 our credit rating agencies. They might have a

1 different view of what a set of projections might
2 look like for the subject company. So that would
3 be part of the consideration, is alternative views
4 as it relates to expected financial performance.

5 Q. And then alter ego, just briefly, what
6 is that for your work?

7 A. I mean, alter -- I call it alter ego.
8 Normally it's a type of analysis that -- again,
9 standard methodologies, there's standard tests that
10 courts often look at when they're making a
11 determination if one company is the alter ego of
12 another company.

13 And so the alter ego work -- again,
14 often it could be valuation related, economic
15 related, forensic accounting related; but to be
16 able to offer the indicia, if you will, for the
17 benefit of the court. Ultimately it's a trier of
18 fact issue. But there, again, are standard
19 methodologies that the courts have historically
20 looked at, and those are the types of things that
21 I'm making observations about for the benefit of
22 the court, and making the determination of whether
23 or not alter ego exists.

24 Q. So is that analyzing things like who
25 owns a subsidiary company?

1 A. Ownership could be part of it.
2 Oftentimes, it's focused on day-to-day business
3 activities between two companies or two
4 subsidiaries or two related entities, looking at
5 the business relationship.

6 Q. Okay. That's very helpful.

7 So just going back to your LinkedIn.
8 So the other things you've listed are "valuation."
9 I believe for valuation, that's -- we've already
10 discussed that.

11 Do you have anything else to add for
12 what valuation means here on your LinkedIn?

13 A. Not specifically.

14 Q. And then "financial advisory," what does
15 that mean here?

16 A. Basically advising a company on
17 financial issues.

18 Q. What's an example of how you would
19 advise a company on financial issues?

20 A. An -- an example would be if there's --
21 excuse me -- if a company is, you know, undertaking
22 a sales process, they're trying to sell themselves
23 or a piece of the business, oftentimes I would be
24 advising on said process.

25 Q. Is -- does that involve testifying work

1 typically? I would think not.

2 A. No, it doesn't.

3 Q. Do you think that that's like advice,
4 like maybe how much you should charge or --

5 A. It's -- it's typically not in the
6 context of litigation.

7 Q. And then going back to your LinkedIn
8 here, Exhibit 1. So the last two I see are
9 "litigation consulting and expert testimony."

10 Could you just briefly say for the
11 record what you mean here for that.

12 A. Yes. It's -- it's me and/or my firm
13 getting hired in the context of litigation to
14 perform analyses related to economic damages,
15 valuation, solvency, alter ego, and forensic
16 accounting.

17 Q. Right. So it can subsume -- it can
18 include some of the things that are previously
19 listed, but then it -- the distinction is it's in a
20 litigation setting; is that fair?

21 A. I think that's a fair characterization,
22 yes.

23 Q. Great. All right. Let's -- if you
24 could just turn to page 2 of Exhibit 1. It's the
25 back here.

1 Do you see here, sort of in the top
2 of the page, it has, it looks like, two positions:
3 "Managing Director," and then below that, "Partner
4 and Managing Director."

5 Do you see that?

6 A. I do.

7 Q. And I think it's -- it's cut off at the
8 top, but it -- I assume, based on the dates, this
9 is referring to AlixPartners?

10 A. It would be, yes.

11 Q. Okay. Does this -- does this look
12 accurate to you?

13 A. Well, no, because it has me listed as a
14 managing director and a partner and managing
15 director at the same time.

16 Q. Right. And I think we discussed earlier
17 sort of what your timeline was.

18 You did start in 2004 at
19 AlixPartners, right?

20 A. That is correct.

21 Q. And I think we already talked about what
22 your -- your roles and positions were.

23 Fair to say that what you testified
24 to earlier today, I guess, overrides what's written
25 here?

1 A. Yeah. Again, I don't do too much
2 LinkedIn, so I'm not quite sure why there's two
3 different titles for the time period.

4 Q. I promise I'm not trying to ding you for
5 that. I just wanted to, you know, make sure
6 because it looked a little odd.

7 And then below that, you see there's
8 education. Does that look accurate to you?

9 A. Yes.

10 Q. It says University of Chicago, Master's
11 of Business. And then below that, University of
12 Notre Dame, Bachelor of Business Administration.

13 Does that look accurate?

14 A. Yes.

15 THE WITNESS: Can we take a break?

16 MR. TAKAGAKI: Yes, absolutely.

17 THE VIDEOGRAPHER: We are going off the record
18 at 10:19 a.m. with the end of Media No. 1.

19 (Short recess.)

20 THE VIDEOGRAPHER: We are back on the record
21 with the beginning of Media No. 2 at 10:30 a.m.

22 Counsel may proceed.

23 BY MR. TAKAGAKI:

24 Q. Just before we move on from your
25 LinkedIn, I see you didn't list it -- list any

1 specialties in economics or statistics; is that
2 correct?

3 A. They're not specifically listed. Just
4 like I don't list damage analysis. That would be
5 subsumed under "litigation consulting and expert
6 testimony."

7 Q. Okay. All right. I want to ask about
8 your prior testimony in your life. I believe your
9 CV lists you've done over 20 arbitrations or state
10 cases or federal cases where you've testified in
11 the past four years?

12 Does that sound accurate to you?

13 A. I'd have to look at my CV.

14 Q. Okay. Does 20 instances of testifying
15 over the last four years seem roughly accurate?

16 A. Again, I'd have to look at my CV.

17 Q. You're not sure or --

18 A. I -- I don't count.

19 Q. Okay. How many times have you testified
20 over the last four years, that you can recall?

21 A. Often. But, again, I don't count, so
22 I'd -- I'd have to look at my CV.

23 Q. And when you say "often," is that like a
24 couple times a year? A couple times a week?

25 A. It's --

1 Q. What's the kind of scale there?

2 A. It -- it depends on -- on the cases and
3 the -- the pace and the cadence of the -- the case.
4 It could be a couple times a year. It could be
5 more than that.

6 Q. Would it ever be, like, I don't know,
7 12 times a year?

8 A. Could be.

9 Q. Okay. And your testimony in those
10 cases, would it have involved the specialties that
11 we were discussing from your LinkedIn earlier
12 today?

13 A. It would -- typically, putting industry
14 aside, it typically involves issues related to
15 valuation, economic damages, solvency, forensic
16 accounting, or alter ego.

17 Q. I guess what I'm just getting at is do
18 you testify on things totally unrelated like First
19 Amendment or, you know, gun rights or something?

20 A. I have not, no.

21 Q. That's what I was trying to get to
22 there.

23 Do you recall if any of the testimony
24 that you've done ever -- not in the last four
25 years, just any of your testimony -- let me pause

1 there.

2 Aside from testimony related to your
3 work, have you ever given testimony in a
4 litigation?

5 A. As not in an expert capacity?

6 Q. Right.

7 A. No.

8 Q. Like a car crash or --

9 A. No.

10 Q. -- you know, you witnessed something?
11 Okay.

12 So when I refer to your testifying
13 experience, that's referring to your work as an
14 expert consultant?

15 A. In the -- correct.

16 Q. Okay. So do you have any testifying
17 experience with regard to cases that were FDUTPA
18 cases, which I'll spell out? That's F-D-U-T-P-A,
19 the Florida Deceptive and Unfair Trade Practices
20 Act.

21 A. I'm sorry. Could you repeat that
22 question.

23 Q. Sure. It's a bad question. I need to
24 get the acronym out first.

25 But do you have any experience

1 testifying in cases where the case was involving
2 the Florida Deceptive and Unfair Trade Practices
3 Act?

4 MS. WOOD: Objection to form.

5 I think it's False Deceptive Unfair
6 Trade Practices.

7 THE WITNESS: I -- it -- it's quite possible.
8 I'd have to go back and look at the cases, to be
9 honest, if I had some cases in Florida. I -- I
10 just don't have a specific recollection if that was
11 the -- the -- the applicable part of the law, said
12 differently. I'm more focused on someone is asking
13 me to do an economic damage analysis. I'm more
14 focused on the damage analysis and -- and less on
15 the law.

16 BY MR. TAKAGAKI:

17 Q. That's fair. And I -- I just wanted to
18 see if you had a recollection of it.

19 Do you recall any testifying where
20 the case prior -- other than this case, do you
21 recall any test- -- testifying where the case
22 involved a hospital ratings system?

23 A. I -- I don't recall a case that was
24 specifically focused on hospital ratings. It -- it
25 would have been -- again, in the context of, you

1 know, a damage analysis or a valuation analysis it
2 would have been -- would have been focused on, I
3 don't have a specific recollection of one that was
4 focused on hospital ratings themselves.

5 Q. And when I say -- I guess I can ask the
6 question again. Do you have a -- any testifying
7 experience where the underlying case related to
8 hospital grading systems or hospital grades?

9 A. Again, I don't have a specific
10 recollection of that. It would have been more
11 along the lines of quantification of damages, as an
12 example.

13 Q. Understood. Fair enough. And this
14 isn't a memory test. I'm just trying to get a
15 general understanding of your -- your experience.

16 Have you ever in your career had an
17 expert opinion be excluded?

18 A. I've never had -- I've never had a
19 successful Daubert challenge. Let's put it that
20 way. I have had one partial opinion limited for
21 legal reasons.

22 Basically, I did some sensitivity
23 calculations as it related to a dispute over an
24 earn-out payment. And so I did some sensitivities
25 at the request of counsel to say if you assume

1 this, this is how the earn-out pay -- payment
2 would -- and the Court did not let in two of those
3 sensitivities because the Court's opinion is that
4 that was effectively not supported by the legal
5 theory offered by counsel.

6 So that would be the one case where
7 I've had any -- any opinion excluded, or partially
8 excluded in this case.

9 Q. Got it. Do you remember the -- the name
10 of that case or?

11 A. It's on my CV. I think it's BBSR versus
12 Anheuser-Busch, if I'm not mistaken. But it was --
13 it's the Anheuser-Busch case that's listed on my
14 CV.

15 Q. Got it. And so I think you said part of
16 the opinion was excluded. So part of it came in?

17 A. Yeah, I had three -- or four main
18 opinions in there. The primary opinion, which was
19 a forensic accounting analysis, all good.

20 It was the sensitivities analyses
21 that were based on the earnout payment that the
22 judge ultimately said that the counsel's legal
23 position did not support inclusion of those in the
24 case record. Let's put it that way.

25 Q. And have your -- you ever had your

1 expert qualifications be challenged?

2 A. My qualifications themselves?

3 Q. Yeah.

4 A. No.

5 Q. Like, for example, has someone ever, you
6 know, argued you're not qualified to offer an
7 opinion on a certain topic?

8 A. I don't believe so because, again, what
9 I do for a living, I've been doing 25 years. And
10 so I think I'm well-qualified to offer opinions,
11 like, on damage analyses or on valuations, sure.

12 Q. No one would even try to challenge you.

13 A. I don't have a recollection that someone
14 tried to get me excluded based on qualifications.

15 Q. Okay. Just to go back to some basic
16 questions.

17 Are you seeking to be an expert in
18 this case, qualified as an expert in this case?

19 A. I've provided my opinions as it relates
20 to my review of the plaintiffs' experts. So...

21 Q. Put -- put it this way: You're offering
22 an expert opinion in this case, right?

23 A. I -- I have two primary opinions based
24 on my review of the -- the plaintiffs' experts'
25 reports, yes.

1 Q. Okay. When were you first contacted
2 for -- about this case?

3 A. I believe sometime in August.

4 Q. August of 2025?

5 A. Correct.

6 Q. Okay. Do you recall who contacted you?

7 A. Counsel at Wilson Elsner [sic].

8 Q. Counsel at Wilson Elser?

9 A. Oh, did I put an N in it? Sorry about
10 that. Yes.

11 Q. Yeah, could you just briefly describe
12 what this current case is about.

13 A. Could you be more specific.

14 Q. Yeah. The -- the lawsuit that's brought
15 us all here today, could you just briefly describe
16 your understanding of what the -- the lawsuit is
17 about.

18 A. Well, I wasn't necessarily focused on
19 the lawsuit, specifically. I can tell you my view
20 of the case.

21 Q. Sure.

22 A. It -- it's basically Plaintiffs have
23 offered three experts who, as I read it, have
24 alleged that the -- the five hospitals at issue
25 have been harmed, in their opinions.

1 And so I was retained to comment on
2 their expert reports; namely, the lack of a
3 quantification of the harm and my opinions of
4 whether or not that one could reasonably quantify
5 the harm.

6 And then, number two, I was asked to
7 run a sensitivity, if you will, related to the
8 gradings themselves, the actual workbook that is
9 used by Leapfrog Group as well as hospital systems,
10 to estimate what their grades would be.

11 So I was asked to run a sensitivity
12 that said if one excludes the four imputed metrics,
13 you know, what -- what -- what's the results? What
14 does that show. And there's a consistency across
15 the different measures in the ultimate grade.

16 Q. And sounds like you're kind of -- I
17 don't want to put words -- words in your mouth, so
18 correct me if I'm wrong.

19 But are you offering sort of two
20 opinions in this case? Is it fair to break them
21 down into two opinions?

22 A. I think that's fair. I think,
23 number one, if one wanted to, one could quantify
24 the damages here. That's Opinion No. 1.

25 And Opinion No. 2, if one excludes

1 the -- my understanding of the disputed imputed
2 grades from the grading calculation altogether,
3 what is the output for -- or said differently, I
4 view it as there's a consistency of all the
5 different measures that are going into the ultimate
6 grade such that if you exclude four of them, you're
7 still getting the same type of grading, again,
8 based on the workbook that is used by Leapfrog
9 Group as well as the hospitals themselves.

10 Q. And for those two opinions, were you
11 asked by counsel -- or were you asked by someone to
12 put forth those opinions?

13 A. Well, yeah. I was asked to, number one,
14 review the three expert reports; and then,
15 number two, I was asked my opinions of what I
16 thought of them.

17 Ultimately, those were the
18 two opinions that I've -- I've offered thus far in
19 this case.

20 Q. Were you asked to -- to look at any
21 other topics for a potential opinion?

22 A. I don't -- I don't believe so.

23 Q. Do you recall your hourly rate that
24 you're charging for this case?

25 A. \$1,275 per hour.

1 Q. And is that for flat across: You're
2 reviewing documents, drafting opinion, testifying?

3 A. There's only one -- excuse me -- I only
4 have one -- one rate. Excuse me.

5 Q. No problem. If you need --

6 A. No, I'm good.

7 Q. Okay. Is that the same -- is that your
8 standard rate?

9 A. I mean, the rate changes every year, but
10 yes, that's my standard rate.

11 Q. For 2025? That's your rate for 2025?

12 A. Yes.

13 Q. And you mentioned earlier teams that
14 you're on. Does that rate include additional
15 support from your teams?

16 A. Does the rate include what?

17 Q. Do the other members of your teams at
18 AlixPartners also charge that rate?

19 A. No.

20 Q. Do they charge a rate at all to the
21 client?

22 A. Yes.

23 Q. Okay. Do you know what their rates are?

24 A. Off the top of my head, no.

25 Q. Okay. Do you know roughly how many

1 people are on your team for this case?

2 A. I think on this one there may be two
3 people that were supporting me.

4 Q. Do you remember who the -- or do you
5 know who the names of the people are?

6 A. One would be Gary Gutzler, and then the
7 other one, I'm drawing -- it's Ivan. I'm -- I'm
8 drawing a blank on Ivan's last name, though, but it
9 would have been a gentleman named Ivan.

10 Q. Okay. So you, Gary, and Ivan were sort
11 of the three people from the AlixPartners team who
12 have worked on this case?

13 A. Correct.

14 Q. And I believe you said you're -- you
15 don't recall what Gary and Ivan's rates are?

16 A. Yeah. I don't -- I don't recall as I
17 sit here.

18 Q. Is it less than your rate?

19 A. Yes.

20 Q. Anyone else from AlixPartners help you
21 out with this matter?

22 A. Those are the two gentlemen that I
23 recall. I mean, it's possible that Gary asked
24 someone else to do something and I'm not aware, but
25 those are the two -- two gentlemen that I recall.

1 Q. And how are -- well, I guess I'll start
2 with you.

3 How are the -- how are you
4 compensated? Not your rate that you're charging,
5 but how are you compensated from AlixPartners? Is
6 it -- I'll leave it there.

7 How are you compensated from
8 AlixPartners?

9 A. I get a combination of -- of cash
10 compensation as well as equity compensation.

11 Q. And is that how Gary and Ivan are
12 compensated, as well?

13 A. They would be getting cash compensation
14 only.

15 Q. And I take it that you're -- the
16 rate -- well, strike that.

17 Your compensation from whoever is
18 paying you in this case is not dependent on the
19 outcome of your opinions; is that right?

20 A. That's correct.

21 Q. It's not dependent on the outcome of
22 your testimony?

23 A. That's correct.

24 Q. Is Gary or Ivan's compensation tied to
25 the outcome of your testimony?

1 A. No.

2 Q. Or the outcome of your opinions?

3 A. No.

4 Q. Or the outcome of this case?

5 A. No.

6 Q. You filed a report in this case, right?

7 A. That's correct.

8 Q. Do you recall roughly how many hours you
9 spent preparing it?

10 A. I don't.

11 Q. And when I say "preparing it," I guess
12 we can go with just -- we'll break it down to
13 actually drafting the report.

14 Do you recall how many hours roughly
15 you would have spent drafting?

16 A. I -- I -- it wasn't insignificant, but
17 I'd have to go back and look at an invoice.

18 Q. Sure. And when I talk about you, I'm --
19 I'm referring to just you, not Gary or Ivan or
20 anyone else. We can break those down later. But
21 just for you, that -- these questions are for you
22 specifically.

23 So for drafting, it sounds like you
24 can't recall. You'd have to check?

25 A. Again, it wasn't insignificant, but I'd

1 have -- to get a specific number, I'd have to go
2 back and look at the invoice.

3 Q. Sure. Was it less than 100 hours?

4 A. Probably. My personal time, probably
5 less than 100 hours, yes, just given the scope of
6 my assignment, you know, which would have started
7 with reviewing the three expert reports and forming
8 my opinions. So...

9 Q. Understood. And I'm not trying to --
10 I'm not judging how much work -- how much time.
11 I'm just trying to understand.

12 Would it have been less than 50
13 hours?

14 A. I don't know. Again, it could have been
15 less than 50. Probably was more, but I'd have to
16 go back and look at the invoice.

17 Q. Okay. And what about -- and -- well,
18 did you draft this report solely yourself?

19 A. I had assistance from Gary.

20 Q. Anyone else?

21 A. It would have been the -- myself and --
22 and -- and Gary.

23 Q. Okay. Do you have a rough recollection
24 of how much Gary would have spent drafting? How
25 many hours?

1 A. I don't.

2 Q. Less than 100?

3 A. Again, I'd have to look at the invoice
4 to know exactly how much time Gary was spending.

5 Q. Sure.

6 Less than 50?

7 A. I -- I would be surprised if it was less
8 than 50.

9 Q. Sure.

10 And so that was for drafting the
11 report. I guess let's talk about sort of
12 everything related to the report in terms of
13 reviewing other documents, research, strategizing
14 ideas, but excluding prepping for this deposition.
15 So I'm just talking about the report only, getting
16 it out the door.

17 Do you recall roughly how many hours
18 you would have spent on that?

19 A. Not specifically. What I can tell you
20 is this was a primary focus of mine for a couple
21 weeks.

22 Q. And is that -- what about for Gary? Do
23 you have a rough sense of how many hours he would
24 have spent working on the report?

25 A. Again, without looking at the invoices,

1 I can't speak specifically for Gary. But, again, I
2 know we were working closely together over the
3 course of a couple weeks. So I would imagine he
4 was -- it's was probably something similar, if not
5 more.

6 Q. Yeah. I would hope it's more. I mean,
7 unless -- why be the head of your team?

8 A. I like to be involved.

9 Q. And what about Ivan? Was he -- is -- do
10 you have a rough sense of how many hours that he
11 would have spent working on the report total?

12 A. I don't without looking at the invoice,
13 as well.

14 Q. More than 50 hours?

15 A. Again, I would -- I'd have to go back to
16 look at the invoices. I -- I wouldn't want to
17 speculate.

18 Q. I'm sorry. Just for my own knowledge,
19 how is Ivan spelled? Is it I-v-a-n?

20 A. Yes.

21 Q. When were -- I believe you just
22 testified that you were contacted about the matter
23 in August of this year.

24 Do you recall when you were retained?

25 A. It would have been about the same time.

1 Q. I guess we'll just stick with the last,
2 say, four years at AlixPartners.

3 What percentage of your work is
4 expert work?

5 A. It -- it -- it depends on the year. It
6 can oscillate a bit. But the -- the majority of my
7 work is expert work.

8 Q. Can you list the different matters that
9 you've been -- in which you've been retained by the
10 defendant in this case, The Leapfrog Group?

11 A. I'm sorry. Can you repeat that
12 question.

13 Q. Yeah. Have you ever worked for The
14 Leapfrog Group before, prior to this matter?

15 A. No.

16 Q. This is your first matter for The
17 Leapfrog Group?

18 A. That's correct.

19 Q. And what about for the -- the law firm
20 in this case that retained you, Wilson Elser?

21 A. I recall one other case.

22 Q. And what case was that?

23 A. I'd have to refresh looking at my CV,
24 but I think it involved a firm called Wakem,
25 W-a-k-e-m. It involved damages, economic damages,

1 related to cryptocurrency.

2 Q. And do you recall, what year was that?

3 A. It wasn't this year. I mean, it's on my
4 CV, so it's in the last four years. I don't know
5 if it was 2024 or 2023, though.

6 Q. For that case, the -- I'll call it the
7 Wakem case, did you work with any of the attorneys
8 you're working with for this matter?

9 A. No.

10 Q. Did you prepare for today's deposition?

11 A. Yes.

12 Q. How did you prepare?

13 A. I reviewed my report and related
14 materials.

15 Q. And when you say "related materials,"
16 what would those be?

17 A. Materials, for example, that are cited
18 in my report and/or cited in the plaintiffs' expert
19 report.

20 Q. Did you look at -- do you recall looking
21 at anything that wasn't cited in your report or any
22 expert's reports?

23 A. I don't have that recollection.

24 Q. Did you meet with counsel to prepare for
25 this deposition?

1 A. We had a brief conversation, yes.

2 Q. Roughly how long was that conversation?

3 A. Maybe 30 minutes, give or take.

4 Q. And that was just to prepare for the
5 deposition, right?

6 A. Mm-hmm.

7 Q. Did you -- I assume you had meetings
8 with them prior to submitting the report, correct?

9 A. Yes.

10 Q. Okay. Did counsel -- for the 30-minute,
11 roughly, meeting you had to prepare for the
12 deposition, did counsel give you any documents to
13 review?

14 A. I don't believe so, no.

15 Q. Is every opinion that you intend to
16 offer at trial included in your report?

17 A. Those are the opinions I anticipate
18 offering. At this point in time, I don't
19 anticipate offering anything different.

20 Q. Understood.

21 Have you ever had to correct one of
22 your reports?

23 A. What do you mean by "correct"?

24 Q. Submit a new version to correct a
25 mistake or -- or alter something. Maybe not a

1 mistake, but have you ever had to -- yeah, correct
2 a report?

3 A. I -- I am almost certain I've never
4 reissued a report. Have there been, you know, a
5 few instances over time where there's been
6 immaterial errors or something and I've noted those
7 for the record? Yes, that's occurred from time to
8 time. But I didn't -- I do not believe I've ever
9 resubmitted a report for any reason.

10 Q. Yeah, and that's what I was getting at,
11 not minor typos.

12 Aside from reports, have you ever --
13 have you ever published anything?

14 A. No. I mean, no, because that's not an
15 active part of my practice.

16 Q. Sure. Maybe the occasional client
17 update or something?

18 A. Yeah, maybe some internal stuff, you
19 know, that type of stuff. But, no, you know, in --
20 out to the market, that's typically not what I do.

21 Q. I want to talk a little bit about your
22 damages opinion in this case.

23 Do damages vary -- strike that.

24 Does a damages analysis that you
25 would conduct vary based on the type of business

1 you're evaluating?

2 A. The -- it -- it could. Again, the --
3 the methodologies are -- are pretty standard across
4 cases, industries, companies, right? And so like a
5 but-for damage analysis, that's -- that's a
6 classic, you know, accepted damages framework.

7 Where it could vary is obviously the
8 facts and circumstance as it relates to the
9 individual company and, you know, how the
10 projections might look from one company to another.
11 That's what would vary, but the methodology is the
12 same.

13 Q. But, I mean, I think you said earlier,
14 there are different types of damages methodologies
15 that one could use, right?

16 A. There -- there could be. And I think
17 what you're recalling is I said that in the context
18 of valuation. We hadn't yet talked about damages
19 methodologies.

20 But, yeah, there are some different
21 damages methodologies, but, you know, the one I
22 referred to immediately was a but-for damage model.
23 At the end of the day, they're all geared toward
24 trying to quantify the alleged harm.

25 Q. Right. Okay. So would -- I -- I know

1 your report talks about some of the different
2 damages methodologies. Is it true that you
3 wouldn't necessarily use each of those to -- you
4 know, for a specific case? You would maybe pick
5 one or maybe more than one, but typically focus on
6 just one of those, right?

7 A. I mean, the ones I note in my report
8 are, in some regards, all variations of kind of the
9 same concept, right? The but-for damage concept,
10 which says but-for the alleged bad acts, what
11 would've occurred versus what actually did occur,
12 and to the extent that there's a -- a difference.
13 That -- that is a quantification of the damages.

14 Q. But I guess in some -- and I guess it
15 depends, as you said, on the case, what information
16 is available to you. But in some instances, you
17 might use the profits to -- you know, as the focus
18 for your damages analysis, and in another case, you
19 might use the -- the revenue; is that fair?

20 MS. WOOD: Objection to form.

21 THE WITNESS: Yeah, I -- I wouldn't categorize
22 or characterize it as that. At the end of the day,
23 you're trying to quantify the economic harm, right?
24 And so profits are -- are a better representation
25 of that economic harm than just revenue.

1 BY MR. TAKAGAKI:

2 Q. Sure. But if it was, let's say, I don't
3 know, the destruction of a physical property --
4 right? -- that may entail some type of different
5 analysis than just loss of profits; is that fair?

6 A. Can you be more specific.

7 Q. Yeah, like, if you owned a construction
8 company -- I think you mentioned construction was
9 one of the areas you worked on -- and, you know, a
10 fire burned down all their bulldozers, I would
11 assume that that specific fact pattern would
12 require a different type -- some different types of
13 damages methodology than, say, someone who breached
14 a contract?

15 A. No, I would still apply a but-for damage
16 analysis because you can quantify the financial
17 impact of losing that factory, I think you -- maybe
18 you said. And that's how one would quantify the
19 harm --

20 Q. Okay.

21 A. -- of losing that.

22 Q. Okay. So it doesn't -- it doesn't
23 really vary based on the type of industry; like I
24 was using a construction company that has a lot of
25 real -- not real property but tangible assets?

1 A. The -- the elegance of the but-for
2 damage model is that it applies across all
3 industries, all companies, because it's -- it's
4 very simple: But for something occurring, what
5 would have occurred versus what actually occurred.
6 And so that applies across companies, across the
7 industries, across facts and circumstances, right?

8 Q. Is it fair to say that you would at
9 least approach your task differently when you're
10 doing expert damage analysis, depending on the type
11 of company?

12 A. No.

13 MS. WOOD: Object to form.

14 THE WITNESS: Not necessarily.

15 BY MR. TAKAGAKI:

16 Q. Not necessarily, but sometimes you
17 might, right?

18 A. No. I think -- I think at the end of
19 the day, it -- it's a very simple question you're
20 trying to answer here, is what is the
21 quantification of the harm, right?

22 And so if that's how I'm approaching
23 it, that's the starting spot for almost all of
24 the -- the damage cases that I've been involved
25 with for over 25 years.

1 Q. Well, what if it's -- it's not a
2 business? What if it's a person and their harm is,
3 you know, you defamed me or something? I assume
4 you can't look at profit there, right?

5 A. You -- you can look at lost
6 opportunities or how that defamation hurt someone
7 from a financial perspective.

8 Q. Right.

9 A. But maybe it didn't.

10 Q. But my question is specifically: You
11 can't look at a specific person's profit if it's
12 just, hey, you harmed my reputation?

13 MS. WOOD: Objection to form.

14 THE WITNESS: I -- I disagree, and I can give
15 you an example. I worked on a case involving -- do
16 you know who Kesha is, the singer?

17 BY MR. TAKAGAKI:

18 Q. I do. But with all due respect, you're
19 not supposed to ask me questions, so I won't answer
20 them.

21 But my -- my point is just that there
22 are some instances where it's not a business and
23 they're still suing, claiming that they're harmed.
24 And in that case, if it's not a business and
25 there's no business or financial implications, then

1 lost profits is necessarily not applicable.

2 Is that -- would you -- do you
3 disagree with that?

4 A. I do disagree with that, and I can give
5 you examples of where defamation, you can quantify
6 a harm.

7 Q. I'm not saying that there's no possible
8 example that exists, but I'm asking if there's a
9 possible example that exists where lost profits
10 simply cannot be used because there's no form of
11 profit involved in this person's life whatsoever?

12 MS. WOOD: Objection to form.

13 THE WITNESS: I'd -- I'd -- you'd have to be
14 very specific with me. But as I sit here now, I
15 disagree with that because, again, over the course
16 of my career, I can't think of an instance where
17 there was an alleged harm where we couldn't
18 quantify the alleged harm.

19 BY MR. TAKAGAKI:

20 Q. I -- I'm not asking about quantifying
21 the alleged harm. I'm using a specific word again
22 and again. It's the profit. And maybe I'm using
23 it incorrectly. But my question is is it your
24 testimony that there's not a -- and -- and, also,
25 I'm not asking about in your career.

1 But just in general, is it your
2 testimony that there is never an instance where a
3 damages analysis could involve not considering lost
4 profit?

5 MS. WOOD: Objection to form.

6 THE WITNESS: I -- as I sit here -- and,
7 again, I'd have to base it on my career, because
8 that is my experience -- I cannot recall an
9 instance where we couldn't quantify the harm,
10 whether it's a breach of contract or a defamation.

11 I just -- I don't recall one where we
12 couldn't, you know, apply a standard damage
13 methodology to be able to quantify it.

14 BY MR. TAKAGAKI:

15 Q. And, again, I'm not asking about
16 quantifying the harm or applying standard
17 methodology. I'm literally asking about profit.

18 Is there a situation where profit
19 could play no role in -- in your damages analysis?

20 A. Profit, to me, if there is a profit,
21 right, that is a part of the quantification of the
22 harm. I can't -- I can't separate the two. That's
23 my point.

24 Q. What is profit?

25 A. What do you mean, "what is profit?"

1 Q. You've -- we've been using that word
2 "profit." You're saying -- profit sounds like it's
3 a key component of your damages analysis.

4 I'm asking what do you take the term
5 "profit" to mean?

6 A. Well, it can mean different things for
7 different companies, but at the end of the day,
8 from a financial perspective, it's the -- it is the
9 net economic benefit to a person or a company.

10 Q. So if you -- if somebody is a retiree in
11 an old folks' home and they get punched, how does
12 profit play a role in their damages there?

13 MS. WOOD: Objection to form.

14 THE WITNESS: Well, I mean, if they get
15 punched, one way that one can quantify the damages,
16 right, is out-of-pocket cost. That is a form of
17 profit. You otherwise would not have had to go to
18 the hospital, as an example, right?

19 BY MR. TAKAGAKI:

20 Q. I understand. I understand.

21 So in your use of the word "profit,"
22 it could be someone having to spend money to get
23 treated for being punched?

24 A. That's -- that's an example, yes.

25 Q. Okay. That's helpful, and I think that

1 might explain why we're disagree -- or strike that.
2 Thank you.

3 So is it fair, then, if you're --
4 the -- the type of person or entity involved that
5 you're analyzing, you would have to take into
6 account the specific harm to understand where to
7 look to measure that, right? Do you agree with
8 that?

9 A. I mean, it's -- in some respects, it is
10 facts-and-circumstances driven, yes.

11 Q. Like an example we were using where a
12 retired person living in a, you know, care facility
13 is punched, you would -- you would want to know how
14 much did they spend on their hospital bills?

15 A. That -- that is an example of a -- the
16 typical category of damages, out-of-pocket damages.

17 Q. Got it. And then given that that
18 person -- given that that person is -- you know,
19 doesn't have profit and loss, they're paying
20 out-of-pocket hospital expenses, you would not be
21 focused on their profit, at least in that case,
22 right?

23 A. Oh, I mean, an expense is a form of a
24 negative profit. I mean -- so, yes, I'm still --
25 at the end of the day, I'm still focused on the

1 economic consequences, if you will, of getting
2 punched in the face.

3 Q. Got it. And if you were representing,
4 say, a publicly traded company and you wanted to
5 know the harm, their damages, I would assume you
6 would ask them for different documents than you
7 would ask the retired person who is punched in the
8 face, right?

9 MS. WOOD: Objection to form.

10 THE WITNESS: Perhaps. It -- it depends on,
11 again, the facts and circumstances.

12 BY MR. TAKAGAKI:

13 Q. The retired person, you would ask to see
14 their -- their hospital bill, right?

15 A. It could be their hospital bill. It
16 could be opportunity costs of getting punched in
17 the face and you missed an opportunity. That could
18 be a form of damage, as well.

19 Q. And when you're looking at two companies
20 who are suing each other for breach of contract, I
21 assume you're not asking to -- you're most likely
22 not going to ask to see their hospital bill, right?

23 A. I doubt a hospital bill would exist in a
24 corporate breach of contract, but you never know.

25 Q. I believe earlier -- have you ever

1 conducted -- apologies if you've already answered
2 this. But have you ever conducted a damages
3 analysis for a hospital?

4 A. Yes.

5 Q. Can you tell me, was it multiple
6 instances or one?

7 A. Several -- several instances. We talked
8 about it earlier, failed Enterprise Resource
9 Planning system is an example. There were several
10 cases that I recall with hospitals, health care
11 systems where the implementation of the whole
12 resource planning system was done improperly, and
13 as a result, it had financial consequences to the
14 hospital or hospital system.

15 Q. So sorry. Can you break that down? I
16 think the first one you mentioned was -- was it
17 ERP? Was that the --

18 A. Yes.

19 Q. Can you just -- what is ERP?

20 A. The ERP stands for Enterprise Resource
21 Planning.

22 Q. And what is Enterprise Resource
23 Planning?

24 A. It -- it's a computer software system
25 that helps run a hospital.

1 Q. And -- and this -- do you remember the
2 name of this case?

3 A. There was multiple.

4 Q. Multiple cases involving ERP?

5 A. Yes.

6 Q. Do you remember the name of one?

7 A. I remember it involved -- I believe
8 Arthur Andersen was one that -- they were trying to
9 implement one of them. But, again, there's
10 probably -- probably at least a half dozen of these
11 I've worked on over my career.

12 Q. Okay. So for the Arthur Andersen case,
13 do you remember the parties in the case?

14 A. No, I don't, unfortunately.

15 Q. That's fine. I understand.

16 So for the Arthur Andersen, I think
17 you said it -- it related to ERP. What were you
18 specifically looking at there?

19 A. We were quantifying the economic -- the
20 harm to the hospital or hospital system of the --
21 the ERP system not being fully implemented
22 correctly. So there was financial consequences
23 of -- of it not being up and running correctly.

24 Q. Did you find that there were in fact
25 economic consequences, economic harm?

1 A. My recollection is yes, that we were
2 able to quantify the -- the financial damages that
3 the hospital was seeking.

4 Q. And was your client the hospital in that
5 case?

6 A. I think -- over the course of the --
7 half dozen or so, I think it was probably half on
8 the hospital side and probably half on the -- the
9 software company side.

10 Q. Were they adverse to each other, the
11 hospital and the software company?

12 A. They were different cases.

13 Q. Oh, I'm sorry. I'm just talking about
14 the Arthur Andersen ERP case only, unless there
15 were multiple.

16 A. There were multiple, because it wasn't
17 an isolated incident with Arthur Andersen.

18 But, again, I -- I think the
19 engagement over the course of those six or so
20 cases, some were on the hospital side and some were
21 on the -- the -- either Arthur Andersen side or --
22 I'm trying to remember who the software company
23 was. But it -- it would have been, I think,
24 half -- almost half and half, if that makes sense.

25 Q. Got it. Were these six or seven cases

1 related in any way?

2 A. No. I think Arthur Andersen was a party
3 to a couple of them, if I recall correctly, but not
4 necessarily related.

5 Q. Was -- I guess I'm just trying to
6 understand, was this like one instance where
7 Arthur -- did Arthur -- strike that.

8 Did Arthur Andersen -- were they the
9 party who created the ERP software?

10 A. Yes.

11 Q. And were they being sued for something
12 about how they created it?

13 A. Failure to implement it correctly.

14 Q. Got it. And for these six or seven
15 cases, were they all related to Arthur Andersen
16 failing to implement the ERP?

17 A. No. I think a couple of them were
18 related to Arthur Andersen, and a couple of them
19 were related to another software company that --
20 I'm drawing a blank on who they were.

21 Q. Got it. So of those six or seven, is it
22 fair to say there were sort of two buckets; one was
23 the Arthur Andersen ERP bucket, and the other was
24 this other case?

25 A. I recall -- I wouldn't say it quite that

1 way. I recall more than a handful of ERP-related
2 systems in the health care hospital industry. I
3 recall Arthur Andersen was probably involved in at
4 least two, if not three, of those.

5 Q. And I think you said there were about
6 six or seven cases where you had to calculate
7 damages for a hospital.

8 Were those all involving ERP systems?

9 A. Generally speaking, yes.

10 Q. Okay. And so of those -- of the six or
11 seven cases you did for hospital damage, they all
12 involved ERP systems, but only some of them
13 involved Arthur Andersen's ERP system?

14 A. That is my recollection, yes.

15 Q. And then for the other -- so not the
16 Arthur Andersen cases -- I think you said that
17 there were maybe two or three Arthur Andersen
18 cases. So that leaves three, four other cases.

19 Do you remember the other -- were
20 that -- was that -- were those other cases all the
21 same company?

22 A. I don't recall specifically.

23 Q. Do you recall the other companies who
24 might have been involved?

25 A. I don't want to speculate. I think

1 Oracle was involved. But, again, I don't want to
2 necessarily speculate and throw their name under
3 the bus, but software companies like that.

4 Q. Okay. So we have Arthur Andersen,
5 Oracle, maybe another company, as well?

6 A. Yeah. I'm just drawing a blank.

7 Q. No problem. No problem.

8 And for each of those cases, Arthur
9 Andersen, Oracle, maybe the other company, had
10 created ERP systems?

11 A. My recollection is they were generally
12 ERP, but at the end of the day, it was effectively
13 breach-of-contract-type cases between a hospital,
14 hospital system, and effectively, a vendor, right?
15 And -- but it's -- my recollection is definitely
16 six or seven that were related to ERPs.

17 Q. Got it. And in each of those cases, did
18 you represent the -- or not represent -- did you
19 work for the software company?

20 A. I think it was -- depending on the case,
21 it was either the hospital or the software company.
22 I think it was almost evenly split.

23 Q. Got it. So in some -- when you
24 represented the software company, I assume that
25 their goal -- not your goal, but their goal -- was

1 to minimize the damage from their ERP system; is
2 that right?

3 A. Well, I think they disagreed with the
4 causation issues, which are obviously outside of
5 the scope of the quantification of the damages.
6 But, yeah, generally speaking, you know, they
7 thought they did a good job.

8 Q. Right.

9 And then for the hospitals in those
10 cases, they, I assume, were the plaintiffs saying
11 there was a problem with the ERP system?

12 A. Yes. They were claiming that there was
13 a problem with the system as a result. It was
14 negatively impacting the operations of their
15 hospital, which has financial consequences.

16 Q. Okay. And just to be clear, in some
17 instances you represented the hospital in those
18 cases, right?

19 A. Yes.

20 Q. And in some instances you represented
21 the software company in those cases?

22 A. Correct.

23 Q. Do you recall, just generally, when the
24 first type of these cases that we've been talking
25 about occurred? Was it when you were at

1 AlixPartners?

2 A. It would -- I think the first one
3 actually was probably when I was at Peterson or
4 Navigant. No, I don't know if that one was a
5 hospital. But there have -- there have been ones
6 definitely since I joined AlixPartners because I've
7 been there for 21 years.

8 Q. Sure. And I think you were at Navigant
9 and -- Peterson and Navigant up until about 2002 or
10 '3; is that right?

11 A. It would have been the same group,
12 though, right? And so not necessarily trying to
13 make a distinction of who was signing my paychecks
14 at the time, it would have been the same group I
15 worked with before I joined AlixPartners.

16 Q. I'm just trying to get a sense of -- so
17 maybe the first type of these cases, these six or
18 seven that we've been discussing, maybe the first
19 one was in the, fair to say, early 2000s?

20 A. I -- I think the first one was in the
21 early 2000s. And I think there's been ones, you
22 know, as recently as in the last couple years.

23 Q. Meaning sometime in 2023, 2024?

24 A. I think sometime post-COVID.

25 Q. Sure.

1 Did you conduct a damages analysis in
2 this case?

3 A. No, because it's my understanding the
4 information that one would use to conduct it was --
5 was made not available by the plaintiffs, as I
6 understand it. So the point being is, while I
7 understand the type of damage analysis that I would
8 have done, right, the information to be able to do
9 it was not made available to me.

10 Q. Have you ever conducted a damages
11 analysis for a -- in a case involving a FDUTPA
12 claim, F-D-U-T-P-A, the Florida Deceptive and
13 Unfair Trade Practices Act?

14 A. As I testified earlier, I've had cases
15 in Florida. I don't know if they were subject to
16 that act because, again, I'm not -- I'm less
17 focused normally on the legalese or the law and
18 more focused on I've been asked to perform a
19 damages analysis for a particular case.

20 And those look very similar to me,
21 regardless of where the case might be filed.

22 Q. Got it. I think we earlier -- we may
23 have been discussing just generally working on one,
24 not necessarily conducting a damages analysis. But
25 I think your answer is that whether you -- have --

1 if you ever conducted a damages analysis in a
2 FDUTPA case, you can't recall or be sure?

3 A. Again, I've done damages analyses in
4 Florida. I don't know if they were subject to that
5 particular law.

6 But my point was a little bit
7 different. Like, regardless of the law, right,
8 the -- the damage analyses, the economic analyses
9 tends to, you know, be the same type of
10 methodology, you know, with a little bit
11 differences between case and case based on facts
12 and circumstances.

13 Q. When you're conducting a damages
14 analysis, does it help to have some familiarity
15 with the business that you are assessing?

16 A. Not necessarily, because, again, the --
17 the -- the methodologies themselves, right, are the
18 same regardless of the business of their industry,
19 right? It's the facts and circumstances that
20 change a little bit, right? So obviously the
21 damages in a hospital case is going to look a
22 little bit different than damages in a construction
23 case.

24 But at the end of the day, the
25 methodologies are the same, and the types of

1 information that one would utilize would be the
2 same.

3 Q. Does it help to have a familiarity
4 with -- with the business at all?

5 A. Again, it -- it depends on the facts and
6 circumstances because, as I note in my report,
7 if -- if one is familiar with or knows how to do
8 but-for damages analysis, right, and knows the type
9 of information that's available that one would want
10 to been considered, be put as inputs into that
11 analysis, it -- you don't necessarily have to be an
12 industry expert, is what I'm saying, right?

13 Q. Yeah, yeah, fair. I'm not asking
14 whether you have to be an industry expert. I'm
15 just saying, does it help to have some knowledge
16 of, say, the entity's revenue streams?

17 A. Well, I think the -- even if one doesn't
18 have existing knowledge, one gains that knowledge
19 as part of the diligence of performing the
20 analysis, if that makes sense, right?

21 Q. And that's what I mean. I don't mean
22 coming into it ahead of time. I mean, as you're
23 doing it, does it help to have some familiarity
24 with the business?

25 A. Does what --

1 Q. Does the damages -- I'll strike that.
2 It was a bad question.

3 When you're actually doing the
4 damages analysis, not -- I'm not asking for coming
5 into it. But once you're actually doing the
6 damages analysis, does it help to have some
7 familiarity with the business you're analyzing?

8 A. Well, I think -- I don't know if I can
9 parse that or make that distinction because, by
10 definition, as you're doing the analysis, as you're
11 getting up to speed with a new company in an
12 industry maybe you've worked in before, but it's a
13 new company, as part of the diligence, as part
14 of -- of the process, if you will, you gain the
15 familiarity that you need. If not, then you can go
16 ask some questions.

17 Q. Right. And so would one of those
18 questions be "Tell me about the revenue streams at
19 this company"?

20 A. It -- it could be part of the diligence.
21 Obviously, if you're trying to quantify economic
22 harm, right, the beginning of that quantification
23 often starts with revenue.

24 Q. So I assume it would help to know, you
25 know, what kind of business is this? Do they

1 have -- do they sell products? Do they serve
2 customers? I assume that's something that you'll
3 have to get into eventually, right?

4 A. I mean, that's the part and parcel of
5 analyzing historical financials and then analyzing
6 projected financials, right?

7 Q. Would it be helpful to know if -- if --
8 at some point as you're doing the analysis, you'd
9 want to know if they were, say, a nonprofit versus
10 for-profit, right?

11 A. I think that would be part of, again,
12 analyzing historical financials, asking the right
13 questions, getting any other answers maybe from
14 management or from third parties.

15 But it's -- it's part of the
16 profit -- or a part of the process. And so if it's
17 a for-profit or a not-for-profit, that would be
18 reflected in the historical financials in
19 prospective projections.

20 Q. And would it be helpful to know, you
21 know, are they -- the number of employees they
22 have, whether they're -- strike that.

23 Would it be helpful to know whether
24 the company is very employee-driven?

25 A. What do you mean by "employee-driven"?

1 Q. Well, that they rely on a large number
2 of employees to carry on operations.

3 A. That's a -- that's not a primary concern
4 in an economic damages analysis. Because the
5 number of employs in itself doesn't necessarily
6 generate, you know, any of the financial, you
7 know -- it -- it helps support, obviously, the
8 business that's -- you know, what I'm concerned
9 with is the financials; then, at the end of the
10 day, the revenues, right?

11 Of course, there's employees that
12 have helped generate revenue, but the primary
13 concern is the revenue and the associated profits,
14 not necessarily if they have a thousand employees
15 or 2,000 employees.

16 Q. Is it relevant to know whether they
17 have -- whether their business is based on selling
18 products versus selling services?

19 A. Again, I think that would be manifested
20 in analyzing historical financials and projected
21 financials.

22 Q. Right. My question is would that be --
23 that's relevant then. That's something you'd
24 probably want to know as you're looking through it?

25 A. It helps contextualize the historical

1 financials and the projections.

2 Q. That's what I'm getting at.

3 Is it helpful to know what is
4 alleging to be damaged?

5 A. I'm not sure I understand.

6 Q. Well, like, example, is it helpful to
7 know we're alleging our warehouse burned down
8 versus you -- your ERP system was faulty, right?

9 Is it helpful to know kind of what is
10 the damage allegation in the case?

11 A. It's helpful from the -- the -- the
12 perspective of how -- how does that manifest itself
13 in the financials, right? And so if it's a
14 warehouse, right, you can say, okay, what have they
15 historically done out of this warehouse, right, and
16 how -- how is that going to change on a go-forward
17 basis? Well, for how long until they can have a
18 replacement or mitigate damages? So it's helpful
19 from that perspective. But at the end of the day,
20 it provides context or -- around the numbers, if
21 you will.

22 Q. Well, put it this way: If you don't
23 even know what the damages claim is and you're just
24 given a company's financials and all of the
25 diligence you ask, is it even possible to calculate

1 a damages analysis?

2 A. It would -- it would beg questions, is
3 the best way can -- I can answer that. And what I
4 mean by that is you've handed me two sets of
5 financial projections for a company, right, and
6 they're materially different, right? I'm going to
7 start asking questions why they're materially
8 different.

9 In your case, the answer might be,
10 well, we had a warehouse burn down, and as a
11 result, for the next year until we can replace
12 that, that's why our revenues and associated
13 profits are going to be way down.

14 Q. Got it. So it's a basic question, but,
15 I mean, it would be helpful to know in a damages
16 analysis what is the actual damages claim or
17 damages theory?

18 A. It helps put context around the numbers.

19 Q. Is it helpful to know whether the -- the
20 business being analyzed has competitors?

21 A. I'm sorry. Can you repeat that.

22 Q. Yeah. Is it helpful to know whether the
23 business that's being analyzed in the damages
24 analysis, whether they have competitors?

25 A. Well, I think yes, but also I think that

1 would be reflected in the historical financials,
2 right?

3 Q. I'm just -- is that a relevant -- it may
4 be in the financials. I'm just asking: Is it
5 relevant in the financials to do your damages
6 analysis?

7 A. Well, it would help explain, for
8 example, you know, how they performed historically,
9 if there was any deviations from a long-term trend
10 or how they might perform on go-forward basis,
11 right? For example, if there's a new competitor,
12 right?

13 Q. So is that a yes, that a company's
14 competitors could be relevant to that company's
15 damages analysis?

16 A. It could be. It -- it depends how it's
17 reflected in the -- in the financials.

18 Q. Agreed. Agreed. I'm just asking just
19 generally for these questions, could it be? Is the
20 company's industry something that you would want to
21 know before doing the damages analysis?

22 A. I think, by definition, I always do know
23 the industry if I know the company name.

24 Q. Well, I'm just asking generally. Maybe
25 I shouldn't say "you."

1 When a person is performing a damages
2 analysis, is it relevant to know the industry of
3 the company that's being analyzed?

4 A. I think it's relevant. Whether or not
5 it actually impacts damages is another question.

6 Q. Have you ever worked -- I don't believe
7 we've talked about your pre-college life. But have
8 you ever worked in the health care industry? And
9 when I say "worked," I don't mean done consulting
10 for health care industry clients at AlixPartners,
11 but I'm just saying have you ever worked in the
12 health care industry?

13 A. Yes.

14 Q. And tell me about that.

15 A. Well, the first thing that jumps to mind
16 is, as a senior in high school, I did a six-month
17 internship with a cardiovascular anesthesiologist
18 at the Cleveland Clinic.

19 Q. I don't believe that was listed on your
20 CV. Does that sound right?

21 A. It wouldn't be listed on my CV.

22 Q. Why not?

23 A. It was an internship in high school. My
24 CV is focused on my professional experience. But
25 I -- I was working at the clinic for the last six

1 months of my senior year.

2 Q. And where was that?

3 A. I'm sorry?

4 Q. Where -- sorry -- where was that?

5 A. The Cleveland Clinic?

6 Q. Uh-huh.

7 A. It's in Cleveland.

8 Q. Oh, I'm sorry. I wasn't sure if they
9 had, you know, like offices in other parts of the
10 world.

11 A. It was the Cleveland Clinic in
12 Cleveland, Ohio.

13 Q. Okay. My apologies. I'm from
14 California.

15 A. Okay.

16 Q. I don't know where they -- we have
17 hospitals all over. You know, so I didn't know.

18 So the Cleveland Clinic in Cleveland,
19 Ohio. You said you spent -- was it a semester as
20 an intern there?

21 A. Six months, yeah.

22 Q. Six months. And just briefly, what did
23 you do as an intern?

24 A. I basically worked with a cardiovascular
25 anesthesiologist in his day-to-day work in

1 operating rooms, you know, filling out paperwork.
2 Everything he did, I did.

3 Q. Well, not -- I assume not everything?

4 A. My hands were in chests. Let's put it
5 that way.

6 Q. All right.

7 A. I was in operating rooms.

8 Q. Okay. Aside from that, have you ever
9 worked in the health care industry?

10 A. No. I think that's the primary work
11 experience outside of, obviously, my professional
12 job these days.

13 Q. Do you have -- you don't have a degree
14 in economics; is that right?

15 A. I do.

16 Q. I'm sorry. You do. That's your BBA; is
17 that right?

18 A. No.

19 Q. Sorry. Tell me about the degree in
20 economics.

21 A. I have a degree in economics as part of
22 my MBA from the University of Chicago.

23 Q. I see.

24 I believe -- was that one of your
25 concentrations? Was that the phrase we used

1 earlier? Okay.

2 A. Correct.

3 Q. So you have a degree in economics from
4 the University of Chicago?

5 A. As part of my MBA, yes.

6 Q. Got it. Do you get -- an MBA is a
7 Master's of Business Administration; is that right?

8 A. That's correct.

9 Q. Did you get a separate degree in
10 economics from University of Chicago?

11 A. No. On my diploma awarding me my MBA,
12 it lists concentrations. The basis for being
13 awarded the MBA had a -- has a concentration in
14 economics, meaning I took a significant number of
15 econ classes as part of my curriculum at the
16 University of Chicago.

17 Q. Got it. Do you have a Ph.D. in
18 economics?

19 A. That, I do not.

20 Q. Do you have a Ph.D.?

21 A. No.

22 Q. Do you have an undergraduate degree in
23 economics?

24 A. No, I don't.

25 Q. Your undergraduate degree is BBA, right?

1 Bachelor's of Business Administration?

2 A. Sure. It's the -- the concentrations
3 were in finance and computer applications. Did I
4 take econ courses as part of getting the BBA? Yes,
5 I did.

6 Q. And I wasn't asking about the courses
7 because I'm sure you took lots of courses, and I
8 don't want to burden you with all those questions.
9 Just the degrees is what I was focused on.

10 So no actual degree in economics, but
11 a specialty or concentration in economics as part
12 of your MBA?

13 A. I would disagree with the
14 characterization of no actual degree. Are you
15 asking me do I have a Ph.D. in econ? No. But as
16 part of my degree from the University of Chicago, I
17 have an economics degree.

18 Q. Okay. Have you ever evaluated health
19 care quality measures?

20 A. Can you be more specific when you say
21 "health care quality measures"?

22 Q. No. I think I -- yeah, I think my
23 question is just: Have you ever evaluated health
24 care quality measures?

25 A. I -- I don't have a recollection if that

1 was a primary focus of, you know, for example,
2 damages work kind of thing that I've done in the
3 space.

4 Q. Have you ever advised a hospital
5 administrator on how to improve hospital quality?

6 A. Me personally? No.

7 Q. When you were doing the internship, did
8 you ever advise the anesthesiologist on how to
9 improve hospital quality?

10 A. I don't have a recollection of that.

11 Q. Have you ever conducted any research in
12 the field of economics?

13 A. What do you mean, "conducted research"?

14 Q. Like academic research for, say, you
15 know, an academic article or publication, have you
16 ever conducted research for -- in the field of
17 economics?

18 A. In -- in that context, no, because as
19 I -- I answered earlier, I don't focus on writing
20 articles. Obviously, as part of my work, of
21 course, I've conducted that type of research as
22 part of my overall work, but not to be published.

23 Q. And when you say as part of your work,
24 you're referring to your work as a consultant for
25 expert --

1 A. For example, in preparing damages
2 analyses, it's not unusual to perform, you know,
3 academic research on various topics.

4 Q. And I'm sorry. I should have asked this
5 before. But how would you -- when we're referring
6 to your work at Peterson and LCG -- LECG and
7 AlixPartners, what title can I use to refer to you,
8 like as a -- as a -- is it as a consultant or as an
9 expert? Or how would --

10 A. I think either as an expert or as a
11 consultant are fine --

12 Q. Okay.

13 A. -- just as a general term.

14 Q. Okay. So I'll use that term to kind of
15 refer to your work, you know, since -- since
16 graduating from Notre Dame and -- and working for
17 these different companies. I'll refer to your work
18 as an expert or as a consultant. Please let me
19 know if at any point that's --

20 A. Okay.

21 Q. -- confusing or wrong.

22 And just going back, I note that you
23 went to work at Peterson right after undergrad at
24 Notre Dame, and it looks like you worked in -- as
25 an expert or as a consultant for a few years, and

1 then you went to University of Chicago to get your
2 MBA in 2006; is that right?

3 A. I continued to work. I was working
4 while I got my MBA.

5 Q. That was going to be my next question.

6 So you were getting the MBA and
7 continuing to work at the same time. At that point
8 in 2006, you were at AlixPartners, right?

9 A. That's correct.

10 Q. So you got your MBA at Chicago while you
11 were working at AlixPartners?

12 A. That's correct.

13 Q. Just very briefly, why did you decide to
14 go get an MBA at that point?

15 A. Because it was something that I was
16 interested in from a personal perspective and,
17 obviously, it helps from a credential perspective,
18 as well.

19 Q. Apart from your working in this matter,
20 do you have any experience with hospital grading
21 methodologies?

22 A. I -- I don't recall a case where that
23 was a primary issue. It's possible it was part of
24 a case and more of an ancillary -- from an
25 ancillary perspective, but -- so I don't recall a

1 case where it was a primary issue.

2 Q. The cases that you've done, when you say
3 "primary issues," the primary issue would be a
4 valuation or damages analysis or alter ego
5 analysis, the things that we were discussing
6 earlier.

7 I guess my question is, under those,
8 at that level of things, have you ever done a case
9 where, like, the actual work was hospital grading
10 methodology?

11 A. I -- I don't believe so where the issue
12 at hand was the financial consequences of grades as
13 I kind of generally understand it here.

14 Q. Got it. And I'm -- even -- I'm not even
15 asking whether the financial consequence was
16 grades, but I'm just actually asking whether the
17 work was building a hospital grading methodology or
18 evaluating one.

19 A. Again, I don't have that recollection
20 because, you know, my areas of expertise are, you
21 know, economic damages analysis that go to the
22 quantification or the -- the import of, you know,
23 something happened or something didn't happen.

24 Q. Understood.

25 I'm just trying to kind of understand

1 the balance of what you've done. Like, I wouldn't
2 have thought about the Cleveland Clinic internship
3 until I asked. So I want to just -- now I have to
4 be more thorough because you're so interesting.
5 And don't mean that -- I mean that seriously.

6 Do you have a position on what are
7 the most important measures that should go into a
8 hospital grading methodology?

9 A. I do not have a specific opinion related
10 to that.

11 Q. Do you have a general opinion?

12 A. No. My opinions are -- as highlighted
13 in my report, those are my two opinions.

14 Q. Okay. Sorry. And I should have been
15 clear. I don't mean necessarily even your expert
16 opinion, but just generally, lowercase "opinion,"
17 you know.

18 Do you have just an opinion or
19 thoughts on what measures should go into a hospital
20 grading methodology to determine hospital quality?

21 MS. WOOD: Objection to form.

22 THE WITNESS: As I sit here now, no, I don't.

23 BY MR. TAKAGAKI:

24 Q. For your opinion in this case regarding
25 the grading methodology, so I'm -- I'm talking

1 about not your opinion regarding the damages that
2 have been quantified. I'm talking about what I
3 think we've been referring to as Opinion 2.

4 A. Okay.

5 Q. For that opinion, the opinion on the
6 hospital grading methodology, can you just list for
7 me the facts or data that you considered for that
8 opinion.

9 A. What do you mean by "facts or data"?

10 Q. Well, what did you consider in rendering
11 that opinion? How did you -- you issued an
12 opinion, correct, on that issue?

13 A. Correct.

14 Q. And I want to know what you considered
15 in reaching that opinion.

16 A. Well, it would have started with the --
17 the -- the scoring methodology document itself, the
18 most recent one; in particular, the one from the
19 spring of 2025 that helps explain how The Leapfrog
20 Group goes about scoring individual hospitals or
21 hospital systems. So that would have been a
22 primary thing.

23 The other primary thing would have
24 been the actual -- the actual analyzing the -- the
25 underlying Excel workbook that does the actual

1 calculations that recalculate z-scores and -- and
2 things of that nature.

3 Those would be the two primary
4 documents that would have been the basis for the --
5 the second opinion. In addition to, obviously, you
6 know, looking at the expert reports of the
7 three plaintiffs' experts.

8 Q. And I believe -- we'll get into this
9 more later. But I believe what you did is you
10 added "N/A" for some of the inputs in the workbook;
11 is that right?

12 A. It -- it -- let me -- it wasn't -- let
13 me just describe it maybe a little bit different
14 way.

15 My understanding, and I think it
16 was -- I think it was Dr. Nicholson. I apologize
17 if I got that wrong. He was doing an analysis
18 where he was doing some regrading, using the same
19 workbook, if you will, where he basically was
20 regrading basically using -- if -- you don't use
21 the imputed grades, right? You use the average
22 across all hospitals. Okay.

23 And so what I was asked to do,
24 whether or not that's inappropriate or appropriate,
25 I was asked to: Well, what did -- what would the

1 score be or is there a consistency across input
2 measures? Even if you just put aside the imputed
3 one, which I think the plaint- -- plaintiffs think
4 are wholly pessimistic, those grades.

5 So we said if we take those
6 four imputed grades aside, well, where would you
7 land with all the other measures? And that's
8 really what that analysis has demonstrated or it's
9 intended to demonstrate for the benefit of the
10 trier of fact, right?

11 I understand there's a dispute over
12 these imputed grades. If you just put those --
13 the -- to the side -- excuse me -- and let the
14 model run otherwise, you know, is there a
15 consistency in the grading? And that's basically
16 what my opinion is as it relates to the second one.

17 Q. What is your knowledge of the term
18 "imputation" as that's used in your report?

19 A. Well, it -- my understanding that the
20 imputed grades, if -- it's basically a default, if
21 you will; that if you don't have the data from the
22 hospitals, right, for those four and there's no
23 backup or secondary support data -- oftentimes
24 there's CMS data, right -- if those don't exist,
25 that The Leapfrog Group -- this is my layman's

1 understanding -- basically assigned a grade based
2 off a scale they developed.

3 Q. And so is imputation there -- what does
4 the word "imputation" mean? Is that -- well,
5 the -- I'll pause it there.

6 What does the word "imputation" mean
7 in that story?

8 A. Well, I think it's exactly what I just
9 described. It is -- if there isn't a
10 self-reporting by the hospital and there's no
11 secondary data, it is Leapfrog in consultation
12 with -- my understanding -- statisticians, their
13 own board, Johns Hopkins, have developed basically
14 a grading system to replace, you know, either
15 primary or secondary data.

16 Q. So imputation, in that sense, means
17 replacing the data?

18 A. My -- my understanding is it is their
19 professional assessment of trying to replace the
20 data that they don't otherwise have.

21 Q. In the context of a hospital ratings
22 methodology -- and when I say "hospital ratings
23 methodology," I'm talking about something like the
24 methodology in this case.

25 Do you understand that?

1 A. Sure.

2 Q. Okay. So in a hospital -- in the
3 context of hospital ratings methodology, has
4 imputation been subjected to scrutiny by the
5 scientific community?

6 A. I think that's outside the scope of my
7 analysis.

8 Q. Do you know whether it has a known or a
9 potential error rate?

10 A. I'd give you the same answer. I think
11 it's outside the scope of my analysis.

12 But my opinion, the second opinion, I
13 think it's -- it's very straightforward. It -- it
14 basically demonstrates that those four imputed
15 grades are -- are not the cause of the overall
16 grade, said differently.

17 So if you pull those out, the grading
18 is still the same, if not worse. And that's simply
19 what that analysis is intended to demonstrate.

20 Q. So for that analysis -- and when I say
21 "that analysis," I mean what you're just
22 describing, what you did for your report.

23 Has that analysis or that method,
24 your method that you used -- strike that. I'll
25 just restart that question.

1 Has the method that you used in your
2 report to generate the score, the Leapfrog score,
3 has your method been subjected to scrutiny by the
4 scientific community?

5 MS. WOOD: Objection to form.

6 THE WITNESS: I believe it has been because --
7 and what I mean by that is it's my understanding of
8 the overall methodology that the Excel workbook
9 with the associated scoring methodology, how they
10 developed it, I believe, within that scoring
11 methodology document, they said that it has been
12 tested by statisticians from Mathematica, their
13 independent board, as well as Johns Hopkins.

14 And what I mean by that is that --
15 that workbook is available to hospitals where they
16 can toggle information. They can put N/As in there
17 to estimate what their own scores are going to be.

18 BY MR. TAKAGAKI:

19 Q. Right. And I think maybe you
20 misunderstood my question a little bit. I'm not
21 asking if generally their workbook has been
22 subjected to scrutiny, if their workbook has been
23 reviewed by experts or Johns Hopkins. And I'm not
24 even actually asking if their, you know, use of
25 putting in the form imputed metrics where Leapfrog

1 comes up, you know, puts in their own numbers. I'm
2 not asking about that.

3 I'm asking if your method where you
4 actually did not input a number in for those four
5 numbers, where you put in what I called "N/A," if
6 that specific method has been subjected to scrutiny
7 by the scientific community.

8 A. And -- and I give the same answer on --
9 based on the same basis that, yes, it is my
10 understanding that it's permissible, and I -- if I
11 have it in front of me, I even think the
12 instructions to the hospitals from The Leapfrog
13 Group is N/As are permissible.

14 You see them in the grading. You saw
15 them in the initial grading that -- my
16 understanding -- that the plaintiffs object to.
17 There's several N/As in there, and when you don't
18 have a reliable data point, it becomes N/A.

19 Q. I don't believe that that is listed --
20 that statement is listed in your report.

21 A. What statement?

22 Q. That hospitals are told that they can
23 put in an N/A if they don't have the data.

24 A. It's -- it's -- I believe it's listed on
25 the first page of the Excel workbook that I relied

1 upon. And -- and just to take it one -- a step
2 farther, because I think it's in the context that
3 they're explaining to the hospitals that if one
4 puts an N/A in there because they don't have the
5 data, the weighting of the measures is
6 redistributed amongst the -- the measures that they
7 do have the data for.

8 Q. So your methodology -- again, when I'm
9 referring to "your methodology," I'm referring to
10 what you did in your report where you put in the
11 N/As for those four metrics.

12 For that methodology, what is the
13 known or potential error rate in that methodology?

14 A. I don't understand your question.

15 Q. Do you know the known or potential error
16 rate with that methodology?

17 A. I don't think there is one because
18 you're simply omitting data from an overall
19 calculation where the workbook's intended to then
20 redistribute to the measures where you do have the
21 data. So I don't think there is an error rate.
22 You're simply omitting data inputs that the
23 plaintiffs believe are biased downward, and -- and
24 the whole point of the analysis is, if you take
25 those out, let's say they -- they are biased. I'm

1 not suggesting that.

2 But if you simply take them out of
3 the analysis, right, is that what was causing the
4 grades to be low, or was it the totality of all of
5 the other data points, as well?

6 Q. Well, my understanding is your -- we
7 said earlier that you are, you know, seeking to be
8 qualified as an expert in this case; is that right?

9 A. Mm-hmm.

10 Q. And you issued an expert report in this
11 case, right?

12 A. Correct.

13 Q. And one of your expert opinions, what
14 we've been referring to as the second opinion,
15 relates to the hospital grading methodology, right?

16 A. Mm-hmm.

17 Q. And I think you said even earlier -- I
18 don't remember the exact wording -- is a simple --
19 what you did was simple or straightforward, where
20 you filled in a few of the cells of the workbook
21 we've been referring to, right?

22 A. I wouldn't call it "filled in." I would
23 say if one -- if one agrees with the plaintiffs'
24 position that the imputed values are biased
25 downward and/or not representative, right, and if

1 you simply take them out of the analysis, right,
2 and let the analysis that's been peer reviewed, run
3 without those, does it change anything materially
4 from a grading perspective, that's simply a way
5 it -- it's showing.

6 As I said earlier, said differently,
7 those four imputed values are not the ones that are
8 dragging it down, said differently.

9 Q. So --

10 A. It's a sensitivity analysis. That's
11 what it is.

12 Q. So your -- your second opinion in this
13 case, I think you've now said, was removing those
14 four metrics from the methodology, right?

15 A. Yes. It's a sensitivity analysis.

16 Q. Right.

17 A. Is the analysis -- is the grading being
18 driven by those four imputed numbers? Or is it the
19 totality of all the other measures, as well?

20 Q. Right. And my question is has that
21 specific methodology that you used where you
22 removed the four -- has that been subjected to
23 scrutiny by the scientific community, simply
24 removing the four from the workbook?

25 A. I think the answer is yes because in the

1 initial grading there's three measures that are N/A
2 in there. So that's how the -- the methodology in
3 the workbook is intended to run.

4 Q. I'm not asking about the three that are
5 removed. I'm asking about the four specific
6 imputed metrics that you removed: BCMA, I believe;
7 CPOE; IPS; and hand hygiene. Those are the four
8 metrics that you removed from the methodology,
9 correct?

10 A. Said differently, I placed zero weight
11 on them.

12 Q. Well, my question is just do you agree,
13 first, just so we're not talking past each other,
14 that those are the four metrics we're referring to?

15 A. Those are the four imputed metrics, yes.

16 Q. And for your opinion, you removed those
17 four from the calculations, correct?

18 A. Right.

19 Q. I'm asking if that specific act,
20 removing those four metrics from the calculations,
21 if that act has been subjected to scrutiny by the
22 scientific community?

23 A. And I think the answer is the same I
24 gave you. It has been.

25 Q. Okay. And when you say "it has been,"

1 your evidence is what?

2 A. Reading of the scoring methodology. It
3 has specific references to the scientific
4 community, statisticians, Johns Hopkins, an
5 independent board, who have all vetted that
6 methodology.

7 Q. I'm not asking about that methodology,
8 but my question is is it your testimony that the
9 only scientific scrutiny that you are aware of is
10 what's written in the methodology where it
11 discusses Johns Hopkins?

12 A. Well, it's -- it's statisticians. It's
13 Johns -- yes, that is the disclosure that says the
14 methodology and the way they've set it up, the way
15 it runs, has all been tested by at least that group
16 of people.

17 Q. And your -- the methodology that you
18 employed where you removed four metrics from the
19 methodology, your testimony is the only scientific
20 scrutiny for that is what's described in the
21 methodology document?

22 MR. MODI: Object to form.

23 THE WITNESS: I'm not saying the only. It's
24 what I'm aware of, right? And so it's crystal
25 clear, from my perspective, that having an N/A and

1 having no weight for an individual measure --
2 excuse me -- of the 22 was thought about and tested
3 by those that put together the methodology and --
4 and the scoring workbook itself.

5 That's -- that's the whole intention.
6 Like, you can see in the math, for example, if you
7 have an N/A for one of the measures, right, it no
8 longer gets weighted in the calculation. That's
9 the point.

10 BY MR. TAKAGAKI:

11 Q. And is your testimony, I think, that
12 there's no possible error rate that could be
13 associated with that specific move, the move of
14 removing the four metrics from the methodology?

15 A. No, I don't think there is. You -- said
16 differently, there wouldn't be an error rate
17 because you are simply placing zero weight on that
18 data point.

19 Q. What are the standards that govern -- so
20 when you did remove those -- I think in your report
21 you use the phrase "exclude." So maybe we can use
22 the phrase "exclude."

23 When you've excluded the four metrics
24 that we've talking about from the methodology, my
25 understanding is the way that was done was by going

1 into the cell of the Excel for each of those four
2 metrics and changing the input from a number that
3 was already in there to the -- the word "N/A"; is
4 that correct?

5 A. That's correct. I did --

6 Q. Is there -- is there -- is there a
7 standard that governs that technique? I would
8 assume there's different ways you could exclude
9 those four metrics. The way you've chosen to do it
10 was to add in N/A. I want to know if that
11 technique of adding an N/A to the Excel, if that
12 technique -- if there's any standards that govern
13 that technique.

14 MS. WOOD: Objection to form.

15 THE WITNESS: I don't know if I appreciate
16 your question, number one, but maybe I'll try to
17 answer it this way. I could have simply reweighted
18 them in the different columns and put zeros in the
19 weighting. But the way the workbook is set up by
20 those that put it together -- and it's been peer
21 reviewed as disclosed -- is by doing the N/A. The
22 formula in the weighting column, if you have an
23 N/A, automatically -- the weighting goes to zero.
24 That's how it functions.

25 And so, yeah, I do think it's peer

1 reviewed because that's the disclosure that
2 Leapfrog and its -- the consultants or whoever
3 worked on them, the people from Johns Hopkins and
4 the statisticians. And their independent board,
5 that's how they designed it. And that's --
6 that's -- that's how they describe it to hospitals.

7 BY MR. TAKAGAKI:

8 Q. But they didn't design it to have those
9 four metrics to be removed altogether. They
10 designed it, over the years, to have different ways
11 of filling in those four.

12 Do you agree with that position?

13 A. No, I disagree with that. They designed
14 it where if one wanted to be able to determine what
15 their grade would be if you changed any of the 22,
16 that is how they designed it to be done. And you
17 see it in the initial grading where they -- they
18 don't have data for three of them. So they're just
19 like how -- how did Leapfrog do it, right? They
20 simply put an N/A in there. As a result, it
21 doesn't get any weight in the overall calculation.

22 Q. I'm sorry. When you say "they," who are
23 you referring to just now?

24 A. Leapfrog. In the initial scoring of the
25 hospitals, there's three N/As in there, and they

1 didn't have the data to be able to do it. So how
2 did they -- how did they place zero weight for
3 those measures? You put in N/A.

4 Q. Now, you say in the initial scoring of
5 the hospitals there's three N/As in there?

6 A. Yes.

7 Q. What are you referring to, the initial
8 scoring?

9 A. The -- if you look at the actual initial
10 scoring from spring of 2025 done by Leapfrog Group,
11 you look at their support. How did they get to
12 their grades? There's at least three that have
13 N/As in them because they didn't have data to be
14 able to put it into the workbook to have it have
15 any weight in the overall calculation or overall
16 grading.

17 Q. And when you say the initial scoring in
18 the spring of 2025, are you referring to only the
19 five plaintiff hospitals in this case?

20 A. Those are the ones that I recall
21 specifically looking at this issue.

22 Q. And so your position is that because the
23 Excel -- sorry -- how did you acquire the workbook
24 or the Excel?

25 A. I don't know. It was given to me by

1 someone. I have a -- I have a PDF that
2 describes -- it's like 29 pages that describes the
3 methodology, how it was developed, what everything
4 means. And there's a corresponding Excel workbook
5 that has three tabs in it, and it's the middle tab
6 where you can go through -- and that's what I
7 did -- and adjust the weighting of individual
8 measures.

9 Simply, all I'm doing is placing zero
10 weight on those four measures, which I understand
11 are at issue with the plaintiffs.

12 Q. Has Leapfrog ever -- do you know when
13 the Leapfrog started issuing a safety grade, like
14 what year?

15 A. I don't know specifically, no.

16 Q. Would you be surprised to learn that it
17 was 2012 when they first started issuing a safety
18 grade to hospitals?

19 A. I don't know why that would surprise me.

20 Q. Do you have an understanding of whether,
21 in 2012, their initial safety grade methodology
22 used imputation?

23 A. I -- I don't know if I've -- have seen
24 documents that go back that far, so I don't know
25 here, as I sit here right now.

1 Q. Do you have an understanding of when
2 Leapfrog started using imputation in their safety
3 grade?

4 A. I don't know specifically.

5 Q. When they did start using -- or for the
6 first instance of imputation in the Leapfrog safety
7 grade, do you know how their imputation model
8 worked?

9 A. Not as I sit here right now, no.

10 Q. Because I -- just to be clear, I think
11 for imputation we've been talking about what to do
12 if you don't have data; you could look at secondary
13 data, et cetera. So that's what I mean by
14 imputation here.

15 Do you know when -- strike that.

16 You're familiar with the current
17 imputation model that Leapfrog uses, correct?

18 A. I am aware that they have a scoring
19 system, a stated scoring system, as it relates to
20 if they don't have the primary data or the
21 secondary data.

22 Q. And is it your understanding that there
23 are multiple steps in that scoring -- in that
24 imputation scoring system today?

25 A. My understanding is that there are two

1 steps.

2 Q. Okay. And what are the two steps?

3 A. I'd have to refresh my recollection with
4 the document, but I think the first one is,
5 effectively, if you don't have primary or secondary
6 data that the second step is you look at the
7 imputation scale.

8 I think that's what it is, but I'd --
9 I would have to refresh my memory based on the PDF
10 scoring methodology that has those details in it.

11 Q. And so for -- we can talk about Step 2.

12 So for -- your understanding is for
13 the current 2025 Leapfrog grading system, if -- if
14 imputation is used, is it your understanding that
15 actual numbers are imputed for those four metrics
16 as opposed to N/A?

17 MS. WOOD: Objection to form.

18 THE WITNESS: My -- my understanding is, yes,
19 that there's a grading system, and they -- if -- if
20 you don't have the data, it falls into a certain
21 category based on that aforementioned grading
22 system.

23 BY MR. TAKAGAKI:

24 Q. Mm-hmm. And I'm just saying, so yeah,
25 when it falls into this second category where

1 they're imputing the numbers, my just -- it's a
2 very basic question. But they are actually --
3 Leapfrog, in 2025, is actually using real numbers
4 as opposed to N/A for the four metrics, correct?

5 MS. WOOD: Objection to form.

6 THE WITNESS: For these five hospitals for
7 those four metrics, yes, they assign a grade. But
8 also there were other metrics, right, that weren't
9 imputed that they didn't have data that are N/A.
10 It just simply means if you have an N/A, it's not
11 getting any weight in the overall calculation.

12 BY MR. TAKAGAKI:

13 Q. Right. And do you have any
14 understanding of the four numbers that Leapfrog
15 currently uses for imputation? How they decide
16 what those numbers are? What the value will be?

17 A. Well, I know they disclose it in the
18 scoring methodology. I'd have to refresh my memory
19 of what context is around there. But based on my
20 review and my recollection is they -- they had a
21 process for developing those numbers.

22 Q. Do you know if that process ever
23 changed?

24 A. I'm aware of there's some allegations in
25 the complaint that maybe they changed at some point

1 in time, but specifically when that was, I -- I
2 don't.

3 Q. Do you know what the previous process
4 was?

5 A. Not specifically, as I sit here right
6 now.

7 Q. Do you know what the process before that
8 was?

9 A. The process before what?

10 Q. Before the previous process. So we're
11 talking about the current process for getting --
12 getting to an actual number to put in --

13 A. Mm-hmm.

14 Q. -- and then I asked you if you knew what
15 the previous one was, and I think you said you
16 didn't. I'm asking if you knew what even the one
17 before that was.

18 MS. WOOD: Objection to form.

19 THE WITNESS: I -- I don't have a specific
20 recollection. Obviously, my -- my analysis was
21 focused on the current.

22 BY MR. TAKAGAKI:

23 Q. Understood.

24 Do you know if in any of Leapfrog's
25 processes, whether the current or the previous,

1 that they ever used N/A for the four imputed
2 metrics?

3 A. I don't know specifically, and -- but I
4 don't think -- I don't think it matters. And the
5 reason I say that is because the concept of N/A for
6 any of the data measurements, any of the 22, is
7 simply not to weight it in the overall calculation.
8 That's what I do know.

9 And it's -- it's a weighting issue at
10 the end of the day. If you have an issue with one
11 of the inputs because you think it's too low, if
12 you just exclude it from the overall analysis and
13 you do the reweighting, as the workbook is intended
14 to do, does that materially change the grades one
15 way or another?

16 Said differently, it wasn't those
17 four inputs alone that were causing the grades that
18 were being given by Leapfrog to the five hospitals
19 at issue.

20 Q. I believe you testified about what the
21 workbook was intended to do. What is the basis for
22 your understanding of what the workbook was
23 intended to do?

24 A. It's based on my review of the
25 associated documents that I've -- I've discussed

1 here already: The -- the 30-page or 29-page
2 scoring methodology as well as the description in
3 the Excel workbook itself.

4 Q. Does the, as you've said, 30- or 29-page
5 scoring methodology -- does that refer to the
6 workbook?

7 A. In my mind, they're two different
8 things. There's the PDF that describes the
9 methodology, and then there's a workbook that has
10 three tabs in it that gives direction to the actual
11 hospitals themselves for when they want to
12 sensitize the scoring. They tell you how to do it.
13 They say "Put an N/A in there."

14 Q. But my que- -- in your answer previously
15 you testified that your understanding of what the
16 workbook was intended to do was the 30- or 29-page
17 scoring methodology as well as the description of
18 the Excel. And I'm asking you if -- for the first
19 part, the 29- or 30-page scoring methodology, if
20 that references the workbook.

21 A. If it references the workbook? I think
22 it does. I think it's got an hyperlink to where a
23 hospital can go online to get the workbook to be
24 able to sensitize it, just like I'm doing here, to
25 say if we had different scores, right, how would

1 that potentially impact our grade?

2 Q. Do you know if -- I believe you
3 testified earlier that your understanding for
4 whether your methodology had been subjected to
5 scientific scrutiny was -- your understanding was
6 that it had been by the experts at Leapfrog, and I
7 believe you mentioned expert panel, Mathematica,
8 and Johns Hopkins; is that correct?

9 A. That's correct.

10 Q. Do you know if those entities ever
11 reviewed a methodology that called for inserting
12 N/A for the four imputed metrics?

13 MS. WOOD: Objection; form.

14 THE WITNESS: I -- I can't speak for, you
15 know, conversations I was not part of. But, again,
16 the instructions, I think, in my mind are very
17 clear because, again, this is a document that's
18 been shared with and can be access- -- accessed by
19 hospitals themselves; that if you don't have the
20 data, you use an N/A. It simply means that -- that
21 that's not getting weighted in the overall
22 calculation.

23 BY MR. TAKAGAKI:

24 Q. Did you review minutes of meetings of
25 Leapfrog's expert panel?

1 A. I -- I don't believe those were
2 available to --

3 Q. Did you -- I'm sorry. I cut you off.
4 Did you have more?

5 A. Yeah, I -- I don't believe those were
6 available. At least I'm not aware of them.

7 Q. Did you review any meetings of any
8 minutes -- meeting minutes from meetings of the --
9 of Johns Hopkins persons who worked with Leapfrog?

10 A. Again, I'd give you the same -- same
11 answer. I'm not aware of them, but I think what is
12 very clear is the workbook has been tested and
13 reviewed by at least those three groups of
14 people -- Mathematica, Johns Hopkins, and the
15 panel -- right?

16 And the instructions are from
17 Leapfrog to hospitals: If you don't have the data,
18 right, use an N/A. As a result, that measure won't
19 be weighted in the overall grade.

20 Q. So I think there's -- you said the
21 expert panel of Leapfrog, Mathematica, or
22 Johns Hopkins. One question is did they review the
23 overall grading methodology that Leapfrog uses?

24 MS. WOOD: Objection to form.
25

1 BY MR. TAKAGAKI:

2 Q. Another question is did they review the
3 workbook to make sure it works properly, has the
4 right coding, et cetera?

5 My question to you is did any of the
6 entities you've mentioned -- the Leapfrog expert
7 panel, Mathematica, Johns Hopkins, or any of the
8 other experts you referred to -- did they, to your
9 understanding, review the actual workbook that
10 you've been discussing today?

11 A. I don't know specifically; however, from
12 my perspective, it's impossible to sign off on a
13 grading methodology without reviewing the workbook
14 that actually produces the grades.

15 Q. I agree.

16 Have you ever spoken to any of the
17 statisticians at Mathematica?

18 A. As it relates to this case?

19 Q. No, just in general.

20 A. That's a good question.

21 I -- I don't know if I've --

22 Q. What about as it relates to this case?

23 A. No. As it relates to this case, no.

24 Q. Have you spoken to any members of
25 Leapfrog's national expert panel?

1 A. Not directly, no.

2 Q. But you have indirectly spoken to
3 members of the expert panel?

4 A. No, not indirectly. What I'm simply
5 saying is I -- I think we -- we asked for
6 verification that -- that the workbook was
7 available to hospitals and the direction on the --
8 the front of the workbook to insert an N/A was what
9 they meant, if that makes sense.

10 Q. When you say "we asked," was that, like,
11 in an e-mail?

12 A. I don't know if it was an e-mail. I
13 asked Gary to basically confirm my understanding.

14 Q. Did you -- are those -- the documents
15 related to that, are those cited in your report?

16 A. I don't think so.

17 Q. Could you produce those for us after
18 this?

19 A. To the extent that there's an e-mail or
20 something, I --

21 MR. TAKAGAKI: Yeah, yeah. I think we're
22 requesting any indirect conversations that he or
23 Gary or anyone at AlixPartners had with Leapfrog's
24 expert panel that he's referring to.

25 THE WITNESS: Well, I don't know if it was

1 directly with the expert panel. It was basically I
2 wanted to confirm with Leapfrog that the
3 instructions contained on the front of the -- the
4 Excel model, as I was reading them, were correct
5 that basically says if you don't have the data, put
6 an N/A in.

7 BY MR. TAKAGAKI:

8 Q. Have you spoken with anyone at any of
9 Leapfrog's partners or people they've worked with
10 at Johns Hopkins Medicine?

11 A. I don't believe so, no.

12 Q. And so my understanding is your Opinion
13 No. 2 is putting in -- which you -- your actual
14 physical act was putting in N/A for those
15 four metrics, correct?

16 Did you make any other -- let me
17 phrase it this way: Did you make any other actual
18 changes to the workbook other than putting in N/A
19 for those four?

20 A. No.

21 Q. Okay. And then your understanding of
22 what the workbook was used for and whether -- your
23 understanding of what the workbook was used for is
24 based on documents you reviewed or conversations
25 with counsel?

1 A. Generally speaking, yes.

2 Q. And your understanding as to whether the
3 workbook -- the methodology within the workbook was
4 signed off by anyone or vetted is based on the
5 documents that you've reviewed, and I think you
6 said the methodology itself, and then the -- the
7 PDF that comes with the workbook; is that right?

8 A. Yes. It's -- it's the same -- as I
9 understand it, it's the same documents that are
10 available to hospitals who want to model their own
11 sensitivity just to their grades.

12 And so my understanding is that the
13 29-page PDF as well as the live Excel workbook are
14 both available to hospitals, and it contains
15 instructions to the hospital --

16 Q. Right.

17 A. -- of how one -- from Leapfrog's
18 perspective, how one should edit the workbook to
19 sensitize what the grades would be if you had
20 different either data sources or N/As or what have
21 you; how you populate the one column and how that
22 translates into a grade.

23 Q. What special expert experience do you
24 have that would render what you've just described
25 helpful as an expert opinion in this case?

1 A. It's in response to Dr. Nichols [sic].

2 Q. Well, it sounds like what you did is --
3 your testimony is you reviewed a document that's
4 given to hospitals that says "Here's this workbook.
5 Here's how you go in to do it." You then went in
6 and did that.

7 I want to know what special
8 experience do you have to do that is -- qualifies
9 as an expert opinion in this case, as opposed to
10 just an opinion that -- something that anyone can
11 do?

12 MS. WOOD: Objection to form.

13 THE WITNESS: Well, I don't agree that anyone
14 could do it. It does require, you know, background
15 in statistics and stuff like that. You have to
16 understand z-scores and the impact of the z-scores
17 and the overall weighting of the analysis.

18 I wouldn't call it that it's no
19 expertise. It definitely is expertise, and I think
20 importantly, it's in response to a similar analysis
21 that Dr. Nichols was doing. It is simply a
22 rebuttal analysis where he's simply saying, "If I
23 use all averages, here's the grades," right? It's
24 a different view of the same analysis. Instead of
25 using all averages, why don't we just take out the

1 four measures that it seems the plaintiffs take
2 particular issue with.

3 And so that's why the analysis
4 exists. It is a version of Dr. Nicholson's
5 analysis, and it's in response to him using the
6 mean for all the grades instead of simply taking
7 out the ones that people apparently take issue
8 with.

9 BY MR. TAKAGAKI:

10 Q. And just -- I just want to just drill
11 down, kind of put a box on what you are opining on
12 and what you're not.

13 Do you have any specialized knowledge
14 of the -- of Leapfrog's imputation model?

15 A. When you say the "model," you're
16 referring to the -- the scoring chart that they
17 use?

18 Q. Yeah. Do you have any specialized
19 knowledge?

20 A. I -- I don't, and I don't think one
21 needs to have that because I'm excluding the
22 weighting of those numbers from the overall
23 calculation.

24 Q. And now stepping back, not just the
25 chart, but just Leapfrog has -- is it your

1 understanding that Leapfrog has an imputation model
2 that has been discussed and generated in terms of
3 what we're going to do for Step 1 and Step 2? Is
4 it your understanding that that is an imputation
5 model, beyond just the Excel?

6 A. My understanding is there is a model and
7 a basis for -- whether you agree with them or
8 not -- for how they have come up with those
9 numbers.

10 Q. And my question to you is just do you
11 have any specialized knowledge of that imputation
12 model?

13 A. The answer is not other than what I've
14 already read, and I don't think it's relevant to my
15 analysis because I'm placing zero weight on those
16 numbers that were imputed. They're being taken out
17 of the analysis. It's simply saying if you
18 disagree with those numbers because you think
19 they're too low, right, where would the grading
20 have been if you base it on all the other measures
21 that you apparently don't have issue with? That's
22 what that analysis is showing, and again, it's in
23 response to Dr. Nichols -- Nicholson. Sorry.

24 MR. TAKAGAKI: I think we've been going for a
25 while. Would it be a good time to take a break?

1 MS. WOOD: Yeah.

2 THE VIDEOGRAPHER: We are going off the record
3 at 12:12 p.m. with the end of Media No. 2.

4 (Lunch recess taken from
5 12:12 p.m. to 1:04 p.m.)
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A F T E R N O O N S E S S I O N

THE VIDEOGRAPHER: We are back on the record with the beginning of Media No. 3 at 1:03 p.m.

Counsel, you may proceed.

EXAMINATION (resumed)

BY MR. TAKAGAKI:

Q. Okay. I hope you had an okay lunch.

So we've been talking about your expert report. Do you know if the documents that you had access to when preparing your report, was it the full universe of documents that were produced by the plaintiffs?

A. I -- I don't believe so because, again, I'm here in a rebuttal position, or that's the scope of my analysis, to respond to the plaintiffs' experts. I believe the documents that I cite in the report, or that we reviewed and relied upon, are effectively the documents that the plaintiffs' experts, Berger, Chakurda, and Nicholson used in offering their opinions.

And so, again, because I was asked to comment on their opinions and provide any rebuttal analyses or opinions, that was my initial focus, it's possible that there were some incremental documents that we asked for beyond that, but I

1 don't know if we had access to the full database
2 or...

3 Q. Are there any documents that you had
4 access to that are not listed in your Appendix of
5 Documents Considered?

6 A. I don't believe so, with one qualifier.
7 We tried to make the Documents Considered, you
8 know, fulsome. It's possible there's something
9 cited in the report that maybe me missed in the
10 appendix. But between the two of them, it should
11 be comprehensive of everything that we considered.

12 Q. That's fair.

13 Then I take it you didn't have access
14 to all of the documents produced by the defendant
15 in this case, The Leapfrog Group?

16 A. Again, I don't believe so, again, given
17 the scope. You know, this was a rebuttal, so I was
18 focused on what the three plaintiff experts were
19 saying and what they relied upon.

20 Q. Did you ever ask counsel for documents
21 that they were not able to provide you?

22 A. I don't believe so. Again, with the
23 same qualifier. You know, I was more focused on
24 what the opposing experts were -- or the
25 plaintiffs' experts -- excuse me -- were saying and

1 what responses we would have.

2 Q. Did you ask counsel in this case,
3 counsel for The Leapfrog Group, did you ask counsel
4 if the documents that they provided to you were
5 complete?

6 A. What do you mean, the document --

7 Q. Like, you know, did you ask whether a --
8 if a given document was the whole document or if it
9 was an excerpt, for example? Did you ask, "Are you
10 giving me the whole document?"

11 A. I -- I don't know if we explicitly asked
12 that because I don't think in our -- the course of
13 our review that there was any indications that we
14 were missing, you know, portions of documents.

15 Q. Did you search for any documents on your
16 own beyond what was provided to you by counsel?

17 A. When you say "search," you're talking
18 like on the internet?

19 Q. Just anywhere. I mean, did you try to
20 find or use other documents beyond what counsel
21 gave to you?

22 A. Again, I -- I don't know. Well, I don't
23 believe I did. I can't speak for Gary or Ivan.
24 And just one clarifier. You said documents counsel
25 gave me, right? My understanding is those

1 documents were the ones identified by the
2 plaintiffs' experts as their reliance materials.
3 So that's -- I want to be clear that, you know, we
4 asked for everything that they were citing.

5 Q. Perfect. And I guess I could have asked
6 that earlier.

7 So for the documents -- you mentioned
8 you had documents that the plaintiffs relied upon.
9 I -- did you receive those -- sorry -- strike that.

10 You asked for the documents that the
11 experts had considered. Did you ask counsel for
12 those documents? Is that how you obtained them?

13 A. I believe that's what we asked for,
14 yeah.

15 Q. As opposed to --

16 A. We asked for the reports and -- and the
17 reliance materials.

18 Q. Right. And so I guess my question is,
19 is there anything that you considered or that you
20 relied on that -- a document that didn't come from
21 counsel to you or your team?

22 A. I'd have to look at my report itself,
23 but I don't believe so, again, given the scope was
24 to respond to the opinions and analyses contained
25 in the plaintiffs' expert reports.

1 Q. I guess, like, as an example -- it might
2 help to have an example. So like we talked about
3 the Leapfrog calculator workbook.

4 A. Mm-hmm.

5 Q. Did you, like, look on your own to see
6 if that was available online or -- I'll stop there.
7 Did you look up on your own to see if that was
8 available online?

9 A. I didn't personally. I know it's
10 referenced in some documents as being available
11 online, but I don't -- I don't know if we tried to
12 confirm that representation that was in some of the
13 documents.

14 Q. Yeah. And, again, I'm not asking you to
15 like confirm their representations. I'm just
16 saying for like that, the calculator workbook, my
17 understanding is counsel provided that file to you.
18 I'm just wondering if you had searched for it on
19 your own, as well?

20 A. Again, I can't speak for the rest of the
21 team. I didn't personally because, again, we
22 had -- we had the workbook, but I did -- I was
23 aware that it was available for hospitals to be
24 able to sensitize their own grades.

25 Q. And my assumption is -- well, strike

1 that.

2 You were aware of -- your awareness
3 there is based on either conversations with counsel
4 or a review of the documents they gave you?

5 A. I think it's -- it's based on the review
6 of the documents themselves.

7 Q. Okay. Did you independently verify your
8 opinions by reviewing all of the documents
9 yourself?

10 A. I verified my opinions based on the
11 documents I was directly relying upon. So for
12 example, in the sensitivity analysis related to the
13 grading, I personally went through and
14 double-checked all the math, making sure that
15 z-scores were being calculated appropriately,
16 making sure that it made sense to me from a
17 statistics perspective.

18 So I did that personally. Did I
19 review every single document that the plaintiffs'
20 experts were relying upon? I did not.

21 Q. Did counsel give you any assumptions
22 that you should rely on to draft your report?

23 A. That's a good question. I think I was
24 asked. And so I don't know if this is an
25 assumption, but I think I was asked for the basis

1 of the second opinion. Counsel asked me what would
2 happen, you know, if the imputed grades were given
3 no weight in the overall grading. So I think that
4 was an instruction from a scope perspective from
5 counsel.

6 And then I did my analysis, you know,
7 understood all the math, all the statistics, and
8 everything like that to say if you do basically
9 place zero weight, the model does work. It's
10 getting reweighted appropriately. That math works
11 and everything like that.

12 So I don't know if that's an
13 assumption more than a, you know, what happens.
14 Because, again, it was in response to -- and,
15 again, if I get this wrong -- Dr. Nicholson, his
16 sensitivity analysis where he's using the means or
17 the average and saying if they were the average,
18 this is the resulting grade, right, and counsel was
19 just like, well, what if you just take the analysis
20 and re-weighed everything.

21 And so, again, I don't know if it was
22 an assumption, but it was a response, in part, to
23 the analysis I saw in Dr. Nicholson's, but also a
24 question from counsel to say, well, what if we
25 don't do what he did, but sensitize in a different

1 way, does it really have an impact overall, you
2 know.

3 Was it the imputed grades that were
4 really driving the bad grade, or was it, you know,
5 basically, all the measures were all fairly
6 consistent such that even if you took those out of
7 the analysis and you had all the remaining ones, is
8 there grade consistency.

9 And that's really what I'm trying to
10 illustrate in that -- that analysis, again, in
11 response to, you know, Dr. Nicholson in his
12 analysis.

13 Q. That makes sense.

14 I know it's hard to remember, but
15 just thinking back, were there any other
16 assumptions they might have given you for either
17 opinion? I mean, yeah. I'll pause there so you
18 can answer.

19 A. I don't believe so.

20 Q. Okay. Did they, like, tell to you
21 assume something about, let's say, for, like,
22 Opinion No. 1, the damages-related opinion, would
23 they have said to assume something about the market
24 that the hospitals are in, for example?

25 A. No.

1 Q. Okay.

2 A. No. But, you know, as it relates to
3 Opinion No. 1, I think maybe the one thing that did
4 come from counsel was the concept of the -- the
5 types of information that one would base a
6 quantification to demonstrate substantial harm. As
7 I understand, it's what's required under that --
8 the specific Florida law that we were talking about
9 earlier.

10 I think they told me that other than
11 some key indicators that were attached to some
12 CEO -- or was it CFO -- CEO dep -- affidavits, that
13 it was represented to them that, you know, the
14 traditional information one would expect to be
15 available, you know, financial projections,
16 historical financial information that one would
17 base a quantification of substantial harm on,
18 were unavailable.

19 Q. And just to break that down, because I
20 think you mentioned two things, and I just want to
21 make sure I'm clear, so counsel gave you some
22 assumptions about the law and allegations in the
23 case. Is that what your first part was saying?

24 A. In part, yes. That in order to
25 demonstrate -- or it's required, as I understand

1 it, being a layperson -- that under the relevant
2 section of the law that a demonstration of
3 substantial harm is required.

4 Q. When you say "a substantial harm is
5 required," do you mean required to, like, win the
6 case or required for what?

7 A. I think that calls for a legal
8 interpretation. It's just --

9 Q. I'm just -- when you said "is required,"
10 I just meant, what do you mean when you said "is
11 required"?

12 A. Basically, the way I, from a layman's
13 perspective, understand "substantial harm," is you
14 have to -- there needs to be some kind of
15 quantification of the harm; hence, the word
16 "substantial."

17 And so that's why, you know, given my
18 25 years doing, you know, economic damages
19 analyses, how one would do that or demonstrate
20 substantial harm, particularly in this case.

21 Q. I see. I see. So -- got it. So in
22 order to conduct a damages analysis, you had to
23 know that substantial harm is required to recover
24 damages?

25 A. Again, I think it calls for a legal

1 conclusion. But I -- yes, that is my
2 understanding. And it's also in response to the
3 positions that the plaintiffs' experts were taking
4 where their discussion of substantial harm wasn't
5 focused on an analysis, per se. It was more maybe,
6 likely, possibly.

7 You know, so the type of -- of
8 analysis that I would expect that would be
9 undertaken, I'm simply saying was not undertaken by
10 the plaintiffs' experts, and here's how one would
11 do it. And the reason I didn't do it is because
12 the information required to do so was withheld in
13 this case, as I understand it.

14 Q. Got it. Right. So in, like, other
15 cases, where you've been required to do a damages
16 analysis -- and actually, I know you didn't
17 actually do a damages analysis here -- or you
18 didn't do a damages quantification here; is that
19 correct?

20 A. Yeah. It -- in part, it's to respond to
21 what was offered by the plaintiffs --

22 Q. Right.

23 A. -- but also let the trier of fact to
24 know that, for example, if I was hired by the
25 plaintiffs, this is how I would do it if I had

1 access to the -- the right information.

2 Q. All right. Okay. Would you -- do you
3 think your opinions would -- were there any other
4 assumptions that, sitting here today, you can
5 recall you made either based on your own or from
6 counsel, you know, telling you?

7 A. I don't believe so.

8 Q. There might have been others?

9 A. I -- I don't believe so.

10 Q. Okay. Would your expert opinions,
11 either one or -- I'll say just the opinions in your
12 report, regardless of how we're dividing them up,
13 would the opinions in your report change if any of
14 the assumptions that you had turned out to be
15 false?

16 MS. WOOD: Objection; form.

17 THE WITNESS: No, I don't believe so.

18 MR. TAKAGAKI: So I think we can show Exhibit
19 No. 2.

20 I have two, I believe, also.

21 (Rule Deposition Exhibit 2 was
22 marked for identification.)

23 BY MR. TAKAGAKI:

24 Q. Now, I'm handing you what's just been
25 marked as Exhibit 2. What is this document,

1 Exhibit 2?

2 A. This is a copy of the rebuttal expert
3 report of Mark F. Rule, CFA, ABV, September 4th.
4 So it's a copy of my rebuttal report.

5 Q. Right. So this is -- this document is a
6 copy of your expert report in this matter, your
7 rebuttal expert report in this matter, correct?

8 A. Yes. It's my response to the
9 three expert reports that the plaintiffs proffered.

10 Q. You authored this report?

11 A. I did.

12 Q. And I'm just noting on the front page
13 it's dated September -- or it says September 4,
14 2025.

15 Do you see that?

16 A. Yes.

17 Q. Is that the date of this report?

18 A. It is.

19 Q. And I think if you go to page 12 of the
20 report, it also says "Executed on September 4,
21 2025."

22 Do you see that?

23 A. I do.

24 Q. So would you agree that this report,
25 your report here, is dated September 4, 2025?

1 A. The dates match, so yes.

2 Q. All right. So just directing you to
3 page 1, using the internal page numbering, there's
4 paragraph 1, paragraph 2, paragraph 3.

5 Do you see that page?

6 A. Mm-hmm.

7 Q. Okay. Paragraph 2, the beginning of the
8 paragraph references the complaint. You say, "In
9 the complaint, plaintiffs claim." Do you see that
10 language?

11 A. I do.

12 Q. And there are some footnotes at the
13 bottom, complaint, complaint, listed multiple
14 times.

15 Do you see that?

16 A. I do.

17 Q. So I don't see -- I guess in the
18 previous paragraph it says -- the end of the
19 sentence, it says that the plaintiffs filed a
20 complaint and demand for jury trial, (complaint),
21 against The Leapfrog Group.

22 Do you see that?

23 A. I do.

24 Q. So that was referring to the complaint
25 that was filed in this case; is that right?

1 A. Yes.

2 Q. Okay. Did you review that?

3 A. I did.

4 Q. And who assisted in drafting this
5 report? And I think we might have touched on that
6 earlier. But now that you see the document, who
7 assisted you in drafting this report?

8 A. We did talk about it earlier. It was
9 myself and Gary Gutzler.

10 Q. So did Ivan help you with drafting it at
11 all?

12 A. I don't believe so.

13 Q. Did Gary -- did it work in the sense
14 that Gary would write the first draft and you would
15 review?

16 A. No, not necessarily. It -- it was a
17 combination of us. Obviously, you know, the scope
18 of it was determined by me. But it was -- it was a
19 working draft that we both worked on. I did most,
20 probably, the writing.

21 Q. Did anyone edit portions of your report?

22 A. Besides myself and Gary?

23 Q. Yes.

24 A. I don't believe so, no.

25 Q. Had you initially prepared a longer --

1 much longer version of the report?

2 A. No.

3 Q. Or let's put it this way. Initially,
4 did you have any -- a larger scope for the report?

5 A. No.

6 Q. I assume you agree with everything
7 written in your report; is that right?

8 A. Yes.

9 Q. Did you use -- did you or Gary or anyone
10 at AlixPartners or anyone -- I'll just say anyone
11 at all -- strike that.

12 Did anyone use artificial
13 intelligence to assist with drafting this report?

14 A. No.

15 Q. I'll say that's a new question that we
16 haven't been asking.

17 A. It's interesting. I've gotten them more
18 regularly in depositions now.

19 Q. Yeah. Got to ask, I guess.

20 And I think we talked about this
21 before. But does this report represent the
22 entirety of the opinions that you intend to give at
23 trial?

24 A. As I answered earlier, it's -- yes, this
25 is what I anticipate providing at trial.

1 Q. So you don't have any opinions that are
2 not reflected in this report?

3 A. No.

4 Q. Are you planning to attend the trial in
5 this matter?

6 A. If I'm called to testify, I would
7 imagine I'll be there.

8 Q. Is there any -- anything that might
9 prevent or make it difficult for you to attend the
10 trial in this matter?

11 A. Not that I'm aware of.

12 Q. So just if you could turn to Appendix 2
13 of your report, which I believe comes after the
14 actual report and after your CV, the page number at
15 the bottom is 1, but it is not page 1.

16 Do you see Appendix 2?

17 A. Mm-hmm.

18 Q. So the top of the page says "Documents
19 and Information Considered."

20 Do you see that?

21 A. Yes.

22 Q. And there's a -- the first section is
23 titled "Documents Produced in This Litigation."

24 Do you see that?

25 A. I do.

1 Q. And then I see a number of documents in
2 three columns that have Bates stamps. Do you see
3 that and agree that that's what's there?

4 A. I do see three columns comprised of
5 Bates stamps, yes.

6 Q. Some are Leapfrog Bates stamps, and some
7 are PBHN Bates stamps.

8 Do you see that?

9 A. Yes.

10 Q. Do you have an understanding of what
11 Leapfrog versus PBHN denotes here?

12 A. I think Leapfrog is the defendants and
13 PBHN is the plaintiffs.

14 Q. And then the next section, which is now
15 on page 2 of the appendix, is titled "Other Expert
16 Reports."

17 Do you see that?

18 A. Yes.

19 Q. And I see four entries: The Expert
20 Report of Jonah Berger; Jonah Burger's Supplemental
21 Report; and then the next two are the expert report
22 of Thomas Chakurda and Professor Sean Nicholson.

23 Do you see those entries?

24 A. I do.

25 Q. And did you review those reports?

1 A. I did.

2 Q. And did you review all the documents
3 cited here for Documents Produced in This
4 Litigation on page 1 and 2?

5 A. I didn't necessarily produce -- or
6 review every single one in full detail. I had some
7 assistance based on my own review of the reports
8 themselves in areas where I thought I would have an
9 appropriate response for the benefit of the courts.
10 And so it would have been a combination of me,
11 myself -- or me, Gary, and Ivan. I know we
12 reviewed all the documents.

13 Q. Got it. So just so I'm clear, what
14 you're saying is for these documents that are
15 listed in the Documents Produced in This Litigation
16 section, for that section, you're saying that some
17 combination of you and your team, Gary and Ivan,
18 would have reviewed those documents?

19 A. That is correct.

20 Q. Got it. Okay. And same for the expert
21 reports listed in the next section?

22 A. I know I personally reviewed every
23 single page of the expert reports. I know Gary and
24 Ivan did -- well, I know Gary did. I believe Ivan
25 did, as well.

1 Q. And the next section is titled
2 "Pleadings and Case Filings."

3 Do you see that?

4 A. Yes.

5 Q. The first entry is the complaint and
6 demand for jury trial. And there's a column, and
7 the date is April 30, 2025.

8 Do you see that?

9 A. I do.

10 Q. Is that the complaint that I was asking
11 about earlier that was cited on page 1 of your
12 report?

13 A. Yes.

14 Q. And there's several other documents
15 listed here. Did you review each of these
16 documents?

17 A. Under "Pleadings and Case Laws"?

18 Q. Yes.

19 A. Definitely reviewed the complaint in
20 the -- front to back in the plaintiffs' expert
21 disclosure. I think I saw parts of the various
22 documents that are listed below those.

23 Q. And the next section is titled "Other."

24 Do you see that?

25 A. I do.

1 Q. And I would characterize this as sort of
2 a miscellaneous section of different types of
3 documents? Would you agree with that?

4 A. Yeah. The way I would -- most of these,
5 not all of them, are, I think, case-specific
6 documents that just aren't Bates-stamped, right,
7 like a declaration. Some of them are, you know,
8 websites and, you know, obviously, a reference book
9 that I cite in the report. Litigation Services
10 Handbook, that would have been something we have a
11 copy of in my office. But, yes, these effectively
12 that aren't Bates-stamped aren't expert reports or
13 case pleadings.

14 Q. Got it. And so I want to direct your
15 attention to -- it's the third document from the
16 bottom of page 2. So if you go to page 2 where
17 there's the section titled "Other" --

18 A. Okay.

19 Q. -- third document from the bottom, it
20 says "Hospital Safety Score, Scoring Methodology,
21 March 2014."

22 Do you see that?

23 A. I do.

24 Q. Do you recall reviewing that document?

25 A. I'd have to see it. From my

1 recollection, I -- I may have, but, again, I'd have
2 to refresh my memory of actually seeing the
3 physical document.

4 Q. And I know here it says March 2014,
5 which I'm assuming is the date of that document; is
6 that right?

7 A. Again, I would have to confirm that by
8 seeing the document.

9 Q. Well, it's hard to know what the
10 document is, right? It's listed here. So, you
11 know, do you know if that's the proper date for the
12 document, 2014?

13 A. I would have to go back to my work
14 papers to look.

15 Q. Okay. Is it possible that -- do you
16 recall looking at any materials from as far back as
17 2014?

18 A. You know, again, that is why I would
19 want to refresh my memory. I just don't have a
20 specific recollection. That's why I would want to
21 see the document, because I would recognize the
22 document if I reviewed it.

23 Q. I think earlier today we talked about
24 Leapfrog's grading methodology or scoring
25 methodology. I think we've used interchangeable

1 terms.

2 And I had asked if you were aware of
3 their -- of Leapfrog's grading methodology in 2012,
4 and I think you testified that you were not?

5 A. I didn't -- I think I testified I didn't
6 have a specific recollection. I was focused on the
7 current grading because that's the issues that the
8 three expert reports take issue with.

9 Q. Seeing this document listed here, the
10 Hospital Safety Score, Grading Methodology,
11 March 2014, does that at least refresh your
12 recollection that at one point you had an
13 understanding of the methodology -- of Leapfrog's
14 grading methodology at least in 2014 based on
15 that -- reviewing that doc?

16 A. Again, I would have to see the document
17 and its contents.

18 Q. Sitting here today, do you recall
19 anything about Leapfrog's scoring methodology in
20 2014?

21 A. I just know that there's allegations
22 that it was different earlier in time versus
23 currently.

24 Q. Fair enough. And then the document
25 below that, so we're still on the bottom of page 2

1 of Appendix 2, it says "Leapfrog Hospital Survey,
2 2025, Leapfrog Survey Binder."

3 Do you see that reference?

4 A. Yes.

5 Q. And what is the survey binder?

6 A. I'd want to see it again, but I believe
7 this is what is sent to the hospitals themselves to
8 be able to -- if they participate in the survey, to
9 be able to produce the information that then goes
10 into the statistical model that produces the grade.

11 Q. And then below that there is a document
12 titled "2025 Leapfrog Survey/Hardcopy."

13 Do you have any understanding what
14 that document is?

15 A. I believe that is the document that I
16 was referring to that explains the details of the
17 scoring methodology and the associated statistical
18 Excel model that goes along with -- that ultimately
19 produces the grade through their statistical model.

20 Q. Got it. And then going to the next
21 page, so page 3 of Appendix 2, the first document
22 that's listed is the Leapfrog Survey Scoring
23 Algorithms.

24 Do you see that?

25 A. Mm-hmm.

1 Q. What is that referring to?

2 A. I'd want to see the document again, but
3 I believe that that document details the
4 statistical algorithm that supports the -- the
5 statistical model that produces the grade. That's
6 what I believe that is, but would have to confirm
7 it with actually seeing the document again.

8 Q. And just a general question for you. In
9 your view, what is an algorithm?

10 A. That's a good question. An algorithm in
11 this case, it's like a statistical code, if you
12 will. I don't want to call it, like, computer
13 coding, but that's one way one can think about it.

14 It is a formula, if you will, that
15 underlies their scoring system. And so in this
16 case, you know, it -- it's heavy in statistics.
17 It's part of what produces the z-scores and the
18 potential statistical significance of said scores.

19 But at -- at its heart, it underlies
20 the overall statistical grades.

21 Q. Are you familiar with the algorithm in
22 this case, the algorithm in -- in this case?

23 A. Well, I believe I am because I spent a
24 number of hours analyzing the Excel -- the
25 statistical Excel model, and that's part and parcel

1 of it.

2 So in my review of understanding the
3 model and making sure that if one is making certain
4 adjustments, how that flows through, how that
5 changes some of the statistics that are produced by
6 some of the -- the models, such as the Z-score or
7 the weightings, and then how that ultimately is
8 standardized to get an actual grade. Because there
9 is an -- an extra degree of calculations before --
10 after you get weighting by measure, there's some
11 extra calculation that basically standardize it to
12 get a score, which then they have formulas within
13 the model that show you, if you're in a certain
14 range, what the score is going to be as a result.

15 Q. And when you say -- when you write here
16 in your appendix that you looked at the algorithms,
17 and I note plural, what is -- is there more than
18 one? Why is that plural?

19 A. Because it -- it's slightly changed
20 depending on time period. Meaning, the underlying
21 statistical algorithms in the fall of 2024 were a
22 little bit different than the fall of -- or in the
23 spring of 2025.

24 Q. And when you say you reviewed the
25 algorithms, I'm asking now what actual document did

1 you review?

2 A. It's the -- well, in addition to what's
3 listed here, it's the -- I was focused specifically
4 on the statistical model, the Excel itself, and how
5 that worked and how changes flowed through that so
6 it was reliable at the end of the day if one wanted
7 to sensitize, you know, various inputs, similar to
8 what Mr. Nicholson did versus what -- what I did.

9 Q. Got it. So I'm just trying to
10 understand. So for the algorithms, if -- if
11 somebody wanted to look at the algorithms that you
12 looked at, they would need to look at the Excel or
13 the workbook, right?

14 A. Well, I -- I think it's -- as I said, I
15 think it's two things. I think it's the document
16 that's labeled "Scoring Algorithms," right, and
17 then it's the actual Excel model, as well. I think
18 it's both. At least from my perspective, it's
19 both.

20 Q. So if you could just turn -- I think if
21 you go to the next page of your report, there's
22 Exhibit 1, Exhibit 2. There's several exhibits?

23 A. Yes.

24 Q. What are these?

25 A. So Exhibit 1 through 5 is the original

1 scoring that was done by The Leapfrog Group, and
2 then Exhibit 6 through 10 are sensitivities of that
3 original scoring, as discussed in my report.

4 And so by changing some of the
5 inputs, where it says "Enter your hospital score
6 here," that has an impact on all the other
7 calculations in the rest of the workbook that
8 ultimately get down to some other statistical
9 calculations, down here, that actually get to,
10 ultimately, a letter grade.

11 Q. And is it correct that the image I'm
12 look -- that you can see on these exhibits is taken
13 from the Excel workbook?

14 A. Yes. So it -- said differently, in
15 putting together this report but also prepping for
16 the deposition, I spent a significant amount of
17 time going through all of the calculations within
18 these to make sure that they're true and accurate.

19 Q. And my question is just -- I just want
20 to confirm that although what we're looking at here
21 is -- is just a piece of paper in your report with
22 a -- is this a screenshot from the Excel? Is that
23 how you would refer -- refer to it?

24 A. I -- yeah. I mean, sure.

25 Q. It's a visual representation of what's

1 in the Excel --

2 A. Correct.

3 Q. -- made to be printed on a piece of
4 paper; is that fair? If we were -- put it this
5 way. If we were to open up these actual Excels,
6 they would have the same numbers here in text as
7 what I'm looking at on this page?

8 A. Yes. There are Excel -- there's an
9 Excel model that backs up this -- these paper
10 representations. And importantly, the Excel model
11 has all the detailed calculations, including, you
12 know, the statistical calculations within it.

13 Q. So that was going to be my next
14 question. So if you were to open up the Excels
15 that you used for these exhibits, if you were to
16 click on some of the cells, you would be able to
17 see the Excel formula; is that correct?

18 A. Correct. Like, for example, if you were
19 to click on -- on any of the cells in, like, for
20 example, in the Z-score, right, or the modified
21 Z-score, there's complicated formulas in there that
22 make those calculations. And so if you're familiar
23 with statistics, you can understand, based on the
24 formula, exactly what they're trying to do.

25 Q. Right, right. But you'd have to be

1 familiar with Excel, too, and at least in terms of
2 how Excel communicates a statistic in their
3 program?

4 A. Correct. You would need to be very
5 familiar with the functionality of Excel.

6 Q. And so just drawing it all back to the
7 appendix where you say that you reviewed the -- or
8 sorry -- the document listed here is the Leapfrog
9 Hospital Survey Scoring Algorithms. Are the -- are
10 you referring to -- I believe you're referring to
11 two things. Are you referring to, first, the
12 actual Excels that we're talking about that formed
13 these exhibits?

14 A. That would be part of it, yes.

15 Q. And then the other part --

16 A. I think it's documents labeled "Scoring
17 Algorithm."

18 Q. And in those documents, do
19 they describe -- do you recall what the -- is
20 described in those documents about the algorithm?

21 A. Again, you're going to have to -- you're
22 going to have to show me the actual document.

23 Q. Is the scoring algorithm -- algorithm
24 contained in the Excel -- Excels, plural?

25 A. I'd have to see this document again, but

1 I think part of some of the hard-coded -- there --
2 there is some hard-coding in the Excel, and I think
3 those, in part, were also based on algorithmic
4 calculations, if that makes sense.

5 Like, for example, you know, the mean
6 and the standard deviation would be examples of
7 that that might be separate and apart calculated
8 elsewhere but are hard-coded in here but important
9 to continue to calculate other things that change
10 based on the input, such as the Z-score or the
11 overall weighting of each measure in the -- the
12 overall grade.

13 Q. And just to make clear for a layman,
14 when you say hard-code being in an Excel, that
15 means -- well, what does that mean?

16 A. That it -- it's -- there's no formula.
17 It -- it's just a number that, you know, is
18 hard-coded in there.

19 Q. Meaning, if you were to type that number
20 in, that's the number that would appear?

21 A. Correct.

22 Q. All right.

23 A. Said differently, there's no formula
24 that calculates that number directly in the Excel.

25 Q. Does it also mean that the number in the

1 Excel is locked, for want of a better term? It
2 can't change?

3 A. No, you can change them. It's just for
4 the purposes of the calculation it doesn't change.
5 So said differently, the mean and the standard
6 deviation columns don't change, right? But you
7 could change them if you had a different view.

8 If you have a hospital, right, had a
9 different view to say what -- again, if you're
10 running a sensitivity analysis, similar to
11 Mr. Nicholson or myself, the hospital has the
12 ability to change the numbers, if they disagreed
13 with them and they would get a corresponding
14 sensitivity grade, if you will, a different grade,
15 how does this change if I do X, Y, and Z.

16 Q. So the -- so the first -- I guess it's
17 the third column. It's entitled "Enter Your
18 Hospital's Score Here"?

19 A. Yeah.

20 Q. Do you see that?

21 That's a hard-coded column, right?

22 A. Yes. It's -- it -- it's a hard-coded
23 column, but it's intended, right, for either The
24 Leapfrog Group to be entering the numbers or the
25 hospitals themselves to be entering the numbers.

1 Because that's a -- that's a key input than -- or
2 an important input than when you're calculating the
3 other statistics in this workbook such as the
4 z-scores or the weighting.

5 Q. Got it. Yeah. I'm just not, you know,
6 massively familiar with where you would draw the
7 line for hard-coding. So that's kind of why I'm
8 asking.

9 So just going to the next column, the
10 "Mean," I think you said earlier that that's
11 also what would be referred to as hard-coded?

12 A. For the purposes of the -- the backup of
13 Excel, yes.

14 Q. And then the standard deviation, is that
15 hard-coded?

16 A. In the Excel, it's hard-coded.

17 Q. The next column is "Original Z-score."
18 Is that hard-coded?

19 A. No. That's a -- that's a statistical
20 formula.

21 Q. And then the next column, "Modified
22 Z-score," is that hard-coded?

23 A. No. That's a formula that's based off
24 the original Z-score, but puts a certain -- if you
25 read the formula, it puts limitations on how wide

1 of a range the Z-score could be.

2 And so there's some -- again, some
3 limitations that are in the formula that it -- it
4 basically limits really extreme values, if that
5 makes sense.

6 Q. And the next column is titled
7 "Evidence." Is that hard-coded?

8 A. "Evidence" is hard-coded.

9 Q. And then "Opportunity," is that
10 hard-coded?

11 A. Yes.

12 Q. Next column is "Impact." Is that
13 hard-coded?

14 A. Yes.

15 Q. The next column is "Number of Component
16 Measures." Is that hard-coded?

17 A. Yes. And apparently all of these come
18 from the associated PDF document that talks about,
19 like -- for example, all of those can be found
20 in -- if you go back to page 3 of Appendix 2, the
21 third document down, for example, Leapfrog Hospital
22 Safety Grade Scoring Methodology, Spring 2025
23 Scoring Grade. So you can find "Evidence,
24 Opportunity, Impact, Number of Component Measures"
25 in that document. You can also find the mean and

1 the standard deviation in that document.

2 Q. Understood. So I think we were -- we
3 said "Opportunity" is hard-coded, right?

4 A. Yes.

5 Q. I just want to keep going through all
6 the columns. "Impact," is that hard-coded?

7 A. Yes, again, from that document.

8 Q. Got it. Okay. "Number of Component
9 Measures," is that hard-coded?

10 A. Yes.

11 Q. Okay. The next column is
12 "Standard Weight." Is that hard-coded?

13 A. No. That's a formula.

14 Q. And then the next column is "Final
15 Weight." Is that hard-coded?

16 A. No. That's a formula.

17 Q. And then the final column is "Weighted
18 Measures z-scores." Is that hard-coded?

19 A. No. That's a formula.

20 Q. Okay. So we'll come back to this later.
21 I just want to keep going through.

22 So just I have -- apologies if I
23 already asked this. But when you -- in the
24 appendix, when you write that you reviewed the
25 scoring algorithms, that means you reviewed these

1 actual Excels along with some of the documents --
2 other documents listed here that explain the
3 scoring methodology; is that right?

4 A. Yes. Said differently -- said
5 differently, I looked -- I reviewed and analyzed
6 all the underlying statistical math that is going
7 on that ultimately produces the grades.

8 Q. Okay. And so the next two documents
9 here are listed Leapfrog Hospital Safety Grade
10 Scoring Methodology, Fall 2024 Safety Grade. Did
11 you review that?

12 A. Yes.

13 Q. And is it your understanding -- how does
14 it -- how does that differ from the Spring 2025
15 Safety Grade, which is the next document?

16 A. I think the methodologies are -- are the
17 same, but I think some of the -- the inputs that
18 can be found in these two documents that go into
19 the calculation -- so as I said, you know,
20 evidence, opportunity, impact, number of
21 occurrences, mean, and standard deviation -- come
22 from those two documents. And they're slightly
23 different because there's a different point in
24 time.

25 Q. I see. Meaning, like the mean, for

1 example, is different in 2024 versus 2025?

2 A. Correct.

3 Q. And that's because different hospitals
4 have different grades that year?

5 A. Correct.

6 Q. Same for the standard deviation?

7 A. Correct.

8 Q. Okay. How many of these columns -- so
9 we've talked about mean, standard deviation. How
10 many other columns would have changed from, say,
11 2024 to 2025?

12 Well, we can go one at a time. Would
13 the original mean score have changed?

14 A. Yes, because that is a function of the
15 input in this particular calculation. And so, yes,
16 absolutely. And those -- those scores change
17 depending on the input. So these are dynamic
18 calculations. So if you do a comparison, for
19 example, between Exhibit 1, which is for Delray,
20 and Exhibit 6, which is my sensitivity of that,
21 you'll see the z-scores are different. And they're
22 updating correctly, but they're different because
23 of the different natures of the inputs.

24 Q. Got it. And then the next -- so we've
25 talked about the top three documents for

1 Appendix 2. So I'm going to ask about the fourth
2 document now. It says "Hospital Safety Grade
3 Calculator, Spring 2025." What is that?

4 A. That, I believe, is the actual Excel
5 model.

6 Q. Got it. So is there some overlap
7 between that and the first document on the page,
8 which is the algorithms?

9 A. I think that the -- the first document
10 on the page helps explain the -- the statistics
11 behind.

12 Q. The -- okay. Is it fair to say that
13 here the grade calculator is the Excel itself?

14 A. That's my -- that is my recollection,
15 yes.

16 Q. And then is it fair to say that within
17 that grade calculator are algorithms that we've
18 been discussing?

19 A. There are statistical formulas within
20 it.

21 Q. And then the last document here I see is
22 Litigation Services Handbook. I believe you
23 testified that that's a document you have in your
24 office?

25 A. It's a -- it's a -- as the title might

1 suggest, it is a reference book that is office --
2 often used by professionals engaging in these types
3 of analysis that offer, you know, advice, best
4 practice examples, that type of stuff. So it's
5 a -- it's a book that I and others in the industry
6 often cite.

7 And it is written by, you know,
8 professionals, like myself, in the industry who
9 have been doing this and have the real world kind
10 of practice to also go with their understanding
11 with what courts have said about certain things.

12 Q. Did you contribute to writing this book?

13 A. I did not.

14 Q. That would be a lot, to rely on a book
15 you wrote?

16 A. Yeah.

17 Q. To stamp through -- just kidding.

18 I see here it says "6th Edition,
19 2017." Is that the most recent edition?

20 A. I believe it is.

21 Q. And I believe if I look at your
22 Appendix 2, that's the only document that's not
23 specifically related to this litigation. Do you
24 agree with that?

25 A. I think that is correct.

1 Q. So for the -- if we go back to the list
2 of the documents produced in this litigation, so
3 that's on pages 1 and 2 of that section, do you
4 know how many documents are listed here in this
5 list?

6 A. Without counting them, no.

7 Q. I'll represent to you that we counted,
8 and we think it's around 190 documents. Does that
9 seem right to you?

10 A. You're talking on all of Appendix 2 or
11 just the Bates stamp?

12 Q. Just the Bates stamp.

13 A. I have no reason to doubt your
14 representation.

15 Q. And I'll be clear. I think it's just an
16 estimate. I'm not going to vouch for that exact
17 number, but I believe it's around 190.

18 We looked at some of these documents,
19 and for the documents that are produced by
20 Leapfrog -- so they have the Leapfrog Bates
21 stamps -- they appear to be media reports,
22 marketing materials, and some changes --
23 explanations of changes to the fall 2024 imputation
24 methodology.

25 Does that sound right to you?

1 A. I'd have to go back and look at the
2 documents themselves. But, again, I -- I don't
3 have reason to doubt that, in part, because my
4 recollection of the plaintiffs' expert reports is
5 there is a fair amount of discussion about
6 marketing materials and -- and whatnot, right?

7 Q. And I believe you testified that this
8 list was entirely based on -- and just for the
9 Documents Produced in This Litigation section, this
10 list was entirely based on what was cited or
11 considered by plaintiffs' experts; is that right?

12 A. Yes.

13 Q. Is it fair to say that many of these
14 documents listed here were -- were not relevant to
15 your opinions?

16 A. Ultimately, not relevant, but,
17 obviously, something we considered in forming
18 opinions to make sure that there wasn't something
19 in those documents that would be either helpful to
20 those opinions or contrary to those opinions.

21 Q. And there's some documents that are
22 produced by the plaintiffs here. I believe some of
23 them were Instagram and TikTok videos about the
24 Plaintiff Hospitals. Did you review those?

25 A. Again, the way I would answer that is it

1 would have been a combination of me and my team.
2 But we -- we collectively reviewed every document
3 that's listed on there.

4 Q. Do you recall, you personally, reviewing
5 any Instagram or TikTok -- TikTok videos?

6 A. Not separate and apart from reading
7 about them in the plaintiffs' expert reports.

8 Q. There's some documents in the -- in the
9 documents produced by the Plaintiff Hospitals on
10 your list that were negative press about the
11 Plaintiff Hospitals. Do you recall reviewing
12 those?

13 A. Again, I think the primary recollection
14 would be reading about them in the plaintiffs'
15 expert reports. I think the ultimate detailed
16 review would have been done by Gary and/or Ivan.

17 Q. Did Gary or Ivan ever discuss with you
18 these Instagram or TikTok videos?

19 A. I don't think we had a separate
20 conversation about them. Obviously, I was aware of
21 them, but I don't -- I don't believe we had a
22 separate conversation because, again, to your
23 earlier point, while they were cited and we have
24 them and we reviewed them, they weren't necessarily
25 germane to my ultimate, you know, responses to

1 plaintiffs' experts.

2 Q. And same question for the negative press
3 about the Plaintiff Hospitals. Do you recall any
4 discussions with Gary or Ivan regarding those
5 documents?

6 A. Not separate and apart from, again, with
7 knowing about them as they were cited in the
8 plaintiffs' expert reports.

9 Q. And then some of these documents
10 produced by plaintiff were the declarations of each
11 hospital CEO. Do you -- did you review those
12 personally?

13 A. I did. And particularly, I think that
14 each one had, like, an Appendix 4 and Exhibit 4
15 that were, like, one-page key indicators that are
16 potentially germane to a damage quantification.

17 Q. Some of the documents produced here were
18 e-mails between -- and when I say "produced here,"
19 I mean listed on Appendix 2 -- were e-mails between
20 the Plaintiff Hospitals discussing employees --
21 excuse me -- the Plaintiff Hospitals' employees
22 discussing the Leapfrog grades. Did you review any
23 of those?

24 A. I -- I do have a recollection of
25 reviewing some of those. I don't know if I

1 reviewed all of them.

2 Q. And did you find them to be relevant to
3 your opinions?

4 A. No. No.

5 Q. Did you -- I believe listed both in some
6 of these documents produced and also elsewhere on
7 Appendix 2 is the Leapfrog web pages. Did you
8 review any of the Leapfrog web pages?

9 A. I do have a recollection of being on
10 Leapfrog's website.

11 Q. Was anything on there relevant to your
12 report?

13 A. I think it was more background context.

14 Q. And then I think the final category of
15 documents that I think are listed in some of
16 these -- that -- that appear in some of these
17 produced documents on your list is literature that
18 was relied on by the plaintiffs' experts. Did you
19 review any of that?

20 A. I did to the extent that it was
21 potentially relevant. But ultimately, at the end
22 of the day, it doesn't directly impact my responses
23 to the plaintiffs' experts.

24 Q. Okay. Are you aware that after your
25 report was served, which I believe we talked about

1 as being September 4th, are you aware that after
2 that, the Plaintiff Hospitals produced documents
3 concerning plaintiffs' revenue, market share,
4 branding, and transfer and admissions data?

5 MS. WOOD: Objection to form.

6 THE WITNESS: Can you repeat what was
7 produced?

8 BY MR. TAKAGAKI:

9 Q. Yeah. Are you aware that after your
10 report was submitted, which was September 4th, that
11 the plaintiffs produced documents concerning the
12 Plaintiff Hospitals' revenue, market share,
13 branding, and transfer and admissions data?

14 A. I think we were aware that there was
15 some further production of potentially relevant
16 information, but I think, ultimately, came to the
17 determination that it wasn't -- it didn't change my
18 opinions.

19 Q. Did you review those new productions?

20 A. I personally did not.

21 Q. Did anyone from AlixPartners receive
22 those documents?

23 A. I -- I would have to confirm that with
24 Gary.

25 Q. Did you discuss any of these documents

1 with counsel?

2 A. I personally did not.

3 Q. And it's your position that if
4 plaintiffs had produced these types of documents,
5 documents relating to revenue, market share,
6 branding, transferring and admissions data, that
7 those would not be relevant to your opinions?

8 A. It could be contextual to the opinions,
9 but it would still be insufficient to be able to
10 quantify a substantial harm, from my perspective.

11 Q. Why would revenue, market share
12 documents not be able to show -- not be able to
13 quantify harm, from your perspective?

14 A. Because you have to get down to the
15 actual economics of it. And revenue is a piece,
16 potentially. You still need the cost structure,
17 right. And so you could have no change in revenue,
18 right. And if your cost structure is the same,
19 then, in theory, there's no damages, right.

20 So it -- it's an incomplete -- and
21 it's the same thing with market share. Because
22 market share might be a factor to help explain
23 revenue, but it still doesn't get you where you
24 need to go to be able to demonstrate an actual
25 harm.

1 Q. So you -- from year -- one year to the
2 next, revenue changes, market share changes.
3 Branding, you have to spend more money on branding.
4 Your transfer and admission data goes down. Your
5 testimony is that that would not be relevant to
6 quantifying harm at all?

7 A. No, that's not what my testimony was. I
8 said it could be contextual, but it's still
9 insufficient, from my perspective, to actually
10 quantify a harm. It's pieces here, right?

11 You could have your revenue go down,
12 and that still doesn't necessarily translate into
13 harm, right, if your profitability changes. And
14 that's part of my point. You could have a change
15 in your market share, but that doesn't necessarily
16 in and of itself translate into an economic harm.

17 It's -- it's not enough information,
18 from my perspective, if one asked me, if I was
19 hired by your clients and I was given that
20 information and say "quantify the harm," I need
21 more information.

22 Q. What else do you need?

23 A. I need, at minimum, projections before
24 the alleged bad act and projections after the
25 alleged bad act, all the way through profitability.

1 Q. I'm sorry. When you say "projections,"
2 projections of what?

3 A. Financial performance, at minimum.

4 Q. So revenue is not enough?

5 A. No. Revenue is a piece of the overall
6 what I need, but just it's one small piece. And
7 just because revenue goes up or down doesn't
8 necessarily mean that that translates into harm or
9 damages. And that's what I'm simply saying.

10 Q. Understood. And I'm not saying it
11 definitely would. But my question is if you were
12 given revenue for several years for any entity and
13 their market share data --

14 A. Okay.

15 Q. -- for any entity, and their branding
16 information, what they're spending on branding,
17 their branding initiatives, and they're a hospital,
18 so their transfer and admissions data -- I don't
19 know if it's, you know, another company, their
20 sales, for example, or their -- you know, their
21 number of clients, if you were given all of that
22 information for several years, you're telling me
23 that you would not -- you would tell your client "I
24 cannot quantify the damage"?

25 A. I -- I'd need more information. I would

1 ask for more information.

2 Q. And if you didn't get it, could you
3 still quantify damages?

4 MS. WOOD: Objection to form.

5 THE WITNESS: If -- if I didn't get
6 information all the way down through profitability
7 on a respective basis, could I quantify the
8 damages? It -- no, it would be -- it would be very
9 difficult --

10 BY MR. TAKAGAKI:

11 Q. So is --

12 A. -- because then I would be speculating
13 or I would have to make assumptions.

14 Q. So I believe you've been serving as an
15 expert or a consultant for the last 25 years; is
16 that right?

17 A. Yes.

18 Q. And you've done many, many damages
19 quantifications, correct?

20 A. Yes.

21 Q. And if I went back and looked at all
22 those, I couldn't find anywhere you were relying
23 principally on market share information, revenue,
24 branding, and we'll call it transfer and admissions
25 data or data regarding, you know, number of

1 products sold or customers? In none of those did
2 you offer --

3 A. No.

4 Q. -- any type of consulting?

5 A. No. It's -- it's incomplete.

6 Q. I'm not -- my question isn't whether
7 it's incomplete, but can you take that data that
8 I'm discussing with you and put together some type
9 of damages quantification?

10 MS. WOOD: Objection to form, asked and
11 answered.

12 THE WITNESS: No. I would need a lot more
13 information. As I've -- as I've testified, just
14 because you have revenue or you have market share,
15 right, that doesn't necessarily mean that that
16 translates into the damages, right?

17 There's a lot more to the -- there's
18 a lot more that needs to be considered. In an
19 ideal world, right, and this is what typically
20 happens, and I know information like this exists,
21 you would look at a set of financial projections
22 immediately before the bad harm, right, and the bad
23 acts.

24 That's what you expect to happen on a
25 go-forward basis, right? Now, you'd have to take

1 that in the -- and put it in the context of what
2 they have historically done and -- to make sure the
3 projections made sense. You would then compare
4 those projections to, like, a current set of
5 projections, right. In the delta, the difference
6 in a cash flow, right, assuming causation, would be
7 the quantification of damages.

8 This is what you expected. Something
9 bad allegedly happened. Your expectations are down
10 here, right, the difference between those. And
11 the -- and revenue doesn't answer it enough.
12 Market share doesn't answer it enough. You need to
13 get down to profitability. You need to get down to
14 cash flows.

15 BY MR. TAKAGAKI:

16 Q. So I'm trying to square this with the
17 conversation we had earlier where you said you
18 could do a damages quantification for a retired
19 person who's living in a, you know, retirement home
20 and got punched in the face.

21 And I think you said all you'd really
22 need to see was their -- their medical bills and
23 maybe a few other documents. Do you recall
24 testifying to that?

25 A. Yeah, out-of-pocket expenses.

1 Q. And I -- I'm just struggling to see how,
2 if you -- if your position was you could do a
3 damages quantification based on so little in that
4 case, why years of revenue data, your market share,
5 your branding, how many customers you have or
6 consumers or patients you have, why that could not
7 show your damages.

8 A. Let me -- let me explain it to you. In
9 the hypothetical you gave me, right, if you use a
10 but-for damage model, right, but for getting
11 punched in the face, right, what do you expect, you
12 don't get -- expect to get punched in the face;
13 therefore, you don't expect to pay for medical
14 bills.

15 So the expenses in the but-for world
16 are zero. In the actual world, you did get punched
17 in the face, right? And let's say you went to the
18 hospital and it was a thousand dollars, the
19 difference, right? You weren't expecting it -- no
20 expenses. You got punched. You got to go out of
21 pocket a thousand dollars. That's why I can do
22 that quantification here, right? There's a
23 comparison there. In the information that you're
24 offering me, there is no comparison, right?

25 Q. Could you look at, let's say, the last

1 several years of revenue data and say that was, you
2 know, fairly consistent year to year, little
3 increases or decreases here or there, and then look
4 at the year in question when there's the alleged
5 harm, and if that revenue suddenly goes down by
6 90 percent, back to basically zero, you're telling
7 me that that would not be something that, you know,
8 you can use to quantify damages?

9 MS. WOOD: Object to form.

10 THE WITNESS: Well, couple things. You're
11 assuming causation. So if you're asking me to
12 assume causation here, that the decline was
13 directly related to the grading --

14 BY MR. TAKAGAKI:

15 Q. Well, do you ever assume causation for a
16 damages model?

17 A. You always assume causation, because
18 without assuming causation, you never get to
19 damages.

20 Q. So when you're -- when you're retained,
21 not only are you looking at the numbers to
22 calculate what the losses are, but then you're
23 going to look into sort of the legal arguments as
24 to whether this causation occurred?

25 MS. WOOD: Objection to form.

1 THE WITNESS: No, that's not what I'm saying.
2 Causation is ultimately a legal conclusion, right?
3 And so in doing a damage calculation, by
4 definition, I'm assuming that there is a causal
5 link or -- or you wouldn't have a damage
6 quantification.

7 Does that make sense?

8 BY MR. TAKAGAKI:

9 Q. Yeah.

10 A. And so I'm focused on the numbers in a
11 quantification, the but-for analysis that I've
12 talked about a couple times.

13 But to go back to your question,
14 revenue in itself is just not enough to demonstrate
15 that there's been economic harm, right? It could
16 go down. You're right. But you need the full
17 picture. You need the full financials, and
18 importantly, you need to be able to compare it to
19 the expectations before the alleged harm, right,
20 because there could be a reason -- and this gets a
21 little bit into causation -- that you were
22 expecting it to go down by 90 percent.

23 Q. Let's say you're a, you know, small
24 mom-and-pop store. You know, you sell yarn or
25 something. And so you don't have all of this

1 available, right? You have my revenue for several
2 years. You have my market share. I used to be
3 the -- the main one of two yarn stores in town, but
4 now no one comes to me, right?

5 I'm just listing off the things that
6 we've been discussing. You have branding
7 information. I've had to quadruple what I'm
8 spending on branding because all these lies have
9 been told about me. And you have your customer
10 data. My customer data is way down.

11 Is your testimony to this judge that
12 you -- at least you, not any expert, but you would
13 not be able to put together any form of damages
14 quantification in that scenario?

15 MS. WOOD: Objection to form.

16 THE WITNESS: Not with a reasonable degree of
17 certainty. I think there's too many assumptions
18 and too much speculation that would have to go into
19 it.

20 But, again, at the end of the day,
21 understanding hospitals that are part of a publicly
22 traded company that have FP&A groups, I would ask
23 for the -- if I was hired by you, I would ask for
24 the projections. It's the simplest way to do this.
25 Tell me what you were expecting before the bad acts

1 and compare it to what is actually occurring now --
2 or what you expect now.

3 BY MR. TAKAGAKI:

4 Q. Did you do that? Did you ask counsel
5 for those documents?

6 A. I was -- as I note in my report, I was
7 told that they were not available.

8 Q. None of them? I'm saying now, are you
9 aware that after your report came out -- this is
10 what started this line of questioning. After the
11 report came out, plaintiffs made additional
12 productions of all of these things. Did you ask to
13 see them?

14 A. Again, I would have to consult with
15 Gary. It would be my expectation it's something
16 that we would want to analyze, take a look at.
17 But, again, I don't -- it doesn't change my -- my
18 opinion that that still be in -- the type of stuff
19 that you're describing would still be insufficient,
20 from my perspective, to actually quantify with a
21 reasonable degree of certainty any economic harm
22 here.

23 Q. Take away from what I'm describing. I'm
24 just talking about additional production that may
25 have had relevant documents in there, did you ask

1 to review it --

2 A. I -- I --

3 Q. -- when you said it would be the
4 simplest thing to do?

5 A. Well, I don't know if I said -- I was
6 talking about projections would be the simplest
7 thing to do. I would have to -- I don't know, as I
8 sit here right now. My expectation is that Gary
9 would have reviewed them, and we would have
10 discussed them, but I don't have a specific
11 recollection as I sit here right now.

12 Q. They're not listed in your documents
13 cited, are they?

14 A. My understanding is they came out after
15 my report.

16 Q. Did you supplement your report to
17 account for the fact that Gary reviewed these
18 documents?

19 A. No, I did not.

20 Q. Did you plan to?

21 A. I haven't been asked to by counsel.

22 Q. My question is do you plan to supplement
23 the report to add documents that Gary reviewed?

24 MS. WOOD: Object to form.

25 THE WITNESS: I would have to confirm with

1 Gary first that he did, in fact, review them, and I
2 would if counsel asked me to do it. Because,
3 again, those documents don't impact my opinions in
4 this report.

5 BY MR. TAKAGAKI:

6 Q. How can you know that if you haven't
7 seen them?

8 A. Because -- as the way you've described
9 them.

10 Q. No, no. Not what I'm describing. I'm
11 saying additional documents that have been produced
12 by plaintiff.

13 A. That deal with market share, revenue,
14 and one expense line item?

15 Q. No, no, no. I'm just talking about
16 additional productions by plaintiff.

17 A. Well, because -- I can tell because you
18 they're not the types of documents that I list in
19 my report that I would want to have to be able to
20 do the analysis.

21 Q. But how do you know what the documents
22 are?

23 A. Because they're not projections.

24 Q. How do you know that they're not
25 projections?

1 MS. WOOD: Objection to form, asked and
2 answered.

3 MR. TAKAGAKI: He hasn't answered how he
4 knows --

5 THE WITNESS: Because --

6 MR. TAKAGAKI: -- these are not projections.

7 THE WITNESS: These are actuals. We just
8 talked about them. These are actual revenue,
9 actual market share.

10 BY MR. TAKAGAKI:

11 Q. Okay. No, no, no. I was just saying,
12 are you aware that that was in some of the
13 production. But I'm just saying if productions
14 occurred that contained even more than I'm
15 describing, right, how could you possibly know what
16 is in those productions without you or Gary
17 reviewing them?

18 A. Because I believe Gary reviewed them.
19 That's what -- that's what I'm saying.

20 Q. Okay. So Gary reviewed them. That is
21 your testimony?

22 A. That is my recollection or at least my
23 understanding that I would have to reconfirm.

24 Q. Okay. So if he reviewed them, I will
25 just say we expect you to amend your report to

1 account -- to list whatever documents he reviewed.

2 Do you understand what I just --

3 MS. WOOD: Is that a question?

4 MR. TAKAGAKI: I'm asking if he understands my
5 expectation.

6 THE WITNESS: I will do whatever counsel tells
7 me to do as it relates to if -- if this needs --
8 Appendix 2 needs to be updated.

9 BY MR. TAKAGAKI:

10 Q. Appreciate that.

11 A. But, again, remember, this Appendix 2
12 relates to the report as it's written, and I still
13 believe in those opinions as of September 4th.

14 Q. Sorry. I cut you off. Go ahead.

15 A. No.

16 Q. And if you do not end up supplementing
17 your report to add those documents, is it fair for
18 us to assume that Gary did not, in fact, review
19 them?

20 MS. WOOD: Objection to form.

21 THE WITNESS: I don't want to speculate
22 without talking to Gary.

23 BY MR. TAKAGAKI:

24 Q. So you're saying it's possible Gary
25 reviewed them, but you're still going to decide not

1 to supplement your report?

2 MS. WOOD: Objection; form.

3 THE WITNESS: I think those are two separate
4 questions. If counsel thinks we need to supplement
5 them, I'm happy to supplement. It's just listing
6 more documents.

7 BY MR. TAKAGAKI:

8 Q. Is it possible that Gary is going to
9 tell you he reviewed them and you're not going to
10 supplement your report?

11 MS. WOOD: Objection to form.

12 THE WITNESS: Again, I will take direction
13 from counsel as to whether or not to supplement
14 Appendix 2 for additional documents that were
15 produced after the date of my report.

16 BY MR. TAKAGAKI:

17 Q. So let's turn back to your report. I
18 want to direct you to paragraph 5 of your report.
19 It's on page 2.

20 A. Okay.

21 Q. And in the first sentence, it says
22 you're a partner and managing director at
23 AlixPartners.

24 Do you see that?

25 A. I do.

1 Q. And then the second sentence, it says
2 you have over 25 years of providing operational,
3 financial, litigation, bankruptcy, and management
4 consulting to clients operating in a diverse range
5 of industries.

6 Do you see that?

7 A. Yes.

8 Q. And in the next sentence, it lists the
9 different industries that you've consulted for or
10 with companies for.

11 Do you see that?

12 A. It lists some.

13 Q. And I think on this list there are a few
14 that we haven't touched on yet today. I believe
15 it's -- they are, reading from your report, wealth
16 management and investment advisory, private equity.
17 I believe we already talked about construction. I
18 don't know about chemical. But it also says
19 electronics, energy, entertainment, food, health
20 care, insurance, manufacturing, metals and mining,
21 mortgage, newspaper, pharmaceuticals, power
22 generation, real estate, recruiting, retail,
23 telecommunications and transportation.

24 Do you see all that?

25 A. I do.

1 Q. Do you agree with your report here that
2 these are different areas in which you've
3 consulted?

4 A. Yes.

5 Q. Okay. So is it fair that this list plus
6 the list we were talking about earlier today are
7 areas in which you've consulted?

8 A. It's not an exhaustive, but, yes, it
9 provides some context, the different industries
10 that I have applied, you know, the damage valuation
11 type work.

12 Q. I guess my point is just the list you
13 gave earlier today shouldn't override the list
14 here, and the list here shouldn't override that
15 list. They should be considered together; is that
16 fair?

17 A. Sure.

18 Q. Okay. I want to direct your attention
19 to paragraph 19 of your report. So this paragraph
20 is under a section titled "Understanding of
21 Relevant Legal Issues."

22 Do you see that?

23 A. I do.

24 Q. The first sentence says "I understand,
25 based on discussions with counsel."

1 Do you see that?

2 A. I do.

3 Q. I assume this is what it says. It's
4 discussing information that you either learned from
5 counsel or clarified with counsel?

6 A. I think that's accurate.

7 Q. And then it says, under the FDUTPA --
8 which I think we've been talking about today is the
9 Florida Deceptive and Unfair Trade Practices Act.
10 Do you agree that that's what you mean here when
11 you write that?

12 MS. WOOD: Objection to form. It's "False,"
13 not "Florida."

14 BY MR. TAKAGAKI:

15 Q. I'll put it this way. Do you agree
16 FDUTPA here, as you use it, is referring to the
17 statute in this case?

18 A. Yeah. I have -- I have it defined in
19 paragraph 3.

20 Q. Paragraph 3. Right. I see it. Okay.
21 Right. Defined in paragraph 3. The language
22 you're referring to is "TLG is subject to the
23 Florida Deceptive and Unfair Trade Practices Act,"
24 correct?

25 A. That is my understanding.

1 Q. And you define that as FDUTPA in
2 paragraph 3. Okay. So if I use that for the rest
3 of the deposition, I won't have to spell it out,
4 which I'm sure everyone will appreciate. Does that
5 work for you?

6 A. That's fine.

7 Q. Going back to paragraph 19, you say,
8 under the FDUTPA, "A plaintiff must prove the
9 following in order to recover damages from the
10 defendant."

11 Do you see that?

12 A. I do.

13 Q. And I assume this is relevant to your
14 report because the report is about -- at least one
15 of your opinions is about quantifying damages,
16 correct?

17 A. In part, yes, specifically the concept
18 of substantial injury.

19 Q. Okay. And then in paragraph -- sorry --
20 in Romanette 2 of this paragraph, you say
21 "Defendant's actions were the legal cause of actual
22 damages sustained by plaintiff."

23 Do you see that?

24 A. I do.

25 Q. Does -- what does actual -- does "actual

1 damages" here, as you're using it, is -- is that
2 what you have been referring to go when you talk
3 about quantifying damages in your work?

4 A. Yes. Loosely, yes. That's exactly what
5 I mean.

6 Q. And if you determined that -- I think we
7 touched on this a little bit earlier with
8 causation, that in your work as an expert or
9 consultant where you're trying to quantify damages,
10 if you determine that what you're seeing in the
11 documents is not the legal cause of those damages,
12 do you not include them in your damages
13 calculation?

14 A. No, because, again, as I said earlier,
15 that's a -- that's a legal determination, right?
16 And so if the trier of fact does not find that
17 there's a causal link, we never get to damages,
18 right?

19 Q. I see. But do you -- you calculate
20 damages in your work before that determine -- that
21 causal link --

22 A. Right.

23 Q. -- is made, right?

24 A. Right.

25 Q. So you're calculating it, and if it's

1 determined that it's the legal cause, then your
2 number is relevant; is that fair?

3 A. Correct. And said differently, in some
4 court proceedings, oftentimes there's a liability
5 phase first. And then if the trier of fact finds
6 that there is liability or causation, then you move
7 to the damage phase.

8 Obviously, for the -- a lot of cases
9 are kind of dual-tracked. And if there's no
10 liability, then, you know, opinions about that --
11 damages don't matter.

12 Q. Right. Are you -- are you aware that --
13 in this case that the liability phase has not yet
14 concluded?

15 A. Yes. That's my understanding, that that
16 is still ongoing.

17 Q. So at this point, any damages
18 quantifications would be sort of, in the example
19 you were describing as not quite relevant yet, but
20 they will be relevant when liability is determined;
21 is that fair?

22 A. I mean, typically, yes, that's how it
23 works. There's a damage quantification, and you
24 get to the damage quantification if liability is
25 found. And if liability is not found, you don't

1 need to pay attention to damages.

2 Q. Right. So is it your understanding that
3 both the plaintiffs' experts in this case -- which
4 my understanding is you have evaluated what they
5 have or have not said about damages; is that
6 correct?

7 A. That's correct.

8 Q. And you've also -- you also have an
9 opinion that -- as it relates to damages; is that
10 correct?

11 A. The opinion is it relates to damages.
12 It's -- if one wants to quantify this because the
13 information exists, one could reasonably quantify
14 this.

15 Q. And my point is, for both the experts,
16 plaintiffs' experts, to the extent they talk about
17 damages, and your report, to the extent it talks
18 about damages, I'm just trying to understand, those
19 are both, in your mind, not quite right yet because
20 we have not reached the liability phase; is that
21 right?

22 A. I -- I don't have an opinion on that
23 because it calls for a legal conclusion. My
24 opinion is basically the -- the plaintiffs'
25 experts, when commenting on damages, don't do a

1 damage analysis and, you know, use terms like
2 "maybe," "likely," and it's in response to the
3 analysis that they do have that they're describing
4 it as "likely" or "maybe," you know, that one could
5 actually be more certain about this if they did a
6 traditional but-for damage calculation using a
7 fulsome set of projections before the bad acts and
8 after the bad acts. And the comparison would give
9 you a reasonable -- it would quantify damages to a
10 reasonable degree of certainty.

11 Q. If you were offering a quantification of
12 damages in this case, is that something that you
13 would do later in the case?

14 MS. WOOD: Objection to form.

15 THE WITNESS: I'm not quite sure --

16 BY MR. TAKAGAKI:

17 Q. Oh, sorry. Go ahead.

18 A. Maybe the best way to answer this, if
19 the information -- the fulsome set of information
20 that would be required to do a but-for damage model
21 was available, right, I would anticipate that
22 counsel would have asked me to do a damage
23 quantification.

24 Because, again, from a layman's
25 perspective, I think that gets to the heart of

1 the -- the concept of substantial injuries.

2 Q. Is it possible that you will, at some
3 point, do a damages quantification and submit a
4 report about that in this case?

5 MS. WOOD: Objection to form.

6 THE WITNESS: I don't anticipate it, again,
7 given the scope of my report was to review and
8 respond to the plaintiffs' experts. If they did
9 one, then maybe I would anticipate counsel would
10 ask me to take a look at it.

11 BY MR. TAKAGAKI:

12 Q. Understood. So you don't currently have
13 any plans to do a damages quantification?

14 A. I -- I currently do not.

15 Q. -- if in this case, the plaintiff -- the
16 defendants are found liable for damages to the
17 plaintiffs, do you anticipate that that would be
18 sort of the moment in the case where you might be
19 called upon to do a damages quantification?

20 A. Again, I think it calls for a legal
21 determination, but, no, I don't expect it. Because
22 my understanding of the information available in
23 this case, regardless of what point in time, if --
24 if you're not producing the right information in a
25 fulsome -- I -- I can't -- I can't do one, again,

1 that raises to the level of reasonable certainty.

2 Q. I understand. Might have been a bad
3 question.

4 Just in your years of experience as
5 an expert consultant, you know, doing damages
6 quantifications in litigations like this -- well,
7 you admit you -- you've done damages quantification
8 in cases -- in litigations.

9 A. Yes.

10 Q. And have there been times where you did
11 the damages quantification after liability was
12 established at, you know, trial?

13 A. Only in cases where it was bifurcated,
14 the case, a liability phase and then a damages
15 phase. It's more often similar to this case where
16 it's dual-tracked, if that makes sense.

17 Q. Meaning, you would do it -- the
18 dual-tracked version is you and our expert, the
19 plaintiffs' experts, would be doing the damages
20 calculation now?

21 A. Correct.

22 Q. I got it. And -- but typically, it --
23 even if done at this point in the litigation, it's
24 not relied on or considered until liability is
25 established?

1 A. That is my understanding because, again,
2 without liability, there aren't any damages.

3 Q. Right.

4 A. Can we -- when you're ready, can we take
5 a short break?

6 Q. Yes. I think I might be done with this
7 section. I might just have one more question.

8 A. That's fine.

9 Q. Okay. I don't want to...

10 Are you aware that there are no
11 damages claims in this case?

12 MS. WOOD: Objection to form.

13 THE WITNESS: I don't know if that's what
14 the -- my recollection of the complaint was. But I
15 understand that, at least based on discussion with
16 counsel, the concept of damages are still relevant
17 because it goes to the heart of the issue of
18 substantial injury. But, again, this is my
19 layman's understanding of the legalese.

20 BY MR. TAKAGAKI:

21 Q. Are you aware of whether there's an
22 amended complaint in this case?

23 A. I -- I don't have a specific
24 recollection one way or the other.

25 Q. Are you aware that the plaintiffs in

1 this case have withdrawn their damages allegations
2 and are only seeking -- seeking injunctive relief?

3 A. Again, I don't have a specific
4 recollection either way. I was more focused on
5 reviewing and responding to the plaintiffs'
6 experts, including their discussion of, you know,
7 injury that was maybe occurred or likely occurred.

8 So that's kind of how I've focused on
9 it. Whether or not that what you're representing
10 is accurate, I -- I have no basis one way or the
11 other.

12 Q. If it turns out that plaintiffs do
13 amend -- amend a complaint or, otherwise, remove
14 their damages claim, would you amend your report to
15 account for that?

16 MS. WOOD: Objection to form.

17 THE WITNESS: I think it calls for a legal
18 conclusion. But based on my -- my understanding of
19 the relevant law, based on my discussions with
20 counsel that the concept of substantial injury,
21 even if plaintiffs aren't asking for monetary
22 damages, that that is why the quantification or the
23 attempt to quantify the damages would still be
24 relevant.

25 MR. TAKAGAKI: Okay. I think we can take a

1 break. Thank you for indulging me in more
2 questions.

3 THE VIDEOGRAPHER: We are going of the record
4 at 2:22 p.m. with the end of Media No. 3.

5 (Short recess.)

6 THE VIDEOGRAPHER: We're back on the record
7 with the beginning of Media No. 4 at 2:37 p.m.

8 Counsel, you may proceed.

9 BY MR. TAKAGAKI:

10 Q. Mr. Rule, you're not an attorney,
11 correct?

12 A. That is correct.

13 Q. And for paragraph 19, which we've been
14 looking at in your report, I believe you've said
15 that it was based on discussions with counsel,
16 correct?

17 A. Yes.

18 Q. Do you recall when those discussions
19 took place?

20 A. Not specifically, but my general
21 recollection it was early, very early in the -- in
22 the process.

23 Q. And I believe you testified earlier that
24 you were contacted and retained by counsel around
25 August of this year; is that right?

1 A. Yes.

2 Q. So would it have been -- well, and your
3 report came out in September, September 4th. So is
4 it fair to say probably in August is when you would
5 have had these discussions with counsel?

6 A. I know for sure it was in August.

7 Q. Okay. Not -- as opposed to -- not
8 September?

9 A. It would not have been September.

10 Q. Okay. Turning -- staying on
11 paragraph 19, you say under Romanette 1, you say
12 defendant -- well, I'll give the -- the opening to
13 that.

14 "I understand, based on discussions
15 with counsel, that under the FDUTPA, Plaintiff must
16 prove the following in order to recover damages
17 from the defendant.

18 "Romanette I, Defendant engaged in a
19 deceptive or unfair act or practice in the conduct
20 of its trade or commerce."

21 Do you see that?

22 A. I do.

23 Q. Are you offering an opinion regarding
24 whether defendant engaged in deceptive or unfair
25 act or practice in this matter?

1 A. I think it called -- is calling for a
2 legal conclusion, and, no, I am not.

3 Q. Okay. And then Romanette II says "and
4 Defendant's action were the legal cause of actual
5 damages sustained by Plaintiff."

6 Are you offering an opinion as to
7 whether the defendant's actions were the legal
8 cause of actual damages sustained by Plaintiff?

9 A. I think using the word "legal cause,"
10 again, calls for a legal conclusion, and I'm not
11 offering that.

12 Q. Okay. And then you write "Additionally,
13 I understand an act or a practice is 'deceptive' to
14 the extent it is likely to mislead a person or
15 entity." I'll pause there. There's a bit more.

16 Do you agree with that statement as
17 it's written here?

18 A. Do I agree that it's written, or do I --

19 Q. Yes. Do you -- I mean, you -- you write
20 here, under -- "Additionally, I understand that" --

21 A. Yes.

22 Q. -- and then I read after "I understand."
23 Do you agree that that is true? That is what you
24 understand?

25 A. That is my understanding.

1 Q. Okay. And then you said in this report,
2 more -- "Moreover, I understand that an act or
3 practice is 'unfair' if it offends established
4 public policy, and is immoral, unethical,
5 oppressive, unscrupulous, or substantially
6 injurious to consumers."

7 Do you see that?

8 A. I do.

9 Q. Are you -- and just going back to the
10 sentence before that about whether the practice is
11 deceptive to the extent it's likely to mislead a
12 person or entity, are you offering an opinion
13 whether anything was deceptive in this case?

14 A. I am not providing any legal opinions.

15 Q. Are you providing an expert opinion as
16 to whether anything was deceptive?

17 A. Again, this is under the heading
18 "Understanding the Relevant Legal Issues." So I
19 think that that is a legal determination, and I am
20 not offering such an opinion.

21 Q. Okay. And I'm just trying to kind of
22 understand the bounds of your opinions. That's --
23 that's what some of these questions are based on.

24 Okay. So back to the sentence we
25 were just looking at. "Moreover, I understand a

1 practice is unfair if it offends established public
2 policy and is immoral, unethical, oppressive,
3 unscrupulous, or substantially injurious to
4 consumers."

5 Are you offering an opinion on that?

6 A. I am not offering an opinion on that
7 sentence.

8 Q. Okay. And then you've talked -- you
9 mentioned "substantial injury" earlier today. I
10 believe your -- your testimony was that some of
11 your report was related to substantial injuries; is
12 that right?

13 A. I think the first opinion is in response
14 to, number one, the analyses and opinions offered
15 by the three plaintiffs' experts, but I think
16 they're offering those opinions in the context of
17 substantial injury.

18 And so I'm simply commenting, I think
19 they're connected. Again, it's -- it's ultimately
20 a legal determination, but, yes, I do believe the
21 first opinion would be relevant from a layman's
22 perspective as it relates to the concept of
23 substantial injury, the ability to be able to not
24 only quantify the injury, but also make the
25 determination that it's substantial, it's

1 significant.

2 Q. So is it your opinion that the
3 plaintiffs' experts in this case have not
4 quantified the substantial injury that plaintiffs
5 have faced?

6 A. Well -- well, they definitely haven't
7 quantified it, right? But also, their language --
8 there's no analysis that I would typically -- I
9 would assume one would typically see a
10 quantification. Their analysis is, you know, it's
11 softer. It's possible harm, expected to sustain,
12 likely to sustain. And my whole point is, in
13 reviewing kind of those opinions in the context of
14 how I understand the legal framework, substantial
15 injury, is you don't need to speculate. You can
16 actually quantify this, and then it would be up to
17 the trier of fact to make the determination if the
18 injury, if there is any, is substantial under the
19 law.

20 Q. So we've talked about quantifying
21 damages a lot today. My understanding is that's
22 one of your key areas of practice in your career,
23 is quantifying damages; is that correct?

24 A. That's correct.

25 Q. How does that differ from opining on

1 substantial injury?

2 A. I'm not sure I understand your question.

3 Q. Well, are they the same thing or -- or
4 is one a subset of the other? I'm trying to
5 understand what "substantial injury" means to you
6 and how it relates to quantifying damages.

7 A. Well, it -- number one, I think
8 "substantial injury" ultimately is a legal term
9 that will have a legal determination. My
10 understanding from counsel is one way a trier of
11 fact could view "substantial injury" is an actual
12 quantification of the injury.

13 Q. I see. And so --

14 A. I'm sorry. Importantly -- and, again,
15 this -- this is getting into legalese -- it's my
16 understanding it's more than just injury. It's got
17 to be substantial, right? And I'm open to -- or
18 it's a legal determination. But based on
19 discussions with counsel, that is my understanding
20 of how one could demonstrate, not only injury, but
21 substantial injury is doing an actual damages
22 quantification, which plaintiffs' experts allude
23 to, but they don't do.

24 Q. So is it your position that a damages
25 quantification can show whether substantial injury

1 has occurred?

2 A. It could show whether an injury has
3 occurred, right? Whether it's considered
4 substantial under the law, I think, is a legal
5 determination.

6 Q. That's -- that's very helpful. Thank
7 you.

8 And going back to paragraph 19, the
9 sentence says "Further" -- near the end, it says
10 "Further, I understand that an unfair practice or
11 act must satisfy three tests. It must produce
12 substantial injury to the claimant; two, the injury
13 must not be outweighed by benefit to consumer's
14 competition that the practice produces; and three,
15 it must be an injury that claimant could not have
16 reasonably avoided."

17 Do you see that?

18 A. I do.

19 Q. Are you offering an opinion as to,
20 number one -- well, actually, for this whole
21 sentence, are you offering an opinion as to whether
22 an unfair practice or act has occurred in this
23 case?

24 A. No. Because, again, I think this calls
25 for a legal determination. But what I am offering

1 is if there is an injury, one could quantify -- we
2 reasonably quantify it.

3 Q. Are you offering an opinion as to
4 Romanette 1 of whether this alleged act produced
5 substantial injury to the claimant -- the
6 plaintiffs here?

7 A. No, I'm not. In part, because I don't
8 have the sufficient financial and economic
9 information to be able to make a determination if
10 there's been an injury at all.

11 Q. And I think you said earlier the -- the
12 determination that it's a substantial injury would
13 be a legal issue, right?

14 A. It seems to me, not being a lawyer, that
15 that would be a legal determination.

16 Q. Fair enough.

17 So I assume you're not opining then
18 on Romanette 2 whether the injury has been
19 outweighed by the benefit to consumers or
20 competition?

21 A. I am not.

22 Q. And for number three, I take it you're
23 not opining on whether or not the injury could have
24 been reasonably avoided, correct?

25 A. I am not.

1 Q. Now, going to the next paragraph,
2 paragraph 20, you say in your report, "Based on my
3 review, an analysis of the economic harm, if any,
4 sustained by plaintiffs" -- I'm skipping ahead a
5 little bit -- "could have been undertaken by
6 plaintiffs, including by plaintiffs' experts."

7 Do you see that?

8 A. I do.

9 Q. And so what's the difference between
10 "economic harm" and "substantial injury," if any?

11 A. Again, "substantial injury" is a term of
12 art in Florida. So I don't know if I can comment
13 on that or make a comparison with "economic harm."
14 What I'm simply saying is if there is economic
15 harm, if there's damages -- right? -- that, from my
16 perspective, can be quantified with a reasonable
17 degree of certainty which I think would point to an
18 injury.

19 Q. And I think you -- you may have just
20 equated "economic harm" with "damages." But did I
21 misunderstand, or is that -- are they roughly the
22 same thing?

23 A. They're -- in my mind, they're the same
24 thing.

25 Q. Got it. So is it my understanding your

1 opinion is that, having reviewed the plaintiffs'
2 expert reports in this case, your opinion is that
3 they did not quantify damages, correct?

4 A. Whether you want to call it damages or
5 injury, from my perspective as a damages expert
6 that regularly quantifies economic damages or
7 injury, they have not provided such analysis, nor
8 have alluded to possible injury or likely injury
9 without any real, in my mind, traditional analysis
10 that one would do to be able to quantify that
11 within a reasonable degree of certainty.

12 Q. And you say at the end of paragraph 20,
13 "Plaintiffs' experts fail to demonstrate and
14 quantify any such economic harm."

15 Do you see that?

16 A. Yes.

17 Q. You agree with that conclusion?

18 A. Yes, I do.

19 Q. Is it your position that they could have
20 attempted to quantify economic harm in this case?

21 A. Yes.

22 Q. And why do you believe that they could
23 have done so?

24 A. Because my understanding of hospitals
25 such as these, being part of a publicly traded

1 company and having done work in the M&A space in
2 hospitals, these hospitals have office of the CFO,
3 CEO, they have financial planning and analysis
4 groups. I mean, they have the information to be
5 able to run their business that would allow someone
6 to be able to do a comparison, as I've described
7 it, a but-for analysis that compares what were the
8 expectations for the business or hospitals before,
9 and what is it currently, right? And the -- the
10 difference is the injury or the -- that were
11 damages, right? Assuming causation, of course.

12 Q. So I just want to talk about injury now,
13 not substantial, because I think we agree the
14 phrase "substantial injury" is a legal term that
15 you're not -- you're not offering a position on,
16 right?

17 A. I think it is a legal determination at
18 the end of the day, yes.

19 Q. Okay. So just focusing on the phrase
20 "injury" only, not "substantial injury," is it your
21 position that economic harm is the only way to show
22 injury in a lawsuit?

23 A. Is the only way to show? I mean, from
24 my perspective, yes, because if -- if there's not
25 financial or economic repercussions to the -- the

1 grading, right, then I don't see how a hospital
2 could be harmed by the grading if there's no
3 financial consequences, right?

4 Q. I see. So -- all right. Your opinion
5 is that the plaintiffs' experts could have analyzed
6 or quantified whether there was any economic harm,
7 and that would have related -- have been relevant
8 to whether or not there was injury?

9 A. I -- I think that's right. Maybe
10 another way to say it is the way I -- when you look
11 at the CEO affidavits and the reason why they're
12 included in these key indicators, right, of, you
13 know, admissions down, whatever things are down,
14 right, at least in that small time frame, why does
15 that matter probably why they -- they're trying to
16 demonstrate from a financial perspective, albeit
17 very incomplete, that there is some financial or
18 economic harm.

19 Q. I believe your report is limited to
20 whether a quantitative analysis of damages or of
21 economic harm could have been done. Do you agree
22 with that? And I'm emphasizing "quantitative"
23 there.

24 MS. WOOD: Objection to form.

25 THE WITNESS: I think that the answer is yes,

1 because that's the point of a but-for damage
2 analysis, is to actually be able to quantify an
3 injury or harm to a reasonable degree of certainty.

4 BY MR. TAKAGAKI:

5 Q. Yeah. And I'll just direct you to
6 paragraph 4 so that, you know, you don't have to
7 remember.

8 If you go to paragraph 4 of your
9 report, about halfway through you say,
10 "Specifically, I've been asked to opine on whether
11 a quantitative analysis could be performed to
12 measure the economic harm."

13 A. Yeah.

14 Q. Is there also, like, a qualitative
15 analysis that could be performed?

16 A. I'm not quite sure what you mean.

17 Q. Well, I just -- you read here whether a
18 quantitative analysis could be performed to measure
19 economic harm, and I'm wondering what other types
20 of analyses could be performed of economic harm
21 beyond quantitative.

22 A. Well, from my perspective, the -- to be
23 able to show an injury, you have to be able to show
24 at least a dollar of harm, right? So I don't know
25 how you demonstrate injury without at least a

1 dollar of harm.

2 Q. Well, let's just -- I want -- if we can
3 take quantitative out, right, and just say not in a
4 legal setting, like, not in your job, but could
5 you -- there's ways that you could show harm,
6 economic harm, without doing a quantitative
7 analysis.

8 Do you agree?

9 A. Not with it -- not with it being
10 potentially speculative, and that's why I've used
11 the term "reasonable degree of certainty," which is
12 the standard for damages.

13 So, again, I don't think -- I
14 don't -- I think you have to try to -- at least
15 from my perspective, I think a quantification is
16 the way you show an injury, or an economic harm is
17 the way you show an injury.

18 And so that's why I'm focused on a
19 quantification of it. Said differently, the -- the
20 plaintiffs' experts say it "maybe," "likely," but
21 it's -- the way I read the reports, it's very much
22 uncertain, the way they've written the reports, if
23 there's been any injury.

24 Q. But would you agree that you can -- I'm
25 not talking about the damages phase because I

1 understand your position would be at the damages
2 phase, you would want to quantify the injury.

3 But at the liability phase, if it's
4 just did Person X punch Person Y, right, we're not
5 going to have to quantify at that stage, you know,
6 the exact harm of it. We're not going to look yet
7 at their hospital bills and, you know, their shame
8 and embarrassment, put a dollar on that. We will
9 later.

10 But just in the beginning, liability
11 stage, did Person X punch Person Y, I would think
12 that's not a -- and that's not quantitative
13 analysis. That's, I guess, qualitative or just an
14 analysis without quantitative.

15 Would you agree with that?

16 MS. WOOD: Objection to form.

17 THE WITNESS: It -- I wouldn't because I think
18 you're asking me a legal question. That liability
19 is very much a legal -- it's in the legal domain --
20 it's not -- domain -- excuse me. So I don't -- I
21 don't think I can comment on, you know, the
22 liability, particularly in your -- your
23 hypothetical.

24 BY MR. TAKAGAKI:

25 Q. Can you show economic harm simply

1 that -- well, let me strike that.

2 Can you show economic harm without
3 showing the exact amount of the harm?

4 A. Again, I think there has to be a
5 quantification.

6 Q. So that's a "no"? Your answer is "no"?

7 A. I don't think so.

8 Q. So if you could show you've breached the
9 contract, you were fired, I lost my job, I'm not
10 getting paid, I don't think that's economic harm.
11 But without the exact amount I'm not getting paid,
12 you're saying -- your -- your position is you can't
13 show economic harm there?

14 A. Well, but we know exact -- we would know
15 with certainty how much you were getting paid, in
16 your example there. This is -- this is different.

17 Q. Well, I just want to know, though, I
18 mean, isn't it possible to show economic harm
19 without showing the exact amount?

20 A. Not necessarily.

21 Q. So -- okay. So your position is that
22 if -- if the evidence in this case was that
23 patients stopped going to the hospitals because of
24 the safety grades, if that was the only evidence,
25 but it didn't show how many stopped going, but

1 there was certainly evidence that at least some
2 stopped going, your position is there would not be
3 any harm there?

4 A. It -- it depends because was the
5 expect -- was there any expectation that you would
6 lose patients to begin with? I just don't think
7 you can have it in such simplified terms.

8 Just because you lose patients
9 doesn't necessarily mean, at the end of the day,
10 that you've been economically harmed. You can have
11 a situation, where you have fewer patients, but
12 you're making more money off the patients.

13 Q. Sure. But just in a narrow scenario,
14 because I don't want to speculate on all of them,
15 you have ten patients. They say, "I'm leaving
16 because of safety grades. I'm not going to do
17 anymore procedures here." Your position is that
18 that alone is not enough evidence of economic harm?

19 A. I think you need to evaluate more issues
20 just beyond, hey, we lost patients.

21 Q. In order to say that there is any
22 economic harm?

23 A. Yes.

24 Q. Because I know you have to do more to
25 quantify the harm --

1 A. Yes.

2 Q. -- but to even show the harm.

3 A. Yes, because it -- just losing patients
4 doesn't necessarily in isolation by itself mean
5 that you've actually are in a financially worse
6 position than you otherwise would have been.

7 Q. If a CEO of a hospital has to spend an
8 inordinate amount of time responding to questions
9 about the safety grades that the question is only,
10 you know, why did you get this lower grade, would
11 you say that that's a form of economic harm?

12 A. I'd be speculating. It -- what it would
13 come down to is, were there any opportunity costs
14 associated with the CEO's time.

15 Q. Do you --

16 A. And then --

17 Q. I'm sorry.

18 A. -- and then not only opportunity costs,
19 you know, do those actually translate to impacts to
20 the finances of the business?

21 Q. So your expert opinion is that if a CEO
22 has to waste their time on something, that
23 there's -- you're not sure whether there's an
24 opportunity cost there?

25 A. It depends. Again, it gets back to me

1 from what -- it gets back to what is the result on
2 the business, right?

3 And in -- in your scenario, if he has
4 to spend or she had to spend a bunch of time
5 filling out the survey, that could be beneficial in
6 some regards.

7 Q. My question is not doing something
8 that's also beneficial. Something that we all
9 agree is purely unhelpful, but we just don't know
10 the exact amount that it's unhelpful.

11 In that scenario, could we show that
12 there's been economic harm?

13 A. From my perspective, I think there needs
14 to be at least a dollar show of -- of harm to the
15 business, right? But I think, ultimately, what
16 you're asking me is, is really a legal
17 determination in your scenario. How would a trier
18 of fact kind of view that?

19 I think that's what you're asking. I
20 think my position, I think, has been very clear.
21 To be able to show an injury, you know, based on my
22 25 years of doing this type of work, you have to at
23 least show a dollar of harm.

24 Q. Do you have to show the exact dollar
25 amount to show the injury?

1 A. You have to show that damages to -- or
2 the injury to a reasonable degree of certainty.

3 Q. That it occurred, that the injury
4 occurred?

5 A. And that the quantification of it is to
6 a reasonable degree of certainty.

7 Q. Now, a hospital losing surgeons, on a --
8 the surgeon leaves that hospital because they got a
9 poor safety grade, would you say that that could be
10 economic harm?

11 A. I -- yeah, I think it needs more further
12 evaluation. I'm always going to come back to that.
13 How did it impact the finances of the -- of the
14 hospital? If it has a real quantifiable impact,
15 then there would be a harm, from my perspective,
16 right? But surgeons leave businesses all the -- or
17 hospitals all the time.

18 Q. So it's a certainty thing, I guess.
19 If -- if a surgeon leaves and takes all of their
20 patients to another hospital, I think we would both
21 agree that that can't be economically good for the
22 original hospital, right?

23 A. Part of -- part of it --

24 Q. Do you disagree?

25 A. Well, part of it gets back to the

1 expectation because oftentimes, hospitals, it's
2 routine. They lose employees. They forecast.

3 Q. Now, let's say this wasn't forecast.
4 Let's say there -- this was not at all forecast.
5 The expectation is they'd stay. They said, "I am
6 going to sign a contract for two years."

7 Later that day, they find out about
8 the grades. They say, "I'm leaving. I'm taking my
9 patients with me."

10 Is it your testimony that that would
11 not be economic harm?

12 MS. WOOD: Objection to form.

13 THE WITNESS: I would need to do more work
14 around it. Particularly -- particularly from the
15 concept of mitigation. Could they turn around and
16 hire another --

17 BY MR. TAKAGAKI:

18 Q. Now, these are, seem like, legal terms
19 to me; mitigation, was it substantial?

20 I'm just asking if you lose a
21 moneymaker from your company, in this case, a
22 surgeon, they go to a competitor, just -- I'm not
23 asking if you could quantify the harm. I'm just
24 asking, is there harm?

25 What is your expert opinion?

1 A. It -- it depends.

2 Q. Could it be?

3 A. Yes. In -- in some scenarios, it could.

4 In others, it couldn't. It -- it depends on the
5 facts and circumstances. And a perfect example
6 would be what I was just talking about.

7 Hospitals lose doctors. Hospitals
8 lose nurses. What's the next best option?

9 Q. Is it your testimony that a surgeon
10 leaving a hospital could never ever constitute
11 economic harm?

12 MS. WOOD: Objection to form.

13 THE WITNESS: I -- I have not provided that
14 testimony. I'm simply saying, I would want to
15 evaluate the issue more before coming to that
16 conclusion.

17 BY MR. TAKAGAKI:

18 Q. Do you believe that surgeons leaving
19 hospitals are never evidence of economic harm?

20 MS. WOOD: Objection to form.

21 THE WITNESS: Again, it depends. It depends
22 what the next best option is. If a surgeon leaves,
23 could you turn around and get another surgeon of --
24 of equivalence, and, therefore, you're not harmed?

25

1 BY MR. TAKAGAKI:

2 Q. So there is a world where you could be
3 harmed?

4 A. Again, it comes back to a surgeon
5 leaving, does that impact the business from a
6 financial perspective? If you can demonstrate
7 that, then maybe there is a harm. But ultimately,
8 it's a legal conclusion, what the injury is and
9 whether or not you have to quantify it.

10 Q. If a CEO absconded with half of the bank
11 account for a company, would that be economic harm?

12 A. If they stole the -- half the --

13 Q. Mm-hmm.

14 A. Potentially. Maybe from at least from
15 an opportunity cost perspective, at least as an
16 initial matter, because maybe the hospital doesn't
17 need half the bank account, right? But -- to
18 operate, right? But the opportunity cost of that
19 either sitting in the bank earning whatever the
20 interest rate is at this point, or alternative
21 investments, or potentially investment in the
22 hospital.

23 It's -- my point is, in isolation, I
24 want to do more analysis to make sure that there is
25 some kind of financial impact on the business.

1 Q. And I guess your testimony is that
2 losing half of the business's bank account, you are
3 not sure whether that would have financial impact?

4 A. It depends.

5 Q. Okay. Now, here in your report,
6 paragraph 22, you reference lost profits for
7 economic harm.

8 Do you see that?

9 A. In this paragraph, yes. This paragraph
10 is focused on lost profits, where the next
11 paragraph is focused on, effectively, diminution of
12 value.

13 Q. Right. Now, you list -- you say that
14 lost profits can be listed in -- sorry -- can be
15 estimated in numerous ways, and you list several
16 examples.

17 Do you see that?

18 A. Yes, and I have a citation.

19 Q. Yeah. A cite I think is the Litigation
20 Services Handbook that we talked about, right?

21 A. That's correct.

22 Q. And actually before we get into this,
23 let's take a look at the next exhibit. We'll do
24 tab 3.

25 MR. TAKAGAKI: I think this is also going to

1 be Exhibit 3.

2 (Rule Deposition Exhibit 3 was
3 marked for identification.)

4 BY MR. TAKAGAKI:

5 Q. All right. Mr. Rule, I'm handing you
6 what has been marked Exhibit 3.

7 Have you ever seen this document
8 before?

9 A. I don't have a specific recollection one
10 way or the other.

11 Q. In this document, the title is in the
12 middle. There's a bold underlined portion that
13 says, "The Plaintiff Hospitals' notice of
14 withdrawal of request for monetary damages and jury
15 demand."

16 Do you see that?

17 A. I do.

18 Q. And at the very top, there's some text
19 with a date on the far right; it says, "Entered on
20 FLSD docket 08/12/25."

21 Do you see that?

22 A. I do.

23 Q. So this is indicating it was filed on
24 August 12, 2025. If you go to page 3 of this
25 document -- if you go to page 3 of this document,

1 you can also see the date near the signature page.
2 It says August 12, 2025.

3 Do you see that?

4 A. I do.

5 Q. Okay. And the title of this document,
6 The Plaintiff Hospitals' Notice of Withdrawal of
7 Request for Monetary Damages and Jury Demand.
8 Having now looked at this document more closely, do
9 you recall seeing this document?

10 A. As I sit here, I don't -- I don't recall
11 seeing this specific document.

12 Q. And in paragraph 2 of this document, it
13 says, "The Plaintiff Hospitals will proceed with
14 their request for equitable relief" -- sorry --
15 strike that --

16 -- "equitable relief, including a
17 judicial declaration and a permanent injunction."

18 Do you see that?

19 A. I do.

20 Q. Do you know what equitable relief is as
21 used here?

22 A. I think it's calling for a legal
23 conclusion.

24 Q. Okay. Do you know what a judicial
25 declaration and a permanent injunction are here?

1 A. Again, both are calling for legal
2 conclusions. I can give my layman's view, but,
3 again, these are legal terms that have legal
4 meanings.

5 Q. How about this way? So in your roughly
6 25 years serving as an expert and consultant,
7 oftentimes in litigations, do you have just a rough
8 sense of what an injunction would be?

9 A. From a layman's perspective, a court
10 order preventing one party from doing something
11 else to another party.

12 Q. And is your understanding that that's a
13 type of relief that a party can seek in a
14 litigation, when they ask for that?

15 A. Again, I think you're asking me legal
16 questions. It appears from this document that this
17 is a type of relief that the plaintiffs are asking
18 for.

19 Q. A type of relief. Exactly.

20 And is -- is it your understanding
21 that, like, asking for damages is another type of
22 relief that can be asked for in a litigation?

23 A. Again, I think you're asking for a legal
24 conclusion. But according to this document, it
25 appears to be a type of relief.

1 Q. Have you been in cases where you had to
2 do a damages calculation? When I say "cases," I
3 mean litigations or lawsuits where you've had to do
4 a damages calculation?

5 A. I'm not sure I understand your question.

6 Q. I'm not trying to fool you. It's a
7 simple question I asked before.

8 Have you -- you've been retained as
9 an expert in cases where damages calculations were
10 sought, correct?

11 A. Yes.

12 Q. And were those for parties -- either for
13 or against parties who were seeking damages as a
14 form of relief in their lawsuit?

15 MS. WOOD: Objection to form.

16 THE WITNESS: I mean, I would have to go back
17 and look at each case, but I'm assuming that -- I'm
18 assuming they were seeking monetary damages.

19 BY MR. TAKAGAKI:

20 Q. Have you served as an expert in any
21 cases where the party was seeking some type of
22 injunctive relief?

23 A. I'm not sure because, again, I'm --
24 I'm -- in my work, I'm less focused on necessarily
25 the legal aspects. And so, I'm just -- I'm not

1 sure as I sit here right now if any of the cases
2 where I quantified monetary damages, they were also
3 seeking some sort of injunctive relief.

4 Q. If you can turn to page 2 of this
5 document of Exhibit 3, the first sentence on
6 page 2. I am just going to direct you to the --
7 I'll just read the first sentence.

8 "In light of the expedited trial
9 schedule, and in consideration of the interest of
10 judicial and party economy, the Plaintiff Hospitals
11 hereby withdraw their request for an award of legal
12 relief (monetary damages)."

13 Do you see that?

14 A. I do.

15 Q. Were you aware of this prior to
16 submitting your report?

17 A. I'm not sure. I don't have a specific
18 recollection because, again, I didn't cite this
19 document. And obviously, I cited the complaint.
20 So I don't know temporally when I became aware that
21 maybe monetary damages themselves were not being
22 sought.

23 Q. Yeah. I was just going to reference you
24 to your appendix of your report. I believe this
25 document that we're looking at was not listed in

1 your appendix, Appendix 2; is that correct?

2 A. I don't believe it is.

3 Q. And then if you go down about halfway
4 through that paragraph, it says, "Proceeding with a
5 bench trial in this matter will obviate the need
6 for the extensive discovery TLG seeks on actual
7 monetary damages."

8 Do you see that?

9 A. I do.

10 Q. Do you agree with that statement?

11 MS. WOOD: Objection to form.

12 THE WITNESS: I think you're asking me a legal
13 question.

14 BY MR. TAKAGAKI:

15 Q. Well, I think that it just says that
16 going to trial will obviate the need for extensive
17 discovery on damages.

18 Do you agree with that?

19 MS. WOOD: Objection to form.

20 THE WITNESS: I can't comment on the concept
21 of extensive discovery.

22 BY MR. TAKAGAKI:

23 Q. Do you understand what it would mean to
24 waive damages in a lawsuit as the plaintiff?

25 A. I'm not sure I understand your question.

1 Q. If you were -- what is your
2 understanding of what that means? What does it
3 mean for a plaintiff to waive damages, to not seek
4 damages in a lawsuit?

5 A. That they're not seeking monetary
6 compensation for any injury, if any, that it has
7 sustained.

8 MR. TAKAGAKI: Let's do the next exhibit, tab
9 4.

10 (Rule Deposition Exhibit 4 was
11 marked for identification.)

12 BY MR. TAKAGAKI:

13 Q. Mr. Rule, I'm handing you what has been
14 marked as Exhibit 4.

15 Do you recognize this document?

16 A. No, I don't.

17 Q. The front page of this document says,
18 "Amended complaint," and there's kind of a red
19 line, although it's not red; it's stricken through
20 in blue.

21 Do you see that?

22 A. Yes.

23 Q. So it says, "Amended," that's with blue
24 addition of text, and then "complaint," and then in
25 the stricken language is "and demand for jury

1 trial."

2 Do you see that?

3 A. I do.

4 Q. Have you seen documents before that have
5 this sort of stricken text before?

6 A. I don't believe so.

7 Q. Have you ever seen, like, a Word
8 document that had, say, track changes in it?

9 A. I -- I have.

10 Q. Okay. Did -- do you -- if you turn to
11 page, say, 3, 4, or 5, do you see what appear to be
12 track changes in this document?

13 A. I do.

14 Q. Okay. And so just turning back to the
15 cover page, do you see that the -- the language in
16 the title appears to be Track Changes?

17 A. Yeah, I -- I agree with that.

18 Q. Okay. And then at the top of this
19 document, it says that the date entered on FLSD
20 docket, 08/28/2025. Do you understand that to mean
21 August 28, 2025?

22 A. Yes.

23 Q. So that would have been before you
24 issued your report, correct?

25 A. Yes, August is before September.

1 Q. And yet, you didn't consider this
2 document in writing your report, correct?

3 A. Well, I'm not quite sure I saw the
4 document, to be honest. But also, I'm not -- I
5 think you're asking me some legal conclusions here.

6 But I -- I don't know if -- well, I
7 haven't read the document, but I -- I don't think
8 it changes my opinions.

9 Q. You didn't cite this document in your
10 Appendix 2 of Documents Considered, correct?

11 A. I did not.

12 Q. And you did not review this document
13 before submitting your report, correct?

14 A. I don't have a recollection of seeing it
15 before today.

16 Q. Are you aware that this is the only
17 amended complaint in this action?

18 MS. WOOD: Objection to form.

19 THE WITNESS: I wouldn't want to speculate. I
20 don't know one way or the other.

21 BY MR. TAKAGAKI:

22 Q. Would it have been helpful to your
23 opinions if you had known that there were no
24 damages been sought in this matter?

25 A. I don't think so.

1 Q. Would you have wanted counsel to have at
2 least informed you before your deposition that
3 these documents had been filed?

4 A. Well, I don't have a recollection of
5 seeing them. That doesn't mean that counsel did
6 not inform me of it. I just don't have a
7 recollection.

8 And, but importantly, based on my
9 discussions with counsel about the relevant Florida
10 law, it's my understanding that substantial injury
11 still has to be shown.

12 Q. That's a legal conclusion, right?

13 A. That's, again, I said it in the context
14 of my discussions with counsel.

15 Q. And your understanding is that
16 substantial injury -- well, strike that.

17 Is it true that -- do you have a
18 position as to whether reputational harm can be a
19 form of substantial injury in a FDUTPA case?

20 MS. WOOD: Objection to form.

21 THE WITNESS: I don't have a legal opinion on
22 that. I think it's calling for a legal conclusion.

23 BY MR. TAKAGAKI:

24 Q. Do you have an opinion as to whether
25 reputational harm must be quantified in order to

1 show liability in a FDUTPA case?

2 MS. WOOD: Objection to form.

3 THE WITNESS: Same answer. I think it's
4 calling for a legal conclusion.

5 BY MR. TAKAGAKI:

6 Q. Do you have an opinion as to whether
7 reputational harm has been shown in this case?

8 MS. WOOD: Objection to form.

9 THE WITNESS: Same answer. I think it's
10 calling for a legal determination.

11 BY MR. TAKAGAKI:

12 Q. Do you have a position as -- I -- I
13 believe we talked earlier about actual damages. I
14 believe the scope of your report is to -- sorry.
15 I'll find the exact language.

16 Turning back to page -- paragraph 19
17 of your report.

18 A. Okay.

19 Q. It's romanette II says, "Defendant's
20 actions were the legal cause of actual damages."

21 Do you see that?

22 A. Yes.

23 Q. Do you have an opinion as to whether
24 reputational harm can be actual damages?

25 A. Generally? Or in this case?

1 Q. Generally.

2 A. I mean, it -- it depends on the facts
3 and circumstances --

4 Q. Okay.

5 A. -- of each case, and -- and the way I
6 would answer it is, even assuming causation, the
7 actual damages need to be quantified.

8 Q. My question was, just could reputational
9 harm be actual damages as that term's used in your
10 report?

11 A. It -- as a general matter, it could be.
12 Again, assuming there's been a financial impact as
13 a result of the reputational -- as a result of the
14 reputational harm.

15 Q. Understood.

16 Is it your understanding that by
17 removing their damages claim, the plaintiffs are
18 not asking Leapfrog to compensate them for any harm
19 they suffered in this case?

20 A. Again, I think, again, from a layman's
21 perspective, if you're not seeking monetary
22 damages, to what I had testified earlier, it seems
23 like they're not asking for monetary compensation.

24 Q. Does that potentially inform your
25 thoughts on why the plaintiffs' experts in this

1 case, at least in your view, did not do a damages
2 quantification?

3 MS. WOOD: Objection to form.

4 THE WITNESS: I can't speculate why they
5 didn't do one, but from my perspective, the -- the
6 easiest way, for lack of a better word, to show
7 that there's substantial injury is to actually
8 quantify the injury.

9 BY MR. TAKAGAKI:

10 Q. Understood.

11 Why don't we take a quick break?

12 A. Sure.

13 THE VIDEOGRAPHER: We are going off the record
14 with the end of Media No. 4 at 3:22 p.m.

15 (Short recess.)

16 THE VIDEOGRAPHER: We are back on the record
17 with the beginning of Media No. 5 at 3:37 p.m.

18 Counsel, you may proceed.

19 BY MR. TAKAGAKI:

20 Q. Why in this case, if the plaintiffs are
21 only seeking to have the grades taken down from the
22 Leapfrog website, is your opinion still relevant?

23 A. I think you're asking me a legal
24 conclusion.

25 Q. Is it fair to say then that you're not

1 sure why it would still be relevant if they were
2 only seeking to have the grades taken down from the
3 website?

4 A. No, that's not what I'm saying.

5 Q. Okay. Are you sort of saying you refuse
6 to answer or -- I'm trying to understand --

7 A. I have a layman's understanding of the
8 legal position, but, again, I think it's ultimately
9 a determination for the trier of fact.

10 Q. What -- without saying what the
11 determination should be, you know, one way or the
12 other, what is the -- what could possibly make your
13 report relevant if the plaintiffs are only seeking
14 to have their grades taken down?

15 A. But because I -- my understanding is
16 that it focuses or centers around the concept of
17 substantial injury.

18 Q. Meaning, your report -- you're opining
19 that the plaintiffs have not been substantially
20 injured in this case?

21 A. I'm not opining that. That's not
22 contained in my report. It's the same reason why
23 the plaintiffs' experts are -- are pointing towards
24 maybe injury.

25 It's my understanding at the end of

1 the day, what substantial injury is. It's Leapfrog
2 Group's opinion, as I understand it, that my -- my
3 report is relevant because of the content of
4 substantial injury even though the plaintiffs are
5 not asking for monetary damages or compensation.

6 MR. TAKAGAKI: Let's do the next exhibit. I
7 believe this is going to be Exhibit 5, and this
8 should be Tab 22.

9 (Rule Deposition Exhibit 5 was
10 marked for identification.)

11 BY MR. TAKAGAKI:

12 Q. Mr. Rule, I'm handing you what's just
13 been marked as Exhibit 5.

14 Do you recognize this document?

15 A. I recognize this is the -- this purports
16 to be an excerpt from the Litigation Services
17 Handbook.

18 Q. And I -- I'll represent to you that we
19 pulled this as an excerpt from the Litigation
20 Services Handbook that you cite in your expert
21 report.

22 Would you have any reason to disagree
23 with that?

24 A. Not as I sit here right now.

25 Q. And I believe you cited the Litigation

1 Handbook multiple times in your report; is that
2 fair?

3 A. I do have a couple citations to it, yes.

4 Q. And so this title, at least on page 1,
5 it says, Chapter 4, Damages Theories and Causation
6 Issues.

7 Do you see that?

8 A. I do.

9 Q. And then do you see there's a table of
10 contents here?

11 A. Yes, I do, too.

12 Q. And it goes on to the next page, as
13 well.

14 Sort of having looked at the -- this
15 page and the table of contents, does this refresh
16 your recollection that you reviewed this document
17 for your report?

18 A. Again, it's -- yes, I cite -- I cite
19 this chapter in my report.

20 Q. Okay. Just turning to the next page, I
21 don't think there's page numbers on mine, but it's
22 the Section 4.1, Introduction.

23 Do you see that?

24 A. I do.

25 Q. If you go to the second paragraph, it

1 starts with the sentence, "Accepted damages
2 theories and elements can differ widely."

3 Do you see that?

4 A. I do.

5 Q. Well, I'll go on. It says, "Can differ
6 widely between state and federal systems in
7 different jurisdictions and for various types of
8 matters."

9 Do you see that?

10 A. Yeah, you missed the word "court," but
11 yes, I do see it.

12 Q. I'm sorry. "State and federal court
13 systems."

14 Do you agree with that sentence?

15 A. I -- I think this is asking for a
16 legal -- legal conclusion or legal interpretation.
17 I do agree that damages can differ, depending on
18 the facts and circumstances, but I think this
19 sentence is pointing to as a result of the state
20 and federal court systems, whatever laws are
21 relevant to the jurisdiction.

22 That's how I read it.

23 Q. Okay. And the next -- sorry.

24 The sentence -- two sentences after
25 that, it says, "Practitioners should discuss the

1 appropriate standards and elements of damages with
2 counsel before investing time and effort on a wrong
3 approach."

4 Do you see that?

5 A. I do.

6 Q. And in this sentence, is "practitioners"
7 referring to experts like yourself?

8 A. Well, that's my interpretation, yes.

9 Q. And do you agree with the advice in this
10 page on this sentence?

11 A. I don't disagree with it. I mean, in
12 this case, we did have it, a similar discussion.

13 Q. And then if you turn to the next page,
14 at the top of the page, there's a section titled
15 Declaratory Relief.

16 Do you see that? It's the second
17 bullet.

18 A. I do.

19 Q. And they give an example. In the second
20 sentence, it says, "For example," and then it says
21 that the Court's decision here may relate to
22 "whether an insurance policy provides coverage for
23 certain types of losses."

24 Do you see that?

25 A. I do.

1 Q. And do you agree with this bullet here
2 on declaratory relief?

3 A. What specifically?

4 Q. Or put it this way, is there anything in
5 this bullet that you disagree with?

6 A. Well, again, it's talking about legal
7 strategy from my perspective. So I don't know if I
8 have a position to agree or disagree.

9 Q. That's fine.

10 So -- now, is your answer -- sorry --
11 then, you don't have a position one way or another
12 whether you agree with that bullet?

13 A. I mean, it's talking about declaratory
14 relief, seeking it -- seeking a preemptive court
15 ruling. To me, that is -- that is -- you're
16 asking -- I think you're asking me a legal
17 question.

18 Q. Fair enough.

19 I -- just, you cited this document
20 and this chapter -- yeah, this chapter, Chapter 4 I
21 believe, in your report. So I was wondering which
22 portions of it you may or may not agree with.

23 A. I don't have an opinion on this bullet
24 point.

25 Q. And then if you turn to Section 4.6,

1 it's several pages from where we are. 4.6.

2 I think at the very top, there's page
3 numbers. It's on page 37 in very small print, if
4 that's helpful.

5 And so if you go to the middle of the
6 page, it says, "4.6, Developing an Effective
7 Damages Claim." The first sentence says, "Experts
8 have no prescribed or universally accepted model
9 for developing a damages claim."

10 Do you see that?

11 A. I do.

12 Q. Do you agree with that statement?

13 A. I don't disagree with it. There are
14 obviously some choices to be made, but it's
15 dependent on the facts and circumstances of the
16 case.

17 Q. And the section below that, is the
18 subsection is titled A, in parentheses, and it
19 says, "Learn the Background."

20 Do you see that?

21 A. Yes.

22 Q. A couple of sentences down, it says,
23 "Counsel often amends complaints and answers, so
24 experts should review the most current pleadings."

25 Do you see that?

1 A. That's what it says.

2 Q. Do you agree with that statement?

3 A. To the extent that the pleadings are
4 relevant.

5 Q. Do you -- did you review the most
6 current pleadings in this case prior to submitting
7 your report?

8 A. Are you asking me, did I review the
9 amended complaint?

10 Q. Sure. Did you review the amended
11 complaint?

12 A. No, I didn't, but I had a conversation
13 with counsel about what, from their perspective, is
14 relevant here from a legal perspective.

15 Q. And I believe you said that conversation
16 was in August, correct?

17 A. There were several conversations, but
18 the initial one would have been in August, yes.

19 Q. I believe earlier you testified that the
20 only conversation you had was in August. August is
21 before September, is I think what you said.

22 A. I had --

23 MS. WOOD: Objection to form.

24 THE WITNESS: -- a number of conversations. I
25 said the first one was in early August.

1 BY MR. TAKAGAKI:

2 Q. And in which of those conversations did
3 you discuss the amended complaint?

4 A. I don't know if I discussed the amended
5 complaint specifically, but I -- we discussed the
6 concept of substantial injury.

7 Q. Now, what is the concept of substantial
8 injury?

9 A. It's ultimately a legal determination,
10 but just because you're not asking for monetary
11 damages doesn't alleviate, as I understand it, the,
12 quote, unquote, requirement to show substantial
13 injury.

14 Q. Did you review Leapfrog's answer to the
15 amended complaint?

16 A. If it's not listed in my Appendix 2, the
17 answer is no.

18 Q. I don't see it listed.

19 A. Yes. So the answer is no, I did not --
20 I did not review it.

21 Q. Did you discuss Leapfrog's answer to the
22 amended complaint with counsel? I don't want you
23 to tell me what was discussed, to be clear.

24 A. It's possible, but I don't have a
25 specific recollection because there was several

1 phone calls, several conversations. I just
2 don't -- other -- other than having a specific
3 recollection of substantial injury, particularly
4 early on in the case, I -- I just don't have a
5 specific recollection beyond that of what was
6 discussed.

7 Q. And when you say "early on in the case,"
8 what do you mean by "early on in the case"?

9 A. One of our first couple conversations
10 about the plaintiffs' experts' reports and my
11 understanding of the -- as I put it in here, my
12 understanding of the -- the legal framework that's
13 required under the Florida standard.

14 Q. And were those, to use your words, first
15 couple conversations have been in August of this
16 year?

17 A. I'm almost certain they were in August.

18 Q. Let's do the next exhibit. It's going
19 to be tab 5.

20 Do you recall reviewing the Court's
21 order on the motion to dismiss in this case?

22 A. I think that one is listed, so let me
23 check. I have defendant, the Leapfrog Group's
24 motion to dismiss pursuant to Federal Rule of Civil
25 Procedure 12(b)(2) and 12(b)(6) dated June 27,

1 2025.

2 If that's what you're referring to,
3 then I've reviewed it.

4 Q. I think I'm referring to something else,
5 but I'll show you the document.

6 (Rule Deposition Exhibit 6 was
7 marked for identification.)

8 BY MR. TAKAGAKI:

9 Q. I'll hand you what's been marked as
10 Exhibit 6. Do you recognize this document?

11 A. I don't believe I've seen this document.

12 Q. Yeah. This document is the Court's
13 decision regarding the motion to dismiss. It's
14 7/15/25, so July 15, '25. And I believe this
15 document is not listed in your list of documents
16 considered Appendix 2; is that right?

17 A. I do not see it listed.

18 Q. Is it your understanding that in
19 Leapfrog's motion to -- sorry -- strike that.

20 You did review Leapfrog's motion to
21 dismiss. I believe that is listed in your report;
22 is that correct?

23 A. At one point in time, I did, yes.

24 Q. Is it your understanding that Leapfrog
25 made various legal arguments in that motion?

1 A. You'd have to show me the document.

2 Q. Do you have just a general concept of
3 what a motion to dismiss is?

4 A. I have a non-legal.

5 Q. If I were to represent that,
6 essentially, it's someone, typically a defendant,
7 files a motion to dismiss the case based on various
8 arguments, would you disagree with that high-level
9 description?

10 MS. WOOD: Objection to form.

11 THE WITNESS: It's my layman's understanding
12 that one party is trying to get the case dismissed.
13 BY MR. TAKAGAKI:

14 Q. I'm sorry. In this document is the
15 Court's order on that motion to dismiss. If you
16 look in page -- on page 1, the first sentence says,
17 "This cause is before the Court on defendant's
18 motion to dismiss."

19 Do you see that?

20 A. That's what it says.

21 Q. And the next sentence says, "Plaintiff
22 filed a response on July 11."

23 Do you see that?

24 A. That's what it says.

25 Q. Then the Court says, "No reply has been

1 filed, but I find no reply to be necessary."

2 Do you see that?

3 A. That's what it says.

4 Q. And then it says, "For the following
5 reasons, the motion is denied."

6 Do you see that?

7 A. I do.

8 Q. And if you go to page 8, which is the
9 last page of the document. I'll save you some
10 time. The top of the page, there's a paragraph,
11 this first full sentence says, "Finally, plaintiffs
12 have filed damages in the form of reputational
13 harm."

14 Do you see that?

15 A. That's what it says.

16 Q. Did you discuss this decision, this
17 Court's decision with counsel?

18 A. I don't have a specific recollection of
19 discussing this.

20 Q. Were you aware of the Court's findings
21 when you -- at the time -- strike that.

22 When you were drafting your report in
23 this case, were you aware of the Court's findings
24 in this decision?

25 A. Again, I haven't reviewed this document.

1 I haven't seen it. What I do know is the
2 conversations I had with counsel about their views
3 of the law, and that is what's summarized in my
4 report.

5 Q. So turning back to Exhibit 5, the
6 Litigation Handbook, back to the paragraph we were
7 looking on Section A, "Learn the Background." So
8 just directing you back again to that language you
9 looked at, in the middle of that paragraph, it
10 says, "Counsel often amends complaints and answers,
11 so expert should review most current pleadings."

12 Do you agree that, at least in this
13 case, you did not fully follow that advice?

14 MS. WOOD: Objection to form.

15 THE WITNESS: Again, to the extent that it's
16 relevant. I had conversations with counsel about
17 what they believe, from a legal perspective, is
18 relevant. That's the guidance I followed.

19 BY MR. TAKAGAKI:

20 Q. And if they were incorrect about what
21 they believed was relevant, would that affect the
22 relevance of your report?

23 A. I -- I can't possibly comment on that.
24 That is a legal determination.

25 Q. Well, if counsel says, cover these

1 topics in your report, they'll be relevant, but the
2 counsel's wrong about that, would that potentially
3 affect whether your report is relevant in this
4 case?

5 A. I wouldn't -- I wouldn't want to
6 speculate. Again, I think you're asking me to
7 interpret what the judge is going to -- how the
8 judge views the law.

9 Q. Well, I -- I want an understanding if
10 what -- whether we call them "assumptions" or
11 "instructions" that counsel gave you, whether those
12 were helpful in form- -- in forming your opinion
13 and drafting your report?

14 A. The contextual background was helpful,
15 yes.

16 Q. And if some of that was incorrect,
17 either intentionally or accidentally --

18 A. Yeah.

19 Q. -- could that possibly affect your --
20 the opinions in your report?

21 A. I don't think it changes my opinions.
22 It might change the judge's interpretation of
23 certain things, but, again, I wouldn't want to
24 speculate or put myself in the shoes of the judge
25 of -- what -- how one should interpret the

1 relevant legal standards here.

2 Q. I'm just -- I -- I'm just not talking
3 about the legal standards anymore. Just generally,
4 at a high level, if you kind of pull yourself back,
5 you -- if you wrote a report based on assumptions
6 that are false, would that -- that turn out to be
7 false, would that affect the findings in your
8 expert report?

9 A. It depends on the -- the materiality of
10 the falsehood, if you will.

11 Q. So it could. It's possible?

12 A. It's possible. I have no reason to
13 believe that here. But, again, I think you're
14 asking me questions about legal interpretation.

15 Q. Now, and I've asked you a couple times
16 about this language in -- in the Litigation
17 Handbook, where it says that you're -- an expert
18 should review the most current pleadings, and you
19 say, "to the extent they're relevant," and I think
20 you've said counsel told you it was relevant.

21 Is it correct that this sentence here
22 doesn't mention relevance at all?

23 A. I think relevance is implied. I had a
24 conversation with counsel based on their views or
25 Leapfrog's views of the legal standard. That's

1 sort of what's reflected in my report, and I don't
2 think that has changed.

3 Q. So here, where it says, "Counsel often
4 amends complaints and answers," does -- is it at
5 least implying that those might be relevant types
6 of documents?

7 A. They could be relevant, but, again, I --
8 I don't -- the -- the discussion I had with counsel
9 I don't think has changed just because the
10 plaintiffs aren't seeking monetary damages.

11 Q. If you are issuing an opinion regarding
12 whether substantial injury has been shown and you
13 don't even know what the injury is being alleged
14 because you haven't read the current allegations,
15 doesn't that make it hard to write that opinion?

16 MS. WOOD: Objection to form.

17 THE WITNESS: No, I know what the injuries cc
18 being alleged, that the -- that Leapfrog misgraded
19 these hospitals. As a result, they're claiming
20 that they've suffered injury. Like, that -- that
21 hasn't changed. What has changed, as I understand
22 it, is at one point in time, the plaintiffs were
23 seeking monetary damages and are no longer seeking
24 monetary damages.

25

1 BY MR. TAKAGAKI:

2 Q. So if you can just quickly turn back to,
3 I believe, it's Exhibit 4, in front of you. It's
4 the amended complaint with the redline.

5 Do you see that?

6 And if you can just turn to page 3 of
7 that. Do you see how there's a redline on the
8 bottom of page 3?

9 A. I do.

10 Q. And then if you turn to the next page,
11 there's a redline.

12 Do you see that?

13 A. I do.

14 Q. And the page after that, there's a
15 redline.

16 Do you see that?

17 A. I do.

18 Q. Then if you turn over to page 9, do you
19 see the section's titled Factual Allegations.

20 Do you see that?

21 A. I do.

22 Q. And there's a red line of the entire
23 page.

24 Do you see that?

25 A. I do.

1 Q. And then if you turn to pages 10, 11,
2 12, 13, 14, 15, 16, 17, and 18, do you see every
3 word of those pages is red lined?

4 A. It is red lined, yes.

5 Q. Have you read the deletions in those
6 redlines that we just went through?

7 A. I have not reviewed this document.

8 Q. Okay. So isn't it possible that there
9 has been a relevant change to the theory of this
10 case that would affect some of the assumptions that
11 you had for your report?

12 A. I -- I would expect that counsel would
13 have updated me on that if our prior discussion is
14 no longer relevant, as it seems like you're
15 suggesting.

16 Q. So your report is partially drafted on
17 the assumption that if there were relevant changes
18 in the case, counsel would have told you about
19 those?

20 MS. WOOD: Objection to form.

21 THE WITNESS: If -- if something impacted my
22 analyses from a legal perspective, I would expect
23 that counsel would inform me of that.

24 BY MR. TAKAGAKI:

25 Q. Okay. And just to be clear, back to the

1 Litigation Handbook, it says, "Experts should
2 review the most current pleadings."

3 Do you agree that you did not review
4 the current complaint in this case?

5 A. I have not reviewed the amended
6 complaint. I did have discussions with counsel
7 about the legal framework. It is my understanding,
8 at least from Leapfrog's perspective, that has not
9 changed.

10 Q. But you did not discuss the amended
11 complaint with them specifically, correct?

12 A. Not specifically.

13 Q. And we also looked at the Notice of
14 Withdrawal of Damages in one of the earlier
15 exhibits, I believe.

16 Is it your view that -- that
17 shouldn't -- didn't need to be reviewed for your
18 report?

19 A. Again, I think I have -- and I've said
20 this many times. I think I have been told by
21 counsel Leapfrog's legal position in this case.

22 Q. They told you that in August, correct?

23 A. Correct.

24 Q. Do you know roughly when in August they
25 would have told you that?

1 A. Not specifically.

2 Q. Would it have been early August?

3 A. I would be speculating.

4 Q. How far before submitting your report
5 would they have told you about that, you would have
6 talked about that? More than a week?

7 A. Yeah, probably more than a week, and
8 then obviously, my report wasn't submitted until
9 September 4th. There was no subsequent update or
10 change.

11 Q. So probably more than a week before
12 September 4th is when you would have had these
13 discussions with counsel that we're talking about?

14 A. Again, I wouldn't want to speculate, but
15 if I had to guess, the answer would be yes.

16 Q. If you could just turn to page, it looks
17 like 41 of the Litigation Handbook exhibit, which
18 is Exhibit 5.

19 Are you there?

20 A. I am.

21 Q. And there's a section at the bottom
22 titled Company Knowledge.

23 Do you see that?

24 A. I do.

25 Q. The first sentence says, "Experts gather

1 significant information for the lost profits
2 model."

3 Do you see that?

4 A. I do.

5 Q. And you reference the lost profits model
6 in your report, correct?

7 A. I -- I reference the concept of lost
8 profits, and I also reference the concept of
9 diminution of value.

10 Q. Did you gather significant information
11 for your analysis of lost profits?

12 A. I don't quantify lost profits because
13 that information wasn't provided in this case.

14 Q. When you say "it wasn't provided," you
15 mean it wasn't provided to you?

16 A. My understanding is, the type of
17 information that I would normally seek to calculate
18 lost profits has not been provided in this case.

19 Q. And you said your understanding. You're
20 referring to based on discussions with counsel,
21 correct?

22 A. Yes, counsel has said, and I've noted
23 counsel has told me that items, such as financial
24 projections, have not been produced.

25 Q. You assumed they hadn't been produced

1 when you were drafting this report?

2 A. I would have no basis to question
3 whether or not they were produced.

4 Q. The next -- sorry -- two sentences down
5 in this paragraph, it says, "The expert should
6 understand the company's operations, markets, and
7 management practice. These factors help explain
8 the negative impact on the company's profits."

9 Do you see that?

10 A. Where exactly are you?

11 Q. Yeah, sorry. It's in the bullet titled
12 Company Knowledge.

13 A. Oh, I'm sorry.

14 Q. It's about the third sentence, "The
15 expert should understand."

16 Do you see that?

17 A. I do.

18 Q. "The expert should understand the
19 company's operations, markets, and management
20 practices." Okay. And then it says, "These
21 factors help explain the negative impact on the
22 company's profit."

23 Do you understand the Plaintiff
24 Hospitals' operations, markets, and management
25 practices?

1 A. Again, I think it's an important
2 calculation. I don't do a lost profit analysis.
3 And this is what this is talking about. If you're
4 going do one, one of the things you need to do is
5 understand their operations and practice.

6 I don't do one because the
7 information is not produced.

8 Q. And then the next sentence says, "They
9 also help the expert account for other factors that
10 could play a role in the company's financial
11 performance and explain the nature and duration of
12 any negative effects caused by factors other than
13 the breach."

14 Do you see that?

15 A. I do.

16 Q. And do you agree with that statement?

17 A. It could be particularly relevant,
18 particularly with the issue of causation.

19 Q. And does your report account for "other
20 factors" that could play a role in the company's
21 financial performance?

22 A. Again, I haven't seen an analysis -- I
23 don't do a lost profits analysis, so these quotes
24 are irrelevant, from my perspective. I don't have
25 the ability to do the analysis, so therefore, I

1 have not considered these types of things.

2 I have a general understanding of the
3 hospitals and where they're located and all that
4 stuff. But the financial information that this is
5 asking for contextual support around doesn't exist.

6 Q. Well, so the -- the previous sentence, I
7 understood it says you should understand
8 operations, market, and management practices.

9 And that's not referring to financial
10 documents, per se, right?

11 A. I think it absolutely is. This is all
12 in the context of a lost profits analysis.

13 Q. So --

14 A. Lost profits analysis is based on
15 financial documents.

16 Q. So management practices, right, that
17 could -- how is that related to financial documents
18 that you need?

19 A. It's the issue of lost profits and
20 causation.

21 Q. And what about just e-mails from the
22 CEOs of the hospitals, talking about the various
23 issues, is that not relevant to you, according to
24 this document, understanding the company's
25 management practices?

1 A. It could be potentially relevant in
2 making a determination of whether your lost profits
3 analysis is reasonable. I don't have a lost
4 profits analysis here because the required
5 information has not been produced.

6 Q. Right. But -- okay. You're not taking
7 the position of that the documents regarding the
8 company's management practices haven't been
9 produced, right?

10 A. This is contextual. And so if you do a
11 lost profits analysis, they're saying that you need
12 to look at other factors beyond the alleged bad
13 act, such as management's operating practices, to
14 make a determination that, in fact, the analysis is
15 appropriate for the case.

16 MR. TAKAGAKI: I'll move to strike as
17 nonresponsive.

18 BY MR. TAKAGAKI:

19 Q. If you could just answer my specific
20 question, that might -- that would be appreciated.

21 My question is just -- it's very
22 simple. Is it your position that documents
23 regarding the plaintiffs' management practices have
24 not been produced in this case?

25 MS. WOOD: Objection to form.

1 THE WITNESS: You'd have to be more specific
2 because management practices could mean a wide
3 array of things.

4 BY MR. TAKAGAKI:

5 Q. I agree. It could mean a wide array of
6 things.

7 Is it your position that there have
8 been no documents produced regarding that wide
9 array of things in this case?

10 MS. WOOD: Objection to form.

11 THE WITNESS: I don't think I can comment --
12 or give you an accurate answer, I should say.

13 BY MR. TAKAGAKI:

14 Q. And then the next sentence here, I mean,
15 the one we've already looked at, it says, "They
16 also help the expert account for other factors that
17 could play a role in the company's financial
18 performance and explain the duration of any
19 negative effects."

20 So what are examples of other factors
21 that could play a role in the company's financial
22 performance?

23 A. It gets to causation. This is simply
24 what that gets to.

25 Q. What is an example just of another

1 factor?

2 A. So, for example, in this case, if you
3 saw a decline in revenue, as an example, that
4 could, in theory, be due, if you find causation,
5 related to the grades or it could be due to other
6 changes at competitors. And so that's an example
7 of additional context, additional diligence, to be
8 able to support the reasonableness of a lost
9 profits analysis, if you're able to do one.

10 Q. Did you consider any of those other
11 factors that are referenced here in this page in --
12 in drafting your report?

13 A. I don't -- I don't perform a lost
14 profits analysis, so no, I wouldn't have considered
15 them.

16 Q. All right. We can go to the next
17 document.

18 MR. TAKAGAKI: It's going to be tab 17 A. I
19 think this is going to be Exhibit 7; is that right?

20 (Rule Deposition Exhibit 7 was
21 marked for identification.)

22 BY MR. TAKAGAKI:

23 Q. Mr. Rule, I just handed you what's been
24 marked as Exhibit 7.

25 Do you recognize this document?

1 A. No, I don't. I recognize a version of
2 this document. This looks like a key indicator
3 that was attached to probably one of the CEO
4 affidavits.

5 Q. Yeah. I'll represent to you that's what
6 this is. This is one of the key indicator
7 documents that I believe you reference in your
8 report, and yes, it was attached to -- in this
9 case, I believe it was the declaration of CEO
10 Cynthia McCauley.

11 Does that sound right to you?

12 A. I can't tell you who it's attached to.

13 Q. But does that sound right, that this is
14 one of the Key Indicators documents that you
15 reference in your report?

16 A. Unless I'm wrong, it looks like one of
17 them.

18 Q. And I'm talking about on page 27 of your
19 report, you reference plaintiffs producing a,
20 quote, "one-page summary of the key indicators that
21 compares changes in certain hospital performance
22 measures."

23 Do you see that in your report? It's
24 paragraph 7.

25 A. I do.

1 Q. Then there's a footnote, number 27
2 there. If you go down, it says declaration of
3 various people, and then it says Exhibit 4 for all
4 of them.

5 Do you see that?

6 A. I do.

7 Q. If you go to the front page of the
8 document, it says Exhibit 4, correct?

9 A. Yeah. My -- my point is it's simply
10 attached to an affidavit. So I don't know whose
11 affidavit it was attached to.

12 Q. But you don't dispute that this appears
13 to be one of the Key Indicators documents that
14 you're referring to in that attached paragraph and
15 footnote?

16 A. It looks like one, but, again, without
17 doing an actual comparison or having it attached to
18 an affidavit, I can't confirm that with 100 percent
19 certainty.

20 Q. All right. And then just directing you
21 to the document itself, so there's several columns.
22 There's text in red and in parentheses. Do you
23 have an understanding of what the text in red in
24 parentheses means?

25 A. It -- it looks like a decline. A lower

1 amount is being calculated. VAR should mean
2 variance.

3 Q. Right. So there's a column sort of -- I
4 don't know how to describe this -- a large column
5 at the top in sort of orange that says FY 2024.

6 Do you see that?

7 A. I do.

8 Q. Does that mean fiscal year 2024 to you?

9 A. I assume so.

10 Q. And then the next sort of larger column
11 says FY 2025.

12 Do you see that?

13 A. I do.

14 Q. And does that, to you, mean year-to-date
15 March 2025?

16 A. Typically, yes.

17 Q. And then just going to, I guess, the
18 third row at the top of the page for Palm Beach
19 Gardens Medical Center, where there's sort of the
20 first red parenthesis, do you see that, that row?

21 A. I do.

22 Q. And it has -- the first column is
23 Actual, and the second column is Prior Year.

24 Do you see that?

25 A. Yes.

1 Q. And then underneath, it's sort of green.
2 It says Total Admissions.

3 Do you see that?

4 A. I do.

5 Q. So does this appear to be showing that
6 for Palm Beach Medical Center, there's a 94-person
7 decrease in total admissions for the fiscal year of
8 2024?

9 A. That's what it seems to indicate.

10 Q. And if you go to sort of the next chunk
11 of columns, there's a number 21 in red parentheses.

12 Do you see that?

13 A. I do.

14 Q. And does that seem to be saying that for
15 2025 year-to-date, there's a 21-person decrease in
16 admissions.

17 Do you see that? Do you agree with
18 that?

19 A. That's what it's purporting to say.

20 Q. If you go through sort of the first
21 chunk of rows up top, it says Total Admissions. So
22 the next green row says Total OP Visits.

23 Do you see that?

24 A. Mm-hmm.

25 Q. Do you understand that might mean

1 outpatient visits?

2 A. That's what I assume.

3 Q. And then the next row says Total
4 Surgeries.

5 Do you see that?

6 A. I do.

7 Q. Then the next row -- I'm skipping -- but
8 the next green row says IP Surgeries.

9 Do you see that?

10 A. Yes.

11 Q. And then the next row, OP Surgeries.

12 Do you see that?

13 A. Yes.

14 Q. And then I'll just read the next few
15 rows. Below that is Total Emergent Encounters, and
16 then Total Elective Encounters.

17 Do you see those two?

18 A. I do.

19 Q. And so, is it your understanding that
20 for all of these rows we've just gone through, the
21 red text is showing a decrease in -- in the
22 relevant category? Is that your understanding?

23 A. Based on the face of this document, yes.
24 Mathematically, if you compare two numbers, the red
25 appear to be a decrease.

1 Q. And so going to, let's say, the second
2 row of the red, so it's Good Samaritan Medical
3 Center. It's under the Total OP Visits.

4 Do you see that? I guess it's the
5 third row of red. I'm sorry.

6 A. Where are you?

7 Q. Strike that.

8 So if you go to the green section
9 titled Total OP Visits, do you see that one near
10 the top?

11 A. Yes.

12 Q. If you go down to the Good Samaritan
13 Medical Center row in that section, do you see
14 that?

15 A. I do.

16 Q. The first box says 97,110.

17 Do you see that one?

18 A. I do.

19 Q. I want to make sure we're on -- I'm not
20 asking questions about that row.

21 So a few columns over in red, in
22 parentheses, it says 3,133.

23 Do you see that?

24 A. Yes.

25 Q. So do you -- do you take it to be that

1 there's 3,133 total outpatient visits that declined
2 in fiscal year 2024 for Good Samaritan Medical
3 Center?

4 A. It appears they did fewer outpatient
5 visits in 2024 versus 2023.

6 Q. And does it appear that the exact number
7 is 3,133 fewer?

8 A. According to this document, yes.

9 Q. And if it turned out that even just some
10 percentage of those outpatient visits that went
11 down were solely caused by nothing else but the
12 Leapfrog grade, would you agree that that would be
13 relevant to your opinion regarding substantial
14 injury?

15 A. Again, I think you're asking me a legal
16 conclusion as my interpretation of what substantial
17 injury is.

18 Q. Okay. For just a calculation of
19 economic harm, you -- you have much experience
20 calculating economic harm, right?

21 A. Yes.

22 Q. Is it possible that if some of these
23 3,133 outpatient visits, if -- if that -- those
24 were caused solely by the Leapfrog grades, that
25 that could be considered in your calculation of

1 economic harm?

2 A. Well, again, I don't have a calculation
3 of economic harm because the documents weren't
4 produced. But this is -- only a small amount of
5 the information that, in my opinion, would need to
6 be required to actually calculate said harm.

7 Q. Understood.

8 And I understand this wouldn't be the
9 only information, but, you know, we can through
10 several pieces of information, like this, but I
11 just want to go through one piece at a time.

12 Would this figure here be at least
13 part of what you would consider for an economic
14 harm calculation?

15 A. It -- it -- it could be, but, again this
16 is only a small piece. I would -- we don't even
17 have revenues. We don't have profitability. I
18 mean, it's the profitability at the end of the day
19 that's most important in trying to quantify
20 economic harm.

21 Q. Okay. I think we can put that aside.

22 You write in your report in
23 paragraph 27, that this document -- yeah, in
24 paragraph 27 in the middle of that paragraph,
25 you -- you talk about the key indicators document.

1 You say, "Compares changes in certain
2 hospital performance measures."

3 Do you see that?

4 A. Yes.

5 Q. So would you say that these -- these --
6 all these various measures we're looking at in
7 Exhibit 7 are hospital performance measures?

8 A. That's what they purport to be.

9 Q. And you say, "The relevance of such
10 summary figures is unclear as no supporting
11 materials were provided."

12 So is it your position that if you
13 did have the materials sort of support these
14 numbers so you could be more confident that they
15 were accurate, that they then would be relevant.

16 A. Potentially, but it would also have to
17 include how fewer admissions translated into less
18 profits, of -- of course, assuming causation.

19 Q. Correct.

20 A. And so, again, this -- this information
21 is, from my perspective, still incomplete to be
22 able to quantify economic harm to a reasonable
23 degree of certainty.

24 Q. Right. But it's possible, too, that the
25 documents that you would, in your mind, need,

1 would -- would be multiple documents. It could be
2 this document as well as other types of documents
3 together, correct?

4 A. Yes, and importantly documents related
5 to an expectation of what was going to occur in
6 2024. It's possible, due to other factors, that
7 they were expecting to have lower admissions. I
8 just don't know based on the face of this document,
9 is the point.

10 Q. Right. And is it -- just going back to
11 the Key Indicators document, Exhibit 7, so do you
12 agree that in, I would say, the vast majority of
13 these rows, there is red text?

14 A. Is there a question there?

15 Q. I believe so.

16 My question was do you agree that
17 the -- for the vast majority of these rows, there
18 is red text?

19 A. I don't know if I'd agree with the vast
20 majority, but yes, there -- there seems to be some
21 red text --

22 Q. Yeah.

23 A. -- by category.

24 Q. Yeah, just it looks like there's
25 five hospitals for each section.

1 Do you agree with that?

2 A. Yes.

3 Q. And I would say in each subsection,
4 except for the first subsection, so excluding that,
5 but for every other subsection there's at least
6 three rows of red text, correct?

7 A. Yes, I would agree with that, except for
8 the first section.

9 Q. In some sections, there's four rows,
10 five; is that right?

11 A. Yes, some have four.

12 Q. And in some, there's red text in both
13 the 2024 column and the 2025 column, correct?

14 A. For some.

15 Q. Would it at least be relevant to
16 determining whether the plaintiffs have been harmed
17 in this case, to consider this document, assuming
18 it's accurate?

19 A. It could be part of the consideration,
20 but as I've said numerous times, you -- I would
21 need a lot more information, importantly. For
22 example, if you just gave me this document, I'd
23 like to know what the trend from 2022 to 2023 was.

24 Q. Do you agree that this document shows
25 that for a number of hospital performance metrics,

1 the Plaintiff Hospitals in this case have been
2 decreasing --

3 A. Yeah.

4 Q. -- in a negative way?

5 A. It -- in some -- some of the hospitals,
6 at least in 2024 and part of 2025, yes. But at the
7 same time, you don't have the full context to look
8 at the prior year before to say is this just simply
9 a trend in hospitalizations in that part of the
10 area or is it something different.

11 Q. Now, what if there was -- what if there
12 was a document that showed there's no trend, that
13 for the last several years they've been consistent,
14 and then this is the outlier, would you agree that
15 that's evidence of harm?

16 A. Again, it depends, number one, on the
17 expectation before the alleged regrade or the --
18 the alleged bad acts, and number two, it -- it
19 depends on how it impacts the profitability of
20 the -- of the hospital.

21 Q. Do you -- do you doubt that this might
22 have some impact on profitability?

23 Is that your opinion?

24 A. I don't know. I just don't have enough
25 information. That's --

1 Q. But do you doubt it?

2 A. I -- I don't want to speculate because I
3 would -- you can lose customers and not necessarily
4 lose profitability.

5 Q. Of course, of course. But you can also
6 lose customers and lose profitability, right?

7 A. I'm not suggesting that either.

8 Q. Can you?

9 A. It's possible.

10 Q. It's possible --

11 A. But just on the -- on the face of this
12 document, it's unclear, as I used the word in my
13 report, what exactly this does mean.

14 Q. But it does -- I mean, we can agree, it
15 does mean there's been a decline, at least from
16 2024 to 2025, right, because you can see the jump
17 in '24 to 2025, correct, on this document?

18 MS. WOOD: I object to form.

19 THE WITNESS: Well, just two -- two
20 periods don't necessarily -- I'd like to see
21 more -- a longer trend, is the point.

22 BY MR. TAKAGAKI:

23 Q. Sure. And I --

24 MR. TAKAGAKI: And I move to strike as
25 nonresponsive.

1 BY MR. TAKAGAKI:

2 Q. Is it correct that one column shows
3 2024, and the other column shows 2025?

4 A. Yes, that's correct.

5 Q. All right. And is it correct that you
6 can see how many, we'll call it, events were
7 decreased in 2024 versus 2025, in this -- in this
8 document?

9 A. I think the document speaks for itself.

10 Q. Okay.

11 MR. TAKAGAKI: All right. Why don't we take a
12 quick break.

13 THE VIDEOGRAPHER: We are going off the record
14 at 4:21 p.m. with the end of Media No. 5.

15 (Short recess.)

16 THE VIDEOGRAPHER: We are back on the record
17 with the beginning of Media No. 6, at 4:33 p.m.

18 Counsel, you may proceed.

19 BY MR. TAKAGAKI:

20 Q. Please turn to page -- sorry --
21 paragraph 25 of your expert reports. I believe
22 that's on Exhibit 2.

23 And at the end of paragraph 5, you
24 just say -- you write -- you were talking about --
25 I'll direct you to the beginning of paragraph 5 --

1 you're talking about --

2 A. Are you saying "25" or "5"?

3 Q. I'm sorry. I should be saying
4 "paragraph 25."

5 A. Okay.

6 Q. Paragraph 25, the first section --
7 sentence says, "As opposed to reliably determining
8 any lost profits or lost business value."

9 Do you see that?

10 A. Yes.

11 Q. And it looks like you have sort of some
12 critiques here. If you go to the very last
13 sentence, you say, "Additionally, Dr. Berger cites
14 various studies that are unrelated to TLG or the
15 relevant health care industry."

16 Do you see that?

17 A. I do.

18 (Rule Deposition Exhibit 8 was
19 marked for identification.)

20 BY MR. TAKAGAKI:

21 Q. Okay. So I'm going to show you
22 Exhibit 8.

23 Do you recognize this document?

24 A. It looks like -- I can't comment on its
25 completeness, but it looks like it is a copy of

1 Dr. Berger's report that I reviewed.

2 Q. And the first page, the cover page says,
3 "Expert report of Dr. Joanna Berger, PhD."

4 Do you see that?

5 A. Yes.

6 Q. Okay. And is this the Dr. Berger that
7 you're referring to in paragraph 25?

8 A. Yes.

9 Q. Okay. And I just want to direct your
10 attention to paragraph 28 of Dr. Berger's report,
11 paragraph 28.

12 Do you see here, footnote 36 at the
13 end of the -- the first sentence of paragraph 28?

14 A. I see footnote 36.

15 Q. And if you go to 36 at the bottom of the
16 page, do you see the citation? There is a document
17 titled Consumer Choice and U.S. Health Care Using
18 Insights from the Past to Inform the Way Forward.

19 Do you see that?

20 A. I do.

21 Q. And do you see the next document cited
22 there after the semicolon, says, "Consumers in
23 health care: The burden of truth"?

24 Do you see that?

25 A. I do.

1 Q. So just turning back to paragraph 25 of
2 your report, you say that Dr. Berger cites various
3 studies that are unrelated to TLG or the relevant
4 health care industry, but at least this citation is
5 relevant to the health care industry, correct?

6 A. Well, it purports to be. Obviously,
7 it's titled Health Care, but also notice I don't
8 cite this as something that's not relevant.

9 Q. Right. And just directing you to other
10 footnotes in his -- in Dr. Berger's report, if you
11 go to the next page, footnote 39, it's a document
12 titled Online Reviews of Hospital Choices.

13 Do you see that?

14 A. I'm sorry. You said footnote 39.

15 Q. Yes, footnote 39?

16 A. Sorry. That's what it's titled.

17 Q. And then if you turn to the next page,
18 there's footnotes 40 through 46.

19 Do you see those, in 40? It's
20 Footnote 40. This is a document titled Parental
21 Awareness and Use of Online Physician Rating Sites.

22 Do you see that?

23 A. I do.

24 Q. Next, 41. Footnote 41 says -- the title
25 is "What is a star worth to Medicare beneficiaries?

1 A discrete choice experiment of hospital quality
2 ratings."

3 Do you see that?

4 A. I do.

5 Q. And do you see every footnote on that
6 page, going down to Footnote 46, all references
7 medicine or health care? Do you see that?

8 A. I do.

9 Q. And paragraph 40--- sorry. Footnote 46,
10 last footnote, that also relates to "how online
11 quality ratings influence patient's choice of
12 medical providers controlled experimental survey
13 study." Do you see that?

14 A. I do.

15 Q. And if you turn to the next page,
16 footnotes 47 through 51, do you see they have
17 similar citations to health care or medical
18 articles, based on their title?

19 A. I mean, 47 does. It's unclear about 48,
20 49, 50.

21 Q. I believe those are citing back to 47.

22 Would you agree?

23 A. Hold on. He doesn't -- yeah, I guess
24 the Bates range is the same.

25 Q. So do you agree then -- the question

1 was, that those footnotes we were just looking at
2 all reference some hospital or medical articles,
3 correct?

4 A. In those particular footnotes, there
5 are. My point was slightly different, that not all
6 of them seemed to be on point related to health
7 care.

8 Q. And your report doesn't cite any studies
9 related to the health care industry, correct?

10 A. No, because that's not the scope of the
11 report or the analysis.

12 Q. And it doesn't cite any studies related
13 to The Leapfrog Group, correct?

14 A. No. Again, I think the scope of my
15 report was a little bit different.

16 Q. Your report was at least partially
17 opining on Dr. Berger's report, correct?

18 A. It's, in part, response to all three of
19 the plaintiffs' experts.

20 Q. Including Dr. Berger, correct?

21 A. Including Dr. Berger.

22 Q. All right. I'd like to shift topics a
23 bit to talking about the -- what we've been sort of
24 referring to your Opinion 2 in this case, the
25 opinion regarding the Leapfrog methodology

1 workbook.

2 A. Okay.

3 Q. You can turn back to your expert report,
4 which I believe is Exhibit 2. Yes. Turn back to
5 Exhibit 2, which is your expert report.

6 So just directing you to paragraph 4
7 of your expert report, do you see the last sentence
8 says, "Further, I was asked to analyze whether the
9 plaintiffs' spring 2025 hospital safety grades
10 would be materially impacted by certain changes in
11 the algorithm inputs"?

12 Do you see that?

13 A. I do.

14 Q. Does that accurately convey the scope --
15 at least part of the scope of your report?

16 A. Yeah, it does. In response to Dr. -- or
17 Mr. Nicholson's sensitivity analysis around the --
18 the grading, I was also asked by counsel to
19 synthesize, effectively, that. And if one just
20 simply provides -- or gave no weight to the imputed
21 measures, the four imputed measures, what, if any,
22 impact would that have on the grades themselves?

23 Or said differently, were those four
24 imputed grades driving a bad grade?

25 Q. And if you -- let's go to paragraph 21

1 of your report. So this is a section under a
2 section titled Discussion and Analysis of Opinions.

3 Do you see that?

4 A. I do.

5 Q. And then beneath that, there's a
6 subsection titled Summary.

7 Do you see that?

8 A. Yeah.

9 Q. Is this -- are paragraphs 20 and 21
10 meant to summarize your opinions in this case?

11 A. At a high level, yes.

12 Q. And so directing your attention to
13 paragraph 21, your -- I won't read the whole
14 paragraph. I will just note the sort of second
15 part of it, it says, "The grades for the Plaintiff
16 Hospitals would not materially change to the extent
17 certain, quote, imputed values were excluded from
18 the calculated methodology."

19 Do you see that?

20 A. Yes.

21 Q. I believe you've testified to this
22 before, but essentially, your opinion here in
23 paragraph 21 is that if -- if the four imputed
24 metrics were excluded from the methodology, your
25 opinion is the grades for the hospitals would not

1 materially change; is that correct?

2 A. That -- that's correct, but the way I
3 really like to think about it is, the inclusion of
4 those grades -- of those measures -- excuse me --
5 were not driving the low grade.

6 Q. Understood.

7 You didn't -- I don't think you used
8 sort of that terminology in the report here.

9 Is there a reason for that?

10 A. I mean, I could have. It's -- it's
11 two -- in my mind, it's two sides of the same coin.

12 Q. Okay. If you go to paragraph 28 of your
13 report, you say in the first sentence, "I
14 understand that TLG's hospital safety grades, which
15 are assigned to nearly 3,000 general acute care
16 hospitals across the nation twice annually, are
17 based on up to 22 patient safety measures."

18 I'll just stop there.

19 Do you see that?

20 A. I do.

21 Q. And does that -- do you -- do you have
22 that understanding as we sit here today?

23 A. Yes, and I have a citation to where I
24 get that from.

25 Q. Right. So it's your understanding that

1 the hospital safety grades are assigned to nearly
2 3,000 general acute care hospitals across the
3 nature?

4 A. That's what Leapfrog said in their own
5 documents, yes.

6 Q. And if you go to the last sentence of
7 that paragraph, it says, "TLG states that the
8 measure set is divided into two domains; one, in
9 parentheses, process/structural measures; and two,
10 in parentheses, outcome measures, with each
11 representing 50 percent of the grade."

12 Do you see that?

13 A. Yes.

14 Q. And then on paragraph 29 and 30, you
15 appear to be explaining your understanding of the
16 imputation methodology that TLG uses; is that
17 right?

18 A. Well, I think 28 and -- paragraphs 28,
19 29, and 30 are all directly from their square
20 methodology that explains to the reader how they're
21 going about certain things.

22 Q. Right. So I understand that a lot of
23 this language is quoted from Leapfrog documents; is
24 that right, in paragraphs 28, 29, and 30?

25 A. Correct. And specifically the Leapfrog

1 spring 2025 scoring methodology document.

2 Q. And just so I'm clear, you've -- do you
3 have any independent understanding of your
4 assertions in these paragraphs beyond what you've
5 cited?

6 A. Yes. I -- I was able to analyze, from a
7 statistical perspective, the actual model itself.
8 And the way that the models work, the way that the
9 Z-Scores and the weightings work, is consistent
10 with my reading of the description, and then the
11 document that's cited.

12 Q. Okay. And then if you go to
13 paragraph 30, sort of in the middle of the
14 paragraph, it looks like you describe the, quote,
15 new two-step imputation approach? I think it's the
16 sixth sentence down, if that helps you.

17 A. Okay.

18 Q. And it says "for determining scores for
19 CPOE, BCMA, IPS, and hand hygiene, if they're
20 missing from the survey."

21 Do you see that?

22 A. I do.

23 Q. Do you have an -- or what is CPOE?

24 A. It is a clinical ordering system
25 effectively, as I understand it, that -- but it

1 also describes -- so it's a computerized physician
2 ordering entry system. So it's a system that
3 allows, as I understand it, doctors to place orders
4 within a computerized system.

5 Q. And what's your understanding of BCMA?

6 A. That, basically, there are barcodes on
7 admission wrists that allow whomever is providing
8 medication to quickly know what the medication is,
9 so there's -- there's not errors in -- in providing
10 not only the right medications, but dosages and
11 stuff like that.

12 Q. And then what's your understanding of
13 IPS as it's used here?

14 A. It simply relates to how frequent
15 specialists are rounding through the ICU.

16 Q. And then hand hygiene, what is your
17 understanding of hand hygiene as it's used here?

18 A. Best practices for washing hands and all
19 that good stuff.

20 Q. And then directing your attention to the
21 next sentence there, it says, "For the purposes of
22 the spring 2025 grades," and then you describe the
23 first step and imputation process.

24 Do you see that?

25 A. I do.

1 Q. And I think earlier we talked about
2 that, and you couldn't quite remember what the
3 first step was. So I'm now showing you this
4 document.

5 Does this refresh your recollection
6 what the first step was in the imputation model?

7 A. Yes, it does.

8 Q. And -- and can you, just in your own
9 words, explain what the first step is?

10 A. Basically, for the period that's being
11 graded, if there's not survey data for these four
12 measures, and because there's not a secondary
13 source for the four measures, the first step in the
14 imputation process -- excuse me -- is to use a
15 prior period estimate to the extent that one
16 exists.

17 Q. Meaning that if imputation is necessary
18 because you don't have -- Leapfrog doesn't have
19 data for these four metrics, the first step is to
20 try to use the hospital's actual data for the prior
21 two years, correct?

22 A. That's correct.

23 Q. Okay.

24 A. Or at least the prior two measurements.

25 Q. I see. You write here, "Previous two

1 rounds of grades, i.e., fall 2024, spring 2024."

2 Do you agree with that?

3 A. I do.

4 Q. And in case we haven't defined it, the
5 four imputed scores are for -- scores for these
6 things we've just been discussing, CPOE, BCMA, IPS
7 and hand hygiene, correct?

8 A. That's correct.

9 Q. And then later in this paragraph, you
10 talk about the second step.

11 Can you just put it -- you know,
12 describe in your own words what the second step in
13 the imputation model is?

14 A. Sure. If you get past the first step
15 and there's no data from prior periods, you go to
16 the second step, for where there is a table on
17 page 10 of my report that you where assigned a
18 numerical value that you use for the model.

19 Q. Right. So if we turn to, yeah,
20 page 10 -- or actually, just staying on page 9 for
21 a second, you -- the end of that sent- -- paragraph
22 says, "If the hospital does not have historical
23 data from the last two rounds of the safety grade,
24 the hospital is assigned a point value that is
25 equivalent to receiving 'limited achievement' for

1 this measure on the survey."

2 Do you agree with that?

3 A. I mean, that's what it says.

4 Q. I mean, do you agree with it?

5 A. What do you mean do I agree?

6 Q. Do you agree that's the accurate
7 description of Step 2?

8 A. Yeah, it's in -- it's quotations. It's
9 cited to the actual document, but yes, that's --
10 that's my understanding that if they don't have the
11 data, they eventually get the points assigned in
12 this chart that's reflected on page 10 of my
13 report.

14 Q. Got it. So, yeah, the chart on page 10,
15 there's a little text above it, it says, "Step two,
16 imputation point assignment," right, and I see four
17 rows here, and each one says, "limited
18 achievement," in the middle.

19 And then do you agree that that's
20 what's here, that I'm describing the document
21 correctly?

22 A. Those are the words on the page.

23 Q. And then in column -- in the, I guess,
24 the third column on the right, it says,
25 "Corresponding safety-grade measure score," and

1 then for the CPOE row, it's 15. For the BCMA, it's
2 25; for IPS, it's 5; and for hand hygiene, it's 15.

3 Do you agree that I correctly am
4 describing what's here?

5 A. I do.

6 Q. And so your understanding that the
7 current imputation methodology for Leapfrog Group
8 is to when you reach Step 2, to assign these
9 four scores to any hospital that has made it to
10 Step 2; is that correct?

11 A. That is my understanding.

12 Q. And do you have an understanding of
13 whether these four numbers are based in any way on
14 the hospital's actual performance on these
15 four metrics?

16 A. I think that's a question better left
17 for Leapfrog. I don't have an opinion on that.

18 Q. Okay. I mean, is it your understanding
19 that if a hospital doesn't submit their actual data
20 on these metrics, that Leapfrog will give every
21 single hospital these four metrics to -- these
22 four inputs for the four imputed metrics, if they
23 make it to Step 2?

24 A. I believe that is their stated policy.

25 Q. So I think earlier, we talked about how

1 in your report, you say that nearly 3,000 hospitals
2 are graded by the Leapfrog grades; is that right?

3 A. That is what they represented in their
4 documents.

5 Q. Fair. And you don't have any -- you
6 don't dispute that in any way?

7 A. I have no basis to dispute that.

8 Q. And so out of those nearly 3,000 for any
9 who don't participate, any hospitals who don't
10 participate, and who then make it to Step 2, they
11 are given these exact scores on the top of page 10
12 for these metrics, correct?

13 A. That is my understanding of their
14 policy.

15 Q. Okay. Do you consider yourself to be an
16 expert in statistics?

17 A. Yes, I do, actually.

18 Q. Have you ever been qualified as an
19 expert in statistics?

20 A. I've been qualified on analyses that
21 involve statistical inputs, statistical analyses,
22 yes.

23 Q. Sure. But beyond just being qualified
24 in a case where statistics were involved, have you
25 ever been qualified as an expert in statistics?

1 A. Like, solely on just statistics?

2 Q. Mm-hmm, yes.

3 A. I -- not solely on statistics. And
4 it's -- again, statistical aspects of financial
5 modeling, yes, similar to what we have here. But
6 as just solely a statistical report, I -- I just
7 don't know if I've issued a report that's solely
8 based on statistics.

9 Q. Yeah, and just going back to your
10 LinkedIn, I mean, you don't list statistics as one
11 of your specialties, right?

12 A. I don't list damages analyses as one of
13 my specialties. It's all captured in litigation
14 consulting and expert testimony.

15 Q. And you don't have a degree specifically
16 in statistics, correct?

17 A. I don't even know -- I guess, maybe they
18 would. I don't have an individual concentration in
19 statistics but definitely part of both my
20 coursework and my professional career.

21 Q. At Notre Dame, you received a bachelor's
22 of business administration, correct?

23 A. That's correct.

24 Q. Not a bachelor's in statistics, correct?

25 A. I'm not quite sure if they offer that,

1 but, no, but part of my -- my foundation, both
2 Notre Dame and University of Chicago, is numerous
3 statistical classes, in addition to, you know,
4 incorporating statistical analyses in the -- over
5 the course of my 25 years.

6 Q. Would you say that most of the people
7 who commit -- who completed the two degrees that
8 you have, the BBA from Notre Dame and the MBA from
9 University of Chicago, also have much of the
10 experience with statistics that you're describing?

11 A. Not from a professional perspective.

12 Q. Right. I just meant in school?

13 A. If they've taken the same classes, yes,
14 but I think importantly is that I've been doing
15 statistical work as a professional for over
16 25 years.

17 Q. I know you -- statistical work is
18 different. I'm asking if you're an expert in
19 statistics. If --

20 A. Yes.

21 Q. -- you believe you are?

22 A. I believe I am.

23 Q. And I don't think you state anywhere
24 that you're an expert in statistics in your CV,
25 your LinkedIn, or your report.

1 Is there a reason you omitted that?

2 A. Not specifically, but I don't know if I
3 talk about alter ego or forensic accounting. Maybe
4 I do.

5 Q. Right. But I'm talking about
6 statistics. You don't -- you don't claim to be an
7 expert in statistics anywhere in the documents in
8 this case, except for this moment in this
9 deposition, correct?

10 A. I believe I'm an expert in statistics.

11 Q. Okay. Are you -- do you have a Ph.D. in
12 statistics?

13 A. No, I don't.

14 Q. Do you have a master's in statistics?

15 A. No.

16 Q. Have you ever published an article
17 related to statistics?

18 A. As I said earlier, I don't publish as
19 part of any practice.

20 Q. Have you ever written any literature at
21 all related to statistics?

22 A. As I've said earlier, I don't focus on
23 writing. I focus on doing.

24 Q. Are you -- you're not a health care
25 economist, are you?

1 A. I don't hold myself out as a health care
2 economist. My expertise is in the areas that we
3 talked about specifically this morning, the
4 five pillars, if you will, and any subset thereof.

5 Q. You don't have a bachelor's of
6 economics, correct?

7 A. I have an economics degree from the
8 University of Chicago.

9 Q. You're referring to the bachelor of
10 business administration?

11 A. No, I'm referring to --

12 Q. Oh, pardon me.

13 A. -- part of my MBA.

14 Q. You're striking to the -- I'm sorry.

15 You're referring to the master's of
16 business administration?

17 A. Yes, with concentrations in economics.

18 Q. Was that concentration in health care
19 economics?

20 A. No, it would have been in economics in
21 general -- general.

22 Q. Would that have been in macro or
23 microeconomics?

24 A. It would have been all of that, but
25 like, they have separate courses for macro and

1 micro.

2 Q. So I want to -- so I want to direct your
3 attention to paragraph 33 of your report Exhibit 2.

4 So I believe this paragraph is
5 describing what you did to create exhibits -- the
6 exhibits to your report; is that fair?

7 A. That is a summary of how I came to the
8 conclusion that the imputed values are not a
9 significant driver of the plaintiffs' hospital
10 grades.

11 Q. Right. So if you go to the top -- or
12 sorry -- the bottom of page 10, so the end of
13 paragraph 33, you say, "Therefore, I have analyzed
14 changes in the Plaintiff Hospitals' grades,
15 assuming that the imputed factors are excluded from
16 the determination of a hospital safety grade."

17 And then you say, "In particular, I
18 entered an N/A as each of the Plaintiff Hospitals'
19 scores for the CPOE, BCMA, IPS, and hand hygiene
20 measures. In this way, the imputed scores were not
21 utilized, the weights were" distributed -- strike
22 that -- "the weights were redistributed across all
23 entered scores, and new grades for each hospital
24 were determined."

25 Is that an accurate description of

1 what you did to create exhibit -- the exhibits to
2 your report?

3 A. Yeah, that -- that's an accurate
4 description.

5 Q. And then in paragraph 34, you conclude,
6 "Based on my analysis, eliminating consideration of
7 the four imputed scores, the grades for the
8 plaintiffs would not materially change."

9 Do you see that?

10 A. I do.

11 Q. Do you agree with that statement?

12 A. Yes, I agree with that statement as well
13 as framing it the other way I did, that imputed
14 values are not a significant driver to plaintiffs'
15 hospital grades.

16 Q. So let me direct you now to the exhibits
17 of your report. So my understanding is that
18 Exhibits 1 through 5 you did not manipulate in any
19 way; is that correct?

20 A. Those are the original grades.

21 Q. Right. Exhibits 1 through 5 are the --
22 your understanding is they're the actual grades
23 that each of these hospitals received in April of
24 2025; is that right?

25 A. In the spring of 2025, yes.

1 Q. Yeah, if I -- if you look at, you know,
2 Exhibit 1, for example, on the top of the page, it
3 says "April 2025."

4 So do you agree that these are for
5 April 2025?

6 A. Yes, they were in the spring of 2025.

7 Q. And I see in each of the exhibits,
8 there's little footnotes that appear, like, for
9 example, above Z-score, in the middle of the page.

10 A. Yes.

11 Q. Do you see that?

12 And there's another one, a
13 Footnote 2, for imputes to weighting imputable
14 measures, and then I see Footnote 3 next to weight,
15 and a Footnote 4 for a number of component
16 measures.

17 Do you see those four footnotes?

18 A. I do.

19 Q. Those four footnotes are not included in
20 any of the exhibits, correct?

21 A. They are outside the print screen.

22 Q. So there's not -- does that mean they
23 are not included in these exhibits?

24 A. They are not -- they are in the
25 electronic version of it. They're not --

1 they're -- again, they're outside of the print
2 screen when this was compiled.

3 Q. Understood. So as I look at the hard
4 copy pages here, I would not see the footnotes,
5 correct?

6 A. Correct. If you looked at the
7 electronic version, you would see the footnotes.

8 Q. Is there anything else from the
9 electronic version that does not appear on these
10 pages?

11 A. There are some hidden columns.

12 Q. Okay. And what are the hidden columns?

13 A. I'd have to look -- or go back and look
14 at it. I think there are some hidden columns that
15 like, for example, calculate the -- the formula.

16 They'll show the actual calculation
17 that basically says opportunity times impact times
18 number of components, multiplied together, plus
19 evidence, goes into calculating the standard
20 weight.

21 So there are a couple hidden columns
22 that are just not displayed that do some extra
23 math, if you will.

24 Q. I see. They contain what you would call
25 Excel formulas in them?

1 A. They are additional formulas that are
2 simply not displayed because -- I don't want to
3 call them redundant, but basically, they go into
4 calculating, for example, like standard of weight.

5 Q. Were those hidden columns hard-coded?

6 A. No, I don't think so. I think they were
7 dynamic.

8 Q. And when you say "dynamic," meaning if
9 you were to change something that relates to a
10 piece of information in that formula, it would then
11 change that output of the formula?

12 A. Yes. If you change the input or an
13 assumption, there would be an impact on the formula
14 itself.

15 Q. So what you're saying is, for those
16 non-hard-coded hidden columns, if you -- if a
17 person were to make other changes to the Excel,
18 change some of the other inputs, it could
19 potentially affect the outputs of those hidden
20 columns, right?

21 MS. WOOD: Objection to form.

22 THE WITNESS: It could and, you know,
23 ultimately affect the -- the weighted measure
24 that -- that is part of the overall grade.

25

1 BY MR. TAKAGAKI:

2 Q. Got it.

3 And then if we go to Exhibits 6
4 through 10, those are the exhibits where you
5 inserted the N/As that you were referencing in your
6 report, correct?

7 A. Yes. By inserting the N/As, it's given
8 no weight in the calculation. The z-scores are
9 recalculated. The weights are recalculated. And
10 as a result, the -- the score is recalculated.

11 So the point really what this shows,
12 and this is how I think about it, the ones
13 highlighted in yellow on Exhibit 6, the four
14 imputed, they were not the significant driver of
15 the low score.

16 Q. Right. And so just kind of going back
17 and forth now between your reports. So on -- in
18 paragraph 33, you say, "In particular, I entered an
19 N/A as to each of the Plaintiff Hospitals' scores
20 for CPOE, BCMA, IPS, and hand hygiene measures."

21 So using Exhibit 6 as an example, I
22 see the column titled Enter Your Hospital Score
23 Here.

24 Do you see that column?

25 A. Yes.

1 Q. And is that the column where you entered
2 the N/As that you described in paragraph 33 of your
3 expert report?

4 A. Yes.

5 Q. Right. So as I see, there's four rows
6 here in Exhibit 6 that are yellow. CPOE is one;
7 BCMA is one; IPS is one; and then three rows down,
8 is hand hygiene.

9 Those are the four metrics you
10 entered N/A for; is that correct?

11 A. Yes. Those are the imputed measures
12 that, in an effort not to have them have any weight
13 in the calculation or the grade, that was the most
14 efficient way to do it. By zeroing them out with
15 N/As, it -- it eliminates the weighting, as you can
16 see in the far right side of the document.

17 Q. And turning back to Exhibits 1 through
18 5, the -- those are the exhibits that are actual
19 scores, hospitals current grades for -- for spring
20 of 2025, correct?

21 A. Correct.

22 Q. And is it true that for each of those
23 same rows, the ones that you highlighted in yellow
24 in Exhibits 6 through 7, in Exhibits 1 through 5,
25 those rows all have the imputed numbers there,

1 correct?

2 A. Correct.

3 Q. Those are the numbers from the top of
4 page 10 of your report?

5 A. Yes. Those are the numbers consistent
6 with Leapfrog's policy.

7 Q. So just using Exhibit 1 as an example,
8 right, the CPOE realized of 15, do you see that?

9 A. Yes.

10 Q. And then the BCMA is 25. Do you see
11 that?

12 A. Yes.

13 Q. Then IPS is a 5. Do you see that?

14 A. Yes.

15 Q. And hand hygiene is a 5. Do you see
16 that?

17 A. I do.

18 Q. Right. So those were from -- those are
19 the limited achievement scores from Step 2 of the
20 imputation model, correct?

21 A. Yes. That's what Leapfrog assigned
22 consistent with their policy.

23 Q. Right. And those scores that I just
24 read from Exhibit 1 are present in Exhibits 2, 3,
25 4, and 5, correct? They're all identical?

1 A. Yes.

2 Q. And then in Exhibits 7 through 10 -- or
3 excuse me -- Exhibits 6 through 10, those scores
4 are not there. Rather, the N/A is there for those
5 rows, correct?

6 A. Yes, in an effort not to give them any
7 weight in the calculation to make a determination
8 whether -- whether or not those were the drivers of
9 the poor score -- or the lower score, excuse me.

10 Q. Now, I want to just compare the first
11 five exhibits to the second five. So let's
12 compare, just for sake of conversation, Exhibit 1
13 versus Exhibit 6, okay?

14 Those are both for the Delray Medical
15 Center.

16 Do you agree?

17 A. Yes.

18 Q. So if I look at the mean column, and I'm
19 looking at just for the four imputed metrics, the
20 mean column stayed the same in both Exhibit 1 and
21 Exhibit 6, correct?

22 A. That column will stay the same. The
23 standard deviation will stay the same. The
24 evidence, the opportunity, the impact, the number
25 of components will all stay the same. What's

1 dynamic is the recalculation of the Z-score, the
2 modified Z-score, the standard weights, the final
3 weights, and then the weighted measure in the
4 score. Those are the columns that are more dynamic
5 when you start changing assumptions in the
6 sensitivity analysis.

7 Q. So those columns that don't change,
8 those are hard-coded; is that correct?

9 A. Yes.

10 Q. Okay. And then the columns that do
11 change, say, the original Z-score column, the
12 modified Z-score column, those change the moment
13 that you entered in the N/A numbers, correct?

14 A. For that individual measurement, yes,
15 because you're -- you're effectively placing zero
16 weight in the calculation for that.

17 Q. Right.

18 A. The total grade doesn't change or won't
19 change until you finalize all of the inputs that
20 are under the column, Enter Your Hospital Score
21 Here.

22 Q. I just want to note -- I am just trying
23 to note, as I -- if I compared Exhibit 1 to
24 Exhibit 6, the z-scores, both original and
25 modified, are different between those two exhibits,

1 correct?

2 A. Correct.

3 Q. In Exhibit 6, they all say N/A, correct?
4 Is that correct?

5 A. Yes, because they're receiving no
6 weight.

7 Q. So my question is just, did you go in
8 and manually change those to N/A, or did they
9 automatically change when you inserted the N/As
10 into the Enter Your Hospital Score Here column?

11 A. That's a good question. I believe we
12 manually changed them as well.

13 Q. You changed the z-scores. Okay.

14 A. It's possible it was done via formula,
15 but I would just have to -- I would have to look at
16 the electronic version to be certain on it.

17 But nonetheless, what's important
18 from my perspective is, they're not being included
19 in the calculation of the z-scores or the weighting
20 at the end of the day.

21 Q. And what is a Z-score?

22 A. A Z-score is basically a standardized
23 measurement that tries to compare -- or tries to
24 express, in standard deviations, how far an
25 observation is from the mean.

1 So it's -- it's used -- it's a
2 calculation to be able to compare, maybe, different
3 hospitals or whatnot. It's -- it's simply a number
4 of standard deviations from the mean.

5 Q. Right. So if you have an N/A score and
6 enter your hospital score here, you obviously can't
7 have a Z-score because you don't even appear
8 relative to the mean?

9 A. Correct.

10 Q. Okay. And then the next sort of set of
11 columns -- evidence, opportunity, impact -- those,
12 I believe, did not change at all from Exhibit 1 to
13 Exhibit 6?

14 A. That's correct. That's based on, again,
15 the corresponding PDF that discusses how those were
16 determined by Leapfrog.

17 Q. Right. And what is your understanding
18 of what the evidence column means? I see here,
19 there's 1s and 2s.

20 What are the 1s and 2s?

21 A. I'd have to refresh my memory based on
22 the -- the supporting document.

23 Q. And what about opportunity? I see that
24 those columns -- those figures don't change,
25 which -- from the exhibits, but there are sort of a

1 large range of numbers?

2 A. Yeah. Again, it's the support for how
3 those were calculated, are in the associated PDF.
4 And, again, as you noted, they're -- they're
5 static, and so they don't change.

6 Q. Do you know what they are, what they
7 signify?

8 A. Again, I would have to refresh my
9 memory. I was less focused on those, given that
10 they don't change. They're more focused on the
11 Z-stats and the weights. But the document, the
12 associated document that I cite several times is
13 found in, like, paragraphs 28 through 30 provide
14 that detail.

15 Q. Got it. And yeah, and the same for the
16 impact column.

17 Do you know what that signifies?

18 A. If I have that document, I could refresh
19 my memory.

20 Q. And that's hard-coded, as well, correct?

21 A. Yeah, but these all basically roll up
22 into how they're calculation -- calculating the
23 weight.

24 Q. And then the number of component
25 measures column, I see they're pretty much all 1s

1 in that column, except there's a tab at the bottom.

2 Do you see that?

3 A. Yeah, I do.

4 Q. And that -- they're the same for
5 Exhibits 1 through 5 and 6 through 10, correct?

6 A. That is correct.

7 Q. Do you have an understanding what those
8 mean?

9 A. Yeah, I think this one -- again, I
10 prefer to refresh my memory with the supporting
11 document, but I think this is basically, it's
12 almost a multiplier, if you will, and so if you
13 multiply it by 1, really that portion of the
14 formula is simply opportunity times impact plus
15 evidence.

16 Clearly, on the last one, as it
17 relates to PSI 90, it's a larger multiplication
18 factor. It's a factor of 10.

19 Q. Does that mean that the -- the PSI 90
20 entry at the bottom, which has the 10, is a much
21 larger portion of the overall Leapfrog grade?

22 A. Well, as you -- as you can tell here,
23 I'm looking at Exhibit 1, the original grading.
24 It's almost 15 percent of the overall grade.

25 Q. You're looking at the Standard Weight

1 column --

2 A. I am.

3 Q. -- or the Final Weight column?

4 A. Correct.

5 Q. Or are you looking at both?

6 A. It's both, but...

7 Q. And those two columns, Standard Weight
8 and Final Weight, those are the same in both
9 Exhibits 1 through 5 and then Exhibits 6 through
10 10, correct?

11 A. No.

12 Q. Oh, I'm sorry. For -- for some of these
13 metrics, they are. They -- they change?

14 A. If -- if -- that's the whole point of
15 the sensitivity analysis is to remove them from the
16 calculation to see if they are the driver of the
17 lower grade.

18 Q. Understood.

19 So just in layman's terms, very, very
20 briefly, so the weight columns -- I see
21 three Weight columns: Standard Weight, Final
22 Weight, and Weighted Measurement Score.

23 Without breaking down any individual,
24 what do the Weight columns here mean?

25 A. Well, the Standard Weight column is

1 the -- how much this measurement will count in the
2 overall grade. That's typically the same as -- it
3 would be the same as the Final Weight column if you
4 didn't have any N/As in it.

5 And so the final weight is a
6 re-weighting, if you will, across all the other
7 metrics that are still in the calculation. And
8 it's that final weight times the modified Z-score
9 that gives you the weighted measure that's
10 contained in the overall score itself.

11 There's some extra math down below,
12 that ultimately arrives at a letter grade.

13 Q. So the Standard Weight column, that's
14 just what Leapfrog has assigned out as the weight
15 for each of these metrics, assuming, you know, full
16 participation; is that right?

17 A. Yeah. So, for example, I'll just point
18 to one. On Exhibit 1, fourth one down, Safe
19 Practice one, Culture of Leadership Structures and
20 Systems. In the original grade, they have an N/A.
21 And so what does that mean? If they would have had
22 a number, it would have counted just over
23 3 percent.

24 But because it's not being counted,
25 it's not being weighted. If you go to the Final

1 Weight column, there's a zero. So what does that
2 mean? That extra 3 percent gets redistributed
3 amongst all the other measurements that are still
4 part of the calculation.

5 Q. Got it.

6 And so turning to Exhibit 6 through
7 10, the ones that are the result of your
8 modifications, you did not change the Standard
9 Weight column at all, correct?

10 A. No, because, again, that -- that doesn't
11 directly impact the calculation. What is important
12 is it's the Final Weight column, the ones that's
13 redistributed if you don't have enough data to be
14 able to assign a number there.

15 And so that -- that's why standard
16 rate is important, but at the end of the day, it --
17 the final weight is what goes into the calculation.

18 Q. And then the -- the Final Weight column
19 does appear to be different between Exhibits 1
20 through 5 and 6 through 10 as to the four imputed
21 methods, right?

22 A. That's correct, because you're doing a
23 re-weighting of all the measures that are in the
24 calculation still. And so said differently, you
25 still need to sum up to 100 percent.

1 Q. Right, exactly. So if the Final Weight
2 column shows that if you delete certain metrics
3 that would have previously had a weight, if you
4 delete those, the final weight for the remaining
5 columns has to change to effect a deletion?

6 A. Correct.

7 Q. Okay. And then is the weighted measure
8 score column at least similar to the Final Weight
9 column, in that they also change as -- as metrics
10 are deleted?

11 A. Yes, that is -- that is correct.

12 Q. And so for Exhibits 6 through 10, I -- I
13 note that there are several zero percents in the
14 Final Weight and the Measured Score column that are
15 not there in Exhibits 1 through 5.

16 You agree, correct? Do you agree?

17 A. I do.

18 Q. Did you manually input those as 0.00s?

19 A. I would have to go back and look at
20 the -- the Excel. It's possible we manually zeroed
21 them out to make sure they weren't given any
22 weight, but at the same time, it might have been
23 formula driven.

24 Q. And so when you say "formula driven,"
25 just so I understand, if it was formula driven,

1 when you inserted the N/A in the Enter Your Score
2 column, those would automatically have changed to
3 0.00, if they were formula driven?

4 A. If -- if you have an -- basically an
5 if-then statement, if you have an N/A in this
6 cell --

7 Q. Return zero, right?

8 A. I -- I just -- I'd have to look at
9 the -- the -- at the Excel itself.

10 Q. So is it fair that -- this -- Exhibit 6
11 through 10, they do redistribute the weight from
12 the imputed metrics to the other metrics in this
13 workbook, correct?

14 A. Yes, because, again, for each -- for
15 process and structure and then outcome measures,
16 because each of those are a 50/50 weight, each one
17 of those individually, though, has to sum up to
18 100 percent.

19 Q. And would they have been redistributed
20 evenly, the percentages of each of these
21 four individual -- imputed metrics, would they have
22 been redistributed evenly across the remaining
23 metrics?

24 A. They are. And that's how the formula is
25 written.

1 Q. So -- so if one of the other remaining
2 metrics, if their weight went up to reflect the
3 fact that you imputed the four N/As, that would not
4 have been something that you did, correct?

5 A. Again, it -- it should have been formula
6 driven, yeah.

7 Q. Is it possible that -- it sounds like
8 you're saying you may have manually added in the
9 zeros for the four imputed metrics in the Final
10 Weight and Weighted Measured Score column, right?

11 A. I -- I don't want to speculate. To be
12 100 percent sure, I'd want the Excel in front of
13 me.

14 Q. Does your -- do you have an opinion, an
15 expert opinion, on how the redistribution should
16 occur to the remaining metrics?

17 A. I don't have a basis to disagree that an
18 even split was not appropriate.

19 Q. But isn't it possible that the
20 four imputed metrics might relate more closely to
21 some of the remaining metrics than others, such
22 that those metrics should get more of their
23 redistributed weight?

24 MS. WOOD: Objection to form.

25 THE WITNESS: I think -- I think we'd be

1 speculating there. Again, it makes sense to me
2 that if there's no obvious distinction between the
3 measures, that you would equally weight them.

4 If you're going to redistribute some
5 of the weighting, then it would be across all of
6 them, because at this end of the day, each one of
7 these are counted once.

8 BY MR. TAKAGAKI:

9 Q. Beyond what this workbook does when you
10 work with it, so setting that aside, do you have
11 any understanding as to how the weights should be
12 redistributed when metrics are removed from the
13 methodology?

14 A. Again, I think I've testified, I don't
15 have a basis for -- to -- to disagree with an even
16 distribution because, again, what you're getting
17 here is a 50 percent weight on process and
18 structure, right, and a 50 percent weight on
19 outcome measures.

20 And so it's not like you're getting
21 a -- of the 50 percent on outcome measures, that
22 25 percent of that 50 percent is related to air
23 embolism, as an example. They're all being equally
24 weighted in the calculation even before adjustment.

25 So I didn't have a basis or a

1 reasonable basis to somehow weight one more than
2 the other, if that makes sense.

3 Q. Understood.

4 Just noting the last metric here,
5 this PSI 90, that has a 15 percent final weight,
6 right?

7 Do you see that?

8 A. Yes.

9 Q. And that's much higher than any of the
10 other weights in the Final Weight column, correct?

11 A. Yes, but, again, it's the same on
12 Exhibit 1 as it is on Exhibit 6, because we're not
13 adjusting any outcome measures.

14 Q. My question is just if -- if the PSI 90
15 is 15 percent, just the one right above it, PSI 4,
16 that's only 2 percent.

17 Do you see that?

18 A. I do.

19 Q. So it's more than seven times as heavily
20 weighted, compared to PSI 4, correct?

21 A. And according to Leapfrog and their
22 methodology, they thought that was warranted.

23 Q. And so isn't it at least reasonable to
24 suggest that if you're going to delete the
25 four imputed metrics, maybe a larger portion of

1 their weight should go to PSI 90, given it's
2 already seven times as high as PSI 4?

3 A. No.

4 MS. WOOD: Objection to form.

5 THE WITNESS: No, because the four imputed --
6 the removal of the four imputed metrics has nothing
7 to do -- has no impact on the outcome measures
8 calculation.

9 BY MR. TAKAGAKI:

10 Q. Right. But it's my understanding, is
11 you're saying let's take out four metrics out of
12 the 22 that are listed here, correct?

13 A. Correct.

14 Q. And so I'm wondering if taking those
15 four out, if some of the remaining metrics should,
16 you know, continue to get a larger percentage of
17 the weight because those other metrics are, you
18 know, so much more?

19 A. I don't know. Maybe we're talking past
20 each other. When you just talked about PSI 90,
21 that is in a separate bucket of the overall grade,
22 so that does not change.

23 Q. Well, even just for the others, I mean,
24 you know, foreign object retained or air embolism,
25 they have a four -- or sorry -- foreign object

1 retained, that's a 4.2 percent. But the one right
2 below it, air embolism, is 2.4 percent. So, you
3 know, we're not quite doubled, but it's -- it's a
4 pretty big difference between those two, right?

5 A. Again, I don't have a basis to
6 reasonably re-weight them. So as a result, I kept
7 the original assumption.

8 Q. So I guess that's my question. Do you
9 have -- so my understanding is your methodology
10 here ultimately resulted in the weights being
11 evenly distributed. Is that fair to say?

12 A. The redistribution, yes, was even.

13 Q. And do you know if there's -- if that
14 specific methodology, removing these four and then
15 redistributing their weights evenly, is supported
16 by any literature on the topic?

17 A. I think it's supported by Leapfrog and
18 their advisors that put this together.

19 Q. Other than Leapfrog, do you know if any
20 literature has come out supporting your method of
21 removing the four metrics and then redistributing
22 their weight to the remaining?

23 A. I'm not aware of literature that would
24 suggest this is in any way, shape or form improper.

25 Q. Are you aware of any literature that

1 supports it?

2 A. I didn't necessarily focus on trying to
3 cite this methodology to the literature. I'm just
4 not aware, from a statistical perspective, any
5 reason why an even redistribution would be
6 improper.

7 Q. If you could just answer my question,
8 that will help a lot. Just are you aware of any
9 literature that endorses this method?

10 A. Again, I think I answered your question.
11 I did not --

12 Q. It's a yes-or-no. Are you aware? Yes
13 or no?

14 A. I'm not aware of it because I did not
15 effort undertake to that.

16 Q. That's okay. I don't need to know why
17 you didn't know, just that you're aware of any.

18 Now, are you aware of the error rate
19 associated with this methodology of -- that we've
20 been discussing?

21 A. Again, you brought that up this morning.
22 I don't think there is an error rate because you
23 are removing.

24 Q. So is that a no?

25 A. That's a no.

1 Q. Okay. Are you aware of whether the
2 plaintiff in this case has advocated for this
3 method of removing the four scores or
4 redistributing them evenly?

5 A. I don't have a specific recollection one
6 way or the other.

7 Q. And are you aware of whether Leapfrog
8 has ever considered that -- using that method as
9 their own imputation method?

10 A. What method?

11 Q. The method that you've used.

12 A. I am using their method.

13 Q. Well, that's not their current 2024
14 imputation method, right? Their current 2024
15 imputation method is to assign the limited
16 achievement scores.

17 A. Sure. I would --

18 Q. Would you agree with that? Strike that.
19 I'll strike that.

20 They've never -- Leapfrog has never
21 actually had their safety grade method do what you
22 have done in Exhibit 6 through 10?

23 A. I disagree with that.

24 Q. So --

25 A. It's --

1 Q. What --

2 A. It's --

3 Q. Well, strike that.

4 Have they ever issued a grade to a
5 hospital that was based on the method in Exhibits 6
6 through 10 of removing those four and
7 redistributing the weights evenly?

8 A. Right. Definitely redistributing the
9 weights. You see --

10 Q. I'm not -- specifically, what you did in
11 6 through 10 -- you know what you did in 6 through
12 10, right? You added the N/As to take out those
13 four metrics, and you redistributed the weights
14 evenly. I'm asking if a hospital has ever been
15 actually graded that way by Leapfrog?

16 A. Yes. I think it's --

17 Q. Where?

18 A. In Exhibit 1.

19 Q. In what year?

20 A. It's right here.

21 Q. I don't -- so in Exhibit 1 -- your
22 testimony is Exhibit 1 has N/As for the imputed
23 metrics?

24 A. It's not for imputed metrics.

25 Q. I'm talking about the imputed metrics.

1 You have four N/As for the imputed metrics. If
2 they did, I don't understand your exercise. You're
3 doing something --

4 A. I'm saying I'm doing something
5 consistent with what they've done.

6 Q. Consistent?

7 A. Yes.

8 Q. The question is -- my understanding in
9 this case is that they have -- Leapfrog has never
10 actually issued a safety grade based on your
11 methodology of using "N/A" for the four imputed
12 metrics. Do you agree with that statement?

13 A. I can't speak because I haven't seen
14 every single grade that they've ever done. My
15 analysis, by the way, is a little bit different.
16 My analysis demonstrates that the four -- the four
17 imputed are not the ones that are driving the
18 grade.

19 Q. I'm not asking about your analysis. I'm
20 asking about your methodology. And when I say
21 "methodology," maybe I should define that. Your
22 act of adding "N/A" for four imputed metrics here,
23 and really that's it. And I guess you're not sure
24 whether you went back and manually changed the
25 weighting or if that happened automatically. But

1 that is my definition of "methodology." Do you
2 follow that?

3 A. I disagree with the way you're
4 characterizing that. My methodology is exactly the
5 same as the methodology that's represented in
6 Exhibit 1. Your issue is it's being applied to
7 different measurements than the ones that's in
8 Exhibit 1.

9 Q. Has Leapfrog ever issued a safety grade
10 where N/A was listed for CPOE?

11 A. Again, I've only focused on these five.
12 I haven't seen the grades for -- so I can't
13 possibly --

14 Q. Have they; yes or no?

15 A. I don't know.

16 Q. Okay. Have they ever issued a grade
17 with N/A for BCMA?

18 A. I don't know.

19 Q. To your understanding, have they ever
20 issued a grade to a hospital with N/A for IPS?

21 A. I don't know.

22 Q. Have they ever issued a grade to a
23 hospital with N/A for hand hygiene?

24 A. Again, I have not reviewed all 3,000
25 hospital grades. I've been focused on the ones at

1 issue here.

2 Q. Did you ask counsel whether they've ever
3 done that?

4 A. I don't think it's relevant.

5 Q. The question is: Did you ask counsel;
6 yes or no?

7 A. No, I didn't ask counsel.

8 Q. In these calculations in Exhibits 6
9 through 10, what I'll call the workbooks that you
10 created, were they done assuming that the other
11 roughly 3,000 hospitals were graded according to
12 Leapfrog's current imputation methodology?

13 MR. MODI: Objection to form.

14 THE WITNESS: I'm not sure I follow your
15 question.

16 BY MR. TAKAGAKI:

17 Q. I guess my question is -- I'll represent
18 to you that there are other hospitals that don't
19 participate in the survey beyond the five Plaintiff
20 Hospitals.

21 A. Okay.

22 Q. Is your expert opinion based on those
23 other hospitals who don't participate also being
24 graded the same way that you've done in 6 through
25 10 with the N/A metrics inserted?

1 A. Again, I -- I didn't analyze the grades
2 for any other hospitals other than these five.

3 Q. So like if -- if -- wouldn't the mean
4 score change -- even in your scenario where just
5 the five Plaintiff Hospitals now get the N/As, the
6 mean score in the mean column would -- would be
7 altered slightly, right?

8 MR. MODI: Object to form.

9 THE WITNESS: Not according to Leapfrog's
10 methodology. That's a stacked number that they
11 published in their -- the corresponding associated
12 documents.

13 BY MR. TAKAGAKI:

14 Q. So the static number, let's say for the
15 first row, 80.23, that represents the mean of
16 all -- what all hospitals received for that score;
17 is that right?

18 A. My understanding of those that report,
19 yes.

20 Q. All right. You can't compare for
21 other -- for other hospitals that don't
22 participate. So for other nonparticipating
23 hospitals, if they do receive the limited
24 achievement scores, so they receive the scores on
25 page 10 of your report, you couldn't do a direct

1 comparison with the five Plaintiff Hospitals under
2 your Exhibit 6 through 10, correct?

3 MR. MODI: Objection to form.

4 THE WITNESS: I -- I think you can. That's,
5 in part, what the Z-score is intended to do.

6 BY MR. TAKAGAKI:

7 Q. So if -- if in your Exhibit 6 through
8 10, the five Plaintiff Hospitals get N/As for four
9 metrics and the other nonparticipating hospitals
10 continue to get the limited achievement scores,
11 wouldn't they not be -- be measured on the same
12 apples-to-apples comparison?

13 MR. MODI: Objection.

14 THE WITNESS: No. I think there's natural
15 differences regardless depending on who's reporting
16 what. For example, again, if you go back to
17 Exhibit 1, they have three N/As in here. That
18 doesn't necessarily mean that another hospital
19 doesn't have data in there.

20 BY MR. TAKAGAKI:

21 Q. Right. But -- that's Exhibit 1. I
22 think you're misrepresenting that. The exhibit has
23 N/As, but it's not for anything that -- any of the
24 metrics we've been talking about today, right?
25 It's not for the four imputed metrics?

1 A. It's -- it's not for the four, but
2 that's the point of the analysis.

3 Q. Right. So in Exhibit 1, right, the --
4 instead of N/A for CPOE, you have 15. And -- and
5 the same for BCMA, IPS and hand hygiene, you have
6 this imputed metric scores.

7 So what I'm trying to understand is
8 if -- if nonparticipating hospitals are given, say,
9 a 15 in CPOE and they get a weight assigned to that
10 15, but the Plaintiff Hospitals are given N/A and
11 they get no weight assigned to that, and the
12 weights of everything else goes up, are you --
13 necessarily, you're not measuring those two
14 hospitals on an apples-to-apples comparison
15 anymore, right?

16 MR. MODI: Objection to form.

17 THE WITNESS: Nowhere in my report do I do a
18 comparison of hospitals. My report, I think, is
19 very straightforward what this analysis is intended
20 to do. It is to demonstrate that the four imputed
21 measures are not the driver of the low grade.

22 BY MR. TAKAGAKI:

23 Q. But I -- I'm trying to -- do you
24 disagree with my question?

25 A. I'm not sure I understand your question.

1 Q. My question is: How can you -- strike
2 that.

3 Isn't it true -- well, let's put that
4 to the side for a second.

5 If the Plaintiff Hospitals in this
6 case had participated in the survey, they would
7 have received scores at least for the four imputed
8 metrics that are different from the N/A scores that
9 you gave them in Exhibits 6 through 10, correct?

10 A. I don't know that. I don't -- I don't
11 know what they would have reported.

12 Q. Well, if they -- if they had reported
13 any amount of data, do you agree that they would
14 have at least been given a numerical score for that
15 data?

16 A. Well, in -- in Exhibits 1 through 5,
17 they are given a numerical score. I don't know if
18 it would be different.

19 Q. I'm not asking if they'd be different.
20 I'm asking if they participated in a survey,
21 submitted their data on CPOE, for example.

22 Can we at least agree that they would
23 be given a numerical input for CPOE in these
24 workbooks?

25 MR. MODI: Objection to form.

1 THE WITNESS: If they participated in the
2 survey, it sounds like they would.

3 BY MR. TAKAGAKI:

4 Q. Right. And so their grade for the CPOE
5 input would be different than the N/A that they
6 currently have in Exhibits 6 through 10, correct?

7 A. Yes, by definition.

8 Q. Right, exactly. So if they had
9 participated, they would have received different
10 grades for the four imputed metrics that you've
11 given in Exhibits 6 through 10, correct?

12 A. You -- you keep saying it's a grade I'm
13 giving them. It -- that's not what 6 through 10 is
14 intended to do. It is simply to demonstrate that
15 by include -- by getting those four grades for the
16 imputed, that's not the primary driver of the
17 grade.

18 That's all this analysis is intended
19 to do is, if you -- if you thought these were
20 downwardly biased, right, that's not what -- if you
21 take them out of the analysis, that's not what's
22 driving.

23 Those four grades are not what's
24 driving the overall grade. As evidenced by of all
25 the other data points, you still get a similar

1 grade.

2 MR. TAKAGAKI: Move to strike as
3 nonresponsive.

4 BY MR. TAKAGAKI:

5 Q. Please answer the questions I'm asking
6 instead of going on with these speeches saying what
7 the purpose of some was. I -- I really just --
8 and -- and I want to be as sort of direct here as
9 possible.

10 I just want to understand, from your
11 perspective, if they -- if the five Plaintiff
12 Hospitals participated in the survey, do you agree
13 that they would have a score that's -- for the
14 four imputed metrics, that is different than the
15 N/A scores that they have in Exhibits 6 through 10?

16 A. They would be included in the overall
17 weighting, so yes, that's the answer. That's just
18 math.

19 Q. Well, and they would have an actual
20 score, right? In Exhibit 1, for example, CPOE is a
21 15.00.

22 Do you agree?

23 A. Yes.

24 Q. And then in Exhibits 6 through 10, the
25 score for CPOE is not 15.0. It's N/A, correct?

1 A. It -- it -- you --

2 Q. Do you -- is that -- did I describe it
3 correctly?

4 Yes or no?

5 A. That is the input, but the -- the point
6 of it is, it's simply the mechanics to -- to give
7 it no weight in the calculation, to demonstrate
8 that that score and the other three imputed is not
9 what's driving the low score, because if you take
10 them out, you don't give them any weight
11 whatsoever, all the remaining other measurements
12 indicate the same type of score.

13 Q. And now, if -- if -- using Exhibit 1 as
14 an example. If Delray had participated in the
15 survey for CPOE and instead of receiving a 15.00,
16 received a 17.00, is that different than N/A that
17 you have for CPO in Exhibits 6 through 10?

18 A. All it would mean is that you're giving
19 an actual weighting to it.

20 Q. Well, they would have an actual score,
21 right? They would be getting 17.00 as opposed to
22 getting an N/A, right?

23 A. Yeah, I mean, I think we're saying the
24 same thing. I'm just --

25 Q. Well, just, is that yes or a no?

1 A. Yes --

2 Q. 17.00 is different from N/A?

3 A. Correct. And as a result, it's being
4 considered in the overall calculation.

5 Q. Right. So if they participated, if
6 Delray, using this example, participated and their
7 CPOE score was a 99.00, that would be different
8 than N/A, which is in Exhibits 6 through 10; is
9 that correct?

10 A. That is correct.

11 Q. Okay. And if they participated and got
12 a 99.0 for CPOE -- strike that.

13 I want to go back to just get some
14 questions we had --

15 A. Can we take five minutes?

16 Q. Oh.

17 A. We've been going a while.

18 Q. Yes, of course.

19 THE VIDEOGRAPHER: We are going off the record
20 at 5:35 p.m. with the end of Media No. 6.

21 (Short recess.)

22 THE VIDEOGRAPHER: We are back on the record
23 at 5:43 p.m. with the beginning of Media No. 7.

24 Counsel, you may proceed.

25

1 BY MR. TAKAGAKI:

2 Q. So, Mr. Rule, have you dealt with
3 imputation in any of your prior cases that you've
4 worked on?

5 A. I -- I don't know if it was called
6 "imputation," but -- I -- I don't think so, in --
7 in at least in the context that's being used here
8 by Leapfrog, where they're effectively assigning
9 grades when data doesn't exist.

10 So with that qualifier, I think the
11 answer is probably no.

12 Q. And have you ever worked previously in
13 any of your cases on using an algorithm to give
14 hospitals some type of a grade or rating?

15 A. No, I think I testified earlier that as
16 it related to hospital grades, you know, I have --
17 I have not given grades.

18 And in this regard, I'm not giving a
19 grade. I'm simply illustrating the impact on the
20 existing analysis, if one thinks that the impute --
21 imputed numbers are too low.

22 Q. Have you ever done any previous work
23 prior to this case involving using an Excel
24 workbook to calculate a grade or a hospital?

25 A. No, again, I think I just testified that

1 I haven't had prior cases where I've calculated
2 grades for hospitals, and -- and I'm not doing that
3 in this case either.

4 Q. And you might have testified to this
5 already. But for -- for what you actually did
6 going into the workbooks, is that something that
7 hospitals can do themselves?

8 A. I can't speak for the hospitals
9 themselves, but it does require some level of
10 sophistication with both Excel and statistics, to
11 be able to understand the model, how it works, and
12 if one were to make a change to the model, if
13 that's -- results in reliable output, if you will.

14 Q. I just -- and I'm not talking about most
15 of them. I'm just asking, in terms of opening up
16 the Excel and inserting scores into the column,
17 titled Enter Your Score Here, is that something
18 that employees of hospitals could do themselves?

19 A. Presumably.

20 Q. I believe you testified even that the
21 purpose of this document was for hospitals to be
22 able to fill in scores into that column, correct?

23 A. Yeah. It's for them to be able to
24 synthesize their scores to see what the resulting
25 letter grades may or may not be, you know, similar

1 to the analysis of -- oh, why am I drawing a blank?
2 You kept calling him the doctor.

3 Q. Nicholson.

4 A. Nicholson. It -- it's a similar
5 flavor-type of analysis. He's assigning different
6 grades and letting the model run. I'm simply
7 saying what was just the impact by including this?
8 Does -- does anything really change?

9 Q. Yeah, and not to minimize what you're
10 doing, but in terms of actually opening Excel and
11 inserting N/A to the four imputed metrics, my
12 question is just, you know, could somebody from a
13 hospital do that exact same action?

14 A. In theory, someone could, but there's an
15 add -- extra layer here about understanding and
16 make sure it functions and make sure that the
17 z-scores are -- are updating appropriately, the
18 weighting is -- is being calculated appropriately.

19 So one could obviously input new
20 numbers into a cell and have a different grade.

21 Q. And I understand you're -- you're
22 testifying that you brought a certain understanding
23 of making sure it was done accurately.

24 But, you know, Leapfrog, I think it's
25 your testimony, is that they intend for hospitals

1 to use this Excel in the same way that you have, in
2 the sense of inputting numbers into the Enter Your
3 Scores Here column, correct?

4 A. Yeah, for some of those, it's -- it --
5 it gives the hospital an ability to synthesize
6 potential grades.

7 Q. Right. And I think earlier you've said
8 essentially what you were doing was a sensitivity
9 analysis for potential grades, right?

10 A. I think very similar to plaintiffs'
11 experts, yes. It's a sensitivity of if one makes
12 this assumption, you know, in my analysis, how
13 impactful were the imputed grades?

14 Q. And as part of your exercise here,
15 you've created a counterfactual; that is, what if
16 the Plaintiff Hospitals did not receive the limited
17 achievement scores, correct?

18 A. I don't know if I'd agree with it's
19 counterfactual, because, again, I'm not saying that
20 these are the grades that they would be awarded.
21 What I'm simply saying, the impact of including
22 those four on the overall score was immaterial
23 because you have so many other data points.

24 That all it's trying to illustrate,
25 that if -- if you think that those imputed scores

1 are too low, all else equal, what was the overall
2 impact on the overall grade by including those.

3 And the grade doesn't change based on
4 their model and adjustments to it, which is -- is,
5 to me, indicates that, again, those four individual
6 data points were not a material driver of the
7 overall score.

8 Q. Understood.

9 My only -- my point is: Currently,
10 the actual grading methodology that Leapfrog uses
11 for the current round of grades does not use the
12 methodology you used with the N/As in Exhibit 6
13 through 10, right?

14 A. It's not for the imputed, but obviously
15 the concept of N/As in re-weighting is something
16 that's very much they do.

17 Q. I'm not talking about the concept. I
18 just mean for the literal actual scores for the
19 four imputed metrics, they do not use N/A in their
20 current grades, correct?

21 A. Well, it's my understanding that their
22 policy is that if they don't have the data, they'll
23 use imputed, right?

24 Q. Right.

25 A. Are they consistent about that? I can't

1 necessarily analyze that because I've been focused
2 on these five.

3 Q. Fair enough. And for hospitals
4 currently in their real world, the hospitals that
5 do participate in the survey are graded in a
6 slightly different way from how you did the
7 calculations in Exhibits 6 through 10, correct?

8 MR. MODI: Objection; form.

9 THE WITNESS: I'm not sure I follow.

10 BY MR. TAKAGAKI:

11 Q. So hospitals that do participate in the
12 survey, they are given actual scores for the
13 four imputed metrics, so to say that 75, 83, et
14 cetera, as examples, but in your Exhibits 6 through
15 10, they're given N/A.

16 So my point is just there's a
17 difference there, where -- there's a difference
18 there, correct?

19 MR. MODI: Objection; form.

20 THE WITNESS: Yeah, but, again, I just want to
21 make sure I'm clear.

22 BY MR. TAKAGAKI:

23 Q. There's a difference there.

24 A. There is, but that's not the point of
25 the analysis.

1 Q. Don't worry about the point of your
2 analysis. That's clear. I just -- they're just my
3 own questions. And you have a duty to just answer
4 my questions. You don't -- you're not here to
5 explain the point of your analysis. You're here to
6 answer my questions.

7 And I would respectfully ask you to
8 do that just for the last few minutes we have.

9 It's correct, right, that for
10 hospitals that do participate in the survey today,
11 they are given scores for the four imputed metrics
12 that are based on the data that they report to
13 Leapfrog, correct?

14 A. That would be --

15 MR. MODI: Objection; form.

16 THE WITNESS: That would be different than the
17 imputed values that they're given, yes, because
18 that's the point of the -- the imputation, is they
19 don't have data.

20 BY MR. TAKAGAKI:

21 Q. Is that a yes?

22 A. Yes.

23 Q. Okay. And the -- and -- and for those
24 hospitals that do participate, the data they're
25 given that -- sorry -- the score they're given by

1 Leapfrog for the four imputed metrics is based on
2 what their submission to Leapfrog is, correct?

3 A. Presumably, yes.

4 Q. Presumably, yeah.

5 And in the 6 to 10 -- Exhibits 6 to
6 10 in your report where the five Plaintiff
7 Hospitals, they get an N/A for the four imputed
8 metrics, that is not based on their actual real
9 life performance on the four imputed metrics if
10 they were to submit it, correct?

11 MR. MODI: Objection; asked and answered.

12 THE WITNESS: Again, I -- I don't know what
13 they'd report, but presumably, they'd have some
14 value there, and as a result, it would be taken
15 into account as part of the weighting.

16 BY MR. TAKAGAKI:

17 Q. Right. And so you would agree, under
18 your method in Exhibits 6 through 10, the five
19 Plaintiff Hospitals are graded differently than how
20 participating hospitals are graded, correct?

21 A. In 6 through 10 or 1 through 5?

22 Q. Exhibits 6 through 10.

23 A. Again, I hesitant -- hesitate on the
24 grade aspect of that because, again, I'm not
25 regrading them. I'm simply just trying to

1 illustrate the impact. That being said, yes, if
2 you had some data in those cells, the numbers could
3 be different.

4 Q. Right. And in Exhibits 6 through 10,
5 the -- the four imputed metrics, their weighting is
6 zero percent, correct?

7 A. Yes, in an effort to illustrate the
8 impact.

9 Q. And for participating hospitals in the
10 current survey, the weight that they have for those
11 four imputed metrics is not zero percent, correct?

12 A. Assuming that they have --

13 Q. Participating hospitals.

14 A. Well, even if -- in imputation, if you
15 have value in there, it's going to get -- it's
16 going to get weighted.

17 Q. I should be clear. When I mean
18 participating hospitals, I mean hospitals that
19 submit data to Leapfrog. So they don't get
20 imputation at all, they just get their actual
21 scores.

22 Do you understand that concept as how
23 I explained it?

24 A. Yes.

25 Q. So under that definition of

1 participating hospitals that actually submit their
2 data to Leapfrog and are given a score for the four
3 imputed metrics that is based on their submissions,
4 they have weights assigned to those four imputed
5 metrics, correct?

6 A. Correct.

7 Q. And in Exhibits 6 through 10 for those
8 four imputed metrics, the Plaintiff Hospitals have
9 no weights assigned or have zero weights assigned
10 for those imputed metrics, correct?

11 A. Yes, they've been excluded from the
12 calculation.

13 Q. So the way that the -- so is it true
14 that the way that the five Plaintiff Hospitals are
15 graded in Exhibits 6 through 10 has a different
16 weighting for the 22 metrics than -- than hospitals
17 that do participate in the survey?

18 MR. MODI: Objection; form.

19 THE WITNESS: I -- I can't comment on if the
20 weighting would be the same or different because I
21 haven't analyzed --

22 BY MR. TAKAGAKI:

23 Q. But you know that the four imputed
24 metrics, they have an applicable weight if -- if
25 they participate, it's, you know, 5 percent or

1 6 percent?

2 A. That's my issue. I don't know what the
3 weight would be, but there would be some weight.

4 Q. Right. Well, I mean, you know that in
5 Exhibit 1, you know that the weight for B -- CPOE
6 is, you know, 7.9 percent, the BCMA at 7.7 percent,
7 right, under each of the final weight columns on
8 Exhibit 1?

9 MR. MODI: Object to form.

10 THE WITNESS: Yes, but at the same time, the
11 weighting could be different because the Z-score
12 could be different.

13 BY MR. TAKAGAKI:

14 Q. But the weight surely would not be zero
15 percent for a participating hospital, right?

16 A. I would not expect it to be zero. If
17 you have a value in there, there would be some
18 weighting to it.

19 Q. So the weights are different for
20 participating hospitals currently and the weighting
21 you give in Exhibits 6 through 10, correct?

22 A. I think the weight is different for all
23 hospitals. But, yes, I think we've been over this.
24 For the imputed ones, I assigned no weighting to be
25 able to illustrate the impact on the Leapfrog

1 grade.

2 Q. Are you aware that the Leapfrog A, B, C,
3 D, the Leapfrog letter grade system is based on --
4 on the distribution of the curve of hospitals that
5 participate in the survey?

6 A. That was my general understanding.

7 Q. Are you aware that under Leapfrog's
8 current methodology, most of the hospitals that
9 participate are given a C, that's sort of the
10 largest part of the curve?

11 A. It wouldn't -- I don't know that
12 specifically, but it wouldn't surprise me if -- if
13 C is considered the -- the average.

14 Q. And is it your understanding that if a
15 significant portion of hospitals stop receiving
16 grades, that the distribution of grades or
17 hospitals could be altered by that?

18 MR. MODI: Objection to form.

19 THE WITNESS: I would expect that if you have
20 fewer hospitals participating, that the mean and
21 the standard deviation could change because you
22 have a different data set.

23 BY MR. TAKAGAKI:

24 Q. That's exactly what I'm getting at.

25 If -- I think we talked about there's

1 about 3,000 hospitals that participate in the
2 survey, at least according to your report, nearly
3 3,000.

4 If, say, 2,000 suddenly stopped
5 participating and receive the N/A score that you're
6 doing in Exhibits 6 through 10, would that change
7 the distribution of the -- of the curve?

8 MR. MODI: Objection; form.

9 THE WITNESS: It depends what's left of the
10 thousand and what those -- what those scores are.

11 BY MR. TAKAGAKI:

12 Q. But it could change them because,
13 obviously, you have many hospitals who are not
14 getting graded at all or getting grades much lower
15 than currently, right?

16 A. Well, it -- it depends on -- again, the
17 way it would manifest itself is in the calculation
18 of the mean and the standard deviation. So with a
19 different data set, yeah, the -- the conclusion, as
20 it relates to the mean or the standard deviation,
21 could change, but I don't know directionally which
22 way it would change.

23 Q. Are you regrading the hospitals in
24 Exhibits 6 through 10?

25 A. No. I'm showing that the -- the four

1 imputed values were not a significant driver of the
2 overall grade.

3 Q. But you are -- one result of -- strike
4 that.

5 If you go to Exhibit 6 through 10,
6 there is a grade on the bottom of the Excel,
7 correct?

8 A. There is, as a function of the workbook.
9 And by comparing the grades, by removing the
10 imputed, right, if -- if -- say --

11 Q. Can I just stop you? It's just a yes or
12 no, and I think you've said it was yes, so I'm just
13 going to stop you there because you've answered the
14 question, and I want to save you time and energy.

15 So I think you've said, yes, there is
16 a grade at the bottom of your Excels in 6 through
17 10.

18 And in some cases, the grade there is
19 different from the grades in -- in Exhibits 1
20 through 5, correct?

21 A. I think they're all the same except for
22 one that actually goes down.

23 Q. Right. One grade step, correct.

24 So in that sense, you are regrading
25 at least that one hospital because it has a

1 different grade than it was given actually,
2 correct?

3 A. Again, I'm not concluding that the
4 grades would be the same. I'm simply saying that
5 the inclusion or exclusion of the -- of the four
6 imputed measurements don't have an impact on the
7 resulting grade.

8 That's the point of the analysis.

9 Q. Isn't one purpose of a grading -- a
10 hospital grading or rating system to be able to
11 compare one hospital to another?

12 A. In theory.

13 Q. To compare, you know, such-and-such
14 hospital has an A, such-and-such hospital has a C,
15 we're going to compare the two, correct?

16 A. I think that's part of the exercise.

17 Q. And isn't it important, for that
18 exercise, for the hospitals to all be graded on the
19 same methodology for that to work?

20 MR. MODI: Objection; form.

21 THE WITNESS: I mean, yes, that's the purpose
22 of the model, that you're applying -- or a hospital
23 can apply or Leapfrog can apply depending on
24 whatever disparate set of data they have, right,
25 because we're not talking about the same data sets

1 or every single hospital having all 22
2 measurements. But, yes, that's -- that's the
3 purpose of this. It is a consistent methodology
4 with disparate data.

5 BY MR. TAKAGAKI:

6 Q. And I believe your report said that the
7 methodology uses a roughly 50/50 split between the
8 two types of measures in the methodology, correct?

9 A. That's correct.

10 Q. If Leapfrog were to say that certain
11 hospitals were going to get an 80/20 split in
12 weights, but another group of hospitals will get a
13 50/50 split, would that make it harder to compare
14 those two groups of hospitals because they now have
15 different methodology -- methodologies?

16 MR. MODI: Objection; form.

17 THE WITNESS: I mean, if -- if Leapfrog was to
18 do that, it would be presumably based on a
19 reasonable basis here. But if the goal is an
20 overall safety grade, and Leapfrog felt there was a
21 reason to treat them different, I think the
22 comparability is the same.

23 BY MR. TAKAGAKI:

24 Q. I'm not saying that -- my question is
25 not if there's a reason to do so. Maybe it's a

1 typo or an accident.

2 But if came -- if the -- if you saw
3 that some hospitals were graded using the
4 80/20 percent split for the structure measures was
5 the process measures and outcome measures, and
6 other hospitals were graded on a 50/50 split, would
7 you agree that it would be harder to compare
8 hospitals in that scenario because they have
9 different grading methodologies?

10 MR. MODI: Objection; form.

11 THE WITNESS: It's -- it's possible that --
12 it -- it depends because, again, for process and
13 structure versus outcomes, it's not like we have a
14 data point for every single one of the 22. So it's
15 possible that a comparison would be more difficult,
16 assuming that Leapfrog went ahead with that
17 methodology.

18 MR. TAKAGAKI: I think I have no further
19 questions.

20 MR. MODI: Nothing from me.

21 THE VIDEOGRAPHER: Thank you, counsels.

22 We are going off the record at
23 6:02 p.m. with the end of deposition of Mark Rule.

24 The total number of media used today
25 was seven and will be retained by Veritext.

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FURTHER DEPONENT SAITH NAUGHT
(Proceedings concluded at
6:02 p.m.)

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ERRATA SHEET

I, MARK RULE, have read the foregoing transcript of my deposition taken on September 29, 2025, and except for any corrections noted below, it is a true and correct transcript of my deposition given on the date aforesaid.

CORRECTIONS BASED ON ERRORS IN
REPORTING OR TRANSCRIPTION

PAGE LINE

MARK RULE

STATE OF ILLINOIS)
COUNTY OF)
Subscribed and sworn to before me
this day of , 2025.

[Seal]

Notary Public

Page 386

1 STATE OF ILLINOIS)
2) SS:
3 COUNTY OF COOK)

4 I, Valerie M. Calabria, CSR, RPR, do
5 hereby certify that MARK RULE was duly sworn by me
6 to testify the whole truth, and that the foregoing
7 deposition was recorded stenographically by me and
8 was reduced to computerized transcript under my
9 direction, and that the said deposition constitutes
10 a true record of the testimony given by said
11 witness.

12 I further certify that the reading
13 and signing of the deposition was not waived, and
14 that the deposition was submitted to Ms. Courtney
15 L. Wood, Defendant's counsel, for signature.
16 Pursuant to Rule 30(e) of the Federal Rules of
17 Procedure, if deponent does not appear or read and
18 sign the deposition within 30 days, the deposition
19 may be used as fully as though signed, and this
20 certificate will then evidence such failure to
21 appear as the reason for signature not being
22 obtained.

23 I further certify that I am not a
24 relative or employee or attorney or counsel of any
25 of the parties, or a relative or employee of such
attorney or counsel, or financially interested
directly or indirectly in this action.

IN WITNESS WHEREOF, I have hereunto
set my hand this 1st day of October, A.D. 2025.



Valerie M. Calabria, CSR, RPR
Illinois CSR License 084-003928

1 Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group
2 Mark Rule Job No. 7621573
3 E R R A T A S H E E T
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23 _____
24 Mark Rule Date
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1 Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group
2 Mark Rule 7621573

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Mark Rule, do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10
11 _____
12 Mark Rule

Date

13 *If notary is required

14 SUBSCRIBED AND SWORN TO BEFORE ME THIS

15 _____ DAY OF _____, 20____.

16
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19 NOTARY PUBLIC
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courtney.wood@wilsonelser.com

October 1, 2025

RE: Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group

DEPOSITION OF: Mark Rule 7621573

The above-referenced witness transcript is available for read and sign.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those on the attached Errata Sheet.

The witness should sign and notarize the attached Errata pages and return to Veritext at errata-tx@veritext.com.

According to applicable rules or agreements, if the witness fails to do so within the time allotted, a certified copy of the transcript may be used as if signed.

Yours,

Veritext Legal Solutions

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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EXHIBIT 9

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION
CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

VIDEO-RECORDED VIDEOCONFERENCE DEPOSITION OF
MICHAEL VREDENBURGH
San Diego, California
Tuesday, September 30, 2025
Volume 1

Reported by:
LESLIE JOHNSON
RPR, CCRR, CSR No. 11451
Job No.: 7616281
PAGES 1 - 317

IN THE UNITED STATES DISTRICT COURT
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Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

VIDEO-RECORDED VIDEOCONFERENCE DEPOSITION OF
MICHAEL VREDENBURGH, Volume 1, taken on behalf of
Plaintiffs, at 401 West A Street, Suite 1900, San Diego,
California, beginning at 9:04 a.m. and ending at
5:21 p.m., on Tuesday, September 30, 2025, before
LESLIE JOHNSON, Certified Shorthand Reporter No. 11451.

1 APPEARANCES:

2
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18 Also Present:

19 BENJAMIN ZICCARDI, Videographer

I N D E X

WITNESS EXAMINATION

MICHAEL VREDENBURGH

Volume 1

BY MR. CRAIN 8, 309

BY MS. WOOD 308

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MICHAEL VREDENBURGH

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1 San Diego, California, Tuesday, September 30, 2025

2 9:04 a.m.

3
4 THE VIDEOGRAPHER: Good morning. We are
5 going on the record at 9:04 a.m. Pacific Time on
6 September 30, 2025. Please note that the
7 microphones are sensitive and may pick up whispering
8 and private conversations. Please mute your phones
9 at this time. Audio and video recording will
10 continue to take place unless all parties agree to
11 go off the record.

12 This is Media Unit 1 of the video-recorded
13 deposition of Michael Vredenburg taken by counsel
14 for Plaintiff in the matter of "Good Samaritan
15 Medical Center, Inc., et al." versus the Leapfrog
16 Group, filed in the United States District Court for
17 the Southern District of Florida, West Palm Beach
18 Division, Case No. 9:25-CV-80526-DMM.

19 The location of the deposition is 401
20 West A Street, Suite 1900, San Diego, California
21 92101.

22 My name is Benjamin Ziccardi, representing
23 Veritext Legal Solutions, and I am the videographer.
24 I am not authorized to administer an oath. I am not
25 related to any party in this action nor am I

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1 financially interested in the outcome.

2 If there are any objections to proceeding,
3 please state them at the time of your appearance.

4 Counsel and all present will now state
5 their appearances and affiliations for the record,
6 beginning with the noticing attorney.

7 MR. CRAIN: Good morning. This is Lee
8 Crain from Gibson Dunn & Crutcher for the
9 plaintiffs. I'm here with my colleague, Adam
10 Garnick.

11 MS. WOOD: Courtney Wood of Wilson Elser
12 on behalf of the defendant, the Leapfrog Group.

13 THE VIDEOGRAPHER: Will the court reporter
14 please introduce herself and administer the oath to
15 the witness, and then counsel may proceed.

16 THE REPORTER: Good morning. Leslie
17 Johnson, License No. 11451.

18 Mr. Vredenburg, please raise your right
19 hand. I'll swear you in before we get started.

20
21 MICHAEL VREDENBURGH,
22 having been first duly sworn, was examined and
23 testified as follows:

24
25 / / / /

EXAMINATION

BY MR. CRAIN:

Q Good morning, Mr. Vredenburg. My name is Lee Crain, and I'm counsel for the plaintiffs, as I said, in this lawsuit, what the videographer read out.

We've not met before today, correct?

A Correct.

Q We met just briefly before the video started, right?

A Yes, sir.

Q And my understanding is you've been deposed, I think, 11 times; is that right?

A Yes.

Q And you've testified at trial twice?

A Yes.

Q So I'm going to go through some ground rules which might be old hat to you, but I want it to be clear for the record, if that sounds fair enough.

A Not a problem.

Q Great.

And before you start, can you state your full name again for the record?

A Michael Vredenburg.

1 Q Have you ever gone by any other names?

2 A No.

3 Q Just in terms of the ground rules, I think
4 you know these, but just in case, you know the court
5 reporter is transcribing our discussion today; is
6 that right?

7 A Yes.

8 Q And you know, you know, we need do our
9 best, at least in this sort of unnatural deposition
10 phase to not talk over each other, correct?

11 A Correct.

12 Q And I'll do my best to let you finish, and
13 you do your best to let me finish, and Leslie will
14 tell us if we're doing a good job; is that fair?

15 A That's fair.

16 Q You understand your oath today is if you
17 were testifying in a court of law?

18 A Yes.

19 Q You understand you need to give audible
20 answers so Leslie can get them down. No shaking,
21 nodding, all that sort of stuff?

22 A That's correct.

23 Q Are you taking any medications today,
24 anything that would impair you from giving truthful
25 testimony?

1 A Just a cup of coffee this morning.

2 Q Fair enough. If anything, that enhances
3 the truth. At least that's any experience.

4 And then the other thing I'll say, just in
5 terms of ground rule, I'm going to assume you
6 understand my questions. They won't all be good, as
7 Courtney has seen from other depositions we've been
8 in.

9 If you have any questions, clarifications,
10 don't hesitate to ask. But I'll assume, if you
11 answer the question, you understand.

12 Fair enough?

13 A Fair enough.

14 Q We talked a little bit about breaks. I'm
15 happy to accommodate any break you need, any break
16 anybody needs. The only thing we'd ask is no break
17 while a question is pending. We'll finish the
18 answer, and then we can take a break, if that sounds
19 good to you.

20 A Yes.

21 Q Great.

22 I assume you know this from your
23 experience, but from time to time, Ms. Wood may
24 object. Unless she instructs you not to and you
25 take that instruction, you'll need to answer the

1 question.

2 Sound fair enough?

3 A Yes.

4 Q Perfect. Okay. We've got that out of the
5 way.

6 Now, starting at the top. So you are
7 currently a retained expert in this case, correct?

8 A Correct.

9 Q And who retained you?

10 A That would be the defense law firm.

11 Q The Wilson Elser firm?

12 A Yes.

13 Q Do you know who originally reached out to
14 you to retain you?

15 A So originally, it was a query through the
16 Expert Institute.

17 Q Okay.

18 A And then I had a Zoom meeting with Kavi.

19 Q With Kavi?

20 A Yeah. I'm not sure his last name.

21 Q Modi?

22 MS. WOOD: Yeah.

23 BY MR. CRAIN:

24 Q Kavi Modi. Okay.

25 And what is the Expert Institute?

1 A It's kind of like a referral agency for
2 expert witnesses, but it's more digitized than most.
3 And I think it's one of the better ones.

4 Q What do you mean "more digitized"?

5 A Like, for some agencies, they'll be kind
6 of a middleman for giving you all of the materials.
7 And they, like, add onto your billing on top of what
8 you're doing. And I don't believe that the Expert
9 Institute does that. They're just like a referral
10 agency where they just help connect people.

11 Q Got it. Okay. So like a matchmaker?

12 A Yeah.

13 Q Now, you are currently the CEO and founder
14 of Cherry Tomato Engineering, right?

15 A Yes.

16 Q Do you have any other current roles beyond
17 testifying expert?

18 A Yes.

19 Q Can you tell us what those are?

20 A Sure. So I am designing and building
21 several different engineering projects and going
22 through the patenting process for them. And the
23 biggest one that most of the other projects rely
24 upon is a 3D printer that's actually larger than
25 this room, the printer. I've got it set up here in

1 San Diego.

2 And I'm on the twelfth iteration of
3 designing that printer. And its purpose is for
4 printing houses and printing buildings. And I take
5 a different approach for that than any company has
6 done before. Instead of printing in concrete, which
7 is typically how the large 3D printers, especially
8 in the Austin area, how they've been going. And
9 they have to get set up and torn down for every
10 single project.

11 My approach is centralized into warehouses
12 and to factories and to print concrete forms rather
13 than the concrete itself, to then have foam forms
14 that get printed in a factory, finished, so the
15 outside and inside are already textured and painted
16 finished, and then set up on site like gigantic Lego
17 blocks. And then concrete is poured into them. And
18 then you have a cost-effective ICF building, which
19 is an insulated concrete-formed building.

20 Q That is super cool. Setting that aside,
21 that's fascinating.

22 So you're a testifying expert, you are the
23 founder and CEO of Cherry Tomato, and you separately
24 work on the 3D printer project; is that right?

25 A Sometimes there can be a little bit of

1 overlap between the expertises. For example, I plan
2 on doing research at The Human Factors and
3 Ergonomics Society.

4 Q Okay.

5 A That kind of melts between the two,
6 between forensics and what I'm doing.

7 So the printer that I use prints in
8 polyurethane foam. And that foam, I believe, has
9 more applications than how it's being currently
10 used. So I am putting together research to coat
11 concrete surfaces with this polyurethane -- sprayed
12 polyurethane foam, and test trip-and-fall
13 biomechanics to evaluate what thickness and how
14 cost-effective that thickness would be for trying to
15 treat surfaces, say like memory care facilities or
16 walkways in areas with people who are more
17 vulnerable, to see if there's a way to reduce
18 damages from trip and falls.

19 Q And you mentioned forensics. What do you
20 mean by that?

21 A Expert witness work.

22 Q Got it. Okay. We'll come to that in a
23 second.

24 So anything else you do? So it sounds
25 like we have testifying, we have Cherry Tomato.

1 Fair to say it's sort of freelance
2 engineering products -- projects?

3 A Yes.

4 Q And freelance research, that sort of
5 thing?

6 A Yes. And I'd say I'm a dad as well. And
7 that's pretty much a full-time job on top of that.

8 Q I can attest to that one too.

9 How old are your kids?

10 A Two months and two years.

11 Q Oh, man. You're in the thick of it. I'm
12 six and three. So I feel like it gets better. That
13 should have been off the record.

14 All right. Let's talk a little bit about
15 your testimony in this case.

16 So what is your rate in this case?

17 A So I can pull up the rate sheet that I
18 have here.

19 Q Uh-huh.

20 A When it gets big, it's a little hard to
21 turn through the pages.

22 So the general rate for this case was \$450
23 an hour. And to my knowledge, the deposition fee
24 rate today is \$600 an hour.

25 Q Okay. Was that -- the deposition fee, was

1 that disclosed in your report?

2 A I don't think it was, actually. I
3 remember reading it last night and thinking "Oh,
4 that probably should have been there."

5 Q Okay. So you're getting \$450 for the
6 report, \$650 for the deposition, correct?

7 A \$600.

8 Q \$600. Sorry.

9 And are you getting a different rate to
10 testify at trial?

11 A No. Also \$600.

12 Q Okay. And then just before we go on, you
13 have a binder in front of you. Before we went on
14 the record, your counsel told me a little bit about
15 what that binder is.

16 Can you, for the record, explain what that
17 binder is?

18 A Sure. So this is just a selection of the
19 discovery that I've decided to print out and have in
20 front of me just for my own reference. I have a
21 couple of highlights here and there.

22 So, for example, on this page, it looks
23 like it is a piece of research that I downloaded and
24 printed out. And I just highlighted something in
25 case we're talking about it. It might be easier for

1 me to reference at some points. Or it was just to
2 help me prepare kind of, depending on how it goes.

3 Q And then the other question, is -- are the
4 documents in your binder everything that's
5 referenced in your appendix or does it --
6 appendices, or do -- are those documents -- are
7 there additional materials in there?

8 A I think that this rate sheet would be the
9 only additional material that I can recall.

10 Q The other thing you showed me before the
11 break, if I can refresh your recollection, were
12 deposition transcripts; is that right?

13 A I think I have two in there.

14 Q Okay. Which ones?

15 A Dr. Sean Nicholson. For some reason, the
16 name is not showing up readily on the front of this
17 one because they're uncertified. So it's not -- it
18 doesn't have the cover page they typically have.

19 Q And you checked the first page where the
20 person gets sworn in?

21 A I didn't see getting sworn in at the
22 beginning.

23 Q Okay.

24 A I am 95 percent sure this is the CEO,
25 Leah.

1 Q Okay. Ms. Binder?

2 A Yeah. But for some reason -- maybe I'm
3 missing a first page, because it's not -- it's not
4 doing the swearing in at the beginning.

5 Q Okay.

6 A But I'm confident that this is for Leah
7 Binder.

8 Q Okay.

9 MR. CRAIN: And I think we mentioned
10 before the break, but I assume counsel is
11 comfortable, on the next break, if we can just take
12 a look through the binder, right?

13 MS. WOOD: Yeah. Correct.

14 MR. CRAIN: So we'll do that.

15 BY MR. CRAIN:

16 Q So you prepared a report, an expert report
17 in this case, correct?

18 A Yes, sir.

19 Q And I handed you -- if you close the
20 binder. And I'm going to ask generally today if we
21 can look at the exhibits we mark. And obviously, if
22 you need a document to refresh, we might have to
23 mark it as an exhibit or we can give you an exhibit.
24 Probably a bunch of things you have in that binder.

25 But generally, so we're on the same page

1 and the record is clear, I'm going to ask you to
2 look at the exhibits.

3 Is that fair enough?

4 A That's totally fair.

5 Q We gave you what's been premarked as
6 Exhibit 1 and Exhibit 2.

7 (Exhibit 1 marked for identification.)

8 (Exhibit 2 marked for identification.)

9 BY MR. CRAIN:

10 Q Do you recognize those documents?

11 A Yes.

12 Q What are those two documents that?

13 A That would be my expert reports and the
14 amendment.

15 Q Great.

16 And did you have anyone help you draft --
17 did you draft these reports? Let's start with that.

18 A Yes.

19 Q Did you have anybody help you draft them?

20 A No.

21 Q Did counsel prepare a draft of the
22 reports?

23 A No.

24 Q Did counsel edit the reports?

25 A I really don't think so. I'd have to

1 recall for this case, but I'm pretty sure no.

2 Q Did anybody from Leapfrog help you prepare
3 these reports?

4 A No.

5 Q Anybody from Leap Frog edit the reports?

6 A No.

7 Q So to the best of your recollection, every
8 word on that page -- on those pages is yours; is
9 that right?

10 A Yes.

11 Q How many hours did you spend preparing
12 each of those documents?

13 A I meant to print that out and have that
14 as -- just after --

15 Q Ballpark is fine.

16 A Typically, for matters like this, it would
17 be 20 to -- probably around 20 hours.

18 Q 20 for both of them or 20 for one, then
19 more for the other?

20 A For both of them. The amendment was
21 short.

22 Q And what was the purpose of the amendment?

23 A So looking over my report, I realized that
24 I had made an error in the computer code that I
25 wrote. It didn't have an impact on the results or

1 the analysis, but there was a bug. And so I was
2 able to identify that and fix it.

3 Q And what was the code you're referencing?

4 A That was to basically produce the charts
5 that are throughout the report, the data analysis.

6 Q Yeah.

7 A I used a software called Python for doing
8 data analysis. It gets used for all sorts of
9 things, but in this case, it was used for data
10 analysis, similar to other softwares like -- another
11 one that's very similar in this case is called R.

12 Q Uh-huh. Okay.

13 And then, to your knowledge, that code has
14 been produced?

15 A Yes. And I have it in the binder as well,
16 if you need it.

17 Q Oh, man. I've never seen a hard copy of
18 code. I might want to take a look at that.

19 Then just to -- I think we know this
20 already, but is your compensation contingent on the
21 outcome of this litigation or any of your opinions?

22 A No.

23 Q What percentage of your income -- we
24 talked about your different roles. What percentage
25 of your income comes from expert work for

1 litigation?

2 A That can really vary, depending on when it
3 is. I would say that -- so I explained my other
4 business right now with the 3D printing. So right
5 now, that is prerevenue. And so right now, my focus
6 within, I'd say the last three to four months, it's
7 been mostly on forensics for income. But it's
8 been -- it hasn't really been primary before that.

9 Q And "forensics" means litigation expert
10 work; is that right?

11 A Yeah. I'm sorry. I use the terms
12 interchangeably.

13 Q Yeah. That's fine. I just want to make
14 sure it's clear.

15 A Yeah.

16 Q You can obviously use whatever terms you
17 like. I just want to make sure we're on the same
18 page.

19 And then so, I guess, separating from
20 income -- I take that point on the prerevenue --
21 what percentage of your time is forensics or expert
22 work?

23 A I'd say probably 40 to 50 percent.

24 Q And is that consistent?

25 A I'd say that the last three, four months,

1 it's been higher. In the past, it's been a bit
2 lower than that. Like the prior year before that
3 was pretty much exclusively dedicated to the
4 patenting process and development of the technology.

5 Q Okay. And then prior to this case, have
6 you ever been retained by the Wilson Elser firm?

7 A Not to my recollection.

8 Q And prior to this case, have you ever been
9 retained by the Leapfrog Group?

10 A No.

11 Q Prior to this case, had you ever heard of
12 the Leapfrog Group?

13 A No.

14 Q Forgive me for asking, but prior to this
15 case, have you ever had any interaction with
16 hospitals for your own care or your loved one's care
17 or something like that?

18 A Yes.

19 Q At a high level, just give me a sense of
20 what that entails.

21 A Sure. I've had two daughters, and I've
22 broken my leg before. And just general care.

23 Q Fair enough. I've had that experience of
24 the kid at the hospital too, so I get it.

25 Let's talk a little bit about deposition

1 prep. We'll get these preliminaries out of the way.

2 Did you prepare for your deposition today?

3 A Yes.

4 Q What did you do to prepare?

5 A Created this binder.

6 Q Did you review the binder?

7 A Yes.

8 Q Sort of top to bottom?

9 A More or less, yes.

10 Q Did you meet with counsel to prepare?

11 A We had a Zoom for, I think, about an hour.

12 Q When was that?

13 A That would be sometime last week. I don't
14 recall the exact day.

15 Q Was that with Ms. Wood?

16 A Yes.

17 Q Anybody else?

18 A I believe Kavi was on the call as well.

19 Q Mr. Modi?

20 A Yes.

21 Q And how many hours did you spend
22 separately from counsel preparing?

23 A This is just an estimate, but I think
24 seven or eight hours.

25 Q And did you review -- you reviewed all the

1 documents in that binder to prepare?

2 A Yes.

3 Q Did you review any documents beyond what's
4 in that binder?

5 A Yes.

6 Q What are the ones that you reviewed that
7 are not in the binder?

8 A So I skimmed through all the depositions
9 that were provided to me.

10 Q And which were those? You have
11 Ms. Binder. You had Dr. Nicholson?

12 A Yep.

13 Q Did you review the deposition transcript
14 of Professor Berger?

15 A Yes.

16 Q Did you review other Leapfrog employees?

17 A Yes. I believe all of them.

18 Q That would be Ms. Stanford?

19 A Yes.

20 Q Ms. Champion?

21 A Yes.

22 Q Who else there? Ms. Jupiter?

23 A Yes.

24 Q Ms. Bailey?

25 A Yes.

1 Q Mr. Banerjee?

2 A I'm not sure. That name is not ringing a
3 bell for me.

4 Q He's sort of the revenue guy. Does that
5 ring a bell?

6 A Yeah, that does. I believe I did.

7 Q He talked a lot about licensing?

8 A For his -- I basically saw it wasn't
9 relevant, so I didn't read his. But I skimmed it,
10 just to see if it was relevant or not.

11 Q Got it. Okay.

12 And how did you decide what was relevant
13 and what wasn't?

14 A Their focus of what they did in the
15 company, what their role was and so forth.

16 Q Can you give me just the general buckets
17 of which roles you deemed relevant and which roles
18 you deemed not relevant?

19 A So I think a good way to jump into that
20 would be my assignment. So, if I can go over that
21 in my report.

22 Q Yeah. Sure. So you're going to your
23 report?

24 A Yeah.

25 Q And you're going to tell me now what was

1 the scope of your assignment here?

2 A Right.

3 Q Before we go through that,
4 Mr. Vredenburgh, I just want to close the loop.

5 Are there any other documents you looked
6 at that are not in that binder?

7 A Yes. So there were all sorts of
8 appendices that Dr. Berger produced.

9 Q So you reviewed Dr. Berger's reports and
10 his appendices?

11 A Yes.

12 Q Did you review other expert reports?

13 A Yes.

14 Q **Mr. Jakerda?

15 A Not in depth.

16 Q And then any other -- I'm trying to think
17 any other -- did you review the depositions of any
18 of the plaintiffs' witnesses, the CEOs of the
19 hospitals?

20 A No.

21 Q Any other documents you can recall
22 reviewing?

23 A So I was pretty good about referencing
24 everything that I relied upon. So I feel like there
25 was all these accessory documents that I wanted to

1 make sure that -- you know, whether I was going to
2 rely upon them or not. And for most of them, they
3 weren't relevant, but I just went through them real
4 quick just to make sure.

5 Q When you say -- what documents are we
6 talking about here? What accessory documents?

7 A So that would be, you know, these
8 depositions.

9 Q Got it.

10 Did you look at the exhibits to the
11 depositions? Is that what you mean?

12 A No, I didn't.

13 Q Did you look at Leapfrog -- any of
14 Leapfrog's websites to prepare for the deposition?

15 A Yes.

16 Q Which pages, to the best of your
17 recollection?

18 A So that would be the leapfroggroup.org
19 website and the --

20 Q Just the home page or pages within too?

21 A Pages within too.

22 Q Okay. Do you remember generally which
23 ones on the leapfroggroup.org you reviewed, just to
24 the best of your recollection?

25 A I believe the ones that I reviewed most

1 significantly should be in the report.

2 Q Okay. So I guess we'll come to that.

3 And what about for

4 hospitalsafetygrade.org?

5 A Yeah. So I reviewed that pretty

6 significantly as well.

7 Q And you reviewed all this in seven to

8 eight hours?

9 A So -- I'm sorry. I think I might have
10 miscommunicated. Because your previous question
11 about review, that was just depo prep --

12 Q Uh-huh.

13 A -- is how I interpreted that question.

14 Q Got it.

15 A In terms of writing the report and
16 reviewing the material before that, I think all that
17 would have been closer to 20 hours.

18 Q Okay. So the depositions came after you
19 served your report, right?

20 A Yes.

21 Q So you reviewed the depositions with the
22 depo prep?

23 A Yes.

24 Q And so just to -- the sum total,
25 approximately, of your time on this case is about 27

1 or 37 hours?

2 A You know, I would need to look through my
3 billing to be sure, but typically, for a case like
4 this, it would be between 20 to 30 hours.

5 Q And that includes the report plus the depo
6 prep?

7 A Yes.

8 Q And then figuring whatever it is today,
9 right?

10 A Right.

11 Q That's helpful.

12 So then let's go to your assignment. You
13 were starting to tell me, and I apologize for
14 cutting you off. I just wanted to make sure we
15 closed the loop.

16 Tell me, what you were retained -- what
17 was the scope of your assignment?

18 A Great. So to summarize it in just a few
19 words, it was to evaluate the clarity and
20 transparency and usability of the hospital safety
21 grade website.

22 Q Let's break that down a little bit.

23 What does "clarity" mean?

24 A So, if you look at paragraph 13.

25 Q Uh-huh.

1 A I think that that's a good introduction to
2 how I evaluated that. Determining the likelihood
3 that a reasonable consumer would misunderstood the
4 website's content.

5 Q Got it. So "clarity" is defined for you
6 as the likelihood that a reasonable consumer would
7 misunderstood the website's content?

8 A Yes.

9 Q And then how do you define "transparency"?

10 A So in the context of this case, I think
11 transparency is making sure that the information
12 that each consumer needs to get to is available to
13 them, and that for each step, for each different
14 level of consumer, that that clarity is available to
15 them. So there's this idea in user experience
16 called progression disclosure.

17 Q Uh-huh.

18 A And it is a way to make sure that a lay
19 audience and an expert audience, or just somebody
20 who is progressing through, doesn't get overwhelmed
21 so you're getting information as you need it. And
22 if you get interested and you want to dive deeper,
23 that's always available for you.

24 Q Is transparency the same as or related to
25 accessibility?

1 A No. I wouldn't say those are the same
2 thing.

3 Q Are they related?

4 A I think that accessibility can be a
5 prerequisite to transparency. Because if you have
6 certain populations that are struggling to find it
7 accessible, then that could be an issue.

8 Q Yeah. So just to make sure I understand,
9 the more -- if it is more accessible, it is more
10 transparent, but it's not necessarily a direct
11 one-to-one; is that fair?

12 A Well, it can be accessible but not
13 transparent, or transparent to some but not
14 accessible.

15 Q How does that work? Yeah. Can you sort
16 of -- if it's accessible to some, but not
17 transparent, I think you said, can you give me an
18 example?

19 A If it's accessible, and say that it has a
20 reading level that matches the person who is
21 reading, so, A, we know that they can go in and read
22 it. And, you know, say if they have limited vision,
23 that it's able to be brought up to whatever size
24 that they need for their vision. So those would be
25 examples of accessibility.

1 But you could have that and still have
2 someone get led astray, even though they have that
3 accessibility. So that's why they're not
4 necessarily always the same, because they could read
5 something that's not necessarily a truth, and then
6 it's not transparent.

7 Q Got it. Okay.

8 A Or they're getting the accessibility and
9 they're not necessarily getting to where they need
10 to get to. So the progressive disclosure is not
11 there, and they hit a brick wall before they're
12 ready, then it's accessible but not transparent.

13 Q Okay. And then what is usability? That
14 was the third word you used.

15 A In the context of human factors, usability
16 is usually related to this concept user experience,
17 Use X, UX. And so usability is to make sure that
18 your content is made for humans; that whoever your
19 users are, that it's going to be successful for them
20 to get to where they need to go.

21 Q Are these related concepts, the three of
22 them?

23 A Yes.

24 Q And then in assessing for clarity,
25 transparency and usability -- I got that right,

1 right? Those three?

2 A Yes.

3 Q Did you assess the content of the
4 underlying things you reviewed for clarity,
5 transparency, and usability?

6 A Now, that's a bit of nuanced question.

7 Q The first of many.

8 A So I would say -- I want to look through
9 my assignment carefully here.

10 Q Yep.

11 A But I think I would say that I evaluated
12 the content only so far as that it relates to
13 clarity, transparency and usability.

14 Q Okay. So let me sort of make it more
15 concrete.

16 A website can be clear, transparent and
17 usable, and yet, at the same time, still convey
18 inaccurate information; is that fair to say?

19 MS. WOOD: Object to form.

20 THE WITNESS: Could you give a more
21 specific example? Because I think that transparency
22 would be the word that kind of would be -- make it a
23 little ambiguous for me.

24 BY MR. CRAIN:

25 Q Yeah. You want a hypothetical, you mean?

1 A Sure.

2 Q Let's say there's a website that offers
3 discounts on cleaning products, right?

4 A Uh-huh.

5 Q And the reading level is super low. It's
6 very clear. It says: "We're offering Clear X for \$5
7 a bottle. Great discount." Right?

8 A Uh-huh.

9 Q Fair to say, with no other facts, right up
10 there, that's the reading level, is it fair to say
11 that that website clear, transparent and usable?

12 A I feel like you're implying that the --
13 that there might be some sort of transparency issue.
14 But based on just, you know, the information you
15 provided, if the user can get all the information
16 they're supposed to get to, then I think that it
17 would be those things.

18 Q Now, what if it's just wrong, right? Like
19 instead of Clorox, it's Borax, right? Does that
20 affect any one of the three measures that you've
21 been looking at?

22 A So you're saying --

23 Q Same website, just different product.
24 They made a mistake.

25 A So you think you're buying one product,

1 but a different product arrives?

2 Q You think what's being offered is a
3 discount for Clorox for \$5, but it turns out that
4 was an accident. It was a typo, and everything in
5 the warehouse is Borax.

6 A That sounds like a transparency issue.

7 Q Okay. Why?

8 A Because they're not providing you the
9 information. You know, with each level of the
10 progressive disclosure, you're supposed to get the
11 information that is relevant for that level. So I
12 think you're presenting this initial page, the first
13 part, and it's presenting -- presenting a product,
14 and it's the incorrect product. So that sounds like
15 a transparency issue to me.

16 Q So transparency relates to whether the
17 information on the page is accurate or not?

18 A I think it would relate to that, yes.

19 Q Okay. All right. We'll come back to that
20 in a minute.

21 Anything else -- within the scope of your
22 assignment, anything beyond those three that sort
23 of -- we'll get to your opinions in a little bit,
24 but with regard to what you were retained to do, is
25 there anything else you were retained to do beyond

1 those three?

2 A Everything written in this report for the
3 assignment section, I feel like it goes into more
4 depth than what we talked about. But I think it's
5 covered by those three words as well.

6 Q So nothing beyond the scope of paragraphs
7 12, 13, 14, 15, and 16, right?

8 A Correct.

9 Q Okay. I want to step back, just while
10 we're looking at your report, and I want to talk
11 about your appendices, just to make sure we're on
12 the same page.

13 If you go to page -- Appendix C on page 23
14 of Exhibit 1, which is your report, right?

15 So I want to understand. This page of
16 references, is that supposed to be the universe of
17 materials that you considered in forming your
18 decision?

19 A Yes.

20 Q Are there any other materials beyond this
21 page -- beyond those listed on this page that you
22 considered in coming to your conclusion?

23 A So I think that documents that I've read
24 throughout my education and professional experience
25 have helped shape me in, you know, how I form my

1 words, how I form my opinions. And so I think that
2 they're shaping me in terms of, you know --

3 Q Fair enough. Yeah. It's sort of a bad
4 question. Let me fine-tune it.

5 From the moment you were retained on this
6 case to the moment you served your report, you
7 reviewed documents to render a decision -- an
8 opinion in this case, right?

9 A Yes.

10 Q Are there any documents during that time
11 period, setting aside your education and broader
12 history, that you reviewed to come to your opinions
13 in this case?

14 A So I would say, in general, this is pretty
15 conclusive, but I was provided some documents in the
16 review. So, you know, just for example --

17 Q Yeah.

18 A -- if I were to pull up Leah Binder, if
19 I'm remembering her name correctly.

20 Q Ms. Binder. Yeah.

21 A Ms. Binder's deposition, I've got a few
22 things highlighted here.

23 Q Well, set that aside for a moment.
24 Because that happened after you served your
25 report; is that true?

1 A Correct. That's true.

2 Q Okay. I thought it was true. But if it's
3 not true, you can correct me.

4 I want to understand what went into your
5 report first. And so I'll give you a concrete
6 example.

7 This list of documents on page 23 does not
8 mention, at least as far as I see, any of the
9 Leapfrog Group's web pages.

10 A So those are referenced directly in the
11 footnotes in the report as they appear. So those
12 are referenced, but they don't show up in the
13 references, which is a good point that you're
14 making. It probably should have appeared there.

15 Q It just makes it hard for us to figure out
16 what you looked at, right?

17 A Yeah. So every time there's a screenshot
18 of one of the pages on the bottom, there should be a
19 footnote to the website there. And so that's
20 definitely included as well.

21 Q So I want to go through this. And there
22 are 20 footnotes. Do you see that? The last
23 footnote is page 16.

24 A Uh-huh. Yes.

25 Q And as far as I can tell -- that was a

1 "yes"?

2 A Yes.

3 Q As far as I can tell, there are either no
4 or very few websites cited. And you can flip with
5 me. And whoever finds a website first can win. I
6 see one at footnote 7 and footnote 8.

7 A Yeah. So there's the home page as well as
8 the -- a specific hospital's page.

9 Q And that's for Good Samaritan?

10 A Yes.

11 Q So what I want to understand is, did you
12 consider other pages beyond those in these
13 footnotes? For instance, are you aware there's a
14 "frequently asked questions" page on the website?

15 A Yes.

16 Q Did you review that website?

17 A Yes.

18 Q Did that factor into your opinion?

19 A Yes.

20 Q Where is that cited in your report?

21 A It's not.

22 Q Did you review the "about the grade" page
23 on your website?

24 A I believe so, yes.

25 Q Is that one referenced in your report?

1 A No, sir.

2 Q What other ones do we have? I mean,
3 there's a long list.

4 But is there any other page that you -- I
5 mean, we can go through them, but you see my
6 challenge.

7 Do you understand where I'm going?

8 A So a good roadmap would be, anything that
9 Dr. Berger referenced, I've reviewed in reviewing
10 his report.

11 Q So Dr. Berger's report, which we can
12 mark -- let's get that out. Page 3. Let's mark --
13 this will be Exhibit 3. Thank you.

14 (Exhibit 3 marked for identification.)

15 BY MR. CRAIN:

16 Q Do you have it in front of you?

17 A Yes, sir.

18 Q Do you recognize Exhibit 3?

19 A Yes.

20 Q What is it?

21 A This is Dr. Berger's report.

22 Q And I want you to go to Appendix C, which
23 is -- actually, it says "page 1," but it's towards
24 the end. It's page 1 of Appendix C. The last
25 appendix.

1 You there?

2 A Yes.

3 Q Great.

4 And do you see, flipping to the end, it's
5 10 pages of documents considered?

6 A Yes, sir.

7 Q Did you review all of these?

8 A No.

9 Q Okay. Which ones did you review, in a
10 nutshell?

11 Let's start with, do you see there's a
12 first page that says "Academic Articles"? It's on
13 page 1 of Appendix C. I think you're on a different
14 appendix.

15 A Appendix C, you said?

16 Q C, as in cat. It says "Documents
17 Considered List."

18 A Uh-huh.

19 Q Do you see that?

20 A Yeah.

21 Q Do you see the "Academic Articles"?

22 A Right.

23 Q Did you review all of these?

24 A No.

25 Q They're lengthy.

1 A Right. Well, I think that's something
2 that's going to come up through this deposition, is
3 I feel like were a little bit parallel to each other
4 in terms of what we evaluated.

5 Q What do you mean "parallel"?

6 A So Dr. Berger's background and expertise
7 is different than my background and expertise. And
8 so the -- you know, the way of going about it --
9 like he's bringing up Journal of Economics, and
10 that's just not relevant to my background.

11 Q Okay. Can you give me your understanding
12 of what Dr. Berger's expertise is?

13 A So, if I'm recalling correctly, he's a
14 marketing professor.

15 Q And has some expertise in terms of
16 consumer choice, consumer psychology? Does that
17 sound right?

18 A Yes.

19 Q And do you have any expertise in
20 marketing, consumer choice or consumer psychology?

21 A Only insofar as they relate to human
22 factors and human factors engineering.

23 Q How do they relate to human factors and
24 human factors engineering?

25 A So, from my evaluation, it was a user

1 experience evaluation. So as far as it's related to
2 user experience.

3 Q Okay. So human -- we'll come back to
4 that.

5 So "Academic Articles," if you flip to
6 page 5, there's book chapters, expert reports, and
7 legal documents.

8 Do you see that?

9 A Yes.

10 Q Did you review any of those?

11 A I believe I reviewed the expert reports --

12 Q Of Dr. Nicholson?

13 A -- the complaint. Yeah. The complaint.

14 Q Your footnotes cite the amended
15 complaint; is that right?

16 A Yeah. I saw the original complaint too.

17 Q Okay. Any other motions under the "legal
18 documents" page?

19 A The legal documents can sometimes get a
20 little bit jargony for me.

21 Q Fair enough.

22 A But I did skim through them. If you said
23 "Was it this document or this document you skimmed
24 through," I wouldn't necessarily be able to estimate
25 well.

1 Q So you considered legal documents beyond
2 the amended complaint?

3 A Initially, when I -- everything I
4 received, I skimmed through it real quick to see
5 whether I thought it was relevant to me or not.

6 Q So certain documents you were given, but
7 deemed not relevant?

8 A Yes.

9 Q And certain documents you reviewed, you
10 deemed relevant?

11 A Yes.

12 Q In terms of legal filings, was the only
13 thing you deemed relevant the amended complaint?

14 A That's certainly the most relevant.

15 Q And what were the other things that were
16 less relevant but still relevant?

17 A Anything that was in my file.

18 Q What is in your file?

19 A Anything that was sent to me by the
20 defense.

21 Q Is that in the binder?

22 A No. It would be like five of these
23 binders.

24 Q Okay. So did you -- so you reviewed other
25 legal filings, right? Just to make sure I

1 understand.

2 A Yes.

3 Q And some you deemed not relevant, so you
4 set aside?

5 A Yes.

6 Q Some you deemed relevant, so you
7 considered them, right?

8 A Correct.

9 Q One of those documents was the amended
10 complaint, correct?

11 A Yes.

12 Q But not all of those documents, right?
13 That was a bad question. Let me make -- that was a
14 bad question.

15 What I mean to say is, of the documents
16 that were legal filings that you deemed relevant,
17 there were other documents beyond the amended
18 complaint that you considered, correct?

19 A Yes.

20 Q Okay. And they are not in your report
21 anywhere, right?

22 A Correct.

23 Q Okay. Let's keep going.

24 You see Dr. Berger's page 6, produced
25 documents -- do you know what a Bates number is?

1 A Yes.

2 Q There's a bunch of Bates-numbered
3 documents. Did you review any of those?

4 A Yeah. They're a little jargony. You
5 know, there's large -- large numbers at the end of
6 each, so it's hard to differentiate.

7 Q Fair enough.

8 Do you remember reviewing any documents
9 with Bates numbers, any internal emails, things like
10 that?

11 A Yes. And I definitely relied on documents
12 that are very similar to this. You know, if it's
13 00065 or some other number, I'm not sure.

14 Q Fair enough. That's just the numbers, so
15 it's hard to say.

16 A Yeah.

17 Q Let's put it into words.

18 Did you rely on, in forming your report,
19 internal Leapfrog emails?

20 A At least a few, yeah.

21 Q Do you recall what those emails were?

22 A Yeah. You know what? I think that there
23 might actually be one document that I have in here
24 that I recall that may not have been in the folder
25 that was produced.

1 Q We'll look at the binder after. If you
2 can't remember now, that's fine. That's a perfectly
3 fine answer. But I want to set the binder aside,
4 and I want to just talk about what you recall
5 reviewing.

6 So you reviewed a number of internal
7 Leapfrog emails in coming to your opinion, right?

8 A Yes. Specifically about the user
9 experience testing.

10 Q Got it. From 2014?

11 A I believe so.

12 Q Do you remember reviewing any other emails
13 about, for instance, like the methodology for
14 grading?

15 A They may or may not have been provided to
16 me. It's ringing a bell to have skimmed it and
17 think, you know, it's in the "good to know" folder,
18 but probably not going in the report.

19 Q Did you review any emails about how
20 Leapfrog drafted the website content?

21 A Yes.

22 Q Okay. From 2014 or subsequently?

23 A So that's the document that I want to pull
24 up. I believe that I referenced the CV for the
25 woman who was hired to help them with their user

1 experience and with their website creation.

2 Q Back in 2014?

3 A I believe so, yes.

4 Q Anything more recent, is what I'm trying
5 to understand.

6 A Not that I recall.

7 Q Let's keep going with Dr. Berger. We're
8 on page 6 of appendix C.

9 Tell me when you're there. It's right
10 towards the end. It's like the last three pages.

11 A Uh-huh.

12 Q You see there's website online content,
13 right?

14 A Right.

15 Q And he has like one, two, three, four --
16 five pages of websites that he reviewed.

17 Do you see that?

18 A Right.

19 Q Did you review all of these?

20 A You know, this is a lot of pages to look
21 through, a lot of links.

22 Q Yeah.

23 A I don't think, just looking at these pages
24 here, I would be able to tell you or not if we
25 pulled up the websites and we went to each one and I

1 said "yes" or "no." I could do it that way,
2 but . . .

3 Q Fair enough. I'll have some documents for
4 you later. Let me ask you this question.

5 Your report, we just looked at footnotes 7
6 and 8, right?

7 A Yes.

8 Q And those list two websites that you
9 considered in forming your opinion, right?

10 A Yes.

11 Q The home page, and I think the other one
12 was Good Samaritan, right?

13 A Right.

14 Q Is it correct that you considered other
15 pages of the Leapfrog website -- of Leapfrog's
16 websites in coming to your opinions?

17 A Yes.

18 Q Do you have a ballpark of how many?

19 A I think that a good ballpark would
20 actually be the amount of time that I spent browsing
21 the website. I would say that I spent probably
22 about two hours browsing the website, so that gets
23 you through pretty extensively.

24 Q So you did a fairly deep dive of the
25 website?

1 A Yes.

2 Q But you did not put a list of what you
3 looked at in your report anywhere, right?

4 A Right. And, you know, maybe Dr. Berger
5 does have the best, you know, style here for listing
6 everything out. But I guess the philosophy that I
7 was following, writing the report, is I wanted it to
8 be easy to follow, you know, have good UX, user
9 experience. I didn't want it to overwhelm people.
10 I wanted to follow the idea of progressive
11 disclosure myself, where, you know, I wanted to make
12 sure it was easy to follow along for the reader.

13 Q Yeah. No, I hear you. And I get his page
14 is lengthy and it's hard to read. It's a lot of
15 numbers.

16 So you understand to -- that to testify as
17 an expert in federal court, your report needs to
18 satisfy Federal Rules of Civil Procedure 26 and
19 Federal Rule of Evidence 702.

20 Do you have an understanding of that?

21 A Yes.

22 Q And Federal Rule of Civil Procedure 26
23 requires you to disclose the facts and documents you
24 relied on; is that fair?

25 A Yes.

1 Q Fair to say you didn't do that completely?

2 MS. WOOD: Objection to form.

3 You can answer.

4 THE WITNESS: I wouldn't necessarily say
5 that's fair because I do -- I do reference with
6 footnotes -- was it, 7 and 8?

7 BY MR. CRAIN:

8 Q 7 and 8.

9 A -- that those were the main pages that I
10 relied on. And for the report, that was the focus
11 of the analysis.

12 So, you know, if you and I here want to
13 discuss today specifics of Dr. Berger's report where
14 he's referring to these other pages, likely I have
15 dived in and looked at what he was saying. But a
16 lot of it was kind of, like I said, parallel to or
17 askew to what my analysis -- what the scope of my
18 analysis was. So that's why it didn't necessarily
19 make it into my report.

20 Q I totally hear you. I'm actually trying
21 to understand your analysis, not necessarily
22 Dr. Berger's. We might come to him later. But I'm
23 trying to understand what you considered.

24 For instance, we talked about the
25 "frequently asked questions" page, right? You

1 considered that, right?

2 A Yes.

3 Q Is that something, in your view, that -- I
4 think you say the typical user -- does the typical
5 user consult "frequently asked questions"?

6 A So I think that goes back to the
7 progressive disclosure, where very likely the
8 typical user is not going to go past the first page.
9 And they are going to focus on that first primary
10 page. And, you know, as someone becomes interested
11 or as someone has more expertise or a reason to dive
12 in, they can go further. So that seems like a
13 next -- you know, second or third step, you know,
14 past. So --

15 Q What page are you?

16 A I'm on page 6. If we look at --

17 Q 6 of Exhibit 1? Your report, right?

18 A Yes.

19 Q Exhibit 1. Okay.

20 A I'm looking at figures 1 and 2.

21 Q Uh-huh.

22 A So you're -- you know, you're asking --
23 and it's totally fair -- you know, "Is this
24 sufficient to say this is the amount of website that
25 you reviewed?" And I would say that this covers,

1 you know, step 1 and 2 of the progressive
2 disclosure.

3 Q Got it.

4 When you say this covers step 1 or 2 --
5 and 2, you're saying you start with Figure 1.
6 That's the main landing page for
7 hospitalsafetygrade.org, fair?

8 A Yes.

9 Q And then you search a hospital, right?

10 A Correct.

11 Q Now, there's an intermediate step. It
12 doesn't just go right to Figure 2, right?

13 A That's fair. Yes.

14 Q Did you review that page?

15 A Yes.

16 Q But that's not in this report, right?

17 A No. That's not a figure in this report.

18 Q Is it cited or referenced anywhere in the
19 report?

20 A No, sir.

21 Q Then when you click on -- from the search
22 page -- I've got it up here. I looked at it a lot,
23 more than two hours.

24 When you click on the search page, it goes
25 into what is effectively Figure 2, right?

1 A Yes.

2 Q Now, then you can go and click onto a more
3 detailed view, right?

4 A Correct.

5 Q Is that referenced in your report?

6 A No, sir. So it's referenced insofar as
7 that I talk about the progressive disclosure.

8 Q Yeah.

9 A But I feel like that's starting to go
10 beyond the scope of what I analyzed. That's
11 starting to get into a different kind of expert
12 territory.

13 Q Why is that?

14 A So I've evaluated that the progressive
15 disclosure is there, that we have, you know,
16 increasing amounts of information for different
17 users. But to, you know, analyze the transparency
18 and accuracy going into these further pages, that's
19 better covered by another one of the experts who was
20 focused more on the algorithm and the clarity.
21 That's starting to go beyond what I analyzed.

22 Q So does your analysis stop at Figure 2?

23 A So I would say that my analysis
24 acknowledges that it goes beyond this page and, you
25 know, acknowledges the progressive disclosure that

1 further -- further, you know, expert information
2 becomes available to expert users.

3 Q So you said your scope was to assess the
4 clarity, transparency -- and help me on the last
5 one -- usability of the website generally, right?
6 That was the scope of your assignment?

7 Paragraph 13, I think you said.

8 A And there's probably some sort of clause
9 for like a reasonably prudent user.

10 Q So here -- yeah. Paragraph 12, "I have
11 been asked by counsel for defendant, the Leapfrog
12 Group" -- that's Ms. Wood and her team, right?

13 A Uh-huh. Yes.

14 Q -- "to evaluate the clarity, transparency,
15 and usability of the Leapfrog hospital safety grade
16 website, www.hospitalsafetygrade.org, from the
17 perspective of a reasonable consumer seeking
18 healthcare information."

19 That's what you're referring to?

20 A Yes. If I can respond.

21 Q Please.

22 A So a -- someone seeking healthcare
23 information, at least the way that I interpreted it
24 for this assignment, is not going to be necessarily
25 a doctor or a hospital administrator.

1 Q I was going to ask. Yeah. So these are
2 average people, right?

3 A Yes.

4 Q Seeking for their care, their loved ones,
5 right?

6 A Right. And you'll see later, you know,
7 I'm analyzing the grade level. So, you know, trying
8 to hit a specific, you know, grade level like 8th
9 grade. That's not going to be very relevant for the
10 hospital administrator.

11 Q Yeah. So we'll come back to that.

12 But when you say you're evaluating the
13 grade level, is that just for the website reflected
14 in Figure 2?

15 A Yes.

16 Q Did you evaluate the grade level of any
17 other website?

18 A No.

19 Q That's all.

20 Now, going back to 12, sentence 1, you say
21 "I've been asked by counsel for defendant, the
22 Leapfrog Group, to evaluate the clarity,
23 transparency and usability of the Leapfrog hospital
24 safety grade website, right?

25 Now, is that under-inclusive or

1 over-inclusive? And what I mean by that is, the
2 hospitalsafetygrade.org website includes a lot of
3 pages under it, right?

4 A Correct.

5 Q Are you saying you're evaluating just the
6 landing page, which I think is Figure 1?

7 A I would say the majority of the focus
8 would be for Figure 2.

9 Q So is it more accurate to say the scope of
10 your assignment was to evaluate the clarity,
11 transparency and usability of
12 www.hospitalsafetygrade.org, as well as -- I think
13 it's in footnote -- the URL in footnote 8, which
14 refers to Figure 2?

15 MS. WOOD: Objection to form.

16 BY MR. CRAIN:

17 Q You can answer.

18 A That's correct. That was my primary
19 focus.

20 Q What I'm trying to understand, you said
21 "primary."

22 Were there other focuses, or is that the
23 only focus?

24 A So I believe I have an opinion about
25 progressive disclosure and the fact that it

1 continues to disclose beyond this point to different
2 levels of expert users. I consider that, that that
3 exists. But the primary focus would really be on
4 Figure 2 and the analysis.

5 Q Figure 2. And Figure 1?

6 A And Figure 1, yeah.

7 Q So then going back to your opinion, did
8 you consider -- well, I'll leave that. Strike that.
9 Sorry.

10 In making your opinion, did you consider
11 the long detailed table view or no? And I can show
12 you a document.

13 A Just that it exists.

14 Q Was it relevant to your opinion or no?

15 A It's relevant for the progressive
16 disclosure, in that, you know, these next steps
17 exist. But it's not -- it's not intended for or
18 pointed to the users that I evaluated in my scope,
19 in my analysis.

20 Q Again, not cited in your report, right?

21 A I'm not sure that's true. I think when I
22 talked about the progressive disclosure, I think
23 that it does talk about the increased levels of
24 information that come up.

25 Q Okay. But you didn't actually disclose

1 which pages you had considered beyond Figure 2,
2 right?

3 A That's correct.

4 Q And you did consider pages beyond Figure
5 2, right?

6 A That's correct.

7 Q Did you consider videos on the website?

8 A Just that they exist.

9 Q Did you review the videos in coming to
10 your decision?

11 A One video.

12 Q What video?

13 A So it would have just been Figure 2, just
14 the first video that's available right on that page,
15 on the top left.

16 Q View. Let's see. Where is that, top
17 left? Oh, I see the pop-up. Okay.

18 So I want to make sure we're just talking
19 about the same video. So we're looking at Figure 2
20 in your report on page 7, which is Exhibit 1 of this
21 deposition. There's a little "play" arrow right
22 under the "D", right?

23 A Yeah.

24 Q Great. Shut that down.

25 Now, we went to that video, and we got a

1 transcript of it. So let's mark as Exhibit 4.

2 (Exhibit 4 marked for identification.)

3 BY MR. CRAIN:

4 Q This is a certified transcript of the
5 video that comes up on that page. Take a look at
6 it. Flip through it. It's short.

7 And I just want to make sure for the
8 record, can you confirm whether or not this was the
9 video that you considered?

10 MS. WOOD: Objection to form.

11 BY MR. CRAIN:

12 Q Do you have that, Mr. Vredenburg?

13 A Yes, sir.

14 Q Does this refresh your recollection as to
15 why you reviewed this video?

16 A Yes.

17 Q And did you consider it in coming to your
18 conclusion?

19 A Yes.

20 Q And is it cited in your report or
21 otherwise referenced? You referenced videos. Do
22 you reference this as the specific video?

23 A So I believe that it would be referenced
24 because it's shown on the screenshot that's in the
25 report.

1 Q Okay. So you're saying is the video
2 that's in the top left corner under the "D" is
3 sufficient to put the other side on notice that you
4 considered the video there in forming your opinions?

5 MS. WOOD: Objection to form.

6 THE WITNESS: So the content of the video,
7 that goes beyond the -- that goes beyond the scope
8 of my analysis. But the fact that this video exists
9 and is on the page and is clearly shown to be a
10 video on this paper shows that -- you know, that
11 there is this progressive disclosure, and that it's
12 a tool for accessibility to help more users.

13 BY MR. CRAIN:

14 Q Yeah. I hear you on progressive
15 disclosure. Let's set that aside for a second.

16 I'm trying to understand what the universe
17 of materials were that you decided on, which is an
18 important prerequisite in the Federal Rules because
19 it gives us notice on what you evaluated, which is
20 for today, right? And for trial, right?

21 A Yeah.

22 Q Are you saying that any link on this page,
23 we were on notice that you considered in forming
24 your opinion?

25 MS. WOOD: Objection to form.

1 THE WITNESS: So the page that you get to
2 from the link, I would say no, that wouldn't be
3 fair. But the content of the leak itself, like
4 saying "show recent past grades" --

5 BY MR. CRAIN:

6 Q Yeah.

7 A -- and like that actual content and what's
8 implied by that link. Yes.

9 Q So let's -- I take -- so do you see on the
10 top right, it says "detailed table view"?

11 A Yes.

12 Q And you know the website that -- you know
13 the website that goes to when you click that link?

14 A Right.

15 Q It's the long table, right?

16 A Yeah. It's not oriented towards a casual
17 user.

18 Q Yeah. It's more -- a little more
19 expertise, right?

20 A Yes.

21 Q Did you consider that table in forming
22 your opinions?

23 A I would say more so that I considered this
24 link and going into -- going into it, seeing like
25 "Is this relevant for the user that I'm looking at?"

1 No. This is more relevant for the expert user."

2 Q Okay. So the user that you were looking
3 at is only looking at Figure 1 and Figure 2?

4 A Well, the statistics show that that's
5 pretty likely.

6 Q What statistics?

7 A The Google Analytics. That that is where
8 most users go. I've got some other research that I
9 cited that I think -- three scrolls below the fold.

10 Q Yeah.

11 A So this first page would be the first
12 scroll. This page and this third in scrolling down,
13 that's where most users are going to end.

14 Q I want to come back to that point in a
15 second because that's just -- he knows what I'm
16 talking about. I give him in code. He can't figure
17 it out.

18 So what I want to understand -- setting
19 aside the content of your opinion, right? You're
20 talking about you had an opinion about progressive
21 disclosures, right?

22 In forming that opinion, did you consider
23 the video under the "D" on Exhibit 2 -- Figure 2 on
24 page 7? Did you consider the table -- all these
25 links, did you actually consider those in forming

1 your opinion?

2 A Yeah. So they were certainly considered.
3 I looked at them, and I considered them. And I
4 thought that I presented, you know, the information
5 that was necessary to then support the -- support
6 the opinions that I have here in this report.

7 Q And you do not cite or reference beyond
8 these links on Figure 2 those other pages, right?

9 A Yeah. I believe that's correct. I think
10 that the citations for the websites and to get to
11 particular pages -- I think page 6 and page 7 is the
12 extent to which they've been cited in this report.

13 Q And you mean footnote 7 and 8?

14 A Yes, sir.

15 Q Just for clarity.

16 Now, a couple other questions.

17 Do you know that -- you reference in your
18 report the 29-page methodology document.

19 Do you know what I'm talking about when I
20 say that?

21 A Yes.

22 Q Did you consider that document?

23 A Yes.

24 Q On the website page on Figure 2, just
25 going back to your Figure 2, there are multiple tabs

1 here.

2 Do you see that?

3 A Yes.

4 Q There's the tabs in blue at the top.
5 There's the different hospital gauges, right?

6 A Yes.

7 Q Did you consider each of those?

8 A Yes.

9 Q You looked at all of them?

10 A Yes.

11 Q Okay. Now I want to go -- I want to mark
12 Exhibit 5.

13 (Exhibit 5 marked for identification.)

14 BY MR. CRAIN:

15 Q Let's look at Exhibit 5 for a second.
16 Because you were starting to talk about -- I'm
17 sorry.

18 Do you have it, Mr. Vredenburg?

19 A Yeah. Can I make a point of clarification
20 on the last question?

21 Q Sure. Yes. Of course.

22 A So I could be wrong, I would need to
23 double-check it, but I don't think that the URL
24 changes depending on which tab that you click on. I
25 believe that this URL does encompass each of the

1 tabs.

2 Q Fair.

3 A I don't believe that it changes. But, you
4 know, if that estimation is not correct, you know, I
5 would like to say that each of the URLs that are
6 relevant, that that would be, you know, what I did,
7 and it should be listed here.

8 And, you know, depending on how the
9 website is actually structured, you know, that's
10 already encompassed in this URL or, potentially, if
11 it does change URLs, that that would be, you know, a
12 typo in this report, and each one of those should be
13 included as well.

14 Q Should have been?

15 A Yes.

16 Q Let me just -- to make sure we're on the
17 same page.

18 On you your Figure 2, do you see where it
19 says "hand washing" in the middle?

20 A Yes.

21 Q And it says "Healthcare workers can help,"
22 et cetera, et cetera?

23 A Yes.

24 Q If you look at what I've given you as
25 Exhibit 5, on the first page, there's sort of a

1 highlight over the MRSA infection.

2 Do you see that?

3 A Yes.

4 Q Now, if you go to the second page, it
5 says -- in the place where "hand washing" is on your
6 Figure 2, it says "MRSA infection" with a little
7 blurb.

8 Do you see that?

9 A I on my Figure 2 --

10 Q On your Figure 2, do you see "hand
11 washing" and the blurb that we just talked about?

12 A Yes.

13 Q And go to figure -- to Exhibit 5, page 2.

14 Do you see where it says "MRSA infection"?

15 A Yes, sir.

16 Q That's the same spot on the page, right?

17 A Yes, sir.

18 Q Did you look at the "MRSA infection" tab?

19 A Yes.

20 Q And did you look at for all five of the
21 Plaintiff hospitals or just one?

22 A I don't think it was all five, but it was
23 several. And there was also other example hospitals
24 as well that I looked at that wasn't necessarily the
25 Plaintiff hospitals.

1 Q Okay. So in footnote 8, do you see the
2 URL there in your report? Going back to your
3 report, sir, footnote 8. Sorry. I'm whipping you
4 around, but tell me if you're confused at any time.

5 Do you see footnote 8?

6 A Yes, sir.

7 Q And do you see there's a URL?

8 A Yes, sir.

9 Q And it says "HTTPS://www.
10 hospitalsafetygrade.org/H/Good Samaritan/medical/
11 center."

12 Do you see that?

13 A Yes, sir.

14 Q And then a whole bunch of gobbledygook.

15 Do you see that?

16 A Yes.

17 Q So there should have, if I'm understanding
18 you right, been pages or references to pages for
19 other hospitals here beyond Good Samaritan, right?

20 MS. WOOD: Objection to form.

21 THE WITNESS: I guess I don't completely
22 understand the question.

23 BY MR. CRAIN:

24 Q Let me fix it. Fair enough. I'll take
25 counsel's objection.

1 So you cite the URL here for the Good
2 Samaritan page in Figure 2, right?

3 A Yes, sir.

4 Q But you just told me you also looked at
5 other pages like this for other hospitals, right?

6 A Yes, sir.

7 Q So there should have been URLs for those
8 other hospitals too here, right?

9 MS. WOOD: Objection to form.

10 BY MR. CRAIN:

11 Q Well, do you disagree or do you agree?

12 A I guess --

13 Q Let me strike the question.

14 You told me you reviewed other hospitals'
15 pages like Figure 2 beyond several of
16 the plaintiff -- including several of the plaintiff
17 hospitals and others not in this case, right?

18 A Correct.

19 Q You can't tell me today which ones you
20 reviewed, right? Because you don't remember it.

21 A Well, it may be in the report. I do
22 remember that there was an example where there was a
23 hospital that still received an A grade that had
24 imputed scores. So . . .

25 Q Imputed. That's gonna be the word that's

1 coming up.

2 So that's one other hospital, but there
3 are others that you looked at in forming your
4 opinion, right?

5 A So I guess --

6 Q I don't mean to belabor the point. We can
7 move on in a second. I'm just trying to confirm if
8 it's right. It may not be. You can tell me not.

9 You -- in addition to the Good Samaritan
10 website you reviewed in Figure 2, you reviewed other
11 hospital websites, including all the tabs on those
12 pages, for at least -- well, you tell me.

13 How many other hospitals?

14 A Probably about four other hospitals.

15 Q And they are not cited or referenced
16 specifically in this report, right?

17 A Right. Well, I -- I was not aware that,
18 you know, if -- if the URL was slightly different,
19 where you would have a different name at the end,
20 where almost everything would be the same except for
21 a few numbers, you know --

22 Q That you had to list it?

23 A Yeah. I wasn't aware that I would need to
24 list that separately.

25 Q And would you agree that it's a different

1 website, right? Webpage.

2 A Different webpage.

3 Q Not website. Website is the umbrella; is
4 that fair to say?

5 A Right. Yes.

6 Q And the webpage is the ones underneath the
7 umbrella, right?

8 A Correct.

9 Q So Leapfrog safety --
10 hospitalsafetygrade.org is the website, and the URL
11 in footnote 8 is a webpage, right?

12 A Correct.

13 Q I'm going to move on from that in a
14 second, but I just want to understand a couple
15 things.

16 Did counsel review your expert report
17 before it was served?

18 A Yes.

19 Q Did counsel advise you at any time of your
20 obligations under Rule 26 or Rule 702 of the Federal
21 Rules of Evidence?

22 MS. WOOD: Objection to form.

23 THE WITNESS: Not that I recall.

24 BY MR. CRAIN:

25 Q So you told me about 20 minutes ago that

1 you had an understanding of what Rule 26 and 702
2 provide.

3 Where did that understanding come from?

4 A So I -- you know, this is my first federal
5 report, and I did some research, when accepting this
6 case, into what requirements are specific to federal
7 reports versus state court reports.

8 So I do remember that coming up in my
9 initial research of what I would be doing
10 differently for this report.

11 Q So you self-checked whether your report
12 was compliant with the Federal Rules, correct?

13 A Yes.

14 Q Are you a lawyer?

15 A No.

16 Q Do you have a law degree?

17 A No.

18 Q Have you ever practiced law?

19 A No.

20 MR. CRAIN: Why don't -- we've been going
21 for more than an hour. Do you want to take a break?

22 THE WITNESS: Sure.

23 MR. CRAIN: Let's go off the record.

24 THE VIDEOGRAPHER: We are going off the
25 record. The time is 10:17 a.m.

1 (Recess taken.)

2 THE VIDEOGRAPHER: The time is 10:34 a.m.

3 We are back on the record.

4 BY MR. CRAIN:

5 Q Thank you, Mr. Vredenburg. Welcome back.

6 A Thank you.

7 Q I want to go back to Exhibit 5. You had
8 started to say something, and then I redirected us
9 back. But I want to make sure you got a chance to
10 say what you were going to say.

11 So you were looking at your Exhibit --
12 your Figure 2, which is the Hospital Safety Grade
13 website -- webpage. I'm going to get that right
14 today. And you started talking about folds.

15 Do you know what I'm talking about?

16 A Yes, sir.

17 Q I want to just -- can you -- if it works
18 for this exhibit -- maybe it doesn't -- can you tell
19 me what is above the fold, what is below the fold?
20 You talked about second or third.

21 Can you give me the analysis you were
22 starting to give me before on this exhibit?

23 A Yes.

24 Q Okay. Let's do it.

25 A Great. So one of the research papers that

1 I cite in my report talks -- talks about that and
2 talks about the frequencies of how far people go
3 down the fold and how that's actually been changing
4 over time. And that's been changing for several
5 reasons.

6 So one of them is that screens are higher
7 resolution, and they can be larger. Obviously,
8 Smartphones kind of change that whole equation too
9 because they're smaller. But that, in the past,
10 being above the fold was pretty much everything,
11 where, you know, 80 percent of the time looking, and
12 eyeballs would be above the fold. And that was kind
13 of a more narrow area too because we had smaller,
14 lower-resolution screens.

15 Now, because screens are becoming larger
16 and people are becoming more used to going deeper
17 into websites and reading deeper into content,
18 that's pretty dramatically changed. And most people
19 make it to at least 80 percent down pages, as a
20 general rule.

21 Q Where does that number come from? Is that
22 from the paper you referenced?

23 A Yeah, it comes from the paper that I
24 referenced. I think it's from The Nielsen Group.

25 Q Yeah. And I think it said it used to be

1 that 80 percent of people don't scroll down the
2 page, but now it's 57 percent?

3 MS. WOOD: Objection to form.

4 THE WITNESS: That sounds correct to me.

5 BY MR. CRAIN:

6 Q Perhaps it's changing now because of
7 phones, as you noted, right?

8 A Yes.

9 Q My question is a little bit different.

10 On Exhibit 5, can you tell me what's above
11 and below the fold, or it doesn't work that way?

12 A That large bit leading in was just to kind
13 of say it depends on a specific person's computer.
14 So it's not always going to be the same. But, you
15 know, I think that the way that this is printed out
16 actually is a decent representation. It's going to
17 be true for at least a lot of average users.

18 First page is above the fold. The second
19 page would be the second fold. Third page would be
20 the third fold.

21 Q And does fold correspond to scrolls?

22 A No.

23 Q Okay.

24 A I think it might be a reference to
25 physical paper.

1 Q Okay. Got it.

2 A But that's my understanding of it, is each
3 fold would be completely scrolled down from the
4 last.

5 Q On Exhibit 5?

6 A Yeah. Well, yeah. So I think it's well
7 represented by each page. So --

8 Q Got it.

9 A -- first page, first fold; second page,
10 second fold and so forth.

11 Q Okay. Got it. That's all.

12 I want to change gears. I just didn't
13 want to leave that, you know, thread. You can set
14 that aside for now.

15 I want to go back. We talked a little bit
16 about your assignment, but we didn't start with your
17 opinions. I want to go into your opinions and also
18 your history and your qualifications. You know,
19 sort of go through that.

20 I assume you've gone through that dance
21 before in other depositions, right?

22 A Yes, sir.

23 Q So can you -- so you talked about the
24 scope of your assignment.

25 Can you tell me what are the -- feel free

1 to reference your report -- what are the opinions
2 you're rendering in this case?

3 And just for the record, can you say which
4 page of your report, which is Exhibit 1, you're
5 going to?

6 A Not a problem. So page 9 for Opinion 1.

7 Q Okay.

8 A And I'm just going to read it verbatim
9 here.

10 Q Great.

11 A "The website's design ensures high clarity
12 and transparency for reasonable consumers."

13 Q And stopping you there, when you say "the
14 website," are we just now talking about Figure 1 and
15 Figure 2?

16 A So, in the way that I see it, I would
17 answer "yes," but I want to put like a disclaimer,
18 just to make sure it's clear.

19 So the -- if we go back to Figure 2.

20 Q Yep.

21 A So Figure 1, that's going to be identical,
22 you know, who whoever is loading in because, you
23 know, it's not to a particular hospital or anything
24 like that. So that's always going to be the same.

25 Q Yep.

1 A And we had a discussion earlier about, you
2 know, this is for the Good Samaritan Medical Center.

3 Q Yeah. I take that point. You're saying
4 that the page -- regardless of the ultimate
5 hospital, the layout, the content of the Figure 2
6 model, right?

7 A Yeah. So the user experience is identical
8 between the different hospitals; while there are
9 different pages, the user experience between the
10 pages is identical. So this is used as, you know,
11 an example of a subject page.

12 Q Yep.

13 A The user experience in terms of where
14 everything is laid out, where all the buttons are,
15 all the links, they're identical for this hospital
16 versus another hospital.

17 Q Sure.

18 A So I'm encompassing all possible
19 hospitals.

20 Q So, in Opinion 1, "The website's design
21 ensures high clarity and transparency for reasonable
22 consumers."

23 When you say "the website," that means the
24 landing page of Figure 1 and any hospitals' page as
25 modeled by Figure 2; is that fair?

1 A Yes, sir.

2 Q And no other pages are the subject of
3 Opinion 1?

4 A So I would say that there is reference to
5 other pages because of the links on this page. So
6 the actual content of them, you know, goes beyond --
7 except for that I evaluated them and said that, you
8 know, this is getting, you know, for an expert user.

9 Q So let me just be a little concrete.
10 We talked about in Figure 2, the top right
11 corner where it says the detailed table.

12 Do you remember that?

13 A Yes.

14 Q Does your Opinion 1 that "The website's
15 design ensures high clarity and transparency for
16 reasonable consumers" -- do you also opine that the
17 detailed table webpage ensures high clarity and
18 transparency for reasonable consumers, or no?

19 A No.

20 Q Got it. Okay.

21 Are there any other webpages for which
22 Opinion 1's -- that you say the design ensures high
23 clarity and transparency for reasonable consumers
24 apply to?

25 A Yeah. So my analysis was focused on these

1 two pages. You know --

2 Q I just want to make sure we're closing the
3 loop.

4 Are there any other pages beyond the ones
5 reflected at Figure 1 and 2. It's not a gotcha
6 question. The models. Any other pages to which
7 this applies?

8 For instance, the FAQ, the "about the
9 grade," the methodology, or is it just those two?

10 A It's an important question. I want to
11 read this over and give that a little bit of
12 thought, if that's okay.

13 Q Okay. You want to read Opinion 1?

14 A Yeah. I'm just going to --

15 Q It's a paragraph. Feel free to read
16 Opinion 1. And then we'll go on to Opinion 2.

17 A Is it all right for me to begin again?

18 Q Yes. I just want to know -- your
19 Opinion 1 says "The website's design ensures high
20 clarity and transparency for reasonable consumers."

21 We've established that your opinion on the
22 clarity and transparency applies to the website
23 at -- webpage at Figure 1 and the model of the
24 website at Figure 2, regardless of hospital,
25 correct?

1 A Correct.

2 Q Are there any other page webpages to which
3 your Opinion 1 applies?

4 A So I think that the last part of the last
5 sentence --

6 Q Where?

7 A -- as well, for the --

8 Q Sorry, which sentence?

9 A It's on the top of page 10. So I think
10 what you said is fair. I just want to throw in "and
11 links to educational video on using the grade and
12 making the site an effective tool for informed
13 decisions without requiring technical expertise."
14 I'm sorry. I probably should have started a little
15 bit earlier.

16 But it's just talking about the different
17 links that are available. So I just wanted to point
18 out that I did evaluate those links, but the focus
19 definitely is on Figures 1 and 2 on those pages.

20 Q Just to make sure, when you say you
21 evaluated -- just because I need to be -- and I
22 don't mean to be difficult, but we need to know what
23 you're going to testify to at trial. And that's the
24 whole purpose of the rules, the whole purpose of
25 today, right?

1 So my question is, when you say
2 "evaluate," is your opinion that the design ensures
3 high clarity and transparency -- are the links
4 informing your view of the website at Exhibit --
5 webpage at Exhibit 2, or are you saying those other
6 pages that are linked have high clarity and
7 transparency?

8 A So, yeah, I'm not opining on those other
9 pages and those other links --

10 Q Great.

11 A -- in terms of their clarity and
12 transparency.

13 Q That's helpful. Thank you. I just want
14 to make sure we understand where we're going.

15 Now, you also say here "educational
16 videos." Is that a typo and there's one, or are
17 there more videos than the one we talked about
18 today?

19 A So it would only be the one, because those
20 are the pages that I evaluated, and I don't believe
21 Figure 1 has any shown, which I'm just going to
22 double-check here. But . . .

23 Q So to the best of your recollection today,
24 that sentence should have been referring to one
25 video?

1 A Yeah. That's fair to say.

2 Q Okay. Again, I'm just asking for your
3 best recollection today. If you don't remember,
4 that's fine too.

5 Okay. So that's Opinion 1. We'll come
6 back and do a little deeper dive.

7 Do you want to go into Opinion 2?

8 A Yes, sir.

9 Q So we're looking at page 10 of Exhibit 1?

10 A Yes.

11 Q Great. Go ahead.

12 A "The website's readability enables
13 accessibility for a general audience."

14 Q You know what my question will be. Just
15 to make sure, is it -- when you say -- we can do it

16 throughout. When you say "the website" in your
17 opinions, are we still just talking about Figure 1
18 and the model of Figure 2?

19 A Yes, sir.

20 Q And again, when I say "the model of Figure
21 2," I mean any hospital page, but just that page,
22 right?

23 A Yeah. I would also say it applies to the
24 search page between them, the link.

25 Q Okay.

1 A You've got your initial home page, your
2 search page, the landing page, which is shown in
3 Figure 2.

4 Q Okay. So that was three, the first of
5 which is Figure 1, the third of which is Figure 2,
6 the second of which is not referenced, right?

7 A Correct.

8 Q But it is part of your opinion?

9 A Yes.

10 Q Okay. All right. So that's Opinion 2.
11 How are Opinions 1 and 2 different?

12 A So Opinion 2 has a focus on readability
13 level based on a couple popular yardsticks. But --

14 Q Is that what "accessibility" means in that
15 context?

16 A Yes. So the main sort of quantitative
17 analysis for Opinion 2 was performing the reading
18 grade -- the reading grade analysis for what reading
19 level the page was at.

20 Q Okay. Got it. We'll come back to it. I
21 just wanted to make sure I understood.

22 And the headers on 1 and 2, 1 says
23 "Transparency and Clarity," 2 says "Accessibility."

24 Is that the primary difference too at a
25 big-picture level?

1 A Yes.

2 Q Go on to 3, which is on page 11.

3 A "Imputed scores are readily clear to users
4 with a basic reading comprehension."

5 Q We'll come back to that one.

6 You want to go Opinion 4, page 12?

7 A "Leapfrogs' UX testing validates the
8 website's clarity in contrast to Berger's untested
9 methodology."

10 Q And then the last one, I think is page 14.

11 A "Google Analytics data demonstrates high
12 user engagement with full-page content, ensuring
13 visibility of key disclosures."

14 Q Now, "full-page content," again, similar
15 question to Opinions 4 and 5.

16 Are we referring to those same webpages
17 only?

18 A Yes.

19 Q Okay. Now, just to make sure we've closed
20 the loop, do you have any other opinions in this
21 case that you intend to present at trial beyond
22 those five?

23 A No.

24 Q Okay. And you've not -- have you
25 developed any additional opinions since serving your

1 report?

2 A No.

3 Q And your supplemental report does not
4 contain new opinions. It just fixes certain
5 ministerial errors?

6 A Computer bug that didn't end up changing
7 any analysis, but it was a bug, and I wanted to fix
8 it.

9 Q Okay. But no opinion change?

10 A No opinion change.

11 Q Okay. So let's shift gears. You can set
12 this aside for now.

13 I want to talk -- we'll go -- I promised
14 you the dance of your qualifications and expertise.
15 Let's talk about that.

16 So your -- so can you -- can you tell me
17 what the area of expertise you or counsel are
18 seeking to offer you at trial as? How would you
19 describe it?

20 A So I would say the umbrella of my
21 expertise is human factors engineering. And a
22 subset of that, which I received the certification
23 in, is user experience.

24 Q So let's start with -- let's take each of
25 those in turn.

1 Human factors engineering. I didn't know
2 what it was before I looked it up, but what is it?

3 A Great. So human factors -- I'll start
4 just there. What's human factors.

5 Q Uh-huh.

6 A So human factors is trying to make
7 products or systems that we live in for humans. So,
8 if you run a factory and you've got robots going on
9 in a factory and you don't have people in there,
10 there's no human factors going on because that's
11 just an industrial system.

12 And I do have a degree in human factors
13 and industrial engineering, a master's in that. And
14 so industrial engineering would be like, you know,
15 you've got this automated factory, and that's just
16 industrial engineering. And human factors would be
17 "How I do make a machine for a human to work with in
18 a factory?" or "How do I make a car safe? How do I
19 do make an interface on a plane safe? How I do make
20 a website understandable?"

21 So it's what are the limitations of
22 humans, and how do we apply that to design and the
23 systems that we create.

24 Q I had read that one example of human
25 factors engineering is just a keyboard; is that fair

1 to say?

2 A Sure.

3 Q Like the design of whether -- and my
4 understanding is our keyboard is a terrible design,
5 and there are better ones.

6 Is that right?

7 A That's correct.

8 Q That's one example of human factors
9 engineering?

10 A Yeah, human computer interface.

11 Q Yeah. Okay. And then -- so -- and then
12 talk to me about what UX is for a second.

13 Is that a subspecialty?

14 A It is a subspecialty. And it stands for
15 "user experience." So that's applying human factors
16 to computer interaction. So it is kind of broad
17 because just a website, that's an obvious
18 computer/human interaction, but now computer/human
19 interactions are getting pretty complex. It would
20 be virtual reality or talking to your virtual
21 assistant and any way that you interact with a
22 computer or a system, that's user experience.

23 Q Is it fair to say that like your human
24 factors engineering is almost like your medical
25 school degree, and UX is like neurology? Like some

1 subspecialty within that broader umbrella?

2 A Sure.

3 Q And then is UX specific to computers only,
4 or are there other applications?

5 A There's definitely other applications.
6 The birth of it, in terms of being heavily studied
7 and documented in the literature, what, you know,
8 students are going to learn about first is pilots
9 working with their instruments and their interface.
10 That's the user experience for, like, flying a
11 plane.

12 Q Got it.

13 That strikes me as a little more analogous
14 to the industrial engineering we were talking about
15 a moment ago; is that fair, or no? I mean, tell me
16 how they're different.

17 A So I would definitely put that under the
18 category of "user experience" and more like a
19 repetitive task with the machine being more like
20 industrial.

21 Q Got it.

22 A But there can definitely be overlap. So
23 you can have user experience of a machine in a
24 factory. So . . .

25 Q Got it. Okay.

1 And then you had said earlier your
2 expertise in human factors engineering, UX, is very
3 different from Professor Berger's, right?

4 A Yes.

5 Q And his is more about -- well, you tell me
6 what his -- what you understand his expertise to be.

7 A So I believe his expertise to be in -- as
8 a marketing professor.

9 Q And consumer choice and consumer
10 psychology?

11 A As it relates to his profession and what
12 he teaches in marketing.

13 Q Okay. And then let me go back to
14 something you said when you were talking about human
15 factors engineering more broadly.

16 You talked about website
17 understandability, I think; is that right?

18 A Usability?

19 Q Usability. I'm sorry. I couldn't even
20 read my own handwriting. Usability. That's not
21 very usable.

22 Tell me -- so what is your experience with
23 website usability?

24 A So I have created several websites that
25 get used for my company, as well as I've done

1 published research on evaluating the usability of
2 online learning platform for WINGS, I believe it's
3 called. So I performed that research and got that
4 published as well.

5 Q So starting -- let's go to that. I want
6 to go to your report again, Exhibit 1, if you could
7 pull it out. Appendix A. Yeah.

8 You mentioned a moment ago that you have
9 done research for online -- for learning platform
10 for WINGS, right?

11 A Yes.

12 Q What is WINGS?

13 A So it's the online learning platform for
14 Wright State, which is the university I got my
15 master's degree on.

16 Q Got it. Okay.

17 And then is that -- so, if you can go to
18 page 20. This is your Appendix A.

19 Do you see that?

20 A Yes.

21 Q And Appendix A, you understand under Rule
22 26, you have to give a list of your publications for
23 the last 10 years, right?

24 A Yes.

25 Q Is that WINGS research reflected here?

1 A Yes. It's at the top of the page.

2 Q Where is -- 2021?

3 A Yes.

4 Q Got it. Okay.

5 So user -- "An evaluation of pilot
6 education platform an online at Wright State
7 University." That's it?

8 A Yes.

9 Q And what was the thesis of that paper?
10 Go ahead. Yeah.

11 A So I started as kind of like a pilot
12 program for Wright State as one of the first online
13 students to ever be at the school. And I believe
14 that that actually started immediately before the
15 pandemic. So it was by coincidence that I had --

16 Q Good timing.

17 A -- that I had already been remote.

18 But they told me it was going to be a
19 hybrid program because they were just trialing it
20 out, and so I would need to fly to campus
21 periodically. But the pandemic hit. Everybody got
22 forced online. And everybody had to do some rapid
23 iteration, really quick learning on how does online
24 learning work.

25 And so they knew that they had some big

1 holes in their program, that it wasn't, you know, a
2 final polished version. It was more like "We got
3 forced onto this, and this is, you know, one of the
4 earlier iterations. So we need to start working on
5 this and how to improve it."

6 So it evaluated different aspects on
7 how -- how it could be improved and what the
8 strengths and weaknesses were. And so it was kind
9 of a proposal for them on how to keep improving.

10 Q And you were getting your master's degree
11 at the time?

12 A Yes.

13 Q So what expertise did you draw on to write
14 this paper?

15 A So the coursework that I was working on in
16 user experience, I published this alongside user
17 experience professor, Dr. Cao, as well as a Ph.D.
18 student, Paul Stone.

19 Q And you're the first author?

20 A Yep.

21 Q Pretty good.

22 A And I had also done a lot of publications
23 before that. This isn't all the publications.
24 There's some more beyond this page. I just did 10
25 years.

1 Q Okay.

2 A And so I'm just in the habit of
3 periodically, when the right opportunity arises,
4 doing a publication. And like I had told you, I'm
5 already kind of working on the next one.

6 Q Yep. So let me ask you, just going back
7 to this one, was this peer-reviewed?

8 A Yes.

9 Q And do you know who -- like, how that
10 process unfolded?

11 A Absolutely. Yeah. This is through the
12 Human Factors and Ergonomics Society. So they are
13 the biggest, you know, sort of authority on the
14 subject. And so it's kind of a professional
15 membership as well as a research membership, and it
16 encompasses a lot. It's a big organization.

17 They throw absolutely huge conferences.
18 And I enjoy attending. I've even -- I've even ended
19 up chairing sessions before through them. And I was
20 the secretary for the Forensics Professionals Group
21 there as well and --

22 Q Let me go back to my original question.

23 I asked you about -- you had mentioned
24 website usability, and I asked you about your
25 experience with that, right?

1 A Yes.

2 Q And you referenced this paper, right?

3 A Yes.

4 Q What other experience do you have with
5 expect to website usability?

6 A So that would be the certification and UX.

7 Q UX. Okay. Tell me more about that.

8 A So after completing my master's and
9 receiving that degree, at that time, I was still
10 pursuing a Ph.D. as well. And so I thought, you
11 know, I might as well add on this certification, do
12 some classes relevant to it. I feel like it's a
13 really useful specialty.

14 And I -- you know, master's through 95 to
15 99 percent of the coursework through Ph.D. Made it
16 through with a 4.0 straight As and --

17 Q Why did you not complete the Ph.D.?

18 A So the problem is, whatever research that
19 you're doing, the university ends up owning at least
20 half of it. And the work that I'm patenting and
21 working on, I definitely don't want to give up half
22 of the ownership of. So it just wasn't a smart move
23 to -- you know, I've only got so much time to be
24 working on patents and research. And, you know, as
25 kind of a tactical decision, I decided that I didn't

1 want the university to own half of it.

2 Q You're saying anything you patent,
3 regardless of how related to the university it is,
4 they would own half of it?

5 A If it's a part of your dissertation
6 research, yes.

7 Q Got it.

8 So for you -- so what was your
9 dissertation going to be on?

10 A On digital warnings.

11 Q And you've not published that?

12 A No.

13 Q Okay. You have another piece I think I
14 saw about digital warnings, right? Or not digital.
15 About warnings generally.

16 A Risk communication?

17 Q Yeah. And there was a hierarchy of three
18 things, right?

19 A Yes.

20 Q Yeah. Okay.

21 Separate from that, that's not your
22 dissertation?

23 A Separate from that, yeah, that's not the
24 dissertation.

25 Q Got it. Okay.

1 So, ultimately, anything relating to
2 digital warnings was going to be owned half by the
3 school?

4 A Yes.

5 Q Did you sign a contract for that?

6 A That's just standard procedure for --
7 that's how schools make almost all their money.
8 The, like, undergraduate tuition and stuff, that's a
9 drop in the bucket. They make all their money off
10 intellectual property.

11 Q Even if you're not -- even if you're
12 researching something separately, like off campus?

13 A If it's a part of your dissertation.

14 Q If it's part of your dissertation. Got
15 it.

16 So like your 3D printer, for instance --
17 right? -- that business, would that have been part
18 owned by the school?

19 A So I wanted to pivot to that because
20 that's -- I've made incredible strides on that, and
21 I didn't have time to do both. So I was thinking,
22 well, do I want to make this my dissertation focus.
23 And then when I found out that the university would
24 own half of whatever, you know, becomes a part of
25 that patent, that is a real business killer.

1 Q And that business was related to your
2 dissertation?

3 A So the Ph.D. was just a Ph.D. of
4 engineering. So anything related to engineering
5 could have been the focus of the dissertation.

6 Q That is crazy. Wow. Okay.

7 So your entire business, they could have
8 claimed half of?

9 A Yes.

10 (Exhibit 6 marked for identification.)

11 BY MR. CRAIN:

12 Q I want to mark as Exhibit 6. Okay. Thank
13 you.

14 Do you recognize this document? Have you
15 ever seen it before?

16 A I recognize it. I'm not sure if I've seen
17 it before or not. Likely I have.

18 Q What does it appear to be?

19 A The graduate certificate information
20 about, I guess, what courses are required for it.

21 Q Now, can you flip through it quickly? I
22 think it's just a page.

23 Is this a true and accurate depiction of
24 the experience you went through when you got the UX
25 certification?

1 A Yes.

2 Q So, for instance, the required courses, do
3 you see that in the middle of the page?

4 A Yes.

5 Q Did you take those three courses?

6 A To the best of my memory, yes.

7 Q Did you take other courses?

8 A Yes.

9 Q Did you take any course specifically about
10 website design?

11 A Well, they definitely accompany that. I
12 don't know if there was -- I don't recall if that
13 was specifically the focus of any, but, you know,
14 doing mockups for websites as definitely the focus
15 for them. So how you do the mockups, how you do the
16 testing for the user experience to see, you know, if
17 you've got an effective design, how to do the
18 iteration, what software gets used for that.

19 Q Got it.

20 So it was covered at least to some degree?

21 A Heavily, yeah.

22 Q And, for instance, the IAG 7340 user
23 experience design for mobile computing, do you see
24 that?

25 A Yes.

1 Q Is that like design for phones?

2 A Yes.

3 Q And that's like website for phones or like
4 phone interface?

5 A Websites or apps.

6 Q Or apps. Got it. Okay. I'm just taking
7 a look.

8 And I think it was nine credits; is that
9 right?

10 A Yes.

11 Q How many courses does that amount to?

12 A Three.

13 Q So it's just these three required courses
14 get you the certification?

15 A Right.

16 Q Did you take those at the same time you
17 were doing your master's?

18 A No. That was after I received the
19 master's.

20 Q Got it. Okay.

21 So you came back to do the certification?

22 A Well, so I entered Wright State as a part
23 of their Ph.D. program initially and received a
24 master's along the way.

25 Q Got it.

1 A And after receiving the master's, I just
2 so happened -- the timing was that I got interested
3 in this certification. And so I received that
4 immediately after the -- receiving the master's.

5 Q Got it. Okay.

6 And just stepping back a little bit, you
7 walked me through your education. You went to high
8 school in Carlsbad?

9 A Yes.

10 Q You graduated in 2012?

11 A 2010.

12 Q 2010. Okay.

13 Then you went to Berkeley? Am I recalling
14 right?

15 A UC Berkeley. Yes.

16 Q What degree did you get there?

17 A Bioengineering.

18 Q Okay. And then from Berkeley, where did
19 you go?

20 A To Wright State University.

21 Q Did you work in between or you went
22 direct?

23 A I did work in between.

24 Q Where did you work?

25 A At Vredenburg & Associates.

1 Q We'll come back to that.

2 But then you went to Wright State to get
3 the master's?

4 A So I got accepted into the Ph.D.
5 program --

6 Q Yeah.

7 A -- and received the master's along the
8 way.

9 Q And then the certification?

10 A Yes.

11 Q Any other educational history?

12 A No.

13 Q Besides middle school and all that. I
14 assume you got those.

15 Going back to the Ph.D. Why did you want
16 to get a Ph.D.?

17 A So you can see from my background that I
18 like research, and I like doing publications. And
19 so the idea of a dissertation and focusing heavily
20 on one topic and really putting together kind of a
21 more substantial research than a typical research
22 paper really appealed to me.

23 Q You were an aspiring academic?

24 A I don't think I wanted to be a professor,
25 but I really like research.

1 Q Okay. And then why did you want your
2 Ph.D. to be in human factors engineering, if that's
3 right?

4 A So the Ph.D. would have just been
5 engineering, a Ph.D. of engineering. So it wouldn't
6 have been attributed to -- you know, it is whatever
7 the dissertation is, basically.

8 Q Got it. Okay.

9 So your specialty would have been whatever
10 your dissertation yielded in the end, right?

11 A Right.

12 Q How far did you get into doing your
13 dissertation?

14 A About a year.

15 Q How far did you -- how much did you write,
16 if anything?

17 A I'd say probably only about 10 pages. I
18 think the focus was more on the background research
19 and figuring out how I wanted to go about conducting
20 the research.

21 Q Okay. And then how long were you at
22 Wright State all told? I think it's there. Feel
23 free to reference. Just figure you're the expert in
24 you.

25 A So it doesn't say exactly. I would have

1 to give my best estimation. I believe I started in
2 2018 or 2019.

3 Q Okay.

4 A And I estimate that I went on hold in
5 2022.

6 Q Okay.

7 A So technically, everything is on hold, and
8 I could pick up there if I wanted to.

9 Q Got it.

10 A But at this time, I don't have the
11 intention to.

12 Q So you were there for like two or three
13 years?

14 A Yeah. Well, I think it was a little bit
15 longer than that. 20- --

16 Q It says your UX certificate was 2021.
17 Do you see that?

18 A I think I was there about four years.

19 Q So what years?

20 A I think between 2018 to 2022.

21 Q Okay. And you had one year of your
22 dissertation?

23 A Well, yeah.

24 Q And how long did it take to get your
25 master's?

1 A Two years.

2 Q Okay. And going back, you said you
3 graduated high school in 2010, right?

4 A Yes.

5 Q And you graduated from Berkeley in 2016,
6 right?

7 A Yes.

8 Q Love Berkeley. Fabulous food. Set that
9 aside.

10 What did you do -- how long did it take to
11 get your degree at Berkeley?

12 A It took six years.

13 Q Did you do extra degrees or it just took
14 more time?

15 A So I, believe it or not, was two classes
16 short from a minor in practice of art. So I did
17 take some extra time to do practice of art, like oil
18 painting.

19 Q Uh-huh.

20 A But at the end, I was pretty ready to go,
21 and I knew that a minor in practice of art was not
22 necessary for, you know, anything that I was doing
23 going forward. So it was more about the process
24 than -- than -- and also, Berkeley is impacted, and
25 it's tough. It's pretty normal for it to take

1 longer than four years for people to get through.

2 Q Got it. Okay.

3 And you got a BS in bioengineering?

4 A Yes.

5 Q And you were going to get a minor in --
6 what was it again?

7 A Practice of art.

8 Q Practice of art. Okay. Got it.

9 And you ultimately decided to set aside
10 the practice of art?

11 A Correct. Yeah.

12 Q Okay. Let's see. Okay.

13 And your BS, were you pursuing that the
14 whole time you were there, or you changed major?

15 A I was always pursuing that.

16 Q Just a challenging degree?

17 A Yes.

18 Q Okay. Let's set that aside.

19 Are you a member of any professional
20 organizations?

21 A Yes. The Human Factors and Ergonomics
22 Society.

23 Q Okay. What is that?

24 A So they have a -- I think they have two
25 conferences a year, actually, now, one focused on

1 healthcare, and one focused on the general human
2 factors. And you can see I published with them and
3 presented with them a decent number of times.

4 Q Yeah.

5 A I mentioned that I've chaired a session,
6 and I was the secretary as well for one of the
7 groups there.

8 Q What session did you chair?

9 A That's a great question.

10 Q I try. Every 10 questions or so.

11 A I remember the process of chairing it. I
12 just want to make sure I give you the right answer.

13 Q I can narrow the question, if it's
14 helpful.

15 A Oh, here we go. I've got it listed. Risk
16 prevention and assessment.

17 Q What does that mean?

18 A In 2017.

19 So I would summarize that by saying hazard
20 management.

21 Q Okay. Got it.

22 And what does "hazard management" mean?

23 A Sure. So it would be taking the design
24 philosophy of designing a system or a thing or a
25 product to not hurt people. And if for whatever

1 reason you can't design that out -- like say a
2 circular saw. You can't remove the blade. It's
3 inherent to the design.

4 Q Yep.

5 A Then the next area is a barrier. So
6 modern saws typically have a barrier that will go
7 over the blade. And then the final hazard
8 management technique is warnings.

9 So, if you've tried to design and barrier
10 out the hazard, then you go through the whole gambit
11 of doing warnings.

12 Q And your paper, I think, says warnings are
13 the least effective to avoid the hazard, right?

14 A Correct.

15 Q And then I'm trying to think.

16 Any of your work for the Ergonomics
17 Institute? I'm trying to say that right.

18 A Human Factors and Ergonomics Society.
19 It's a mouthful.

20 Q Yeah. It is a mouthful. I'll say "the
21 society." How about that?

22 A Yeah.

23 Q Does any of your work for the society
24 involve website design?

25 A No.

1 Q Any other papers or expertise in your
2 history relating to website design?

3 A No.

4 Q Okay. So just to summarize, you have the
5 article from 2021, right?

6 A Correct.

7 Q Anything else I'm missing?

8 A Related to user experience in particular?

9 Q Well, related, sorry, first to website
10 design.

11 A Correct.

12 Q Okay. And then related to user
13 experience.

14 A I want to say yes. I feel like there
15 might be tangentially related to user experience
16 because it's pretty broad for some of the other
17 ones --

18 Q Yep.

19 A -- like risk communication.

20 Q That's on page 21 of your report, Appendix
21 A?

22 A Page 20, I think.

23 Q 20. I see risk communication for consumer
24 products.

25 A Yeah. That could be related to user

1 experience.

2 Q But that one was not about websites,
3 right? I think that was the one you just gave the
4 example about the saw.

5 A My apologies for the delay. I was just
6 reading through it.

7 Q Yeah.

8 A I believe that you're correct.

9 Q Okay. Got it.

10 And correct -- sorry, just so we're clear,
11 because I lost my question. My question was, any
12 other experience, published article, presentation
13 about user experience beyond -- it looks like risk
14 communication. There's a paper and a presentation.

15 Anything else?

16 A User experience of websites.

17 Q Yeah.

18 A Yes.

19 Q Nothing else?

20 A Correct. For user experience of websites.

21 Q Okay. What about user experience more
22 broadly?

23 A Using consumer products, that's definitely
24 a type of user experience. Risk communication --

25 Q Sorry. What's an example of -- just for

1 the record, consumer products, what does that mean
2 in this context?

3 A How you use a consumer product. So a car
4 is a consumer product. How you use a car, that's
5 definitely deep into user experience.

6 Q Does my cleaning product example work from
7 earlier or no?

8 A I think it could.

9 Q So physical products more?

10 A Yeah.

11 Q Got it. Go ahead. Sorry.

12 A And so risk communication of consumer
13 products, that's related to user experience.

14 Q Okay. Anything else?

15 A And then I had an older publication too.
16 They requested it yesterday.

17 Q That was the one --

18 A That was the one was related to user
19 experience as well.

20 Q That was referenced, I think, in one of
21 the paragraphs of your report, right?

22 A No, it wasn't.

23 Q Oh, it wasn't. We're talking about the
24 2019 article?

25 A Yeah. I don't think I referenced it.

1 Q Got it.

2 Take a look at paragraph 5.

3 A Oh, yeah. No, actually, I did. You're
4 right. It's a not footnote. That's what I was
5 thinking.

6 Q It's not a footnote. Yeah. It's not
7 listed in your publications, right?

8 A Yeah.

9 Q Because it's beyond 10 years.

10 A Yeah. I know which paragraph you're
11 talking about now, yeah.

12 Q What's your recollection of what that
13 paper provided?

14 A Sure. So the main thing was that
15 communicating health literature, communicating
16 health information to consumers is challenging. And
17 it's been a major challenge for pharmaceutical
18 companies and for healthcare providers for a while,
19 figuring out how to do it effectively.

20 And that particular research found that,
21 for the drug that was a part of the study -- I
22 believe it was Warfarin, a blood thinner, that was
23 evaluated with a comprehension test with a -- I
24 believe it was a pretty decent number of
25 participants, and found that even college-educated

1 participants were making kind of life-critical
2 errors.

3 So it was just an indication that the
4 patient information sheet was not written to an
5 accessible level. So it was evaluation of when and
6 how and why health information is accessible.

7 Q And this is not a piece about websites,
8 right?

9 A No. This is about the written word.

10 Q I just want to mark the exhibit, just so
11 we're sure what we're talking about.

12 MR. CRAIN: This is exhibit what, 7?

13 (Exhibit 7 marked for identification.)

14 BY MR. CRAIN:

15 Q And I apologize, this one is not stapled.
16 Just for identification, Mr. Vredenburgh,
17 is this the article you were referring to?

18 A Yes.

19 Q Great. Okay.

20 Let me shift gears. I'm not going to ask
21 you about it. I just wanted to make sure we were
22 talking about the same thing.

23 Do you have any experience with respect to
24 healthcare beyond the topic of this article?

25 A So I did an internship at UCSD med school

1 for a summer as well, doing research on studying --
2 and this is going to sound obvious, but this was
3 what the research was on -- on the link of people --
4 children being exposed to cigarette smoke at home
5 and adverse events from that.

6 Q Got it.

7 A So I got the opportunity to do that as
8 well.

9 Q Okay. Anything else?

10 A No.

11 Q Okay. You can -- oh, and one last
12 question.

13 That was published in 2009, right?

14 A Correct.

15 Q So you were in high school, right?

16 A Correct.

17 Q Okay. Got it. Okay. You can set that
18 aside.

19 A Yeah. The context for this -- because you
20 might be thinking, like, why is a high school
21 student publishing --

22 Q You love research.

23 A -- in the Human -- in this professional
24 society. I was very competitive with the science
25 fairs as a high schooler. I believe I got first

1 place in sweepstakes every year and first place in
2 the International Science Fair. And that was the
3 research that ended up getting published here.

4 Q Okay. Got it.

5 So that's -- that paper is the product of
6 the sweepstakes?

7 A Yes.

8 Q And what's the name of the sweepstakes, if
9 you recall?

10 A So there's the Greater San Diego
11 Sweepstakes, and then that leads on to the state and
12 international science fairs. And for the state
13 science fair, this got first place as well. And I
14 think for the international, it was fourth.

15 Q Got it. Okay.

16 A So it was pretty substantial research to
17 get to that point to be able to, you know, make it
18 through those competitions.

19 Q Yeah. Okay. You can set that aside.

20 I want to talk -- you mentioned briefly
21 employment history, right?

22 So you -- I think you -- the first thing
23 on your CV is Vredenburg & Zackowitz.

24 What is Vredenburg & Zackowitz?

25 A So at the time -- for most of the time

1 that I was working for the company, it just would
2 have been Vredenburg & Associates. It's the
3 company that my mom owns. She is also a human
4 factors expert witness and consultant.

5 Q Runs in the blood.

6 A And so I grew up in the firm. I was going
7 to inspections since middle school and --

8 Q Inspections of what?

9 A Of accidents for litigation.

10 Q Got it.

11 What type of cases were those for?

12 A One that really stuck out in my head early
13 on was for an underwater welding system, which I
14 thought was super cool.

15 Q That is cool.

16 A And got to use the welder, and I thought
17 that was -- that really stuck with me.

18 Q That's interesting.

19 Did you go underwater?

20 A I didn't. I didn't get to go underwater,
21 but that was fun.

22 Q That's cool.

23 Is it fair to say most of your experience
24 in human factors is more like about the physical
25 engineering?

1 A Well, user experience doesn't really have
2 much to do -- well, it's 50/50. It does have to do
3 with the physical world too.

4 Q Yeah.

5 A But that's an interesting question. I
6 feel like, you know, my -- my engineering degree at
7 Berkeley, I would say didn't have too much focus on
8 the physical world because it was focused in
9 computational biology for bioengineering.

10 Q Got it.

11 A So that doesn't have much focus on
12 physical products in the physical world.

13 Q Thus the interest in med school?

14 A The interest in --

15 Q You did the internship at UCSD --
16 right? -- medical?

17 A Oh, yeah, yeah. That was between -- that
18 was either going to college or like one of the first
19 summers of college. And yeah, I was interested in
20 premed at first and quickly wised up.

21 Q Fair enough.

22 So post that, what have you been -- well,
23 I'll come to that.

24 Then just your roles at the firm. So is
25 it fair to say, just to make sure we're on the same

1 page, from 2006 to 2010, you were a forensic and
2 research intern?

3 A Yes.

4 Q From 2010 -- in 2010, you graduated high
5 school, right?

6 A Yes.

7 Q From 2010 to 2016, while you were in
8 college, you were a systems and research analyst?

9 A Correct.

10 Q And then after college, including when you
11 were at Wright State, you were an industrial and
12 human factors engineer, right?

13 A Yes.

14 Q And I'm just trying to think. Did your
15 role change while you were at Vredenburg &
16 Zackowitz? Or Vredenburg?

17 A Certainly. So, you know, before receiving
18 my degree or entering undergraduate, I actually was
19 attending a lot of inspections. And I was even
20 attending depositions. And so I got a lot of early
21 exposure. I got to participate -- or actually, I
22 wasn't participating. I was helping run a lot of
23 big research projects.

24 The firm was doing a lot of research into
25 wheelchair accessibility, so there was a very large

1 study that got put together for that. So I got to
2 set up ramps, set up rooms for that, as well as,
3 like, you know, give the participants, you know,
4 water bottles and stuff to drink and doing -- so
5 things were not automated back then. So I did a lot
6 of data analysis too where there would be, you know,
7 binders like this full of -- full of surveys and
8 tests. And so I would be the one inputting them
9 into the computer at that early point.

10 Q And now you can do it in a minute.

11 A That's probably a good thing.

12 Q Yeah. I'm going to mark as Exhibit 8.

13 (Exhibit 8 marked for identification.)

14 BY MR. CRAIN:

15 Q Do you recognize this document?

16 A Yes.

17 Q What is it?

18 A This is the Vredenburgh & Zackowitz
19 webpage.

20 Q And just flip through it. I just want to
21 get a sense, is this an accurate depiction of the
22 types of work you did during your time at
23 Vredenburgh & Zackowitz or just Vredenburgh?

24 A Yes.

25 Q If you go to page -- there's no page

1 number, but if you go to page -- the third page, do
2 you see it says "Our Expertise"?

3 A Yes.

4 Q "Our consultants serve as forensic, the
5 application of science to law, human factors experts
6 for product liability, personal injury and
7 employment cases in the area of human factors safety
8 and industrial organizational psychology."

9 Is that a fair reflection of Vredenburgh
10 or Vredenburgh & Zackowitz's expertise?

11 A So now that I have my own firm, I would
12 definitely say that is true. There was a period of
13 time where I was the firm's engineer because they
14 don't have engineering degrees. Their focus is on
15 pure human factors. Dr. Alison Vredenburgh and
16 Dr. Ileen Zackowitz, the partners. And so --

17 Q What's the distinction that you're drawing
18 between human factors and engineering? Can you just
19 articulate it?

20 A Sure. We touched on it earlier. I was
21 going the umbrella of human factors, and then
22 underneath it can be various different things, like
23 user experience and human factors engineering.

24 So human factors engineering, I would say,
25 is definitely a specialty within it where you

1 focus -- so on the design hierarchy, as I was
2 telling you about, in order to really opine on what
3 designs are possible or what barriers are possible,
4 doing rapid iterations, making mockups, making
5 models on computers and imprinting them, performing,
6 you know, testing, like destructive testing and so
7 forth.

8 Q Sounds fun.

9 So just the design hierarchy, can you lay
10 it out for me again, the one, two, three?

11 A Sure. So design is the primary first
12 focus of hazard management. So when you're creating
13 a product, creating a saw, first you try to figure
14 out "How do I make this saw so that it can't hurt
15 someone?"

16 Q And then it's guardrail?

17 A And then it's guarding.

18 Q Guarding.

19 A Guarding or barriers.

20 Q And then it's warnings?

21 A And then it's warnings, yes.

22 Q Does the engineer focus on one and two?

23 A No. The engineer will focus on all three.

24 Q Does do all three?

25 A Yeah.

1 Q So the engineer helps with the warnings
2 too?

3 A Yes.

4 Q Going back to this page, it says there's
5 experience for products liability, personal injury,
6 and employment cases.

7 Is that a fair depiction of the types of
8 cases that you worked on at Vredenburg & Zackowitz?

9 A I never did any employment cases.

10 Q Did you do any cases beyond those three,
11 products liability, personal injury, and I guess not
12 employment cases?

13 A I'm not sure if you included it or not,
14 but there was industrial accidents. That would be
15 something that would come up pretty regularly.

16 Q Okay. That may be personal injury. It
17 may be different. That's the question?

18 A Yeah. I would say like factory accidents,
19 that would treat differently than personal injury.

20 Q Okay. And did you serve as a testifying
21 expert at any point for Vredenburg & Zackowitz or
22 Vredenburg?

23 A Yes.

24 Q How many times did you serve as a
25 testifying expert?

1 A I'm going to have to give you --

2 Q Ballpark is okay.

3 A -- an estimate.

4 Q Well, you were deposed 11 times, right?

5 You have been deposed 11 times?

6 A Right. Especially early on, I was
7 retained and worked on a ton of cases, but didn't
8 get deposed.

9 Q Got it.

10 A A lot of the smaller cases would settle
11 early on.

12 Q Of those 11 depositions, how many of those
13 happened while you were at the Vredenburg company,
14 approximately?

15 A I can give you a good approximation on
16 that.

17 Q Okay.

18 A That would be 100 percent of them.

19 Q Got it. Okay.

20 And when was the last time you were
21 deposed?

22 A Looks like August 2nd of 2024.

23 Q So last year?

24 A Yes.

25 Q And when -- well, we'll come to that.

1 Okay.

2 So you are no longer with the Vredenburg
3 firm in any iteration, right?

4 A So I'm still on great terms with them. I
5 don't know if you're going to find it here or not,
6 but I actually still am on their website, still get
7 referrals from them. But I wanted to create my own
8 company because I'm doing so much more beyond --
9 than what they were doing in their company. And
10 so --

11 Q Just to close the loop, are you an
12 employee or contractor, or you're just affiliated?

13 A Just affiliated.

14 Q And then when you say your own company, is
15 that Cherry Tomato?

16 A Yes.

17 Q Tell me about Cherry Tomato.

18 A Sure. So I believe I brought it up
19 before, but there's two primary focuses. It would
20 be consulting and litigation support, as well as
21 product creation, patenting, and kind of the more
22 hard core engineering.

23 Q The case you were deposed in last year,
24 was that a Vredenburg case or a Cherry Tomato case?

25 A Vredenburg.

1 Q Have you gotten any cases through Cherry
2 Tomato yet?

3 A Yes. I believe that I -- I just checked
4 this the other day. I think I'm currently
5 designated on about 20 cases.

6 Q Okay. When you say "designated," do you
7 mean retained or you've been --

8 A Retained, yeah.

9 Q So you're currently serving as a retained
10 expert in 20 cases through Cherry Tomato?

11 A Yes.

12 Q Got it. Okay.

13 And you had said you've been, all told,
14 retained in about a hundred cases, right?

15 A Yes.

16 Q And 70 percent of them have settled; is
17 that right?

18 A Oh, I think it's a higher percent than
19 that.

20 Q Higher percent. Okay. Got it.

21 Because you've only testified at trial
22 twice, right?

23 A Correct.

24 Q I want to just -- before we leave -- we'll
25 come to that in a second. I want to just get --

1 talk a little about Cherry Tomato. We're going to
2 mark as Exhibit 9.

3 (Exhibit 9 marked for identification.)

4 BY MR. CRAIN:

5 Q I've handed you what is marked as
6 Exhibit 9.

7 Can you tell me what this document is?

8 A Sure. This is just like a little
9 AI-generated placeholder project that I did right as
10 I incorporated the company. This isn't -- this
11 isn't like -- I didn't even know that this was even
12 live. This is just -- this is just like a little
13 placeholder for the website.

14 I think the main website that I'm using is
15 sculptedspaces.com for the 3D printed. So this
16 was -- this was just like a little fun weekend thing
17 to show kind of my wife like "Hey, I incorporated.
18 I made a website. Check this out."

19 Q Got it. Okay.

20 This is, I'll represent to you, what comes
21 up when you Google "Cherry Tomato." Engineering,
22 which is of course what we did as counsel in this
23 case.

24 So you're saying -- is this not accurate
25 or it's just not live?

1 A I didn't even know this was live. And
2 it's definitely not accurate.

3 Q Okay. What is not accurate in here? Can
4 we just go through it so we're on the same page?

5 A So none of these products exist. They're
6 just theoretical.

7 Q Got it. So start -- let's work through it
8 a little more methodically, if we could.

9 Page 1 says "Cherry Tomato Engineering,
10 welcome to the future of sustainable living."

11 Is that actually a phrase that Cherry
12 Tomato Engineering uses?

13 A No.

14 Q Does Cherry Tomato have any employees?

15 A I am in the process of hiring one person
16 now, and I have a partner for the printer aspect of
17 the company.

18 Q Is the printer owned under Cherry Tomato,
19 or you said there was a separate website.

20 A It is owned under Cherry Tomato, but the
21 branding for the printer is Sculpted Spaces.

22 Q Got it. Okay.

23 So "Welcome to the future of sustainable
24 living," is that something you actually say, or
25 that's like an AI-generated phrase?

1 A Yeah. This was just like -- I think it
2 was Squarespace. They just said, like, you know,
3 "Throw in some stuff, and we'll generate a website
4 for you." That's all this is.

5 Q Got it.

6 So then let me just go -- the "about us"
7 page. You have dogs named Cherry and Tomato?

8 A Unfortunately, just one of them now.

9 Q Oh, I'm sorry to hear that.

10 A The golden retriever there has moved on,
11 but, yeah, those are my dogs.

12 Q And that's what the company is named
13 after?

14 A Yes.

15 Q Okay. Got it.

16 So that's accurate, at least in a broad
17 sense, right?

18 A Yes.

19 Q And then when we look at "products," so
20 these products and photos are not -- so tell me what
21 these are, I guess.

22 A These are not real products. These are
23 just -- so these are just little projects that I've
24 either done at home with the fish tank or just
25 nonexistent, not real things.

1 Q Which one is not -- which one is an idea,
2 and which one has actually been created?

3 A So the --

4 Q You know I'm going to ask about the Pooch
5 Potty Palace.

6 A Ask away.

7 Q Real or not real?

8 A Unfortunately, it's not real. I think
9 it's a cool idea.

10 Q I have a dog too, so I agree. Okay. So
11 just an idea?

12 A Yeah. This is just -- this was meant just
13 as a joke for my wife.

14 Q Got it.

15 I mean, tell me, like, is there -- there's
16 a human factors design element to that idea, right?

17 A Yeah.

18 Q Tell me a little bit more about that
19 notion.

20 A So I've been working on the project of
21 creating the house construction 3D printer for a
22 long time now. And I was trying to think of
23 applications for it beyond -- beyond just making
24 houses. And so a few of those ideas are proposed
25 here.

1 Q I'm sorry, I'm just looking at the
2 Sculpted Spaces, and it's nice-looking art there.

3 A Thank you.

4 Q Going back to Fish Foster Flora. Real or
5 idea?

6 A So that's a very old picture there. That
7 was like something that I created in college. It's
8 just a fish tank with custom 3D printed inserts.

9 Q Okay. So I won't run you through -- I was
10 going to ask about the Clucky Clean Coop too.

11 So generally, these ideas are -- like,
12 this is not the business, right?

13 A No, not at all.

14 Q The business is the 3D printer that you're
15 growing to create the prefab type houses, right?

16 A Yes.

17 Q So this was just for fun, so to speak?

18 A Yeah. I didn't even know this was on the
19 internet. I thought that I had relinked to Sculpted
20 Spaces. I thought that it just jumps there. So
21 this is a surprise to me. But it's a fun surprise.
22 You're welcome to ask about any of it.

23 Q I mean, Pooch Potty Palace was really
24 exciting. I was like, has someone figured out that
25 problem?

1 And then -- so the real website for Cherry
2 Tomato is supposed to go to Sculpted Spaces?

3 A No. It actually -- in a lot of my
4 materials, I just link back to Vredenburg &
5 Zackowitz because it's HFexpert.com.

6 Q Got it.

7 A So I've just been kind of piggybacking off
8 their website for the human factors stuff now.

9 But you make a very good point. It's
10 probably time for me to have Cherry Tomato have its
11 own forensics spacing.

12 Q I mean, fair to say it's at the top of
13 your CV, right?

14 A I thought it was the HF expert.

15 Q Let's double-check.

16 A Yeah, I'm seeing "HF expert" on here.

17 Q Oh, was I wrong?

18 A I'm not seeing it anywhere on the CV.

19 Q Oh, it's not on the top. It's
20 "professional experience" at the top. You see that?
21 Page 19 of Exhibit 1.

22 A I see "HF expert" at the bottom.

23 Q Where are you looking?

24 A I see "Sculpted Spaces" on there as well.

25 Q What page are you on?

1 A Page 19, I thought you said.

2 Q 19 is -- yeah. I have 19 as Cherry
3 Tomato.

4 A I see the words "Cherry Tomato
5 Engineering." I don't see the website, though.

6 Q Oh, not the website. I was saying the
7 company is --

8 A Oh, yeah. That is the company's name. It
9 is incorporated as that.

10 Q Yeah. So my question, just to fix it, is
11 not the website at the top of your page.

12 My question is, isn't it true that the
13 lead professional experience in your CV is Cherry
14 Tomato?

15 A Yes.

16 Q Yeah. Okay. Okay. I want to do that.
17 We have another Poochy Potty Palace exhibit. I love
18 the idea. I just want to see, is there anything
19 else?

20 Let's talk about your testifying history.
21 So you've testified at trial twice, right?

22 A Yes.

23 Q Were you qualified as an expert by those
24 courts?

25 A Yes.

1 Q And has any court rejected your testimony
2 in full or in part?

3 A Not to my knowledge.

4 Q Okay. Do you -- so tell me what the
5 two -- what were you qualified as an expert in those
6 two cases as?

7 A So I believe it was human factors and
8 biomechanics. And I think both of the cases that
9 went to trial were about car accidents.

10 Q Okay. Can you tell just generally, what
11 were your opinions in those two cases?

12 A I believe that they related to conspicuity
13 and foreseeable and reasonable behavior.

14 Q And what is conspicuity?

15 A So it's just like a derivation of the word
16 "conspicuous." So it's like how conspicuous is
17 something, the conspicuity.

18 Q And were you retained -- which side were
19 you retained in those cases?

20 A It was both plaintiff and defense for one
21 and for -- for one and two for the trials.

22 Q One was plaintiff, one was defense?

23 A Yes.

24 Q And then do you recall a case called
25 Torres v. Rivera? Is that one of those cases?

1 A Yes.

2 Q Do you recall the Court rejecting your
3 testimony in part in that case, or no?

4 A I was never informed on that.

5 Q Let's just go -- oh, I'm sorry, my
6 colleague tells me I was wrong.

7 My question is, do you know the Bermudez
8 case? We can refresh --

9 A Yes. Yes. I'm starting to remember that
10 one.

11 Q Is that one of the two?

12 A No. That never went to trial.

13 Q Got it. Okay.

14 So you testified -- were you deposed in
15 that case?

16 A It was a while ago. If you can refresh my
17 memory.

18 Q Yeah. I want to give you -- this will be
19 Exhibit 10. This is a court opinion.

20 (Exhibit 10 marked for identification.)

21 BY MR. CRAIN:

22 Q Have you ever seen this document?

23 A No.

24 Q You see it's a court decision. The
25 caption is "Bermudez versus Crunch Holdings, LLC."

1 Do you recall that?

2 A Yes.

3 Q And if you just look at the introduction,
4 it says:

5 "Appellant Christina M. Bermudez
6 fell and injured her wrist during an
7 exercise class at a gym owned by
8 Respondent Crunch Holdings. She then sued
9 Respondent for premises liability,
10 claiming it caused her injuries through
11 gross negligence."

12 Do you see that?

13 A Yes.

14 Q Does this refresh your recollection about
15 facts of this case?

16 A Yes.

17 Q Tell me a little bit about what you
18 remember about this case.

19 A I remember flying out for the inspection
20 for this case. It was an inspection at a gym. And
21 I remember taking measurements at that gym.

22 Q Okay. And do you recall, did you testify?

23 A I don't recall.

24 Q Did you serve a report?

25 A It was a while ago. I don't remember.

1 Q Let's go to page -- it says "*10" at the
2 top. And you'll see number 2, "Analysis."

3 A Star eight? I don't see a star 10.

4 Q Star 10. Oh, I'm sorry, I'm on the wrong
5 document. You have the right one. I was looking at
6 the wrong one.

7 Go to star eight.

8 Do you see that?

9 A Yes.

10 Q And it says:

11 "Next, Plaintiff relies on
12 expert declaration of Michael Vredenburgh
13 to support our argument the defendant was
14 grossly negligent."

15 Does this refresh your recollection maybe
16 it was an expert declaration, not a report?

17 A You know, that's what the document says.
18 I don't recall one way or the other.

19 Q Okay. And then it says:

20 "Vredenburgh opines that 'the
21 personal training room was inappropriate
22 for the L.E.F.T. test exercise.' However,
23 there is no evidence showing that the
24 L.E.F.T. test exercise was conducted. In
25 support of the statement. Vredenburgh

1 cites to pages 56 and 58 of the deposition
2 transcript of Adele Albano, the trainer
3 who led the class, but the portions of her
4 deposition which were submitted do not
5 include these pages. Therefore,
6 Vredenburg's opinion is based on
7 assumption of fact without evidentiary
8 support."

9 Do you see that language?

10 A Yes.

11 Q Were you aware of this decision?

12 A No.

13 Q Okay. No, the counsel on the case didn't
14 show it to you?

15 A No.

16 Q Are you aware whether it was appealed?

17 A I do actually remember the client not
18 paying for this case.

19 Q Got it. Okay.

20 So you remember the client not paying your
21 fees for this case?

22 A Yeah.

23 Q But you don't recall that the Court
24 concluded that your opinion was based on an
25 assumption of fact without evidentiary support?

1 A Yeah. He never showed me this document.

2 Q And are you aware of any other instance
3 where a court has rejected, criticized, or otherwise
4 discarded one of your opinions?

5 A Not that I'm aware of.

6 Q Okay. Okay.

7 A So, if I'm understanding correctly, if you
8 can walk me through what this means. Because I'm
9 not always sure about the legal language. It looks
10 like the main issue is that pages weren't
11 included --

12 Q Yeah.

13 A -- of a transcript?

14 Q Mr. Vredenburg, there is no question
15 pending. If your counsel wants to go back over it
16 later. But I have no more questions about this
17 document. You can set it aside. Okay?

18 A Sure.

19 MR. CRAIN: So we've been going how long?
20 A little over an hour. Are you good? Do you want
21 to keep going for lunch or do you want to --

22 THE WITNESS: I'd like to take a break, if
23 that's okay.

24 MR. CRAIN: Absolutely. You can take a
25 break any time. Let's go off. Courtney?

1 MS. WOOD: Yeah.

2 THE VIDEOGRAPHER: We are going off the
3 record. The time is 11:46 a.m.

4 (Recess taken.)

5 THE VIDEOGRAPHER: The time is 12:48 p.m.
6 We are back on the record.

7 BY MR. CRAIN:

8 Q Welcome back, Mr. Vredenburg. Hope you
9 had a nice lunch.

10 Before we turn to the next topic, I just
11 wanted to note for the record -- so we inspected the
12 binder during the break, and we noted the second
13 deposition, I think, was Ms. Binder, Leah Binder not
14 white binder. And then we noted also you have the
15 Harris report in your binder.

16 Do you know what I mean when I say "the
17 Harris report"?

18 A Yes.

19 Q Did you review that as well?

20 A Yes.

21 Q Did you review, prior to when you drafted
22 your report, the Harris report?

23 A No. I believe that was after.

24 Q So you reviewed it in preparation for your
25 deposition?

1 A Yes.

2 Q Just to set that aside.

3 I want to talk a little bit -- we were
4 talking about your opinions generally -- right? --
5 before the break.

6 Do you recall that?

7 A Yes.

8 Q And then one of the things you were asked
9 to opine on -- and this is in paragraph 15 of your
10 report -- is to rebut, you said, certain notions of
11 Processor Berger's opinions.

12 Do you recall that language?

13 A Yes.

14 Q What -- just can you tell me, what were
15 the notions of Professor Berger's report that you
16 were asked to evaluate and rebut? Let's just get it
17 on record. And it's paragraph 15.

18 A So a little bit farther down in the
19 paragraph, it talks about that, "Counter to the
20 implication that stakeholders such as hospital CEOs,
21 doctors, and other healthcare professionals
22 inherently do not understand the imputation
23 methodology."

24 Q So do you have -- are you saying that's
25 the notion that you were responding to in Professor

1 Berger's report?

2 A That wouldn't really be the main focus.
3 The main focus would be how it educates a broad
4 audience.

5 Q Okay. Because your analysis focuses on
6 the typical user -- right? -- not the users
7 reflected in paragraph 15 you just read?

8 A Yeah, the upper sentence. A little bit
9 lower in 15, it talks about the broad audience.

10 Q Do you have any opinion about how
11 stakeholders, such as hospital CEOs, doctors and
12 other healthcare professionals, do or do not
13 understand the imputation methodology?

14 A So --

15 Q Just start first with "yes" or "no,"
16 please. I can repeat it, if helpful.

17 A Can you please repeat it?

18 Q Yeah. My question is, do you intend to
19 offer at trial any opinion as to whether
20 stakeholders, such as hospital CEOs, doctors and
21 other healthcare professionals understand the
22 imputation methodology?

23 A So I would offer that they should at least
24 understand it just as well as the broad audience, if
25 not better. And that there was a progressive

1 disclosure specifically designed for those users.

2 Q Got it. Okay.

3 Your point is, to the extent that the
4 typical user, as you have framed it in your report,
5 can understand something, those with higher
6 expertise should be able to understand it too?

7 A At least to that point. And potentially
8 further, with these extra resources that are
9 available to them.

10 Q Okay. So just to be clear, you have no
11 medical training, right?

12 A That's correct.

13 Q And you have no experience running a
14 hospital?

15 A That's correct.

16 Q And beyond the UCSD internship, you have
17 no experience working in the medical field, right?

18 A That's correct.

19 Q Do you have any expertise to opine how
20 hospital CEOs, doctors, or other healthcare
21 professionals do or do not understand something?

22 A So based on my understanding of
23 populations, you know, they should at least have the
24 understanding of the general population.

25 Q Okay.

1 A So the design of these websites is
2 typically for lower -- lower reading level, you
3 know, the -- I'm trying to think of the phrase.

4 Q The average?

5 A You're trying to focus on, you know,
6 accessibility first. And so the first pages should
7 be the most understandable. And as you progress,
8 there's a little bit less focus on accessibility and
9 a little bit more focus on transparency.

10 Q Okay. Got it. Okay.

11 On the first and second pages, Figure 1
12 and Figure 2 we talked about before.

13 Do you know what I'm referencing?

14 A Yes.

15 Q There's less focus on transparency on
16 those pages and more on accessibility?

17 A So I would say that there is definitely
18 still a significant focus on transparency, but
19 transparency that's appropriate for the audience.

20 Q Okay. And transparency, again, as you
21 said earlier, goes to the accuracy or the truth?

22 MS. WOOD: Objection to form.

23 THE WITNESS: So accuracy is definitely a
24 component of transparency. I would say that it has
25 to be read, understood, and be true. So the --

1 BY MR. CRAIN:

2 Q Got it.

3 A There's the component of reading and
4 understanding it too.

5 Q Okay. So read, understood, and be true is
6 what you said?

7 A Yeah.

8 Q Okay. Got it. We'll come back to that.

9 Are there any other notions in
10 Dr. Berger's report that you respond to in your
11 report?

12 A So my rebuttal for Dr. Berger is limited
13 to user experience.

14 Q Okay.

15 A So that's what the focus of my report was.
16 And so any part of his report that's talking about
17 the marketing, that definitely doesn't apply to me
18 outside the scope of my assignment.

19 Q Is that specific to your Opinion 4, or is
20 that one of the other opinions too? Feel free to
21 look. The summary is on the bottom of page 8 of
22 your five opinions.

23 A Okay. So the main point there --

24 Q Uh-huh.

25 A -- is that in UX, the gold standard is to

1 do -- to do studies, to do hard science, to do
2 iteration and to test with users. So testing is
3 absolutely key.

4 And so you need to -- you need to be -- so
5 say he had a criticism of the webpage saying it's
6 not understandable. He should try to -- try to show
7 it beyond just saying, like, "I looked at it, and I
8 thought this."

9 It should be "I presented it to these
10 users, you know, following the standard protocols
11 for UX, and I conducted this study, and the study
12 indicated that there was a problem with
13 comprehension."

14 Q Okay.

15 A That's the gold standard for the industry.

16 Q Let me break that down just to make sure I
17 understand.

18 So his opinion, as you understand it, is
19 that the website is not sufficiently understandable.

20 Is that fair enough?

21 A Yes.

22 Q Your opinion is that it is? I think
23 that's Opinions 1, 2, 3 and 4?

24 A With the information available, I would
25 say that, you know, the best practice for evaluating

1 this question as a whole for all of us would be to
2 do these studies and to truly find out with
3 scientific rigor an answer to all these questions.

4 And I believe that Leapfrog attempted to
5 do that when they were first creating this website,
6 hiring, you know, experts in that field. But, you
7 know, he had sufficient time and ability and
8 resources to be able to do this testing, and I think
9 it's fair to point out saying, you know, it would
10 have been -- it would have been a much better
11 practice and added a lot of credibility to the
12 claims to say "Not only I do believe these things
13 and, you know, I found research one way or the
14 other, but I did scientific testing that can be
15 repeatable and followed the scientific method."

16 Q So here's what I'm struggling with. Isn't
17 that same critique equally applicable to your
18 opinions?

19 A So I think that that's fair, and I -- you
20 know, I anticipated that you were going to say that.

21 I don't think it was feasible to give me
22 that scope for this case, given -- given the time
23 constraints that were placed on -- placed on me.

24 Q Okay. So I take that point. We can only
25 do what we can do, right?

1 A Yeah.

2 Q The issue I have, though, in response, is
3 isn't your opinion more conclusive than his?

4 A I would say that my opinions are more
5 quantitatively based and --

6 Q But you have no data.

7 A Well, the page is a page full of data.
8 Every, you know, piece of information on the page is
9 data. So we can apply algorithms to the page, which
10 I did. I applied several algorithms to the page.

11 Q Three minutes ago, you told me that
12 testing is key, right?

13 A It's the gold standard.

14 Q And you didn't do any testing?

15 A That's correct.

16 Q And he didn't do any testing?

17 A That's correct.

18 Q And his opinion was "Many consumers would
19 be unlikely to understand that Leapfrog assigns the
20 minimum score on the imputed measures on the impact
21 of this practice on the safety grades."

22 Do you recall that opinion in his report?

23 A Yes.

24 Q And he says: "Many consumers would be
25 unlikely."

1 So he hedges to some degree, right?

2 A Uh-huh.

3 Q Because he doesn't have the data.

4 A Right.

5 Q You say imputed scores are readily clear
6 to users with basic reading comprehension, right?

7 A Yes, sir.

8 Q Isn't that more conclusive than his?

9 A I would put them as pretty similar. I put
10 them on different ends of the spectrum.

11 Q If he didn't do any testing -- sorry,
12 let's go back to what you said. You said different
13 ends of the spectrum.

14 What do you mean by that?

15 A Can you read his statement again to me?

16 Q Yeah. His says -- if you want to look at
17 it, it's Exhibit 3, I think. 3. Exhibit 3. I'm
18 just looking at the table of contents. Tell me when
19 you have it. And it's Roman VIII.

20 And he says:

21 "Many consumers would be
22 unlikely to understand that TLG assigns
23 the minimum score on the imputed measures
24 and the impact of his practice on the
25 safety grades TLG assigns to

1 non-participating hospitals based on TLG's
2 impugnation disclosures."

3 Do you see that?

4 A Yes.

5 Q Now, aside from being three lines long and
6 rather a mouthful -- our side can take
7 responsibility for that -- he does hedge to a
8 certain degree, right? He says "many consumers,"
9 not "all," right?

10 A Uh-huh.

11 Q And he says they're likely, but he doesn't
12 state the position that -- well, he says they're
13 unlikely. He doesn't state the position that
14 consumers -- he knows for sure that consumers don't
15 understand, right?

16 A Right.

17 Q But you do. Right? You say "Imputed
18 scores are readily clear to users with basic reading
19 comprehension."

20 And I guess my question is, if your
21 critique of him is that he doesn't have enough data
22 to make his opinion, which is more qualified than
23 yours, how do you have enough data to make your
24 opinion?

25 A Well, I feel like that's why we're

1 discussing it now. I think, you know, I have the
2 data and the analysis that -- that's here to support
3 it. But I would say the gold standard of actually
4 doing the research and going forth and using the --
5 the standards at hand would be the way to make the
6 strongest statement.

7 So I would say that the purpose of this
8 was brevity, not, like, finality, saying, like, this
9 is the -- this is certain, this is to, you know, a
10 reasonable professional estimation.

11 Q What is the -- you mentioned a few minutes
12 ago -- let's see. You said "I have the data and the
13 analysis that's here to support it."

14 What were you referring to?

15 A So for Opinion 2, you were --

16 Q I think -- I'm looking at Opinion 3, but
17 we can go to -- 1, 2 and 3 I see as related.

18 Is that fair to say?

19 A Yes.

20 Q So for any of 1, 2 and 3, what is the --
21 just give me buckets, and we can dig deeper. But
22 what is the data you were referring to there?

23 A So the actual words on the webpage is
24 data, and that data can be applied to grade-level
25 algorithms, which I did.

1 Q Yeah.

2 A And so that would be well studied, super
3 well established practice used across the board in
4 study after study. To be a yardstick, it's not
5 definitive. The original authors give examples
6 where their algorithms don't always hold up.

7 So it's, again, not a substitute for
8 doing -- doing user experience testing, but it is a
9 yardstick to use, and it's a well respected
10 yardstick that's been used for decades.

11 Q I hear you, and I appreciate the
12 qualification too.

13 Just to clarify, the readability
14 algorithms test how easy it is to read something,
15 not the message that's conveyed, right?

16 A Correct.

17 Q I want to dig deeper into your opinions,
18 but I just want to make sure, with respect to
19 Professor Berger, we close the loop.

20 I just want to make sure -- your report --
21 does your report respond to Professor Berger's
22 opinion that D and F grades likely impact consumer
23 perceptions of the plaintiffs' hospitals and/or
24 deter consumers from choosing to receive care there?

25 A No.

1 Q Does your report respond to Professor
2 Berger's opinion that if Leapfrog continues to
3 publish low or failing grades for the Plaintiff
4 hospitals in the future these effects are likely to
5 be amplified?

6 A No.

7 Q And this may be a little tedious, but I
8 have to close the loop, so I apologize in advance.

9 Does your report address or respond to
10 Professor Berger's opinion that D and F grades
11 likely negative -- negatively impact consumers'
12 perceptions of Plaintiff hospital's quality?

13 A No.

14 Q Does your report to respond to Professor
15 Berger's opinion that D and F grades likely affect
16 consumers' choices and deter consumers from choosing
17 the plaintiffs' hospitals?

18 A No.

19 Q You don't rebut Professor Berger's opinion
20 that D and F grades are likely to evoke negative
21 emotions from consumers about Plaintiff hospitals,
22 right?

23 A No.

24 Q And you don't rebut Professor Berger's
25 opinions that the effect of the D and F grades for

1 plaintiff hospitals would be intensified if Leapfrog
2 continues to repeatedly publish the grades in the
3 future?

4 A No.

5 Q You don't rebut Professor Berger's opinion
6 that Leapfrog's imputation disclosures are unlikely
7 to help user -- sorry. Strike that.

8 Let's see.

9 You don't rebut Professor Berger's opinion
10 that the only disclosure that explains the
11 imputation methodology is found on page 16 of TLG's
12 28-page spring 2025 scoring methodology document, do
13 you?

14 A I do.

15 Q We'll come to that.

16 That's one you respond to?

17 A Yes.

18 Q Got it.

19 And then -- I think that may be it for
20 now.

21 And all the ones that you just noted that
22 you do not rebut in your report, you don't intend to
23 offer trial testimony rebutting those opinions
24 either, right?

25 A Correct.

1 Q So let's talk a little bit about your
2 Opinion 1. And I want to talk about -- so with
3 respect to transparency, we talked a little bit.
4 You said something has to be read, understood, and
5 be true, right?

6 And you evaluated the transparency of the
7 disclosures on the page that your lay out as
8 Figure 2 with respect to how it communicates the
9 imputational model, right?

10 Do you understand what I mean when I say
11 that?

12 A I was turning pages there. If you could
13 just say that one more time.

14 Q No worries. Let me start over.
15 Absolutely.

16 So I'm going to talk about your Opinions
17 1, 2 and 3 together, if that's fair with you.

18 A Yes.

19 Q They're overlapping to some degree, right?

20 A Yes.

21 Q So you evaluated in Opinion 1 the clarity
22 and transparency and, in Opinion 2, the
23 accessibility of the websites depicted at Figure 1
24 and Figure 2, right?

25 A Yes.

1 Q And going forward, I'm just going to say
2 "the website" and "the webpages," and unless we're
3 talking about something else, it will refer to those
4 two. Fair enough?

5 A Fair enough.

6 Q Just to make it a little less cumbersome.
7 And then in Opinion 3, you sort of round
8 it out and say "the imputed scores are readily clear
9 to consumers with basic reading comprehension,"
10 right?

11 A Yes.

12 Q So, to make those opinions, you had to
13 have some understanding of what the imputation
14 methodology prescribes, right?

15 A Yes.

16 Q Can you tell me in your words, how does
17 Leapfrog's imputation methodology post-2024 work?

18 MS. WOOD: Objection to form.

19 BY MR. CRAIN:

20 Q Fair enough. Let me break it down.

21 You understand Leapfrog assigns a hospital
22 safety grade, right?

23 A Yes.

24 Q And you understand Leapfrog has a
25 methodology that puts that all together, right?

1 A Correct.

2 Q And you understand part of that
3 methodology for certain missing data scores,
4 measures, includes imputation?

5 A Yes.

6 Q And what does "imputation" mean?

7 A It means it's an assigned score.

8 Q Okay. And do you understand how the
9 imputation in Leapfrog's grading system works?

10 A So that was actually outside --

11 Q First "yes" or "no." Do you understand
12 how the imputation methodology works?

13 A So I have a high-level understanding. I
14 definitely don't have a detailed technical
15 understanding.

16 Q Where did you get the high-level
17 understanding?

18 A So that would be from what's presented on
19 these pages. For example, the webpage showing this
20 hospital score 15 with an asterisk, and the asterisk
21 below is describing "This hospital declined to
22 report on their performance on this measure, so a
23 score was assigned to reflect the lack of available
24 information."

25 Q And you're quoting on Figure 2, on

1 Exhibit 1 to this deposition, your report, the
2 asterisk's footnote at the bottom of the page,
3 right?

4 A Yes, sir.

5 Q Is it your testimony that that language
6 explains how a score is imputed?

7 MS. WOOD: Objection to form.

8 THE WITNESS: So I believe that, on this
9 page, it is shown that this hospital's score, 15
10 with the asterisk, and then below it shows average
11 and worst. The fact that that's clearly displayed
12 and the two line up, it's clearly that the imputed
13 score is the worst hospital score. They're the same
14 number right next to each other.

15 BY MR. CRAIN:

16 Q Yeah. So it shows that it got the worst
17 score for that measure, right?

18 A Yes.

19 Q Does it show why it got that score? Maybe
20 "why" is the wrong word, but answer that first.

21 A Because it was assigned.

22 Q Does it show how it was assigned?

23 MS. WOOD: Objection to form.

24 THE WITNESS: So that goes beyond the
25 scope of what I analyzed.

1 BY MR. CRAIN:

2 Q Okay. Is it your view -- and you write
3 about this a little bit in your report -- that the
4 imputed score -- which I think on that page is the
5 worst score, right? That's what you just said?

6 A Yes. Worst hospital score and this
7 hospital score.

8 Q That's for hand washing -- right? -- on
9 that page?

10 A Yes.

11 Q And you're looking at Figure 2 of
12 Exhibit 1, which is your report, right?

13 A Yes.

14 Q Does that lowest score convey that the
15 hospital failed in its performance on hand washing
16 or that it failed to participate in Leapfrog's
17 hospital survey?

18 MS. WOOD: Objection to form.

19 THE WITNESS: It says, in red bolded text,
20 that "the hospital declined to report their
21 performance on the measure, so a score was assigned
22 to reflect the lack of information available."

23 BY MR. CRAIN:

24 Q So what does that convey? I'm sorry. I
25 don't think that answered my question. I'm going to

1 ask it again.

2 Does the lowest score convey that the
3 hospital failed in its performance on hand washing
4 or that it failed to participate in Leapfrog's
5 hospital survey on hand washing?

6 A I think that it does display that they did
7 not respond and that data was not available, so this
8 lowest score was assigned.

9 Q So you're opining on how a typical user
10 would view this page, right?

11 A Yes.

12 Q Would the typical user, in your opinion,
13 come away from that language thinking that the
14 hospital is a poor performer at hand washing or just
15 that they didn't respond to the survey?

16 A I think that there's different things that
17 they could think, depending on the person. And,
18 again, following the gold standard of actually doing
19 the user experience testing and finding out from
20 people firsthand is -- is honestly what I think
21 should be done for -- for trying to -- trying to
22 settle questions like this.

23 But that said, somebody needs to -- needs
24 to start somewhere. And so, you know, come to
25 expert estimations before -- before you do those

1 tests usually, you know, leads to the first
2 iterations of those tests to figure out.

3 So I were being proposed to put together
4 these first iterations of the testing, what I would
5 say is that they would believe a couple -- a couple
6 of different possibilities.

7 Q Uh-huh. What are they?

8 A One, you know, they read it as written.
9 And, you know, maybe, you know, they have good
10 comprehension and they believe that the hospital did
11 not respond to a survey, and so a minimum score was
12 assigned due to lack of information. And they may
13 think, "Well, you know, I'd rather err on the side
14 of caution. If the information is not available,
15 then I'd rather err on the side of caution. If I
16 don't know, it could be good, could be not. I would
17 rather be careful than to just assume that's it good
18 if we don't know."

19 Q So you would agree that at least some
20 users can walk away from that webpage thinking
21 that -- I think it's Del Rey -- or no, it's Good
22 Samaritan?

23 A Good Samaritan.

24 Q -- thinking that Good Samaritan actually
25 performs poorly on hand hygiene?

1 MS. WOOD: Objection to form.

2 THE WITNESS: I think that's a reasonable
3 hypothesis, but until we test it, it's hard to know.

4 BY MR. CRAIN:

5 Q Fair enough.

6 It's possible. You just don't have the
7 data, right?

8 A Correct.

9 Q You say something different in your
10 report.

11 Do you know that?

12 A If you want to read it to me.

13 Q You say "This ensures users can understand
14 that grades reflect non-participation rather than
15 direct performance data."

16 Isn't that a little consistent?

17 A We're talking about edge cases, though.

18 Q Why are they edge cases? How do you know
19 they're edge cases?

20 A Because we tested the reading level for
21 the statements, and the reading level was to a good
22 standard that most of these users are going to be
23 able to meet. And the statement is straightforward
24 saying "The hospital declined to report on their
25 performance on this measure. So a score was

1 assigned to reflect the lack of information
2 possible."

3 And furthermore, we saw that the average
4 user actually was seeing that asterisk because they
5 were scrolling down further --

6 Q Scrolling.

7 A -- past that part of the page. And in
8 user experience, the eye is drawn to bold and to red
9 text. So, you know, within the research provided,
10 that is a very good indicator of conspicuity. And
11 so this statement would have stood out, and it's
12 written in plain language.

13 Q You mentioned -- I'm going to just pull
14 some of the threads a little bit.

15 You mentioned the scroll data, right?

16 A Yes.

17 Q The scroll data is your Opinion 5, right?

18 A Yes.

19 Q Would you say it's material to your
20 Opinion 1, 2, 3 and/or 4?

21 A Can you define for me what you mean
22 "material" in this case?

23 Q Fair enough.

24 So your scroll data opinion is that --
25 tell me if this is a fair characterization or not --

1 that most users scroll down the page when they get
2 to the websites, right?

3 A Yes.

4 Q And that allows them to see the asterisks?

5 A Yes.

6 Q Is that an important part of your Opinions
7 1, 2, 3 and 4?

8 A Yes.

9 Q If that data were wrong, would that cause
10 you to change your Opinions 1, 2, 3 and 4?

11 A It wouldn't change 4. 4 that, you know,
12 the UX testing is the gold standard and that it
13 should have been done on the untested methodology,
14 that would stay the same.

15 It would potentially have an effect on 3.
16 I would say that the scores and the numbers are
17 still clear. So it would be -- it would be clear
18 that scores are being imputed, or at least the score
19 assigned is the lower score.

20 Q But if no one scrolled to the footnote --
21 right? -- doesn't your opinion depend on the
22 footnote?

23 A It's definitely an important factor. So
24 it kind of depends. Like on the right-hand side
25 with the question mark, "declined to report" --

1 Q Yeah.

2 A -- "for staff working together to prevent
3 errors." You know, my opinion would be that that
4 would be a good practice to be using for these other
5 gas meters as well when the data is missing, and
6 that would help bridge the gap for the asterisk.

7 Q Just to make sure I understand, you're
8 aware that, when Leapfrog does its imputation model,
9 for instance, on hand hygiene -- are you aware of
10 that?

11 A Yes.

12 Q And Leapfrog has no data as to hand
13 hygiene performance.

14 Do you understand that as well?

15 MS. WOOD: Objection to form.

16 BY MR. CRAIN:

17 Q If you don't, I can walk you through it a
18 little bit.

19 Do you understand that?

20 A Yeah. So they don't have data from that
21 hospital. And then, you know, I would say, if the
22 imputation is fair and that whole process, that's
23 beyond the scope of my analysis.

24 Q I hear you. But I'm trying to get to what
25 you just said a moment ago.

1 So you just said -- you were talking about
2 staff worked together to prevent errors, right?

3 A Yes.

4 Q And you said that was -- I think you said
5 a good practice to put the question mark and decline
6 to report, right?

7 A Yes.

8 Q Because Leapfrog has no data about how
9 staff work together, correct?

10 A Yes.

11 Q Because that's informed by the hospital
12 survey.

13 Are you aware of that?

14 A Yes.

15 Q So, if the hospital doesn't participate in
16 the hospital survey, there's no data about how staff
17 are working together, right?

18 A Yes.

19 Q So the clearest thing to do there is just
20 decline to report, right?

21 MS. WOOD: Objection to form.

22 MR. CRAIN: That's what he just said.

23 BY MR. CRAIN:

24 Q Do you want me to read it back to you?

25 A If you could just put the sentence all

1 together without saying, like, this and --

2 Q Fair. It's a leading question. Let me
3 see.

4 You said "For staff working together to
5 prevent errors, my opinion would be that would be a
6 good practice to be using for these other gas meters
7 as well when data is missing."

8 Do you recall saying that?

9 A Yes.

10 Q Hand washing --

11 A Yes.

12 Q -- is similarly situated to "staff work
13 together to prevent errors."

14 Would you agree with me?

15 A Yes.

16 Q There's no data, right?

17 A Correct.

18 Q And yet Leapfrog does something different
19 on that, right?

20 A Correct.

21 Q And the gas gauge you analyzed in your
22 report, right?

23 A Yes.

24 Q Does gas gauge convey something about
25 performance?

1 A Yes. So continue.

2 Q What does it convey? It's red.

3 A Yeah. So it shows a low score.

4 Q And is that consistent with what you said
5 was a good practice for something that Leapfrog has
6 no data as to?

7 A So, if I were putting together, you know,
8 testing for constant improvement on the website,
9 that would be one of the things that I would test,
10 for improvement to see if this practice would
11 also -- if including that practice on all the
12 imputed values would increase comprehension.

13 Q So you just said it was a good practice as
14 to staff work together to prevent errors, right?

15 A Yes.

16 Q Are you refusing to say it's a good
17 practice for hand washing too?

18 A No. I'm not saying that.

19 Q Okay. Would it be a good practice for
20 hand washing too?

21 A Likely, it would be a good practice.

22 Q Okay. I want to talk a little bit -- so I
23 want to go back to your understanding of the
24 imputation methodology.

25 And your testimony -- is it your testimony

1 that consumers looking at Figure 2 can understand
2 how the imputation methodology works?

3 A I think, looking at Figure 2, they can see
4 what the imputed value is.

5 Q Different question. Do they understand
6 how it works?

7 A I don't quite see how it's a different
8 question. They're definitely not seeing under the
9 hood of how the experts got to produce that number,
10 but they are seeing the number themself.

11 Q What is your understanding of how Leapfrog
12 imputes for scores like hand washing for
13 nonparticipating hospitals?

14 A So that's outside the scope of my
15 assignment.

16 Q So then you have no opinion as to how it
17 works?

18 A I believe that's being covered by another
19 expert.

20 Q But how can you opine as to whether
21 consumers will understand it if you don't know how
22 it's assigned?

23 A What I'm saying is that they can
24 understand what score is assigned. I think that --

25 Q Got it.

1 A -- it's fair for it to be -- you know, as
2 you pointed out, I'm not a medical expert. I think
3 it's fair to have another expert who is cover that
4 material.

5 Q So you are opining that -- if you look at
6 Figure 2, it's really clear that Good Samaritan gets
7 a 15 on hand washing, right?

8 A Yes.

9 Q And it's also really clear what safer
10 hospitals do.

11 Do you see that language?

12 A Yes.

13 Q So does this website effectively state
14 that this hospital doesn't do what safer hospitals
15 do because it's a worse hospital?

16 MS. WOOD: Objection to form.

17 BY MR. CRAIN:

18 Q It's a little confusing. Fair. Let me
19 take that back a little bit.

20 Do you see the language under what safer
21 hospitals do?

22 A Yes.

23 Q Can you read that into the record?

24 A "Hospitals provide training and implement
25 policies to make sure that all hospital staff cleans

1 their hands before touching a patient."

2 Q Now, on the left, it says "Best hospitals
3 score 100," right?

4 A Yes.

5 Q Does a reasonable consumer, a typical user
6 in your analysis, understand that a best hospital
7 does what safer hospitals do?

8 A Yes.

9 Q Would that same typical user understand
10 that this hospital, because it's so conspicuous that
11 they're 15, doesn't do what safer hospitals do?

12 A So I think that, if they read the
13 statement, the hospital declined to report on their
14 performance on this measure, so a score was assigned
15 to reflect the lack of information. They would know
16 that, you know, we don't know what their hand
17 washing procedure was.

18 Q Okay. And what if a user didn't scroll
19 down to the footnote?

20 A If they didn't scroll down to the
21 footnote, then they would likely believe that they
22 received the worst score, and they would not
23 necessarily know about the imputation.

24 Q They would think they do the opposite of
25 what best hospitals do, right?

1 A Yes.

2 Q Because it's a worst hospital?

3 A Yes.

4 Q Now, how would consumer -- strike that.

5 Okay. I want to talk a little bit -- you
6 have no understanding of step 1 and step 2 in the
7 methodology?

8 A Of how imputation takes place?

9 Q Yeah.

10 A So a little bit was explained to me, but
11 that's not really relevant to this assignment or
12 what I'm doing.

13 Q Okay.

14 A It was more of a curiosity. I feel like
15 it's not relevant to my testimony.

16 Q Because all you're opining on is that the
17 number is clear, not how it's derived?

18 A Correct. How it's derived is by a
19 different expert with that background.

20 Q Which expert?

21 A I believe that's Dr. Harris.

22 Q Okay. Fair enough.

23 He's doing the mathematical analysis,
24 right?

25 A Yes.

1 Q I'm asking for you to do something more
2 qualitative.

3 Do you understand what I mean by that?

4 A Not yet. If you could explain more.

5 Q Yeah.

6 MR. CRAIN: Let's go -- give me the spring
7 methodology document. It's tab 12.

8 BY MR. CRAIN:

9 Q So I want to -- this is Exhibit 11.

10 All right. Do you have in front of you
11 Exhibit 11?

12 A Yes, sir.

13 (Exhibit 11 marked for identification.)

14 BY MR. CRAIN:

15 Q Do you recognize this document?

16 A This was in my file.

17 Q Okay. So you considered this document in
18 forming your opinions?

19 A Yes.

20 Q You referred to, if I recall, this
21 document as "dense," right?

22 A Yeah. It appears that way.

23 Q This is not a document that you said a
24 typical user would read, right?

25 A Correct.

1 Q And in fact, in Dr. Berger's report, do
2 you recall a supplemental report said only 3 percent
3 of users actually download this document from the
4 website?

5 A Yes.

6 Q Does that surprise you?

7 A No.

8 Q And in fact, you have -- you've cited
9 research that says only about 3 percent of consumers
10 actually look at user manuals.

11 Do you recall that research?

12 A I don't recall that figure.

13 Q Okay. I was pulling that out of my memory
14 there. If you don't remember, that's okay.

15 So did you review this when you were
16 drafting your opinion or preparing your opinions?

17 A Not heavily. I did scan through it,
18 because I feel like this isn't relevant to my
19 analysis.

20 Q Because a typical user wouldn't really
21 look at this, right?

22 A Correct.

23 Q I want you -- just so we're on the same
24 page, I'm going to educate you a little bit about
25 how it works.

1 Let's go to page -- first of all, I want
2 to go to page 4. I'll just ask you some questions
3 about this one.

4 Actually, go to page 5. Let's stick with
5 hand hygiene.

6 So you see this table, right?

7 A Yes.

8 Q Do you see there's a table, and there's a
9 second column at the top that says "Primary Data
10 Source"?

11 A Yes.

12 Q And under "Hand hygiene" -- it's the third
13 row down -- it says "2024 Leapfrog Hospital Survey,"
14 right?

15 A Yes.

16 Q Now, if you go to "Secondary Data Source,"
17 do you see where it says "Imputation model applied"?

18 A Yes.

19 Q Now, reading this, is there a secondary
20 data source for hospitals like Good Samaritan?

21 A That's outside of the scope of my
22 analysis.

23 Q Because you just looked at Figure 2 and
24 Figure 1, essentially -- right? -- of your report?

25 A Yeah.

1 Q And Figure 2 and Figure 1 don't speak to
2 this concept -- right? -- reflected on page 5 of
3 Exhibit 11?

4 A I don't have any opinions about page 5.

5 Q You have an opinion about Figure 2,
6 though, right?

7 A Yes.

8 Q Does Figure 2 convey the information that
9 you see on page 5?

10 A I have not read or understood, you know,
11 the content of page 5. That's outside of my
12 expertise.

13 Q Okay. So you have no opinion as to
14 whether Figure 2 conveys the information on page 5?

15 A Correct, I have no opinion to that.

16 Q So let's go down then -- I want to go to
17 page 15.

18 You're a researcher, right?

19 A Yes, sir.

20 Q Do you understand the distinction between
21 primary and secondary data?

22 A You know, that hasn't been something
23 that's come up for me before.

24 Q It was worth a shot.

25 We can move on from it if you don't know.

1 So I want you to look at page 15 of this
2 document.

3 Now, if you look at the top, it says --
4 see "using secondary data sources"?

5 A Yes.

6 Q And it says:

7 "12 of the 22 measures,
8 including the safety grade, are derived
9 from the Leapfrog Hospital Survey. The
10 Leapfrog Hospital Survey is voluntary and,
11 as such, hospitals may choose not to
12 submit a survey. To address this gap in
13 available data, the safety grade
14 methodology uses secondary data when
15 available."

16 Do you see all that?

17 A Yes.

18 Q Then it gives -- further down the page and
19 onto 16, it gives a step 1 and step 2.

20 Do you see that?

21 A Yes.

22 Q Step 1, it says:

23 "If the hospital had a score
24 assigned by Leapfrog in the two previous
25 rounds of grades, i.e., fall 2024, spring

1 2024, excluding imputed scores, the
2 hospital is assigned the most recent score
3 on that measure in the current hospital
4 safety grade, i.e., spring 2025."

5 Do you see that language?

6 A Yes.

7 Q Do you have a general understanding as to
8 what that means now? I could break it down for you,
9 if it's helpful.

10 A You know, I hear the words that are said
11 here. But, you know, I haven't made an attempt to
12 get into the weeds for how this is done.

13 Q So the first step is essentially taking an
14 historical score for measure and imputing it into
15 the hospital grade for that measure.

16 Does that make sense to you?

17 A Yes.

18 Q It's taking -- if you have a prior hand
19 hygiene score for fall 2024 you're not reporting
20 now, we're just going to use the last score, right?

21 Make sense?

22 A Yeah. I'll take your word for it.

23 Q Okay. I mean, it's here, but -- I'm not
24 trying to pull a fast one. I just want you to
25 understand before we turn to the next sequence.

1 Step 2 is different. That's what we've
2 been talking about.

3 Do you understand the automatic assignment
4 of limited achievement?

5 Does that mean something to you?

6 A Yes.

7 Q So, if a non-participating hospital in
8 step 2 doesn't have an historical score, Leapfrog
9 just gives them limited achievement.

10 Is that your understanding of how it
11 works?

12 A Yes.

13 Q So there are two ways to impute.

14 Do you understand that now?

15 A Yes.

16 Q You didn't understand that before, right?

17 A No.

18 Q This is a new concept to you, right?

19 A Correct.

20 Q So step 1 is you get some historical
21 score, if there is one. And step 2 is you get the
22 limited achievement.

23 Do you understand that now?

24 A Yes.

25 Q And limited achievement is the lowest

1 possible score, right?

2 A Yes.

3 Q So I want to show you --

4 MR. CRAIN: Let's get tab 24, please, and
5 25.

6 THE WITNESS: Page 24?

7 BY MR. CRAIN:

8 Q No. It's tabs -- I'm going to give you
9 two new exhibits. This will be Exhibit 12 and 13.

10 This is Exhibit 12. This is Exhibit 13.

11 (Exhibit 12 marked for identification.)

12 (Exhibit 13 marked for identification.)

13 BY MR. CRAIN:

14 Q Do you have Exhibit 12 and 13 in front of
15 you?

16 A Yes.

17 Q So Exhibit 12, you see, is for White Rock
18 Medical Center.

19 Do you see that?

20 A Correct.

21 Q You don't know anything about White Rock
22 Medical Center, right?

23 A No.

24 Q Have you ever been to Dallas, Texas?

25 A I've passed through.

1 Q Passed through. But you've not been to
2 White Rock in Dallas, right?

3 A No.

4 Q Okay. Exhibit 13 is for Lima Memorial
5 Health System, right?

6 A Yes.

7 Q And it's 1001 Bellefontaine in Lima, Ohio.
8 Have you ever been there?

9 A Yes. I have not.

10 Q And you see both of them have -- are
11 highlighted on the "Safe medication administration."

12 Do you see that?

13 You can sort of put them side by side.

14 Do you see that?

15 A Do you need me to turn the page? I'm not
16 sure --

17 Q Yeah. Fair enough.

18 So do you see all of them -- all of the
19 little tabs there are a grade except for one?

20 A Yes.

21 Q That's the one that's highlighted, right?

22 A Okay. I see now.

23 Q See it now?

24 So if you go to page 2 of both documents,
25 you see they both have the lowest score.

1 Do you see that?

2 A Yes.

3 Q And they both have a 25 on "safe
4 medication administration."

5 Do you see that?

6 A Yes.

7 Q And again, this says: "What safer
8 hospitals do: When hospitals use barcoding
9 technology effectively for all orders, medication
10 errors happen far less frequently," right?

11 A Yes.

12 Q And in theory, as you said before, if
13 somebody is just looking at the worst hospital
14 score, it means they didn't do those things, right?
15 If they don't see the footnote.

16 MS. WOOD: Objection to form.

17 BY MR. CRAIN:

18 Q Well, strike that. Let me take that back.

19 So I'm going to represent to you that one
20 of these -- both of these hospitals are imputed.

21 You see that from the footnotes, right?

22 A Yes.

23 Q One of these hospitals is from step 1, one
24 of these hospitals is from step 2.

25 Which is which?

1 A That information is not displayed on this.

2 Q Correct. It's not anywhere on this page,
3 right?

4 A Correct.

5 Q So the hospital that has the historical
6 score imputed is totally indistinguishable from the
7 hospital that has the automatic assignment of
8 limited achievement, right?

9 A Correct.

10 Q The typical user will have no idea which
11 is which, right?

12 A Correct.

13 Q It's all the same?

14 A Yes.

15 Q Okay. Well, there we go. I can move on.

16 All right. I want to look at a couple
17 other things.

18 And again, just to round out, the
19 footnotes that you relied on and looked at in your
20 report, they don't say anything about step 1 or
21 step 2, right?

22 A Correct.

23 Q They don't disclose whether the score is
24 historically imputed or automatically assigned,
25 right?

1 A Correct.

2 Q Do you have any understanding as to
3 whether Leapfrog deems the automatic assignment
4 arbitrary?

5 A That's outside of the scope of my
6 analysis.

7 Q Would it change your opinion if Leapfrog,
8 when they drafted the asterisks, believed that they
9 were arbitrarily assigning a score?

10 A I think getting into the specifics of the
11 imputation and how it's done and what's fair and
12 what's not fair is best left to the medical experts.
13 I'm, you know, a user experience expert. I want to
14 focus on that lane.

15 Q So if, when drafting this footnote,
16 somebody said "We can't put in the footnote external
17 data sources because we're arbitrarily assigning
18 them the points assigned with the bottom scoring
19 category," would that have any impact on your
20 opinion?

21 A I think that would be something for
22 Dr. Harris to consider. That wouldn't be relevant
23 to the user experience.

24 Q What if they were drafting the footnote to
25 make it sound like the expert panel approved it and

1 the assigning of these points was legitimate? Would
2 that have any impact on your decision?

3 A That's outside of the scope of my
4 analysis.

5 Q Does it have any impact on whether you
6 think these footnotes are fairly drafted?

7 A I truly believe that to be outside of, you
8 know, my knowledge base. I don't know if it's fair
9 or not.

10 Q So you don't have an opinion one way or
11 another?

12 A I don't have an opinion.

13 Q And what is your opinion with respect to
14 the footnotes? What message do they convey?

15 A That the value -- I mean, I think it's
16 pretty clear the way it's written. "Hospital
17 declined to report on performance." So that's
18 implying they were given a chance, but they chose
19 not to. And a score was assigned to reflect a lack
20 of information. And that, paired with the fact that
21 the numbers line up to being the worst, show that
22 they were assigned the lowest score.

23 Q But it doesn't show how, right? It
24 doesn't show where that lowest score came from, does
25 it?

1 A It doesn't show under the hood, but it
2 does show that it is the lowest score.

3 Q And do you think it's transparent to not
4 show under the hood, at least in that regard?

5 A You know, I don't think I'm the right guy
6 to ask for that question, but I do think that it's a
7 good practice they showed the number. I think that
8 definitely does help with the transparency.

9 Q But it would have been a better practice
10 to say they declined to report, question mark,
11 right?

12 A For these gas gauges, I agree with that.
13 I think that could be a future improvement.

14 Q Okay. Dr. Berger, in his opinion -- in
15 his report opines that there are only four places on
16 the Leapfrog website that describe how the
17 imputation model works.

18 Do you dispute that opinion or no?

19 A I didn't find anything to the contrary.

20 Q You don't have an opinion one way or
21 another or you just -- you don't disagree with him?

22 A Yeah. I don't have an opinion.

23 Q I want to go to -- there. Tab 14.

24 This is going to be Exhibit 14.

25 (Exhibit 14 marked for identification.)

1 BY MR. CRAIN:

2 Q Do you recognize the page in front of you?

3 A Yes. In the time that I went through the
4 website, I went through this page. But I didn't
5 read it in any kind of detail.

6 Q Before -- you went through this webpage
7 before you wrote your report?

8 A Yes. In getting ready to write the
9 report, yeah.

10 Q In your opinion, does your typical user,
11 as you frame it in your report, go to a page like
12 this to look at this information?

13 A You know, that's a great question. I
14 think Google Analytics and looking at that would be
15 a good way to analyze that. And at this point, I
16 don't know.

17 Q Okay. Fair enough. You don't know.

18 So, looking at this page, let's just
19 assume for a minute that a typical user will go to
20 this page, or any user, right? I want to go to
21 page 3. There are no pages on it.

22 And if you look at -- do you see a line,
23 "How the Leapfrog Hospital safety grade is
24 produced"?

25 A Yes. On the second page or third page.

1 Q Right. Third page, I think, yeah.

2 And do you see there's a paragraph that
3 says "The expert panel selected"?

4 A Yes.

5 Q If you go about halfway down, there's a
6 sentence starting "In some cases."

7 Do you see that?

8 A Yes.

9 Q And it says:

10 "In some cases where a
11 hospital's information is not available
12 for a certain measure, Leapfrog uses a
13 supplemental data source. In cases where
14 a hospital's information is not available
15 from any data source, Leapfrog has
16 outlined a methodology for dealing with
17 the missing data."

18 Do you see that language?

19 A Yes.

20 Q Okay. You didn't consider this language
21 when rendering your opinions, right?

22 A No. This page was not a focus of my
23 analysis.

24 Q Do you have an opinion one way or another
25 as to whether -- as to how this communicates the

1 grade is calculated?

2 A Well, just giving you, like, a rough
3 professional estimation, this does look like it's
4 written for a higher grade level than the main
5 pages. If you look, there's a lot -- there's longer
6 sentences, and there's longer words.

7 Q Okay.

8 A That's what the algorithm focuses on, is
9 length of words and length of sentences. You know,
10 I'm estimating that these are longer.

11 So, if this was to be consumer-facing, it
12 might -- it might -- well, not consumer-facing. If
13 this was the typical consumer -- if the Google
14 Analytics data shows that the typical consumer is
15 reading this, there may be a little bit of
16 accessibility issue. So that's a potential --
17 potential criticism.

18 But it does -- it does look like they are
19 definitely trying to go for transparency, giving
20 lots of information. My analysis is that this is
21 likely for that next step, you know, for the
22 progressive disclosure, where if somebody wants to
23 get to the next step and wants to know information,
24 I would say this is the -- a reasonable next step.

25 Q Got it. Okay.

1 Now, given what you now know about the
2 imputation methodology, is the language I read to
3 you, the "in some cases," actually transparent?

4 A Well, my understanding is that, you know,
5 it gets analyzed every year with the -- with the
6 board and is subject to change.

7 Q The language I read to you. Sorry. Go
8 down -- I'm not talking about the expert panel at
9 the top. Do you see that? I'm talking about the
10 sentence starting "In some cases."

11 Do you see that at the end of the
12 paragraph?

13 A Yes.

14 Q You said transparency requires that
15 language to be read, understood, and be true, right?

16 A Yes.

17 Q Assuming this is read -- maybe it is,
18 maybe it isn't. I take your point, Google Analytics
19 will reveal. Assuming it's understood to some
20 degree, is it your view, conducting your
21 transparency analysis, that it's true?

22 A I think at this point, getting into
23 whether it's true or not is going to go beyond the
24 scope of my analysis and fall more onto Dr. Harris.

25 Q Okay. Is it consistent with what's

1 communicated in Figure 2 of your report?

2 A So I feel like the meat and potatoes
3 of 2 -- of Figure 2 and what we compare it to is the
4 red bolded asterisk saying -- so I'll read them in
5 parallel to kind of help my brain think about the
6 two:

7 "The hospital declined to report
8 their performance on this measure, so a
9 score was assigned to reflect the lack of
10 information available. In some cases
11 where a hospital's information is not
12 available for certain measures, Leapfrog
13 uses supplemental data sources. In a case
14 where a hospital's information is not
15 available from any data source, Leapfrog
16 has outlined a methodology for dealing
17 with the missing data."

18 So, yeah, to me, this seems like a great
19 next progressive disclosure, where it starts with
20 what bare basics is needed with the first sentence,
21 and this next sentence is introducing more
22 information and helping to point you to where you
23 could get more data if you want to go even deeper.

24 Q So on Exhibit 14, it says:

25 "In some cases where a

1 hospital's information is not available
2 for a certain measure, Leapfrog uses a
3 supplemental data source," right?

4 A Yes.

5 Q Is it your testimony that Figure 2
6 communicates that same content?

7 A There is overlap, but this is introducing
8 more information, which is typical for progressive
9 disclosure.

10 Q What's the more?

11 A The more is, you know, multiple data
12 sources.

13 Q Okay. So it's not clear you're saying in
14 Figure 2 whether Leapfrog uses a supplemental data
15 source; is that your testimony?

16 A Yes.

17 Q Okay. Then you go to this about the
18 grade, and Leapfrog says it uses a supplemental data
19 source for missing data, right?

20 A Yes.

21 Q And that's not true -- is it? -- for
22 certain measures?

23 A Does it -- it's saying in some cases.

24 Q Uh-huh.

25 A So it's not saying they always do.

1 Q Well, they say they have a methodology for
2 dealing with missing data, right?

3 A Yes.

4 Q And that methodology we just looked at,
5 and at least in step 2, there is no supplemental
6 data source, right?

7 A In step 2. Are you referring to Figure 2?

8 Q No. Step 2 that we looked at a moment ago
9 from the methodology document where they assigned
10 limited achievement, right?

11 A Yes.

12 Q They just automatically assign it, right?

13 A Yes.

14 Q In fact, their internal employees say they
15 arbitrarily assign it.

16 MS. WOOD: Objection to form.

17 MR. CRAIN: I'll withdraw it. I didn't
18 put the document in the record. Where was my
19 question? I broke my rhythm because of that aside.

20 MS. WOOD: Sorry.

21 MR. CRAIN: No, no. It's a fair
22 objection. I withdrew it.

23 BY MR. CRAIN:

24 Q So a consumer reading this page of the
25 "about the grade" could, at least in theory, come

1 away thinking Leapfrog, for a hospital like Good
2 Samaritan in your report, has a supplemental data
3 source for the missing data, right?

4 A Yes.

5 Q And in fact, isn't it worse because of the
6 good practice you highlighted? Because some of the
7 gas gauges say there is missing data because they
8 declined to report, and others say there is bad
9 performance, right?

10 MS. WOOD: Objection to form.

11 THE WITNESS: So I do agree with you.
12 You're making a good point. I want to be objective
13 and fair on both sides here. And I do see that as
14 being a reasonable criticism.

15 BY MR. CRAIN:

16 Q It's confusing, right?

17 A I don't think that it takes away from the
18 analysis that I have in this report. I do share
19 that criticism with you.

20 Q Okay. And just so it's clear, what is
21 that criticism?

22 A That the question mark with the claim
23 report is used for staff work together to prevent
24 errors; whereas, you know, with the other imputed
25 values, they don't -- they don't have -- they don't

1 have that. So . . .

2 Q And fair to say that looking at those gas
3 gauges implies that there is data for things like
4 hand washing?

5 A No. Because they do clearly have an
6 asterisk, and users were clearly getting that far
7 down. It is bolded, and it is in red. So I feel
8 like this is an iterative improvement that they need
9 to get to over time, especially with, you know, the
10 community reaching out and saying, like, "Hey, you
11 know, you're making this change, and we want you to
12 improve on this."

13 Nobody starts perfect. Everybody has to
14 iterate and get better and better. That's just how
15 everything works.

16 Q Fair enough.

17 But circling back to what you said a
18 moment ago when I asked you about comparing the two
19 gas gauges. You went back to the footnote --
20 right? -- the asterisk?

21 A Yes.

22 Q So does your opinion on the clarity of the
23 gas gauges depend on users actually scrolling down
24 to that footnote? Right?

25 A Yes.

1 Q And that's the Google Analytics data in
2 Opinion 5, right?

3 A Yes.

4 Q And the fact your data, as you calculated
5 it, showed that every user scrolls down at least
6 once, right?

7 A That's not quite.

8 Q Tell me what I'm missing.

9 A So it's saying the average user scrolls
10 down a little bit over once.

11 Q Fair enough.

12 A So you'll have some users that don't and
13 some users that do it multiple times.

14 Q Fair enough. It's an average. I take --
15 that's a fair point. Okay.

16 Let's go back to "About the Grade,"
17 Exhibit 14. I want to take you through one more
18 thing.

19 Let's go to what's the third page from the
20 end. And the first full paragraph starts "A
21 hospital."

22 Do you see that?

23 A I'm sorry. Am I on the right page here?

24 Q No.

25 A What page did you say?

1 Q I said I'm looking from the third page
2 from the end. What page do you have?

3 A (Indicating.)

4 Q The next page. Do you see that first
5 paragraph on top starts "A hospital"?

6 A Yeah.

7 Q I'm going to read this into the record as
8 well:

9 "A hospital must have enough
10 safety data available for our experts to
11 issue them a letter grade. Hospitals
12 missing more than six process measures,
13 more than five outcome measures, or PSI
14 90, are not graded. All hospitals" --
15 blah, blah, blah.

16 Do you see that language there?

17 A Yes.

18 Q And I assume you would say this is a
19 higher degree of readability?

20 A What do you mean by "higher degree of
21 readability"?

22 Q When we looked at the prior page, you were
23 talking about it was a higher grade level of
24 readability.

25 Do you recall that?

1 A Yes.

2 Q Is that the same for here, or is this the
3 lower grade reading level?

4 A Without running the algorithm, it's
5 difficult to say. I can only give you a
6 professional estimation here on the spot. But the
7 words actually seem to be, you know, smaller, and
8 the sentences aren't too long here. So this would
9 probably have a lower grade level.

10 Q So this would have a lower grade level?

11 A Yeah.

12 Q So I want to just focus on the language.
13 You see "Hospitals missing more than six process
14 measures," and I'm going to give an ellipses, dot,
15 dot, dot, "are not graded."

16 Do you see that?

17 A Yes.

18 Q I'm going to represent to you that, when a
19 hospital does not respond to the Leapfrog Hospital
20 Survey, Leapfrog is missing seven of these process
21 measures.

22 Were you aware of that before?

23 MS. WOOD: Objection to form.

24 THE WITNESS: So that's outside of the
25 scope of what I analyzed.

1 BY MR. CRAIN:

2 Q You've never heard that before?

3 A No.

4 Q So I want to just understand. If a
5 typical user was looking at this, "six process
6 measures are missing, then we don't give a grade,"
7 do you think the user would understand that Leapfrog
8 assigns grades and doesn't count them in the six if
9 they're imputed?

10 Did that make any sense? Maybe not.

11 MS. WOOD: Objection to form. I'm
12 confused.

13 MR. CRAIN: Fair enough. Okay.

14 BY MR. CRAIN:

15 Q When a hospital does not respond to a
16 survey, it's missing seven process measures.

17 Do you understand that?

18 A Yes.

19 Q What Leapfrog does is, for three of those
20 measures, it discards them. It doesn't use them.

21 Were you aware of that?

22 A Again, that's outside the scope of my
23 analysis.

24 Q But you do know there are four imputed
25 measures, right?

1 A So there is the ones that were -- that we
2 clearly talked about on that page.

3 Q There's the hand hygiene. You remember
4 that one?

5 A Yes.

6 Q And then there's the safe administration
7 of medicines, right?

8 A Yes.

9 Q And then there's the computerized order of
10 medicines, right?

11 A Yes.

12 Q And the fourth one is ICU physician
13 staffing. Are you aware of that?

14 A Yes.

15 Q Those four, when a hospital doesn't report
16 it, is it your understanding that Leapfrog has no
17 data as to the hospital's actual performance on
18 those four measures?

19 MS. WOOD: Objection to form.

20 THE WITNESS: I'm going to have to defer
21 to Dr. Harris on that. That's starting to get out
22 of the scope of, you know, the user experience on
23 the website.

24 BY MR. CRAIN:

25 Q Okay. Fair enough.

1 So going to your experience on the user
2 experience -- going to your expertise of the user
3 advice on the website, do you think it's clear to a
4 typical user, looking at this, that hospitals that
5 get imputed four of these process measures are
6 missing data for seven?

7 MS. WOOD: Objection to form.

8 THE WITNESS: I'm going to have to defer
9 that to Dr. Harris. That's getting outside of the
10 scope. I'm having trouble following.

11 BY MR. CRAIN:

12 Q Fair enough. Me too. It's a confusing
13 website.

14 Okay. I'll set it aside.

15 Let's go to just one more document.

16 We're going to take you to the "Frequently
17 Asked Questions."

18 (Exhibit 15 marked for identification.)

19 BY MR. CRAIN:

20 Q This will be Exhibit 15.

21 Okay. Mr. Vredenburgh, do you have in
22 front of you a document entitled "Frequently Asked
23 Questions about the Leapfrog Hospital Safety Grade"?

24 A Yes.

25 Q And you reviewed this when you were

1 drafting your report, right?

2 A I saw the page. I didn't get into the
3 details of reading it.

4 Q Okay. So did you -- this report has been
5 discussed. It's not subject to your opinions in 1,
6 2 and 3, right?

7 A This webpage you mean or this report?

8 Q I'm sorry, did I say "report"? Let me fix
9 that.

10 This webpage is not one of the webpages to
11 which your Opinions 1, 2 and 3 apply, right?

12 A Yeah. This was outside the scope. I feel
13 like, you know, if it -- if I was asked to analyze
14 it and there was the time to do so, it would have
15 made sense. But my analysis is more concise.

16 Q Okay. Are you aware of the scholarly
17 research about whether consumers look at Frequently
18 Asked Questions pages?

19 A So, yeah. Again, it was outside the scope
20 of what I looked at. But I think a good starting
21 point would be looking at the Google Analytics and
22 seeing how many people look at it.

23 Q Fair enough.

24 Okay. So I want to take you to page 3 of
25 this document.

1 And it's one of the FAQs. In the middle
2 of the page, do you see "Does a hospital get a
3 better safety grade if it reports to the Leapfrog
4 Hospital survey?"

5 Do you see that?

6 A Yes.

7 Q And the answer says:

8 "The hospital safety grade
9 reflects how well a hospital does on
10 safety, not whether they complete the
11 Leapfrog Hospital survey."

12 Do you see that?

13 A Yes.

14 Q How readable, in your professional
15 estimation, is that language?

16 A It's on par with a lot of the other pages.
17 It's probably at that eighth grade level.

18 Q Consumer friendly?

19 A Yeah.

20 Q And you say in your report -- let me just
21 go back to the language -- that users can understand
22 that grades reflect non-participation rather than
23 performance data.

24 Do you recall saying that in your report?

25 A I'm sorry. Can you repeat it one more

1 time?

2 Q Yeah. You say in your report "Users can
3 understand that grades reflect non-participation
4 rather than direct performance data."

5 A Yes.

6 Q Seeing this FAQ, does that change your
7 view about what users can understand?

8 A I think, based on the page that I
9 analyzed, that that statement would --

10 Q Maintain?

11 A -- maintain, yeah.

12 Q Now does this change your opinion, this
13 language? I mean, this is a consumer-facing
14 website, right?

15 A Yeah, it is.

16 Q Readability about eighth grade level,
17 right?

18 A "The hospital safety grade reflects how
19 well a hospital does on safety, not whether they
20 complete the Leapfrog Hospital survey." So --

21 Q This is how Leapfrog is depicting what its
22 methodology shows, right?

23 MS. WOOD: Objection to form.

24 THE WITNESS: Yeah. So I would say this
25 is outside of the scope of what I analyzed, and it's

1 getting into the realm of how things are imputed.
2 So I would want to defer to Dr. Harris on this.

3 BY MR. CRAIN:

4 Q It was also outside the scope of your
5 analysis whether this is readable or not, right?

6 A That's correct. I just gave you a
7 professional -- you know, I want to try to be
8 agreeable, you know, in deposition and not just say
9 "no" to everything. So . . .

10 Q And I appreciate that. I'm asking you to
11 do the same with this language in this question.

12 Does this language, how Leapfrog is
13 putting out what its safety grade terminology do,
14 affect your opinion about what a typical user would
15 understand about how the safety grade works?

16 A Yeah. I feel like there may be -- there
17 may be an issue here with this statement.

18 Q What's the issue?

19 A My estimation is that this was written
20 before they changed the imputation to become
21 punitive, because this seems to reflect the way that
22 the company was before that point.

23 Q So this is inconsistent with how you
24 understand the methodology to work today?

25 A Yes.

1 Q Okay. You can set that aside. Unless
2 Adam tells me I'm missing something.

3 MR. CRAIN: How long have we been going?

4 MR. GARNICK: I think a little over an
5 hour now. Yeah, about an hour and 15.

6 MR. CRAIN: You want to take a break?

7 THE WITNESS: Yeah. Let's take a break.

8 THE VIDEOGRAPHER: We are going off the
9 record. The time is 1:59 p.m.

10 (Recess taken.)

11 THE VIDEOGRAPHER: The time is 2:18 p.m.
12 We are back on the record.

13 BY MR. CRAIN:

14 Q Okay. Mr. Vredenburg, welcome back. I
15 want to turn to Opinion 2. We talked a little bit
16 about, I guess, sort of 1, 2 and 3 together. But I
17 want to focus on Opinion 2.

18 Is this fair enough?

19 A Yes.

20 Q Opinion 2, just looking at your report, is
21 "The website's readability enables accessibility for
22 a general audience."

23 Do you see that?

24 A Yes.

25 Q And in Opinion 2, the crux of it is you

1 conducted the Flesch-Kincaid Grade Level and the
2 Gunning analysis of readability, right?

3 A Yes.

4 Q And you conducted it for the home page,
5 Figure 1, and the model, I'll say, of Figure 2,
6 right?

7 A Correct.

8 Q And your ultimate conclusion was, based on
9 those analyses, those two pages had an eighth grade
10 reading level?

11 A Between 7.9 to 8.3.

12 Q Okay. And the 7.9 and 8.3, those are the
13 grade levels?

14 A Yes.

15 Q Got it. Okay.

16 And again, this opinion does not test the
17 content -- right? -- just the readability?

18 A It tests sentence length and word lengths.

19 Q Okay. You did not analyze the readability
20 under Opinion 2 of the methodology document, the
21 29-pager right?

22 A Correct.

23 Q Would it surprise you that, when we ran it
24 through Flesch-Kincaid, that it scored a 45?

25 A No.

1 Q Okay. And that -- to the best of your
2 professional understanding, that's a college level
3 or even a graduate level reading level?

4 A Yes.

5 Q Okay. Now, you opine, based on research
6 that you cite, that for healthcare, an eighth grade
7 reading level is what you need, right? Feel free to
8 correct me, but I think that's what you said, right?
9 Or sorry, you said the metric -- strike that.

10 You say in your opinions, page 10 of
11 Exhibit 1:

12 "These metrics are widely used
13 in healthcare to evaluate patient
14 education materials where research
15 recommends aiming for sixth to eighth
16 grade levels to accommodate diverse
17 literary abilities and reduce
18 comprehension barriers in health
19 information."

20 Do you see that?

21 A Yes.

22 Q And then you cite Footnote 13, which is an
23 article about readability of patient education
24 materials on the American Orthopedic Society for
25 Sports Medicine website.

1 Do you see that?

2 A Yes.

3 Q I have that -- what I think is that
4 article. We'll find out. This is Exhibit 16.

5 (Exhibit 16 marked for identification.)

6 BY MR. CRAIN:

7 Q Is this the article cited in Footnote 13
8 of your report?

9 A Yes, sir.

10 Q I apologize for the watermark. I think --
11 did we get it this way?

12 MR. GARNICK: This is the only way we
13 could find it.

14 MR. CRAIN: Oh, okay.

15 THE WITNESS: Yeah. I have a version
16 without a watermark if you want to make photocopies.

17 MR. CRAIN: Yeah. We actually may -- with
18 your permission, may want to scan the binder, if
19 that's okay.

20 THE WITNESS: Sure.

21 MR. CRAIN: We may need to take that back
22 to our house and ship it to you. But we'll maybe
23 talk to counsel about that off the record.

24 THE WITNESS: Okay.

25 MR. CRAIN: You guys have a scanner here?

1 MS. WOOD: Yeah, we can scan it here.

2 MR. CRAIN: You can scan it. Okay.

3 MS. WOOD: Yep.

4 BY MR. CRAIN:

5 Q I want to just go through a couple of
6 things in this letter -- in this article.

7 Now, this is -- is this a peer-reviewed
8 study, to the best of your knowledge?

9 A American Journal of Orthopedics. I would
10 assume so, yes.

11 Q Okay. Now, I want to look at -- if you go
12 to page E65, which is the first page.

13 Do you see that?

14 A Yes.

15 Q And the first paragraph under the
16 watermark, do you see the footnote 2,12.13? Kind of
17 funny, but . . .

18 A I'm not quite sure what you're pointing
19 out.

20 Q Fair enough.

21 Do you see the footnotes -- I mean, it
22 says 2, comma, 12, dot -- I'm just trying to orient
23 you.

24 Do you see the language "Many healthcare
25 organizations"?

1 A Yes, I see that text.

2 Q It says:

3 "Many healthcare organizations
4 have called for patient education
5 materials to be written at or below the
6 sixth grade level."

7 Do you see that?

8 A Yes.

9 Q And then it cites a bunch of sources.

10 And then if you go to page E67. And sort
11 of in the middle of the page, do you see the
12 paragraph that starts "Previous reports"?

13 A Yes.

14 Q And it says:

15 "Given the average readability
16 of U.S. adults, the National Institutes of
17 Health has recommended that patient
18 education materials be written between
19 sixth and seventh grade reading levels."

20 Do you see that?

21 A Yes.

22 Q Is that what your citation is to?

23 A Let me take a look.

24 Q Yeah. It's your citation to Footnote 13.

25 A Yeah. So, if you look at the abstract,

1 it's saying that the average reading level for U.S.
2 adults is about eighth grade. So that -- that is
3 how I got to eighth grade level that's in the
4 report.

5 Q Where is that language on my exhibit?

6 A It would be right kind of in the middle
7 right of the abstract.

8 Q Got it. Okay. "15 of the 170 articles
9 had a readability level at or below eighth grade."

10 Do you see that?

11 Is that what you're talking about?

12 A Yeah.

13 Q Got it. Okay.

14 And then -- okay. So I see where you're
15 pointing to now.

16 If you go back to page E67.

17 And do you see at the top of the page the
18 sentence beginning "According to"?

19 A "According to Nationwide Survey"?

20 Q Yep. Why don't you read the rest of that
21 sentence.

22 A "About 20 percent of all U.S. adults read
23 at a level below fifth grade."

24 Q Okay. So this article, I take your point
25 on the abstract saying that the average readability

1 level was below eighth grade. But you also see that
2 many healthcare organizations on page 1 have called
3 for patient education materials to be written at or
4 below the sixth grade level.

5 And on page 2, the NIH says that
6 educational materials have to be -- should be
7 written between the sixth and seventh grade levels,
8 right?

9 A Correct.

10 Q That's lower than the one you have in your
11 report, right?

12 A Yes.

13 Q Okay. And 20 percent read at or below
14 fifth grade reading level, right?

15 A Yes.

16 Q Now, your analysis shows that Figure 1 and
17 Figure 2 are at the higher end of the spectrum --
18 right? -- 7.9 and 8.3?

19 A That's correct.

20 Q And that would be above what this article
21 is recommending as readable for medical --
22 medicine-related patient education materials?

23 MS. WOOD: Objection to form.

24 THE WITNESS: I think it's important to be
25 reasonable. If you look at this pie chart in this

1 same publication, they're looking at the
2 distribution of readability for their own
3 publications in this. And they're saying "Within
4 our own publication," you know, "less than 1 percent
5 meet the sixth grade standard."

6 And I found that with my own research, and
7 it is pretty well established. It's really hard to
8 write health information at a sixth grade level.
9 And oftentimes, it's written at the college level,
10 like you were pointing out with that other document.

11 So is there room for improvement?
12 Possibly. You know, getting it there is a great
13 standard to try to get to. But it's very rare. And
14 getting at an eighth grade level is still actually
15 pretty good.

16 BY MR. CRAIN:

17 Q Okay. Fair enough.

18 And when you say your own research, that's
19 the 2009 article we looked at before?

20 A Yes.

21 Q Got it. Okay.

22 I think that may be all I have on this.
23 So you can set -- that's all I have on 2.

24 I think I want to go to Opinion 3, if I
25 can. And I don't have a lot on Opinion 3 because we

1 covered some of these concepts before; fair to say?

2 Do you agree?

3 A I'm sorry. I was flipping through.

4 Can you repeat the question?

5 Q Of course.

6 I said I don't think I have a lot on
7 Opinion 3 because a lot of the concepts in 3 overlap
8 to some degree with 1 and 2; is that fair?

9 A Sure. Whatever questions you want to ask,
10 that's fine.

11 Q Well, I'm asking you about the content.

12 Do you think that -- like, is it fair to say that
13 Opinions 1, 2 and 3 overlap in content?

14 A Yes. Yeah, 3 is just focused on the fact
15 that the -- and we've talked about it plenty. I
16 feel like we've covered 3.

17 Q Okay. And 3 -- so just looking at 3, I
18 want to ask -- if we look at paragraph 26 -- I think
19 you have -- so does your Opinion 3 revolve around
20 your progressive disclosures concept?

21 A Yes.

22 Q So tell me a little bit about -- can you
23 describe for me how that works?

24 A Great. So it's a large challenge to be
25 trying to tailor towards, you know, entry-level

1 grade reading, as well as making something that's
2 also engaging and challenging for experts. And so
3 this idea of progressive disclosure, which this
4 website utilizes, where you're going to present the
5 basic information first that is going to apply to
6 almost everyone, actually -- most people -- people
7 fall off very quickly on these levels making it
8 further.

9 And that was reflected in the analytics
10 data, that they used, you know, their experts to
11 determine what was -- what was needed to -- to be
12 displayed to users at this accessibility level. And
13 then they kind of removed the reins and brought it
14 up to a college level or even, you know, research
15 level for, you know, these further documents.

16 Q Your Opinion 3 is that the imputed scores
17 are readily clear to users with a basic reading
18 comprehension, right?

19 That's the header?

20 A Yes.

21 Q The progressive -- so you didn't analyze
22 the websites that come after Figure 2 in the
23 progressive disclosure, right?

24 A Correct.

25 Q So can the content of those websites

1 inform your opinion in 3?

2 A So just in -- so that I saw that they're
3 written at a higher level, I agree with your
4 analysis that they were written at a college level,
5 at least the document that you showed, that made
6 sense.

7 Q That's the scoring methodology?

8 A Yes. That follows and makes sense, based
9 off of this progressive disclosure. And so they are
10 analyzed insofar as that they exist and that they're
11 more advanced. But beyond that doesn't really
12 matter to me.

13 Q The content doesn't matter to you, right?

14 A Correct.

15 Q Again going to Opinion 3 -- we covered
16 this before, but I just want to make sure I
17 understand this right -- your opinion is just the
18 scores themselves are clear, the 15, the 25, the 5?

19 A Yes.

20 Q We're just conferring. See, Adam keeps me
21 focused. Okay.

22 So I want to talk about -- okay. In
23 Opinion 3, you wrote that Leapfrog's use the score
24 comparisons reflects UX best practices; is that
25 right?

1 A So near the middle? Top?

2 Q It's towards the end. Do you see "this
3 consumer-facing design" --

4 A Yes.

5 Q -- "informed by readability standards and
6 UX best practices provides adequate tools for lay
7 users and expert users through progressive
8 disclosures," et cetera, et cetera.

9 Do you see that?

10 A Yes.

11 Q What is the UX best practice you're
12 referring to there?

13 A Using progressive disclosure.

14 Q Got it. Okay.

15 That's the only practice there?

16 A Yes.

17 Q Okay. Any other?

18 A So related to the -- I think that -- I
19 think that sums it up for that particular opinion.
20 I think the other opinions speak for themselves.

21 Q Okay. So should this have been singular?
22 UX best practice, meaning progressive disclosure?

23 A Well, they also -- no. I think plural is
24 correct because we talk about the conspicuity in the
25 earlier opinions. So that still applies here.

1 Q Conspicuity of just the number grade --
2 number score?

3 A Yeah. Conspicuity of the number grade of
4 the red bolded asterisk, which is linked to
5 interpreting, you know, the scores.

6 Q And you have to scroll down to see it,
7 right?

8 A Yes.

9 Q Okay. Anything else there?

10 Okay. Let's go to 4, Opinion 4.

11 And your Opinion 4 is "Leapfrog's UX
12 testing validates the website's clarity in contrast
13 to Berger's untested methodology."

14 Do you see that?

15 A Yes.

16 Q Now, let's break this down.

17 So Leapfrog's UX testing. You reviewed a
18 document for that, right?

19 A Yes.

20 Q And Adam is giving me the document, so I
21 will pass that to you because he thinks ahead. This
22 is Exhibit 17.

23 (Exhibit 17 marked for identification.)

24 BY MR. CRAIN:

25 Q Are you going to --

1 A I'm just pulling up the same document in
2 here.

3 Q Got it. Okay.

4 So let's just start maybe at the basics,
5 stepping back.

6 What does UX testing typically look like?

7 A Sure. So it involves creating a mockup of
8 websites or, you know, actual functional websites
9 and doing user testing on a large number of users, a
10 comprehension test or, you know, some sort of
11 biometrics, like eye tracking, are then used to try
12 to ascertain how to improve and comprehension.

13 Q Wow. So they actually use eye tracking to
14 figure out where people are looking?

15 A Oh, absolutely.

16 Q That's very cool. Sorry. Setting that
17 aside.

18 So a lot of data?

19 A Yes.

20 Q And when someone conducts a UX test, what
21 is the format through which it's ultimately
22 communicated?

23 Do you understand the question?

24 A It's usually published research.

25 Q Like a peer-reviewed document?

1 A Yes.

2 Q Spreadsheet maybe with the data?

3 A A lot of the research doesn't publish the
4 data like that. It would be more publishing the
5 analysis.

6 Q Like the conclusions?

7 A Yeah.

8 Q Okay. So my question is, did you review
9 anything like that in this case for the UX testing
10 that you claim Leapfrog did?

11 A So that -- can you rephrase the question?

12 Q Yeah.

13 Is there any peer-reviewed research of the
14 UX testing that Leapfrog allegedly did in 2014?

15 A Oh, okay. I see what you're saying.
16 Yeah. So I feel like it's different for a company
17 than a researcher. So a company is not going to do
18 a peer-reviewed publication about their own website.
19 But they would still follow the same process, the
20 same sort of validation and so forth.

21 Q There would be some sort of a report?

22 A There could be an internal report.

23 Q Okay. So my question, is this the
24 document you relied on, Exhibit 17, to underlie your
25 opinions in Opinion 4 about Leapfrog's UX testing?

1 A This is one of them.

2 Q What are the other documents?

3 A So this was a document that I mentioned
4 before that I think was not disclosed that gets tied
5 to the document that was disclosed and --

6 Q What document are you talking about?

7 A I'm not sure if you have this or not.

8 Q Should we mark it?

9 A It's the contract for consulting services.
10 And this was for the -- the doctor that they
11 hired -- I apologize to her -- Zarcadoolas.

12 Q Do you know if that was produced to us?

13 MR. CRAIN: Ms. Wood, do you know if that
14 was produced to us?

15 MS. WOOD: I thought it was. I'm trying
16 to double-check.

17 MR. CRAIN: Is there a Bates stamp on
18 those documents?

19 THE WITNESS: (Handing document.)

20 MR. CRAIN: Thank you.

21 THE WITNESS: And you mentioned at the
22 beginning, is there anything like this. I alluded
23 to it and wanted to show it to you guys. I think
24 that that document was not referred to in the
25 report.

1 BY MR. CRAIN:

2 Q Let's do this. I think we're going to
3 need that binder to scan in.

4 A Of course.

5 MR. CRAIN: Courtney, do you want to mark
6 the binder? Like, should we do that and give it to
7 the court reporter, or how do you want to handle
8 that? Or should we talk about that off record?

9 MS. WOOD: I just plan to scan it in as it
10 is. I don't think it makes sense to make it an
11 exhibit.

12 MR. CRAIN: Do you have tabs, numbered
13 tabs on this? I think we should mark these
14 documents because I've never seen this. Courtney,
15 do you have any objection to that, these documents?

16 MS. WOOD: No.

17 MR. CRAIN: This will be Exhibit 18.
18 Okay. Exhibit 19 we've seen.

19 Can we go off for a second?

20 THE VIDEOGRAPHER: We are going off the
21 record. The time is 2:40 p.m.

22 (Discussion held off the record.)

23 THE VIDEOGRAPHER: The time is 2:46 p.m.
24 We are back on the record.

25 (Exhibit 18 marked for identification.)

1 (Exhibit 19 marked for identification.)

2 BY MR. CRAIN:

3 Q Okay. Before the break, Mr. Vredenburg
4 handed us a document that, to our knowledge, we had
5 not seen before. We only have one copy, so Ms. Wood
6 graciously agreed to copy it and used the Wilson
7 Elser facilities to give us multiple copies. We've
8 now marked that document as Exhibit 18.
9 Mr. Vredenburg has the 18 that will become part of
10 the record.

11 And Ms. Wood has agreed to copy
12 Mr. Vredenburg's binder, scan it in as-is and
13 produce it to us hopefully later today, if the
14 scanning facility works.

15 MS. WOOD: Correct.

16 MR. CRAIN: So we're all on the same page.

17 BY MR. CRAIN:

18 Q I want to ask you about -- so you gave me
19 two documents before the break. One was Exhibit 18.
20 One was Exhibit 19.

21 18 is a contract for consulting services;
22 is that right?

23 A Yes.

24 Q And it's dated October 21, 2013.

25 Do you see that?

1 A Yes.

2 Q And we're going to go through this a
3 little bit because I'm seeing it for the first time.
4 So I apologize, it's a little tedious.

5 And it says:

6 "The purpose is the client
7 wishes to engage the services of
8 contractor to recommend strategies for
9 usability and navigability of hospital
10 safety score website and app."

11 Do you see that?

12 A Yes.

13 Q Is that the UX testing we're talking
14 about?

15 A Whatever iteration that they did, whatever
16 the standard was in 2013. I know things have
17 progressed since then.

18 Q Fair enough.

19 And this is a document you relied on in
20 rendering your opinions, right?

21 A Yes.

22 Q And now, this is a contract with how to
23 health literacy contractor.

24 Do you see that at the top?

25 A Yes.

1 Q And if you go to the next page, on page 2,
2 it says "Dr. Christina Zarcadoolas,"
3 Z-A-R-C-A-D-O-O-L-A-S, "will provide oversight
4 direction."

5 Do you see that?

6 A Yes.

7 Q And Dr. Zarcadoolas is the person for whom
8 Exhibit 19 is the biography, right?

9 A Yes.

10 Q And she was, to your understanding, the
11 lead UX tester; is that right?

12 A I believe so.

13 Q You've not spoken to her, right?

14 A No.

15 Q Now, just looking at this, if you go back
16 to page 1, there's a "Scope of Work" section.

17 Do you see that?

18 A Yes.

19 Q And it says:

20 "Working under the direction of
21 Leah Binder, president and CEO, contractor
22 shall perform the following scope of
23 work."

24 Do you see that?

25 A Yes.

1 Q It says "The scope of work shall include
2 but deliver the following." That's a strange
3 phrasing. And there's a list of bullets.

4 Do you see that?

5 A Yes.

6 Q Okay. And then bullet 1 says:

7 "A report and full analysis of
8 website app and media messaging as it
9 pertains to literacy load and effective
10 communication with diverse populations."

11 Do you see that?

12 A Yes.

13 Q Is this consistent with what we were
14 talking about before, how something might -- how
15 these UX testings might be communicated, once
16 complete?

17 A Yes.

18 Q Have you seen the report contemplated in
19 this first bullet?

20 A No.

21 Q Are you aware that it was ultimately
22 produced?

23 A No.

24 Q Okay. So are you certain that this
25 contract was performed?

1 A So I spoke with the VP, Missy Danforth,
2 and she told me that it was and that this was the
3 person that did it.

4 Q Okay.

5 A When speaking with her, she said that it
6 was.

7 Q Did she give you -- how long did you speak
8 with her for?

9 A Probably like 20 minutes to a half hour.

10 Q How many times?

11 A One time.

12 Q Was this the only topic covered?

13 A It was -- it was the main topic for sure.

14 Q What else was covered?

15 A So for my curiosity. It's outside of the
16 scope of the work. She just gave me a quick rundown
17 of, you know, how the scores are computed.

18 And on that topic, actually, I want to
19 just kind of generally say -- I've said it a bunch
20 before, but it seems like we might be getting past
21 that section now. You know, the methodology, how it
22 was created, how the scores were created, you know,
23 the fairness of the scores are not -- that's outside
24 of the scope of my work.

25 And I believe that I used the word

1 "punitive," and that was outside of the scope. It's
2 really not a term that I should have used because I
3 don't -- I don't know one way or the other. That's
4 outside of the scope of what I analyzed. I didn't
5 analyze the Frequently Asked Questions or --

6 Q Why did you use the word "punitive" then?

7 A I guess it would be based off of my
8 limited knowledge. But it's really -- really
9 outside of the scope, so it's not something for me
10 to opine on one way or the other. That would be
11 Dr. Harris' court there.

12 Q And the scope of your analysis is how a
13 reasonable user -- typical user would interact with
14 Figure 1 and Figure 2?

15 A Yes.

16 Q And that's the scope of your understanding
17 of how the methodology works, right?

18 A No. No scope for methodology. That's
19 outside.

20 Q Well, you have some understanding --
21 right? -- because you've opined on the accuracy of
22 the pages -- the transparency of the pages?

23 A Just insofar as they convey the
24 information that we've discussed here today.
25 Anything that goes into the methodology would exceed

1 the scope of what I was asked to do, as well as
2 exceed my expertise. So the -- I've got no opinion
3 on the methodologies.

4 Q The question of whether the methodology is
5 punitive, you're saying -- so you said it was
6 punitive before, right?

7 MS. WOOD: Objection to form.

8 THE WITNESS: I believe I used that term
9 when you had two documents in front of me and the
10 sentences and trying to interpret between the
11 difference.

12 BY MR. CRAIN:

13 Q And now you're walking that word back,
14 right?

15 A I am, yes.

16 Q After a break where you spoke with
17 counsel, right?

18 A Yes.

19 Q Okay. During that break -- I don't want
20 to know what was discussed. Did you discuss the
21 substance of your testimony with counsel?

22 MS. WOOD: Objection to form.

23 THE WITNESS: Is it okay to answer?

24 BY MR. CRAIN:

25 Q I'm not asking for the content, just

1 whether it was discussed.

2 MS. WOOD: You can answer as to "yes" or
3 "no."

4 THE WITNESS: Yes.

5 BY MR. CRAIN:

6 Q Okay. And now you are walking back the
7 word "punitive," right?

8 A Yes.

9 Q Following that break?

10 A Yes.

11 Q Okay. In which you discussed with counsel
12 the substance of your testimony?

13 A Yes.

14 Q Got it. Okay.

15 Going back to this contract. So you spoke
16 with Ms. Danforth.

17 Did you speak with any other Leapfrog
18 employees at any time about this case?

19 A No.

20 Q About the weather?

21 A No.

22 Q About a barbecue?

23 A No.

24 Q Okay. Just Ms. Danforth?

25 A Correct.

1 Q Now, did she communicate to you that this
2 report and full analysis was actually issued, bullet
3 1?

4 A I got this document after speaking with
5 her. So that wouldn't have been exactly how we
6 would talk about it. She was more like that
7 conversation led me to here.

8 Q Now, the only document you had when you
9 wrote your report was Exhibit what?

10 MR. GARNICK: 19.

11 MR. CRAIN: Tab 27.

12 MR. GARNICK: 17.

13 BY MR. CRAIN:

14 Q Exhibit 17; is that right? Do you have
15 that in front of you? It's the final narrative
16 report. That one (indicating.)

17 A So I would have had 17, 18 and 19.

18 Q When you rendered your opinions, you had
19 17, the final narrative report; 18, the contract,
20 and 19, the bio of Dr. Zarcadoolas, correct?

21 A Correct.

22 Q Only one of which I think was disclosed in
23 your Appendix C, right?

24 A No.

25 Q The biography was disclosed?

1 A It was disclosed.

2 Q So two of the three were disclosed, right?

3 A Yeah. So I apologize. That was a
4 mistake. This document I reviewed, and it should
5 have been on there. It was just an honest mistake.

6 Q Okay. Fair enough.

7 So I want to talk about this final
8 narrative report.

9 A Okay.

10 Q Is this the only evidence, besides your
11 discussion with Ms. Danforth, that UX testing was
12 actually done?

13 A Well, there is also Exhibit 18.

14 Q Well, Exhibit 18 says it was contracted
15 for, but it doesn't say it was done, right?

16 A Well, it's a good step towards getting it
17 done, to get the ball rolling.

18 Q Fair enough.

19 But we don't have the report that was
20 promised here, right?

21 A Correct.

22 Q Okay. So what is Exhibit 17, the final
23 narrative report? I can be more precise if it's
24 helpful. Just let me know.

25 A So my understanding is that they had

1 applied for a grant.

2 Q Uh-huh.

3 A And within the grant process, you know,
4 there's monitoring and questioning and seeing how
5 things went with the grant. And so this is
6 answering the questions. For example, "What are the
7 post-grant plans for the project if it does not
8 conclude with the grant?" I guess they're trying to
9 analyze, you know, do they want to continue funding
10 or -- you know, from that perspective.

11 Q And this is not written by
12 Dr. Zarcadoolas, right? This is written by
13 Ms. Binder?

14 A I don't see a signature at the end.

15 Q You see the email address on the bottom of
16 page 1?

17 A Yeah. That's --

18 Q Does that at least suggest she wrote it?

19 A That does suggest it, yes.

20 Q Okay. Now, did you ask, when you were
21 conducting your analysis for Opinion 4, for a copy
22 of the report and full analysis of the UX testing?

23 A Yeah. I asked them to give me everything
24 they had.

25 Q And this was all they had?

1 A Yeah. This is what was produced.

2 Q Okay. And this is not actually a report
3 of the UX analysis, right?

4 A Correct.

5 Q This is a -- almost like a -- well, as you
6 said, a grant recap in a way, right?

7 A Yes.

8 Q And almost trying to, in some ways, as you
9 read this, justify further grants, right?

10 A Yes.

11 Q In your expert opinion, is this the type
12 of document an expert analyzing UX testing should
13 rely on to evaluate the merits of a test?

14 A It doesn't paint the full picture. I feel
15 like -- you know, like you were saying, having the
16 actual report in front of me would say more than
17 what's here. But I think that there is important
18 information that is here, you know, saying that they
19 do have a focus on UX and that they have a credible,
20 qualified person doing so.

21 So I feel like the information that's here
22 is useful, but, you know, there could be further
23 documents that are even further useful.

24 Q Do you acknowledge in your report that you
25 don't have the full UX testing? I'm looking at

1 pages 12 to 14.

2 A Without going further through all of it, I
3 feel like the footnotes do paint pretty clearly
4 what's there.

5 Q The footnotes cite the document you relied
6 on, right?

7 A Yeah.

8 Q Now, you say "Leapfrog's UX testing
9 validates the website's clarity, in contrast to
10 Berger's untested methodology."

11 That's your opinion, right?

12 A Yeah. So assuming that they did go
13 through with the contract, that she did perform her
14 services, that is definitely an attempt on their
15 part to hire, you know, licensed -- not licensed,
16 because there is no license for that, but, you know,
17 a reputable professional to work on that and to
18 perform the UX testing.

19 And based off of the scope of work that's
20 given to them, it looks really reasonable to me of
21 the things that they were looking to do.

22 Q But you haven't read their conclusions --
23 right? -- the UX test report conclusions?

24 A That's correct.

25 Q For all you know, it could have told

1 Leapfrog to do the opposite of what they did, right?

2 MS. WOOD: Objection to form.

3 THE WITNESS: I don't have those
4 documents.

5 BY MR. CRAIN:

6 Q Yeah. And we've already discussed today
7 problems with the websites, right?

8 MS. WOOD: Objection to form.

9 BY MR. CRAIN:

10 Q At times, you characterize it as an issue,
11 right?

12 A I would say that there is always room for
13 constant improvement. And, you know, when we put
14 something under the microscope this much, we're
15 going to find stuff.

16 So I would say that, if I were being hired
17 to conduct further improvement, that I would
18 definitely have some suggestions of how to conduct
19 testing and proceed on that.

20 Q Then how can you opine that the UX testing
21 validates the website's clarity?

22 A The fact that they're following the
23 method. So the -- if I can draw an analogy to the
24 scientific method is you don't always start in a
25 perfect place. You can make a hypothesis and you

1 can be wrong. And it's true for companies too. You
2 don't always start perfect. It's about constant
3 improvement and iteration.

4 Q But that's not your opinion. Your opinion
5 is this -- isn't "This is pretty good, but we all
6 can do better." Your opinion is the UX testing
7 validates the website's clarity.

8 Do you want to withdraw or change that
9 opinion?

10 A No.

11 Q So you just said -- you referred back to
12 the scientific method.

13 The scientific method requires testing of
14 hypotheses, right?

15 A Yes.

16 Q What hypotheses did the UX testing test?

17 A It looks like it's related to literacy and
18 effective communication --

19 Q No, no. That's the contract you're
20 looking at, right?

21 A Right. But the scope of work, that's -- I
22 feel like they're one and the same in this case.

23 Q But how do you know it was done that way?

24 A That would be based off of the interview
25 with Ms. Danforth.

1 Q So she said this contract that you didn't
2 have at the time you were talking to her was fully
3 complied with?

4 A No. She --

5 MS. WOOD: Objection to form.

6 THE WITNESS: She said that this expert
7 was relied upon for fulfilling, you know, the
8 obligations.

9 BY MR. CRAIN:

10 Q So in the UX testing, presumably the
11 expert offered, as you see bullet 2,
12 "recommendations for revisions and new messaging,"
13 right?

14 A Yes.

15 Q That's your assumption?

16 A Yes.

17 Q You have no idea whether any of those were
18 actually followed, right?

19 A Correct.

20 Q Because we don't know what they are,
21 right?

22 A Well, I do remember them -- them saying
23 that they -- they were able to make, you know, large
24 strides and improvements based on -- based on the
25 work.

1 Q I'm asking a different question. They may
2 have done better, but let's set that aside.

3 You don't know -- so I said "You have no
4 idea whether any of those were actually followed,
5 right?" And you said "correct." And I said
6 "Because we don't know what those recommendations
7 are," right?

8 A Well, to me, it does look like they hired
9 an expert to do user experience on their website, as
10 I've said throughout my report.

11 Q So it's your opinion that it's enough to
12 hire an expert?

13 A I think that that's -- that's the start.
14 And --

15 Q So I go out and hire an expert to look at
16 my website, and then I can opine that UX testing
17 validates the website's clarity?

18 MS. WOOD: Objection to form.

19 BY MR. CRAIN:

20 Q I assume that's not your testimony, right?

21 A Do you want to rephrase the question?

22 Q Fair enough.

23 So you just told me that they hired an
24 expert, right?

25 A Yes.

1 Q And I asked you whether that was enough.
2 And you said "I think that's the start," right?

3 A So, in some cases, that can be enough and
4 that can be the end. It kind of depends on the
5 company and the webpage and, you know, if there
6 is -- if there is problems or not. And then, like,
7 a good practice that is encouraged in human factors
8 and industrial engineering is continuous monitoring
9 and receiving feedback, which, to my understanding,
10 you know, Leapfrog does do with, you know, having
11 open forum and opening up to the public, asking
12 about potential changes. And so --

13 Q Changes to the methodology, though, not
14 the website.

15 MS. WOOD: Objection to form.

16 THE WITNESS: So those specifics, you
17 know, I don't know.

18 BY MR. CRAIN:

19 Q But you just made a statement about them.
20 So where is that statement coming from?

21 A That they hired a professional to perform
22 UX testing. And, you know, I've got the bread crumb
23 trail of their work and who they are. You know, I
24 only have what's available. And I see the website,
25 and the website, you know, based on my other

1 opinions, does follow UX principles. So I think
2 it's reasonable to conclude what I did with my
3 opinion.

4 Q So is your opinion that the website
5 follows UX principles, or is your opinion that the
6 testing validates the website's clarity?

7 A Yeah. So the testing that she did
8 definitely did help validate the clarity.

9 Q What testing did she do?

10 A So she was hired to do testing related to
11 clarity. That was the main scope of her work.

12 Q Name everything that she did to test.

13 MS. WOOD: Objection to form.

14 THE WITNESS: You and I both know what
15 information is available here for us.

16 BY MR. CRAIN:

17 Q My view is none. But I'm trying to get
18 your view.

19 A So we have her credentials. We have that
20 she is --

21 Q Did she conduct the biometric eye movement
22 test that you talked about before?

23 MS. WOOD: Objection to form.

24 THE WITNESS: It's unlikely at that age,
25 you know, when she did it. I think it was like

1 2013.

2 BY MR. CRAIN:

3 Q Okay. How many types of UX testings
4 methodologies are available for this type of review?
5 Just in general.

6 You're reviewing the contract now,
7 Mr. Vredenburgh?

8 A Yes.

9 So would you please repeat the question
10 for me?

11 Q Yeah. The question was, how many types of
12 UX testing methodologies, techniques are available
13 for someone conducting this type of review? Just a
14 ballpark. I'm trying to understand.

15 A Two or three.

16 Q Okay. So one of those is the biometric
17 eye movement thing, right?

18 A Yeah. Which I think we can rule out.

19 Q Okay. Because that was developed later?

20 A Yeah.

21 Q What are the other techniques? Just two
22 or three.

23 A One would be just applying best practices,
24 you know, expert consultation, essentially, where
25 someone goes in and, based on their expertise, makes

1 the changes.

2 Q Is that like qualitative, as opposed to
3 quantitative?

4 A You can have a little of both, but I think
5 bringing in qualitative is fair.

6 Q Is there data in that analysis?

7 A Depending on their education and how they
8 choose to do it. So I think that would be the
9 straightforward approach that the majority of
10 websites and companies are going to choose.

11 Q What type of data would you use there?

12 A So for me personally?

13 Q Like, you're saying one way that somebody
14 would test is somebody would go in and look and give
15 feedback, right?

16 A Yeah.

17 Q And I asked you whether that's qualitative
18 or quantitative, and you said it could be both,
19 right?

20 A Uh-huh.

21 Q And I asked you what type of data informs
22 the quantitative side. And that's what I'm trying
23 to figure out.

24 What data goes into that, if any?

25 A Sure. Like font sizes, determining --

1 Q Got it.

2 A -- if it's going to be appropriate for
3 your users.

4 Q Okay. So data, just to make sure I'm
5 understanding, is not data like a consumer test of
6 what they view. It's the facts of how the page is
7 constructed, so to speak?

8 A Right.

9 Q And would this person also use, like,
10 scholarly research?

11 A Yes.

12 Q Like peer-reviewed academic journals?

13 A Yes.

14 Q Do you see where I'm going with this?

15 A Yes.

16 Q Isn't this exactly what Dr. Berger did?

17 A Yes.

18 Q And it's one of the two or three ways of
19 UX testing that you said were the ways that
20 Dr. Zarcadoolas could have done this, right?

21 A Yes.

22 Q So do you want to withdraw your opinion
23 that he did the wrong thing here? Because I assume
24 you want to be consistent.

25 MS. WOOD: Objection to form.

1 MR. CRAIN: Fair enough.

2 BY MR. CRAIN:

3 Q I'll just ask the question.

4 Do you want to withdraw your opinion as to
5 the permissibility, I'll just say in contrast to
6 Berger's untested methodology, which I think you
7 just said was the right way to do it?

8 A So I see the point that you're making, and
9 I think one issue is that a lot has changed over
10 time, and that 2013 is, you know, in technical terms
11 and with computers and websites, a different era
12 than, you know, the modern day.

13 Q So is it no longer permissible for someone
14 to analyze the data, meaning the facts on the page,
15 and academic research to identify the user
16 experience?

17 I mean, isn't that kind of what you did?

18 MS. WOOD: Objection to form.

19 THE WITNESS: So as I've been saying, I
20 think that it's important to, you know, apply the
21 gold standards that are available at the time now.

22 BY MR. CRAIN:

23 Q What gold standard did Dr. Berger not
24 apply?

25 A Research on participants, on users.

1 Q On users. Okay.

2 And Leapfrog has never done that --
3 right? -- to your knowledge?

4 A We don't know. I feel like this
5 information here, it doesn't say to me one way or
6 the other. They very well may have. Likely, they
7 did. But I can't say with certainty one way or
8 another with the documents in front of me.

9 Q So you are not withdrawing your opinion as
10 to Dr. Berger's methodology, right?

11 A I still stand by what I said before, that
12 I feel like that would have been the right way of
13 going about it, to use -- yes, to use the, you know,
14 efficient, quick, inexpensive UX testing that can be
15 done, that's taught, you know, in universities and
16 that's widely done by a lot of companies.

17 So I think, you know, following --
18 following the scientific method and doing -- doing
19 a -- doing an iterative set of testing with real
20 data, real users, I feel like that critique still
21 stands.

22 Q So you need user data to validate the
23 clarity of the website today, right?

24 A Yes. That's how it's taught.

25 Q And you didn't need that as of 2014?

1 A So it definitely was -- it was a different
2 time back then where, you know, it was still a
3 maturing field.

4 Q Okay. So your opinion was issued after
5 this gold standard came to be, right?

6 A My opinion was issued after -- can you
7 repeat that?

8 Q Yeah, let me fix that question.

9 In 2013, it was not the gold standard to
10 test website UX, user experience, with actual user
11 data, right?

12 A I would say it was still the gold standard
13 then as well.

14 Q Even though you say that the UX testing
15 validates the website's clarity?

16 A So my reading -- and this may be my own
17 bias. My reading of these documents was that she
18 did do user testing and --

19 Q Where does it say that?

20 A As I'm saying, that may be my own bias.
21 So, you know, in the writing of this report, you
22 know, I assumed that. And there very well may be
23 information that comes up to support that. But this
24 is the information that I have now.

25 Q Fair to say you just assumed that she had

1 done the gold standard, but you have no actual
2 evidence to support that?

3 MS. WOOD: Objection to form.

4 THE WITNESS: Based on the scope of work,
5 it would be reasonable.

6 BY MR. CRAIN:

7 Q To assume it?

8 A Yes.

9 Q But you have no data that actually shows
10 it occurred?

11 A Well, we have the website on the other end
12 that does follow the best practices.

13 Q Except for the issues we've talked about
14 today, right?

15 A Yes.

16 Q So for all you know, her recommendations
17 were against those problems, right?

18 MS. WOOD: Objection to form.

19 THE WITNESS: So based on that
20 conversation with Ms. Danforth, I don't think that
21 would be the case.

22 BY MR. CRAIN:

23 Q Ms. Danforth told you that they
24 implemented everything she recommended?

25 MS. WOOD: Objection to form.

1 THE WITNESS: That she was an expert that
2 they utilized and was useful.

3 BY MR. CRAIN:

4 Q That's different from what I'm asking,
5 though.

6 What I'm asking is, did Ms. Danforth tell
7 you that Dr. Zarcadoolas gave recommendations and
8 Leapfrog followed them?

9 A I don't know that detail.

10 Q Okay. So you see why I'm struggling,
11 right? You have an opinion that says Leapfrog's UX
12 testing validates the website's clarity, but you
13 have no conception of what the UX testing actually
14 resulted in, right?

15 A Well, you know, I do have a disclaimer on
16 the report as information becomes available and my
17 best estimation, and we discussed here that I
18 estimate that she did use, you know, the best UX
19 methods of the time. But, you know, with the
20 information available, we don't know.

21 Q Okay. So is it fair to say that the sum
22 total of facts relied upon for your decision -- your
23 opinion in Opinion 4 are that Leapfrog hired someone
24 with good credentials, Ms. Binder sent a response to
25 the grant agency that gave the money to do the

1 testing, and the website came into being in its
2 current form?

3 A Yes.

4 Q Let me change one other point.

5 The UX testing done was done in 2013,
6 right?

7 A Yes.

8 Q Way before the imputation model ever
9 existed, right?

10 A That's outside of the scope of my
11 analysis.

12 Q Okay. Is it outside the scope of your
13 analysis to assess whether your opinion -- well, let
14 me strike that.

15 You say Leapfrog's UX testing validates
16 the website's clarity, right?

17 A Yes.

18 Q You don't qualify as to time, right?

19 A So what I'm saying is that, to the -- you
20 know, the best of their ability hiring experts at
21 the time, they thought about UX and tried to tackle
22 the problem head on, and that, you know, the website
23 reflects it, and that it does reflect that UX was
24 thought about for creating this website and
25 progressive disclosure. And, you know, I think that

1 the website was well made and still stands today to
2 being -- to holding to that.

3 What I'm saying is, if you're going to
4 make a bold claim, if you're -- you know, in
5 science, if you want to make a bold claim -- say
6 you've got a bold hypothesis. Well, you need great
7 evidence to support it.

8 Q I agree.

9 A You know, nobody is going to agree with a
10 bold claim unless you have strong evidence. And so
11 I think, you know, coming forth and making a bold
12 claim that, you know, somebody's website is
13 misleading, you know, that would be a bold claim.

14 And I would say that, you know, taking --
15 and you guys have -- you hired Dr. Berger, and you
16 have taken it seriously with him. But I would
17 wonder -- you know, it's easy, it's inexpensive.
18 Large amounts of data can be collected quickly. And
19 it's the gold standard. Why wouldn't you do it?

20 Q Is your claim not equally as bold?

21 A I don't see where you're coming from. Can
22 you --

23 Q You say UX testing validates the website's
24 clarity, right?

25 A Right.

1 Q That's not a bold claim?

2 A So --

3 Q Yes or no?

4 You said our claim that the website was
5 misleading is a bold claim, right?

6 A Yes.

7 Q Why is a claim that the website is a
8 beacon of clarity not a bold claim?

9 MS. WOOD: Objection to form.

10 BY MR. CRAIN:

11 Q Okay. Strike "beacon."

12 A So I think that we can -- we can walk
13 through opinions 1 through 3 again to talk about
14 clarity. But I think there's --

15 Q None of them are bold, right?

16 MS. WOOD: Objection to form.

17 THE WITNESS: You're saying that Opinions
18 1 through 3 are not bold?

19 BY MR. CRAIN:

20 Q That's my question to you. Are they bold
21 claims? You said Dr. Berger's claim was -- or our
22 claim was bold -- right? -- our client's claim that
23 the website was misleading?

24 A Yes.

25 Q Are any of your opinions bold?

1 A I don't think so. I think that they hold
2 to the standards pretty straightforward.

3 Q Okay. Back to the UX testing point.

4 Do you have any present understanding of
5 what the website looked like, the
6 leapfroghospitalsafetygroup.org, leapfroggroup.org,
7 in 2013, '14 or '15?

8 A You know, I don't think so.

9 Q Do you have any understanding of what the
10 hospital safety grade pages in Figure 2 looked like
11 back at that time?

12 A I don't have that information.

13 Q Do you have any understanding as to
14 whether the website has been changed in the last 10
15 years, since the UX testing was purportedly done?

16 A I'm not sure.

17 Q Okay. So your assumption -- your opinion
18 relies on a further assumption that what was tested
19 back then vis-à-vis the website that existed at the
20 time is sufficiently close to what exists today?

21 MS. WOOD: Objection to form.

22 THE WITNESS: Or that, you know,
23 continued, you know -- so my understanding of the
24 documents that I read is that it has stayed pretty
25 consistent in terms of its form, and that it hasn't

1 changed much since then. I'd need to kind of dive
2 through the documents, but that is my recollection
3 of what I've seen.

4 BY MR. CRAIN:

5 Q What document says that?

6 A That's a good question. I can start
7 diving for it if you like.

8 Q I would be very keen.

9 Are you -- is it any document on your
10 Appendix C?

11 A Well, I do -- I do have -- let's see. I
12 do have some of their earlier documents. Like
13 they've got an archive that goes back to the prior
14 years, and so -- of reports that they've published.

15 Q What reports?

16 A So I think it's all reports.

17 Q Reports of what, though?

18 A Any kind of reports that they put out to
19 the public. And it's structured by year. And so I
20 have looked at the earlier year.

21 I remember printing out their very first
22 report. I think that it was like an analysis of
23 2013, and it was a dated 2014 document.

24 Q Was this a document you considered in
25 forming your opinion?

1 We're back to the beginning.

2 A Yeah. I think I might need to let the
3 point go, but I do remember somewhere in the
4 discovery review, there is so much about that. It
5 has remained relatively the same, the gas gauges and
6 so forth.

7 Q The gas gauges have remained the same,
8 you're saying?

9 A Yes.

10 Q But you don't know what document says
11 that, if any?

12 A I don't recall at this time, but I do --
13 my memory is telling me that that has -- that that's
14 been constant.

15 Q And do you know whether it's on your
16 Appendix C? You can look at it if you want. Page
17 23 of Exhibit 1.

18 A I think what I have, looking at the final
19 narrative report, is probably going to be my best
20 bet.

21 Q That's from 2014, isn't it?

22 A Right. But that's getting pretty close to
23 the years that we're talking about here.

24 Q It's 10 years ago, isn't it?

25 A Yeah. That's my point, is looking back to

1 an older document to seeing the similarity.

2 Q I see. You're saying the fact that the
3 gas gauges are in that document suggests at least
4 some degree of continuity in that respect?

5 A Yes.

6 Q Got it. I didn't understand that. Okay.
7 Got it.

8 A I feel like what you're asking is a little
9 bit out of the scope of what I looked at. But it's
10 a reasonable question, so I'm trying to find what I
11 have available for it.

12 Q No. I appreciate your trying. You know,
13 it's a little challenging when we don't have it.
14 Okay.

15 So outside of the gas gauge, is there any
16 other component of the Figure 2 type website?

17 A Yeah. So you can see here that there is
18 definitely a lot of similarity. This, I think, was
19 the document that I was thinking about.

20 Q What page are you on?

21 A It's the final narrative report. And, you
22 know, we've got such a large amount of paper, it's
23 hard to think of the particular page, but I know it
24 was here.

25 Q So you have -- what page are you on?

1 Bates No. 2723?

2 A One, two, three, four -- yeah, 2723.

3 Q Okay. So I see that. And let's just look
4 at this together. Okay.

5 And I see the gas gauges. That's what
6 you're referring to?

7 A Yeah, as well as other UX elements. Like
8 the tabs that they use, that looks like it's
9 remained the same as well.

10 Q Got it. Okay.

11 So this figure on page 2723, right?

12 A Yes. That validates -- that answers your
13 question about, you know, has it changed. I would
14 say that this is the core of the UX here. This is
15 the most important element that we've all been
16 talking about. This looks like it's remained
17 relatively unchanged.

18 Q Those gas gauges are the core?

19 A I would say, along with the tabs and the
20 information below, it's definitely part of the core.
21 It's an important part.

22 Q And you don't know whether any other
23 component of the website has been consistent, right?

24 A I think that, you know, as we sit here
25 today with this information, this is going to be the

1 best source to look at for that kind of historical
2 information, historical site.

3 Q So this is all we've got, right?

4 A You know, at the moment, with what we
5 have, I think this is the best source, without
6 trying to dig around.

7 Q I'm just trying to make sure you don't
8 come to trial with something new. I'm just saying
9 today, your opinion relies on this document, page
10 2723, right?

11 A Yeah. I mean, I'm confident in saying
12 that the UX is similar to this. That's not a
13 substantial change.

14 Q Okay. Got it. So that's the basis.
15 Okay.

16 One other question. The footnote, the
17 asterisk's footnote we've been talking about a lot
18 today.

19 Do you know the one I'm referring to?

20 A Yes.

21 Q The one that you've got to scroll down to,
22 right?

23 A Yes.

24 Q That did not exist in 2014, right?

25 A I don't know.

1 Q I can show you a document if it's helpful.

2 Well, I'll represent to you Ms. Danforth
3 has testified that imputation didn't even start
4 until 2020, 2021.

5 MS. WOOD: Objection to form.

6 MR. CRAIN: You were there.

7 MS. WOOD: I don't think that's what she
8 said or met Austin.

9 BY MR. CRAIN:

10 Q Do you have any knowledge to think that
11 imputation existed as of 2013 and 2014?

12 A That's outside of the scope of my
13 analysis.

14 MR. CRAIN: Give me the Campione document.
15 We're just going to get this, lock this down a
16 little bit.

17 MR. GARNICK: Email?

18 MR. CRAIN: Yep.

19 BY MR. CRAIN:

20 Q I'm going to show you the email. Well,
21 let me not narrate. I'll give you the document.

22 MR. CRAIN: I'll ask Courtney to narrate.

23 MS. WOOD: Please do. I need something to
24 do.

25 I do just want to put on the record that

1 the project contract was produced in discovery,
2 along with --

3 MR. CRAIN: It was. Is there a Bates
4 number?

5 MS. WOOD: Yes. Along with
6 Mr. Vredenburgh's report.

7 MR. CRAIN: Can you read the Bates number
8 in, just so we have it?

9 MS. WOOD: Yes, I can.

10 MR. CRAIN: I appreciate your copying it,
11 nonetheless.

12 MS. WOOD: No problem.

13 The first page of the Bates for that
14 Leapfrog project contract is LEAPFROG 03632712. And
15 it goes on for seven pages. So the last Bates No.
16 is LEAPFROG 03632718.

17 MR. CRAIN: Thank you.

18 (Exhibit 20 marked for identification.)

19 BY MR. CRAIN:

20 Q This is going to be Exhibit 20.

21 Mr. Vredenburgh, I've handed you an email
22 marked as Exhibit 20. It also has an Exhibit 21
23 from another deposition.

24 Do you see that in blue?

25 A Yes.

1 Q And the Bates number is ending 7863.

2 Do you see that on the bottom right?

3 A Yes.

4 Q You said earlier today you reviewed some
5 internal emails.

6 Am I recalling that right?

7 A So it's not anything that I have relied
8 upon in the report.

9 Q Okay.

10 A Kind of a frenzy of a lot of documents I
11 looked at real quickly. But it does jog my memory
12 that I reviewed it, and I remember reviewing this
13 too. It just took me a little while to remember and
14 find it.

15 Q I hear you. You're saying, looking at
16 this email, you think you reviewed this and
17 considered it in rendering your opinion? Take a
18 second to read it, if it's helpful.

19 A I don't think so.

20 Q All right.

21 A This looks outside of the scope of what I
22 would have analyzed.

23 Q But you're saying you remember looking at
24 other internal emails that you considered in
25 rendering your opinion?

1 A Honestly, I don't recall.

2 Q I'm just trying to understand.

3 So this is an email. If you look back to
4 the beginning -- and it goes in reverse order, so
5 you have to go to the end, page 7868. Okay.

6 And do you see there's an email from
7 Alexandra Campione at 4:45 p.m. on May 29, 2024?
8 It's the last one.

9 A Yeah. When you get to a good stopping
10 point in your questions, I'd love to take a break
11 soon.

12 Q Do you want to take a break now, or can we
13 finish this email?

14 A Let's finish the question, finish the
15 email. Whenever you think is a good stopping time.
16 I just want to put that on the radar.

17 Q Let's take a break now. We'll come back
18 to do this email, if that's okay with Ms. Wood.

19 MS. WOOD: Sure.

20 MR. CRAIN: Okay. Take a break.

21 THE VIDEOGRAPHER: We are going off the
22 record. The time is 3:33 p.m.

23 (Recess taken.)

24 THE VIDEOGRAPHER: The time is 3:48 p.m.
25 We are back on the record.

1 BY MR. CRAIN:

2 Q Okay. So we were looking at Exhibit 20.
3 This is Exhibit 20. It's an email that we started
4 talking about. The first page is 7863, Bates
5 ending.

6 Do you see that?

7 A Yes.

8 Q Okay. Let's go to the last page. And the
9 last page is 7868.

10 Do you see that?

11 A Yes.

12 Q And there's an email from Ms. Campione to
13 Paulina Litter dated May 29th at 4:45 p.m.

14 Do you see that?

15 A Yes.

16 Q And it's 2024, right?

17 A Correct.

18 Q Do you know who Ms. Campione is?

19 A I reviewed her deposition.

20 Q Do you know who she is or . . .

21 A It will take me a little while to
22 remember. I remember she's one of the Leapfrog
23 employees.

24 Q When you say you reviewed her deposition,
25 did you read it closely or just sort of scan it?

1 A No. I just scanned it.

2 Q Her title -- I don't know if it says here.
3 Let me just see. Yeah. If you look at page 7865,
4 it says she's a program analyst healthcare ratings,
5 for what it's worth.

6 I want to go to her email.

7 Do you see "Here's the final mockup and
8 description. Thanks again."

9 Do you see that language?

10 A No.

11 Q Are you on page 7868?

12 A Yeah.

13 Q Okay. Look right under the subject matter
14 of her email.

15 A Yeah. Oh, okay. Yeah, I see it.

16 Q Do you see it?

17 A Yeah.

18 Q And then after the next paragraph, she
19 provides the mockup, right?

20 A Yes.

21 Q And what does the mockup look like to you?

22 A The -- similar to the current site.

23 Q And do you see she has an arrow towards
24 the bottom?

25 A Yes.

1 Q And what's that towards?

2 A The asterisk.

3 Q And then you can see -- let's go to the
4 first page. Actually, go to the second page,
5 please. Page 7864.

6 Do you see that?

7 A Yes.

8 Q And if you look at the top, you're going
9 to see Paulina Litter writes to Ms. Campione at
10 11:42 a.m.

11 Do you see that?

12 A Yes.

13 Q And a couple lines down from the subject,
14 she says "A few thoughts on the language."

15 Do you see that?

16 A Yes.

17 Q And if you scan through those bullets,
18 fair to say that those are like drafts of the
19 asterisk's footnote?

20 A Yes.

21 Q Now go one more forward, page 7863. And
22 look at the subject.

23 Do you see it says "New imputation
24 denotation"?

25 A 7865 or --

1 Q I'm sorry, 63. It's the first page of the
2 document.

3 A Okay. My mistake.

4 Q No worries. You got it?

5 A Yes.

6 Q See at the bottom. Look at the subject
7 note on Ms. Campione's email from 12:29 p.m.

8 Do you see that?

9 A Yes.

10 Q And she says "New imputation denotation."
11 Do you see that?

12 A Yes.

13 Q And she says:

14 "Thanks for doing this. But we
15 can't say 'external data sources' because
16 we're arbitrarily assigning them the
17 points associated with the bottom scoring
18 category, limited achievement, or old data
19 from the previous survey, internal data
20 source. Leo wanted us to make it sound
21 like the expert panel approved it, and the
22 assigning of these points was legitimate.
23 What about this? The hospital declined to
24 report data for this measure, so a score
25 was calculated using an imputation model

1 approved by patient safety experts."

2 Do you see that?

3 A Yes.

4 Q That's not the ultimate footnote they
5 adopted, right?

6 A Correct.

7 Q But reviewing this email now, does this
8 give you a -- does this refresh your recollection as
9 to when the footnote was developed, the asterisk's
10 footnote?

11 A So this the first time I've seen this
12 document.

13 Q Did you have an understanding of when the
14 footnote was first drafted?

15 A That was, yeah, outside of the scope of
16 what I analyzed. I didn't -- I didn't focus on that
17 in the report.

18 Q Okay. So you had -- when you issued your
19 Opinion 4, that you UX testing from 2014 and 2013
20 validated the clarity of the website, you did not
21 consider whether the footnote was on the website at
22 the time?

23 A Correct.

24 Q Okay. Did you ask Ms. Danforth, when you
25 spoke to her, whether the footnote had been on the

1 website at the time?

2 A No.

3 Q Okay. And the footnote is pretty
4 important to your analysis, right?

5 A Well, you know, back in the -- 2013, 2014,
6 it wasn't -- it wasn't important, so . . .

7 Q No, but you -- I'm talking about you
8 sitting here today in 2025, right?

9 A Yes.

10 Q It's important to your analysis, right?

11 A Yes.

12 Q And the fact of people scrolling down and
13 reading it is important to your analysis, right?

14 A Yes.

15 Q Okay. And so, if -- I'm going to
16 represent, based on this document and other
17 depositions, that the footnote did not get put on
18 the website until 2024.

19 You didn't know that until this moment,
20 right?

21 MS. WOOD: Objection to form.

22 BY MR. CRAIN:

23 Q Assuming it's right.

24 A Yes.

25 Q Okay. And so you have no knowledge to

1 suggest that the UX testing from 2013 and 2014
2 validated the clarity of the footnote, right?

3 A The 2013, 2014 UX validation predates
4 that.

5 Q Okay. And just to be clear, if it
6 predates it, it can't have analyzed it, right?

7 A Correct.

8 Q Okay. All right. You can set that aside.
9 I want to ask, going back to your
10 report -- you say -- I think this is Footnote 3. So
11 I'm on page 13. Here we go. You there?

12 A Sorry. I think I had what I needed in
13 front of me, but I -- no, that's not it. I'm
14 looking for my report.

15 Q Yeah. Look for Exhibit 1, your report.

16 A I've got a lot of paper in front of me.

17 Q Yeah. I agree. And make sure the
18 exhibits go, at the end, to the court reporter, by
19 the way.

20 A I'm pretty sure this is it.

21 Okay. What page do you want to look at?

22 Q Page 13, please.

23 A All right.

24 Q This is in Opinion 4.

25 Do you see that?

1 A Yes.

2 Q And it says "Leapfrog adopted." I'm
3 looking -- it's about six, eight lines from the end.

4 Do you see that?

5 A Yes.

6 Q Okay. And it says:

7 "Leapfrog adopted the 'Worst
8 Hospital Score' benchmark in their
9 methodology because consumer testing
10 revealed potential confusion with scales
11 where low values are worst in outcome
12 measures (e.g., infection rates) and high
13 values are worst in process/structural
14 measures (e.g., compliance scores); this
15 is also why they employ a 'gas meter'
16 visual with colors to clearly indicate
17 good or bad performances," et cetera,
18 et cetera.

19 My question to you is, you say Leapfrog
20 adopted the worst benchmark score because of
21 consumer testing.

22 What consumer testing are you referring
23 to?

24 A So that would be based off of the --
25 Dr. Zarcadoolas and the discussion there. And I

1 think that everything that could be found was
2 produced to me. So this is the information that we
3 have to work off of.

4 Q But didn't we, in the last session,
5 conclude that we have no knowledge of her doing
6 consumer testing? Right?

7 MS. WOOD: Objection to form.

8 THE WITNESS: Correct.

9 BY MR. CRAIN:

10 Q And you said that was the gold standard
11 now, but not necessarily then, right?

12 A Correct.

13 Q Okay. So what were you referring to here?
14 Is that just a slip-up?

15 A Yeah. So I told you my assumption, while
16 I was writing this report, that that was the testing
17 that was done.

18 Q But that was not something Ms. Danforth
19 communicated to you, right?

20 A I can't recall from the conversation.

21 Q Okay. And you're not aware of any actual
22 consumer testing having been done, despite this
23 language, right?

24 A I think that there's evidence here that,
25 you know, it definitely could have been done. But

1 we don't know for certain.

2 Q Okay. I want to go back to something you
3 mentioned earlier, which is -- you said there were
4 two or three best practices for UX testing.

5 And we started talking about the first two
6 and then went in a different direction.

7 Can you just tell us for completeness what
8 the third is?

9 A Can you read back the testimony from --

10 Q I don't have it readily, but my
11 recollection -- and tell me if this is wrong -- is
12 you said the first one was the biometric eye-catch
13 system; is that right?

14 A Would the court reporter be able to read
15 back that testimony?

16 Q Okay. Why don't we come back to it after
17 a break, and we'll find it, and we'll come back to
18 that. But I want to close the loop as to what the
19 third is. We'll come back to it.

20 Tab 29. There is one last thing you say
21 in your fourth opinion I want to ask you about.

22 You say in your fourth opinion that
23 hospitals can still receive an A rating, even with
24 imputed scores.

25 Do you recall that?

1 A Yes.

2 Q That's in paragraph 27.

3 What's that based on?

4 A What page?

5 Q It's in paragraph 27, towards the end.

6 MR. GARNICK: "It is important to note."

7 MR. CRAIN: Page 13?

8 MR. GARNICK: 13.

9 BY MR. CRAIN:

10 Q It's about eight lines from the bottom.

11 There it is. Okay.

12 The sentence -- do you see where we were
13 before, Mr. Vredenburg? "Leapfrog adopted"?

14 A Yes.

15 Q Go, like, three lines up. And you say "It
16 is important to note that hospitals can still
17 receive an A rating, even with imputed scores."

18 A Yes.

19 Q Where did that come from?

20 A That was based on the conversation with
21 Ms. Danforth. So I remember that clearly, her
22 telling me that. And that was via Zoom. So she was
23 able to show me an example.

24 Q And she -- okay. She did not show you an
25 example.

1 And did she distinguish between hospitals
2 subject to step 1 imputation versus step 2
3 imputation?

4 A You said she did not show an example, but
5 my understanding is she did show an example.

6 Q Oh, I'm sorry. I misunderstood you. She
7 showed an example?

8 A Yes.

9 Q Got it.

10 Do you recall the example?

11 A I don't recall now.

12 Q Do you remember how many there were?

13 A My estimation, based on the conversation,
14 was maybe about five.

15 Q Okay. Pretty good estimation.

16 And then do you recall whether there was
17 step 1 or step 2 imputation?

18 A That wasn't disclosed.

19 (Exhibit 21 marked for identification.)

20 BY MR. CRAIN:

21 Q Okay. I'm going to mark as Exhibit 21.
22 This is a demonstrative summarizing data, the
23 grading data.

24 And this is not a document I think you've
25 seen before, right?

1 A No.

2 Q So this is a demonstrative that lays out
3 non-participating A-graded hospitals on the right
4 side.

5 Do you see that at the top of the chart?

6 A Yes.

7 Q And you can see a dramatic difference
8 between the first three rows and the bottom two
9 rows.

10 Do you see that?

11 A Yes.

12 Q And do you see it says "Subject to step 1
13 imputation" in about the middle column?

14 A Yes.

15 Q And in fall 2024, there are only two
16 hospitals that got an A, subject to step 1.

17 Do you see that?

18 A Yes.

19 Q Whereas, before there had been 96?

20 A Yes.

21 Q And then in spring 2025, there are four.

22 Do you see that?

23 A Yes.

24 Q And then subject to step 2, it's three and
25 two respectively.

1 Do you see that?

2 A Yes.

3 Q And then, finally, subject to step 2
4 imputation, excluding hospitals that are missing IPS
5 score, is zero.

6 Do you see that?

7 A Yes.

8 Q Okay. So is it more accurate to say that
9 hospitals subject to certain forms of imputation can
10 still get an A, but not all?

11 MS. WOOD: Objection to form.

12 THE WITNESS: That's outside of the scope
13 of my analysis.

14 BY MR. CRAIN:

15 Q So that line in your opinion is not within
16 the scope?

17 A I believe that line holds up to what this
18 chart is saying.

19 Q Okay. A hospital can still get an A,
20 regardless of the form of imputation, right?

21 A Yeah. So that wasn't based on this chart.
22 That was based on the conversation with
23 Ms. Danforth. And this chart seems to confirm that.

24 Q And you don't have any idea as to which of
25 these three buckets the five Plaintiff hospitals

1 fall in, right?

2 A No.

3 Q All right. You can set that aside. We'll
4 come back to the last UX exhibit, but let's turn to
5 your Opinion 5 now. Okay.

6 We've talked about Opinion 5 throughout
7 the day, right? Would you agree?

8 A Yeah, we've touched on it.

9 Q So your Opinion 5 is "Google Analytics
10 data demonstrates high user engagement with full
11 page content, ensuring visibility to key
12 disclosures."

13 Do you see that?

14 A Yes.

15 Q That's based on -- you have a figure that
16 looks -- it's Figure 4 -- that has the average, as
17 you said earlier, scrolls per user, right?

18 A Yes.

19 Q Now, I want to take a look at some of the
20 analytics data.

21 Will you give me, Adam -- now, just to
22 make sure I understand how you did this -- let's get
23 the scroll data. Tab 30, please.

24 You reviewed the Google Analytics data
25 that was procured through the inspection with

1 Cornerstone; is that right?

2 A Yes.

3 Q And it was a fairly lengthy set of
4 analytics data, right?

5 A Yes.

6 (Exhibit 22 marked for identification.)

7 BY MR. CRAIN:

8 Q So I'm going to mark as Exhibit 22 -- it's
9 a subset of that data for -- I'm sorry -- for you to
10 use.

11 All right. So this is just the analytics
12 data for the five Plaintiff hospitals.

13 Do you see that?

14 A Yeah. I did a similar thing in this file
15 here. I want to compare.

16 Q Okay. When you say "a similar thing," you
17 mean narrow the analytics data to just the five
18 plaintiffs hospitals?

19 A Yeah. I've got a nearly identical
20 document in here. I want to just --

21 Q Oh, I see that. Okay. Did you get into
22 our files?

23 Tell me if it looks consistent with yours,
24 which I'd love to see too.

25 A Yeah. I'm not going to jump into

1 everything, but I think this looks consistent.

2 Q Now, just to make sure I understand, when
3 you -- so your analysis relied on what is in our
4 Exhibit E, right, "Events count per active user"?

5 A Yes.

6 Q And that's the scrolls for the total user
7 in D, right?

8 A Yes.

9 Q And event count in column C is the
10 scrolls, right?

11 A Yes.

12 Q So you basically took C and divided it by
13 D to output an average, right?

14 A Correct. And when you say "scrolls," it's
15 actually got a little bit more of a technical
16 definition.

17 Q Okay. What is it?

18 A It would be the time that a user has
19 scrolled to at least 80 percent of the page.

20 Q Okay.

21 A So it's when they've made it to the
22 bottom, essentially, that that event count triggers.

23 Q Yes. Okay.

24 Now, in analyzing this data, did you
25 evaluate Google Analytics' definitions of these

1 concepts?

2 A Yes.

3 Q Okay. I want to look at tab 31, which I'm
4 going to mark as Exhibit 23.

5 (Exhibit 23 marked for identification.)

6 BY MR. CRAIN:

7 Q Mr. Vredenburg, do you recognize this
8 document?

9 A This is a little bit different than the
10 document that I provided.

11 Q What document did you provide?

12 A So it would have been in the file that I
13 produced, and it's here in my references. It looks
14 like it's from a similar page, but a slightly
15 different page from the Google Analytics. But you
16 can proceed with your questions on it, and I'm going
17 to find another document too.

18 Q Can you find the other document? Because
19 I just want to see if there is any inconsistency.

20 And you're saying -- was this produced to
21 us as well?

22 A Yes, it was produced. And it should be
23 cited on the report.

24 Q So yours, we think, is
25 support.Google.com/analytics/answer.

1 Is that right?

2 A That sounds right to me.

3 Q This, I think, is a slightly different
4 page, which has definitions for the analytics.

5 A Yeah.

6 Q Does that sound right?

7 A Yeah.

8 Q You tell me when you're ready.

9 A Here we go. Similar page, but also
10 different in some important ways.

11 Q May I see that? Thank you.

12 So I'm looking at a document called
13 "Enhanced Measurement Events."

14 Okay. Yeah, it looks like it has some
15 definitions, but not all, right?

16 A Yes.

17 Q And this is an additional -- the page that
18 we have handed you says "GA 4," and yours says
19 "GA 4" too. That's interesting. Okay.

20 So I want to look at our document. That's
21 helpful. So your document has different -- certain
22 different definitions than the one that we've pulled
23 from Google Analytics.

24 A This one includes the definition for
25 scroll.

1 Q Yes. It doesn't include the definition
2 for total users, right?

3 A That's a good question.

4 Q Take a look.

5 A No, it does not.

6 Q Go to the last page of Exhibit 23. And
7 you'll see the bottom, it says "Total users."

8 Do you see that?

9 A Yes.

10 Q It says "The number of unique users or
11 user IDs who triggered at least one event."

12 Do you see that?

13 A Yes.

14 Q What does that mean?

15 A Unique users. So, if -- let me take a
16 second and think about that.

17 Q Take a look.

18 A Great. So I think a good way to think
19 about this is if one user, you know, triggered it a
20 bunch of times, they're only going to get counted as
21 one user. Like if they come back and forth to the
22 page again, they're still just one user. So that's
23 what makes them unique users. And --

24 Q This number is not all users who access
25 the website, right?

1 A I believe that it is all unique users.

2 Q Who triggered at least one event?

3 A Right. But I think just loading a page is
4 triggering an event.

5 Q Isn't the event the scroll?

6 A There's a "page view" event. There's all
7 sorts of different events. It's saying if you
8 trigger at least one of them.

9 Q So your total users -- let's go to St.
10 Mary's, right? Do you see St. Mary's on the page?

11 A Yeah.

12 Q Look at your Figure 4. Sorry, look at
13 your Figure 5 for St. Mary's.

14 A I'm sorry. What was that document, Figure
15 5?

16 Q Exhibit 1, your report.

17 A Okay.

18 Q Okay. Page 16. Next one, page 16.

19 A Yeah. My fingers aren't quite turning the
20 page.

21 Q I hear you.

22 A A little slippery. Okay.

23 Q Okay. So first St. Mary's. You
24 calculate, based on this graph, about 100 total
25 users, right?

1 A Correct. And the number of users, if
2 we're going to go into that, that's the main point
3 of the amendment. Because that was the information
4 that was the most off from this original analysis.

5 Q Fair enough.

6 I'm not quarreling with your numbers,
7 actually. You were -- if I look at Figure 5 in your
8 supplemental report, which feel free to pull out,
9 it's similar. It's a hundred in change or maybe
10 around 100 in your Exhibit 2.

11 A Yeah.

12 Q So St. Mary's wasn't that different,
13 right?

14 A Yeah. I think the main one that changed
15 was Good Samaritan.

16 Q Okay. So let's stick with St. Mary's.

17 Now, if you look at the exhibit I gave
18 you, Exhibit 23 of the analytics data, do you see
19 St. Mary's is row 12?

20 A Yes.

21 Q And it says "Total users, 104," right?

22 A Yes.

23 Q Now, I want to give you another document
24 from Google Analytics. And this is going to be
25 Exhibit 24.

1 (Exhibit 24 marked for identification.)

2 BY MR. CRAIN:

3 Q Do you recognize this document?

4 A Yes.

5 Q What is this?

6 A This is a chart of St. Mary's grade page
7 and St. Mary's methodology download page.

8 Q Okay. And it says -- do you see where it
9 says "Active users"?

10 A Yes.

11 Q What's the number under St. Mary's grade
12 page?

13 A That looks like 547.

14 Q So isn't it right that the number of users
15 on the page was 547, but the number of users who
16 scrolled was 104?

17 A So that comes down to the discretion of
18 unique users because you're going to have repeats.
19 So this is for unique. This is total.

20 Q Okay. But that's unique users who
21 triggered an event, right?

22 A Yes. But just loading a page is
23 triggering an event.

24 Q How do you know that?

25 A Because that was the first event on this

1 page.

2 Q Do you see on Exhibit 23, it says the
3 event name?

4 MR. GARNICK: Exhibit 22.

5 BY MR. CRAIN:

6 Q Exhibit 22. Sorry. Column A says "Event
7 name"?

8 A Yes.

9 Q It says "scroll," doesn't it?

10 A Yes.

11 Q Doesn't that mean the event here for the
12 total users who triggered an event was scroll?

13 A Yes.

14 Q So this means 104 is the number of users
15 who triggered a scroll, right?

16 A So this is -- I feel like the discretion
17 is between unique users and total users. Because
18 this isn't saying unique users here. This is just
19 active users.

20 Q Is it your position -- I'm not sure I
21 understand that. Say more of what you mean. How
22 are you getting that?

23 A Because this is just saying active users,
24 and this one is unique users.

25 Q Okay. It's not unique users who triggered

1 a scroll?

2 Let me ask you this question: If a unique
3 user went to this same website and did not scroll,
4 would they show up in column D?

5 A I believe they would.

6 Q Why?

7 A Because this is the -- because it's
8 showing the total number of users.

9 Q Who triggered an event.

10 A Right.

11 Q Which is scroll.

12 A But it's the event count per active user.

13 So --

14 Q So if some active user did not trigger the
15 event, they would not be counted; isn't that right?

16 A No. It should be counted because it's
17 event count per active user, per unique user.

18 Q That triggered an event. Why are you
19 omitting that from your statement?

20 A It doesn't say here event count per active
21 user that triggered the event. It's just saying per
22 active users.

23 Q This is saying, the Google Analytics
24 definition, that total users means the total number
25 of unique users or user IDs who triggered at least

1 one event.

2 Do you think that definition is wrong?

3 A No. That's the definition.

4 Q So, if an active user did not trigger at
5 least one event, meaning scroll here, they wouldn't
6 show up in column D, right?

7 A But it's saying active count per active
8 user.

9 Q I want an answer to my question.
10 If a user did not trigger at least one
11 event, scroll, would they show up in column D?

12 MS. WOOD: Objection to form.

13 THE WITNESS: I believe that they would.

14 BY MR. CRAIN:

15 Q What is the basis for your opinion?

16 A Because it's saying "event count per
17 active user," not per user that did a scroll.

18 Q Are you just saying this definition
19 doesn't apply, or are you refusing to read it?

20 A I've read the definition. I'm not sure
21 what the discrepancy is.

22 Q What is the readability level of this
23 definition?

24 MS. WOOD: Objection to form.

25 THE WITNESS: I'm not sure.

1 BY MR. CRAIN:

2 Q You've been giving me your best
3 professional estimate all day. Can you give it to
4 me for this one?

5 A It looks similar to the rest of the page.

6 Q Which is what?

7 A About eighth grade.

8 Q About eighth grade.

9 Okay. So my question to you is what does
10 the triggered at least one event mean to you, if not
11 scroll here?

12 A Triggered one event means that, in any
13 event has been triggered, that makes them a unique
14 user.

15 Q What is that based on?

16 Let me ask you this question: That's not
17 based on the definition on the Google Analytics
18 page, right?

19 A Yeah, it is.

20 So, you know, someone would become a
21 unique user that triggered at least one event if
22 they did a page view. So someone who viewed the
23 page, that should trigger it.

24 Q Is this data, which you said was
25 materially identical to the one that you compiled --

1 is the data showing the events of scrolling?

2 A Yes.

3 Q Okay. It's not showing any other events,
4 right?

5 A Correct.

6 Q Okay. And this data for St. Mary's says
7 104 unique users scrolled, right?

8 A Right. By saying "per active user."

9 Q I'm asking you, in column D -- right? --
10 it says "total users," right?

11 A Yes.

12 Q That's not the total number of people who
13 visited the website during this time period, right?

14 A I believe that's the total unique -- total
15 unique users.

16 Q What is that based on?

17 A That it lines up with this definition of
18 "total users." It's the same term.

19 Q Who triggered at least one event.

20 A Right. And a page view would be
21 triggering an event.

22 Q So your testimony under oath today is that
23 104 unique users went to the website, not that 104
24 unique users scrolled?

25 A That's my understanding of how this reads,

1 yes.

2 Q And if that's wrong, if the number in your
3 denominator, the calculation was higher, your scroll
4 data would be wrong, right?

5 A Yes.

6 Q If the number of unique users who were
7 using a -- were accessing the page was higher than
8 what's in column D, your whole analysis on Opinion 5
9 would be incorrect, right?

10 MS. WOOD: Objection to form.

11 THE WITNESS: That's correct.

12 BY MR. CRAIN:

13 Q Okay. Is that why you're fighting the
14 definition?

15 A I'm reading the definition here of unique
16 users who triggered at least one event, and it's
17 saying total users and active users. So I'm just
18 reading the definition that you're giving me.

19 Q Okay. But just -- okay.

20 A Because it says "total users" here, but on
21 this other page that you produced, it doesn't say
22 "total users." It says "active users" --

23 Q That's fair.

24 A -- which has a different definition.

25 Q What's the definition?

1 A I'm not sure. I don't think I have that
2 here in front of me. But the -- these terms have
3 precise meanings.

4 Q So what did you calculate?

5 A I calculated based off of this document
6 here.

7 Q What is the -- what did you calculate,
8 though? What were you trying to show with your
9 calculation?

10 A User engagement with the website and
11 scrolling.

12 Q Were you trying to show, the number of
13 users who access the page, how many of them scroll?

14 A So --

15 Q Can you give me your analytics document
16 again, Mr. Vredenburgh?

17 Okay. I'm going to do something a little
18 bit -- what we've been doing in different
19 depositions. I'm going to show you a computer
20 screen. So I'm going to read into the record, the
21 website is [https://support.Google.com/analytics/](https://support.Google.com/analytics/answer/12253918?HL=EN)
22 [answer/12253918?HL=EN](https://support.Google.com/analytics/answer/12253918?HL=EN). And the title of the page is
23 "Understand User Metrics."

24 MR. CRAIN: I'm going to share with
25 counsel, make sure I read that mostly right.

1 Hopefully all right. Confirmed?

2 MS. WOOD: Yeah.

3 BY MR. CRAIN:

4 Q Now, Mr. Vredenburg, you said definitions
5 are precise, right?

6 A Yes.

7 Q Okay. On this page, there's a definition
8 for "active users."

9 Can you read the definition?

10 A Sure. "The number of unique users who
11 engaged with your site or app in specified data
12 range."

13 Q Okay. So the active users' number on
14 Exhibit 24 includes the total number of unique users
15 who engage in your site in a specific range, right?

16 A Yes.

17 Q The active -- the total users on
18 Exhibit 23 is the total number of unique users who
19 scrolled, right?

20 A Can you repeat the question?

21 Q Yes.

22 I started with, the active users on
23 Exhibit 24 is the total number of unique users who
24 engaged with the site at all. And you said
25 "correct," right?

1 A Yes.

2 Q The total users on Exhibit 23 in column D
3 is the number of unique users that triggered a
4 scroll, correct?

5 A I think it's an important question that
6 you're asking. If we could potentially take a
7 break. I want to take some time to --

8 Q No. No breaks while a question is
9 pending. I want an answer to my question.

10 A I don't know.

11 Q Based on the definitions that I have shown
12 you today, total users is the active -- the number
13 of unique users who trigger a scroll, right?

14 A I'm not sure.

15 Q Okay. If that's correct, what you have
16 calculated is the number of scrolls per users who
17 triggered a scroll, right?

18 A Like I said, I would need to look in to
19 double-check. I feel like --

20 Q Yes. I'm asking you to accept a
21 hypothetical. We've been doing hypotheticals all
22 day. You invited one earlier today, five hours ago.

23 My hypothetical is, if I'm right that the
24 definitions say what they mean, what you have
25 calculated -- and you can fight the premise later,

1 but if I'm right, what you have calculated is the
2 number of scrolls per user that triggered a scroll,
3 right?

4 MS. WOOD: Objection to form.

5 THE WITNESS: I don't believe that's what
6 I said. Can you repeat the question, the
7 hypothetical?

8 BY MR. CRAIN:

9 Q If I'm correct that column D is just the
10 number of unique users who triggered a scroll, what
11 your calculations show is the number of scrolls per
12 user who scrolled.

13 MS. WOOD: Objection to form.

14 BY MR. CRAIN:

15 Q Correct?

16 A Yes.

17 Q That is a very different number than the
18 number of scrolls per user -- unique user who
19 accessed the website, right?

20 A Yes.

21 Q Okay. Now, I want to do the math with you
22 because your number, I think you said earlier today,
23 was a high proportion of scrolls, right? Do you
24 remember the approximate number?

25 A Yes.

1 Q What was it for St. Mary's? Can you tell
2 me?

3 A A little bit over one.

4 Q A little bit over one.

5 So each -- in your calculation, as you
6 presented it, the average user scrolled one time,
7 right?

8 A Yes.

9 Q Now, if I'm right, what you calculated is
10 the average user who scrolled scrolled one time,
11 right?

12 A Yes.

13 Q Okay. Now, if we do the math based on
14 this, do you know what percentage of people actually
15 scrolled? Let's take it -- I can walk you through
16 it.

17 St. Mary's. Let's go to the event count.
18 You see it's row 12 in column C?

19 A Roughly one-fifth.

20 Q One-fifth. So 20 percent, right?

21 A Yeah.

22 Q That's impressive math. I was going to
23 have to do it on my calculator.

24 So, if the numbers -- if the numbers
25 actually reflect that only 20 percent of people

1 scroll, that means, at most, 20 percent of users to
2 the website even get to the portion of the page
3 where the footnote exists, right?

4 MS. WOOD: Objection to form.

5 THE WITNESS: Yes.

6 BY MR. CRAIN:

7 Q And the footnote doesn't appear on every
8 page, right?

9 MS. WOOD: Objection to form.

10 THE WITNESS: Correct.

11 BY MR. CRAIN:

12 Q If you don't click into the right tab, it
13 doesn't show, right?

14 A I would need to double-check that.

15 Q Let's bring it up and make sure the record
16 is clear. Just pull the page up. We're going to
17 hospitalsafetygrades.org at St. Mary's. Okay.

18 MR. CRAIN: I'm showing counsel, this is
19 the St. Mary's safety grade page.

20 Do you see, Counsel?

21 MS. WOOD: Correct.

22 BY MR. CRAIN:

23 Q Do you see, Mr. Vredenburg?

24 A Yes.

25 Q Now, if you click on -- let's go to hand

1 washing.

2 Do you see I've clicked on "hand washing"?

3 A Yes.

4 Q The footnote appears, right?

5 A Yes.

6 Q That's one of approximately 30 of those
7 tabs, right?

8 A Uh-huh.

9 Q If I click on another one, let's say MRSA
10 infection -- do you see that, "MRSA infection"?

11 A Yes.

12 Q -- the footnote doesn't appear, right?

13 A Correct.

14 Q So that means, of that 20 percent of users
15 who scroll, that's likely an overcount of people who
16 actually see the footnote, right?

17 MS. WOOD: Objection to form.

18 THE WITNESS: Yes.

19 BY MR. CRAIN:

20 Q And it's a further overcount of people who
21 actually read it, right?

22 MS. WOOD: Objection to form.

23 THE WITNESS: It's likely, if they scroll
24 and they have it on their page, that red bolded text
25 is going to get read.

1 BY MR. CRAIN:

2 Q So, if the numbers are as I've suggested
3 they are, and it's about, as you said, 20 percent of
4 users who scroll, it's a smaller number who actually
5 see the footnote.

6 And of that proportion, you're saying it's
7 a high likelihood that they read it?

8 A Yes.

9 Q Do you want to take that break?

10 A Sure.

11 Q Okay. Let me -- before we go off, do you
12 still have reason to doubt that we're right about
13 the numbers here?

14 MS. WOOD: Objection to form.

15 THE WITNESS: I think, in these kind of
16 matters, it's always really important to do a
17 careful analysis and not just speak before, you
18 know, checking.

19 BY MR. CRAIN:

20 Q Are you saying you want to take a break to
21 check?

22 A Yes.

23 MR. CRAIN: Okay. Let's take that break
24 if counsel agrees.

25 MS. WOOD: Uh-huh.

1 MR. CRAIN: Take that break.

2 THE VIDEOGRAPHER: We are going off the
3 record. The time is 4:30 p.m.

4 (Recess taken.)

5 THE VIDEOGRAPHER: The time is 4:58 p.m.
6 We are back on the record.

7 BY MR. CRAIN:

8 Q So Mr. Vredenburg, welcome back.

9 We were talking about your Opinion 5 and
10 Google Analytics before. And then you asked to take
11 a break for about 20 minutes; is that right?

12 A Yes, sir.

13 Q And it's been about 30 minutes, right?

14 A Yes.

15 Q And I -- what I had asked you before
16 was -- that prompted the break -- let's see. I
17 should have had this before. Here we go.

18 I had asked you if the total users on
19 Exhibit 23 in column D is the number of unique users
20 that triggered a scroll.

21 Do you recall that question?

22 A Yes.

23 Q And then we went through a bunch of
24 calculations, just assuming for a second that that
25 was right, correct?

1 A Yes.

2 Q And before we go on, we did the
3 calculation for St. Mary's, right?

4 A Yes.

5 Q And you estimated -- you did the math on
6 the spot, which was very impressive, and you said
7 the -- if I was right about what column D
8 represented, that it would be about 20 percent of
9 users that scroll down the page, right?

10 A Yes.

11 Q And that would be approximately the same
12 for the other five hospitals, if I was right,
13 correct?

14 A Yes.

15 Q During the break, did you have a chance to
16 assess the definitions?

17 A I did.

18 Q Okay. Do you have a view as to whether we
19 got it right as to what "total users" here means?

20 A Yes. So, you know, I really thank you. I
21 believe that you caught an important mistake. And
22 I'd like to withdraw that opinion because your
23 analysis was correct there.

24 And my goal here is to, you know, try to
25 find and get towards the truth. And I'm glad that

1 you're helping to aid at doing that. That was a
2 mistake.

3 Q We appreciate it. And we appreciate your
4 integrity in doing that. So thank you, sir.

5 So just for the record, it's clear you are
6 withdrawing Opinion 5, correct?

7 A Yes.

8 Q Just give me one second.

9 We talked during the day that Opinion 5
10 had spillover -- had relevance to the other
11 opinions, right?

12 A Yes.

13 Q Do you -- does your withdrawal of Opinion
14 5 change your opinions 1, 2, 3, or 4?

15 A So, in looking at the data, based on what
16 you said, I find that the Google Analytic data is
17 actually inconclusive. It doesn't say whether there
18 was low engagement or high engagement. It really
19 just didn't say much one way or the other because --
20 if I pull up this example of the webpage that you
21 printed out -- it's going to take me a little bit
22 here to find it.

23 Q What are you looking for? We can help
24 you.

25 A It was the exhibit that had an example of

1 the webpage. And we used it as an example for the
2 fold, to show what percent of the page is showing.

3 I believe Exhibit 5.

4 Q Exhibit 5. Okay.

5 Is this the West Boca Medical Center
6 exhibit?

7 A Yes.

8 Q Got it. Okay.

9 A So, if you look, there's a lot that comes
10 after the asterisk.

11 Q Uh-huh.

12 A So scrolling down to all this, you know,
13 kind of legalese text at the bottom of the page, it
14 would require doing that to trigger the event.
15 So --

16 Q I see.

17 A -- what we're seeing is the number -- the
18 percent of the people that got down to this part,
19 not -- we don't have data on how far getting to the
20 asterisk.

21 Q Okay. Got it.

22 Your opinion, though, relied earlier on
23 the notion that people did scroll down, right?

24 A Sure. So we can go through the opinions
25 again if you like.

1 Q Okay. Ultimately, though, your new
2 opinion on 5 is that it's inconclusive how far down
3 the page people go?

4 A Yes.

5 Q Does that affect, if at all, Opinion 1?
6 I'm looking at page 9 for the header.

7 A Yeah. So it looks like 1 is mostly
8 focused on the effect of bold text and the effects
9 of colors. So I would say that that's not affected.

10 Q Okay. And what about 2?

11 A So 2 would be unaffected as well because
12 that's based off of the readability algorithms. So
13 that would have no effect.

14 Q Does that cover the whole page?

15 A Yeah.

16 Q Okay. And 1 -- I'm just looking back
17 again. Does 1 rely on -- well, 1 relies on the
18 footnote to some degree or no?

19 I'm sorry, did you answer the question?

20 A Can you repeat the question?

21 Q Yeah. Let me go back to it.

22 Does 1 -- 1 relies on the footnote to some
23 degree or no?

24 A The 2 footnote. Which footnote? Because
25 there's footnotes on this page too, which --

1 Q Oh, I'm sorry. Yeah. The asterisk's
2 footnote on Figure 2.

3 Does the question of whether users scroll
4 down the page to the footnote affect your Opinion
5 No. 1?

6 A So the asterisk would need to be seen on
7 the screen in order for its red and bold text to
8 then be seen.

9 Q Okay. So on certain screens, it won't be
10 seen without a scroll, right?

11 A Correct.

12 Q And you don't know how many users scroll
13 down, right?

14 A Correct. The data is inconclusive.

15 Q Okay. Opinion 3 says "Imputed scores are
16 readily clear to users with basic reading
17 comprehension."

18 Does this opinion rely on users having
19 read the asterisk's footnote?

20 A So it looks like the focus of this was
21 assuming that there was typically about an eighth
22 grade reading level, that we went over the idea of
23 progressive disclosure and how the page was designed
24 for different users, and different information being
25 presented. And that the numbers that are being

1 shown in Figure 2, the matching of the 15 to the 15,
2 that that would be readily clear.

3 Q So this opinion is not about the footnote?

4 A Correct.

5 Q It's about the number?

6 A I think that the -- the asterisk helps
7 with the comprehension, comparing the numbers. And
8 I think when someone sees the asterisk, that's going
9 to draw them to want to go to the bottom of the
10 page.

11 Q But you don't know how many people went to
12 that area of the page, right?

13 A Correct. I don't think that information
14 is knowable at this point to anyone.

15 Q Okay. And that point you just made is not
16 in your report, correct?

17 A Correct.

18 Q Okay. Opinion 4, does that rely on users
19 having viewed the asterisk's footnote?

20 A No.

21 Q Okay. Give me one more second.

22 Mr. Vredenburgh, I'm going to pass the
23 witness and reserve.

24 MR. CRAIN: Ms. Wood, do you have any
25 questions?

1 MS. WOOD: I do, but I'm going to need a
2 moment. So if we could take a quick break.

3 MR. CRAIN: Going off.

4 THE VIDEOGRAPHER: We are going off the
5 record. The time is 5:08 p.m.

6 (Recess taken.)

7 THE VIDEOGRAPHER: The time is 5:13 p.m.
8 We are back on the record.

9 EXAMINATION

10 BY MS. WOOD:

11 Q Mr. Vredenburgh, I just have a couple
12 follow-up questions for you.

13 Are you a retained expert in this case?

14 A Yes.

15 Q And are you retained expert for the
16 Leapfrog Group?

17 A Yes.

18 Q Are you a user experience expert?

19 A Yes.

20 Q Are you a digital low-literacy expert?

21 A Yes.

22 Q Okay. And then can you just grab
23 Exhibit 1, which is your report. And I'll have you
24 flip to page 7 of that report.

25 And then you see here on page 7 -- we've

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1 been talking about Figure 2 extensively, but this is
2 a webpage from Leapfrog's Hospital Safety Grade for
3 Good Samaritan Medical Center; is that correct?

4 A Yes.

5 Q And as an expert, is it your opinion, to a
6 reasonable degree of certainty, that Figure 2
7 transparently displays to a reasonable consumer that
8 a hospital is assigned the worst hospital score to
9 reflect the lack of information available?

10 MR. CRAIN: Objection to form.

11 THE WITNESS: Yes.

12 BY MS. WOOD:

13 Q And is it your opinion, to a reasonable
14 degree of certainty, that this webpage shown in
15 Figure 2 is displayed at an eighth grade reading
16 level?

17 MR. CRAIN: Objection to form.

18 THE WITNESS: Yes.

19 MS. WOOD: That is all I have for you.

20 FURTHER EXAMINATION

21 BY MR. CRAIN:

22 Q Just to follow up on that.

23 Counsel said "Are you an expert in digital
24 low literacy?"

25 Do you recall that question?

1 A Yes.

2 Q What does that mean?

3 A So that would be, I would say, a subset of
4 UX, to make sure that the literacy of what you're
5 writing matches the -- matches your user.

6 Q Where is that in your report?

7 A So that would be, I think, mostly handled
8 by, I think, Opinion 2.

9 Q No. I'm asking where is -- where is your
10 expertise in that regard identified?

11 A Sure. So I think that that would be --
12 that would be covered with the -- my publications,
13 such as public health and epidemiological study to
14 explore the relationship between literacy, language,
15 age -- aging, and familiarity on comprehension of
16 health information, as well as the publication that
17 we talked about with the user experience for the
18 online learning platform.

19 Q That you wrote while at Wright State?

20 A Yes.

21 Q And the other one was the one you wrote in
22 high school?

23 A Yes. And --

24 Q Okay. Do you recall maybe five hours ago
25 now I asked you to identify your areas of expertise?

1 A Yes.

2 Q You did not identify yourself as an expert
3 in low literacy, right?

4 A So I would say that that would be a
5 subtopic of user experience.

6 Q Okay. But you did not say those words,
7 right?

8 A I have not used those words.

9 Q Okay. And it's not anywhere in your
10 report, right?

11 A Well, my report does talk about literacy
12 and literacy-appropriate grade levels. And so I
13 think that that's what it's referring to.

14 Q Is it correct that your report nowhere
15 strings together the words "low literacy"?

16 A I don't think that the report has those
17 two words together.

18 Q And is it fair to say, until Ms. Woods'
19 redirect, that we had no notice of this new claimed
20 expertise?

21 A So I don't think that that's necessarily
22 fair because this talks about literacy throughout
23 it. I feel like talking about whether it's a sixth
24 grade level or an eighth grade level or a college
25 level, that is talking about low literacy.

1 Q What is a low-literacy expert as compared
2 to the UX expert you previously identified yourself
3 as?

4 A I would say it's a UX expert that's
5 analyzing the reading level.

6 Q So how is that different from being an
7 expert in UX?

8 A I think it's just being a little more
9 specific about what the analysis entails.

10 Q And what is your experience in
11 low-literacy expert?

12 A Sure. So like I said, the title of the
13 report that specifically talks about literacy, about
14 online learning platform, which, again, is
15 thinking -- thinking about education level and
16 literacy and making sure that it's understandable.

17 And I have a paper for risk communication
18 for consumer products, which heavily relates to
19 literacy and making sure that the literacy level is
20 appropriate for consumer products.

21 Q Is that the paper you just referenced
22 before from 2009?

23 A No. This is a different paper --

24 Q What's the title?

25 A -- from 2017. Risk communication for

1 consumer products.

2 Q That's the hierarchy of warning? There's
3 three hierarchy we discussed earlier today?

4 A I believe so.

5 Q Why does that make you an expert on low
6 literacy?

7 A Because risk communication for consumer
8 products is very important to consider the
9 low-literacy populations that may be working with a
10 product.

11 Q And again, why didn't you identify
12 yourself specifically as a low-literacy expert
13 earlier in the day?

14 MS. WOOD: Objection to form. Asked and
15 answered.

16 THE WITNESS: So I see it as one and the
17 same. I feel like that analysis has been all
18 throughout. I think it's just changing the words.

19 BY MR. CRAIN:

20 Q Okay. So then what is your understanding
21 as to why counsel is now trying to proffer you as a
22 low-literacy expert?

23 A So I feel like they've been consistent
24 about that since retention, saying that that's what
25 they're looking for in their assignment. So I think

1 it's just their word choice.

2 Q What document that went to our side
3 identified you as an expert in that regard?

4 A Well, I would say this report.

5 Q Okay. So you're an expert now, you're
6 saying, in three things?

7 A No. I wouldn't say this is a distinct
8 thing. I would say that this is a part of a user
9 experience analysis.

10 Q Okay. So --

11 A I would say that it's a part of human
12 factors. You always have to think about literacy.
13 It's foundational for human factors, for anything
14 that's written for consumer product or for, like,
15 warnings. I've got a lot of -- a lot of experience
16 and work in warnings. Absolutely critical to
17 literacy -- low-literacy writing for warnings.

18 MR. CRAIN: Okay. I'm just going to lodge
19 an objection, to the extent that counsel is
20 expanding the areas of your expertise five hours and
21 something minutes into this deposition.

22 With that, I think no further questions.
23 Anything?

24 MS. WOOD: No.

25 MR. CRAIN: You're free to go.

1 THE VIDEOGRAPHER: Before I take us off
2 the record, Leslie, do you want to get orders?

3 No?

4 Ms. Wood, did you want to order a video
5 today?

6 MS. WOOD: Yes, please.

7 THE VIDEOGRAPHER: Would you like that
8 synced?

9 MS. WOOD: What does that mean?

10 MR. CRAIN: With the transcript.

11 MS. WOOD: Oh, sure. Yeah.

12 THE VIDEOGRAPHER: Understood.

13 And you have a standing order, correct,
14 Counsel?

15 MS. WOOD: Yeah. I think we want synced,
16 but yeah.

17 THE VIDEOGRAPHER: Thank you very much.

18 We are off the record at 5:21 p.m. Pacific
19 Time. And this concludes today's testimony given by
20 Michael Vredenburgh. The total number of media used
21 was eight and will be retained by Veritext Legal
22 Solutions.

23 (TIME NOTED: 5:21 P.M.)
24
25

DECLARATION UNDER PENALTY OF PERJURY

I, MICHAEL VREDENBURGH, the witness herein, declare under penalty of perjury that I have read the foregoing in its entirety; and that the testimony contained therein, as corrected by me, is a true and accurate transcription of my testimony elicited at said time and place.

Executed this _____ day of _____ 2025, at

_____, _____.

(City)

(State)

MICHAEL VREDENBURGH

REPORTER'S CERTIFICATION

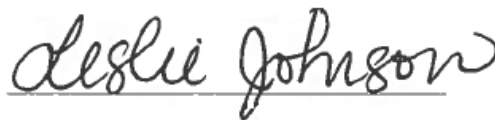
I, Leslie Johnson, a Certified Shorthand Reporter of the State of California, do hereby certify:

That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were administered an oath; that a record of the proceedings was made by me using machine shorthand which was thereafter transcribed under my direction; that the foregoing transcript is a true record of the testimony given.

Further, that if the foregoing pertains to the original transcript of a deposition in a Federal Case, before completion of the proceedings, review of the transcript [] was [] was not requested. I further certify I am neither financially interested in the action nor a relative or employee of any attorney or any party to this action.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: October 2, 2025

A handwritten signature in cursive script that reads "Leslie Johnson". The signature is written in dark ink and is positioned above the printed name.

LESLIE JOHNSON

CSR No. 11451, RPR, CCRR

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Michael Vredenburgh Job No. 7616281

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[wood - wrong]

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[wrote - zarcadoolas]

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[zarcadoolas - à]

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à
à 254:19

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

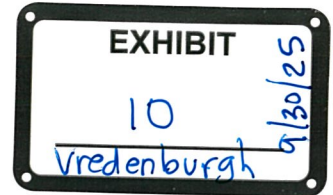
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EXHIBIT 10



Bermudez v. Crunch Sunset Llc

Superior Court of California, County of Los Angeles

July 28, 2021, Decided

19STCV35283

Reporter

2021 Cal. Super. LEXIS 90827 *

CHRISTINA M. BERMUDEZ v. CRUNCH SUNSET LLC, et al.

Counsel: [*1] For Plaintiff(s): Christina M. Bermudez (Telephonic) by Seri Kattan-Wright, For Defendant(s): Kevin D. Campbell by Jeffrey Lenkov and Karen Liao (Telephonic).

Judges: Edward B. Moreton.

Opinion by: Edward B. Moreton

Opinion

CSR: Tammie Moore, CSR#11525 Judicial Assistant: J. Fletes

ERM: None

Courtroom Assistant: None

Deputy Sheriff: None APPEARANCES:

NATURE OF PROCEEDINGS: Hearing on Motion for Summary Judgment

Pursuant to [Government Code sections 68086](#), [70044](#), and [California Rules of Court, rule 2.956](#), Tammie Moore, CSR#11525, certified shorthand reporter is appointed as an official Court reporter pro tempore in these proceedings, and is ordered to comply with the terms of the Court Reporter Agreement. The Order is signed and filed this date.

The matter is called for hearing.

The Court issues a tentative ruling:

INTRODUCTION AND FACTUAL BACKGROUND

On October 3, 2019, Plaintiff Christina Bermudez ("Plaintiff") filed this action against Defendants Crunch Holdings, LLC ("Defendant"), Crunch Sunset, LLC, Crunch, LLC, Crunch LA, LLC, and Crunch JV Partners, LLC. Plaintiff asserts a cause of action for premises liability and alleges that Defendant was grossly negligent in the operation of the premises "by instructing [her] to run at competitive speeds in a relay race" inside a personal training room. [*2] (Compl., Prem.L-1.) Plaintiff also alleges that Defendant willfully and maliciously failed to guard or warn against the dangerous condition, use, structure, or activity. (Compl., Prem.L-3.)

Defendant filed an answer on November 5, 2019 and now moves for summary judgment on multiple grounds. First, Defendant argues that Plaintiff cannot establish that it had actual or constructive notice of any alleged dangerous condition. Second, Defendant argues Plaintiff's action is barred because she executed a release of liability. Third, Defendant claims Plaintiff executed an express assumption of risk. Fourth, Defendant argues that her cause of action is barred based on the primary assumption of risk doctrine.

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Although Defendant requests summary adjudication of issues in the alternative, a motion for summary adjudication may only be granted if it completely disposes of a cause of action, an affirmative defense, a claim for damages, or an issue of duty. ([Code Civ. Proc., § 437c, subd. \(f\)\(1\)](#)). Defendant does not identify which issues are to be summarily adjudicated in its notice of motion.

FACTUAL BACKGROUND

It is undisputed that Plaintiff was injured on October 7, 2017 at a gym facility while participating in an hour-long workout class [*3] consisting of a nutrition discussion and exercise. (Defendant's Undisputed Material Fact ("UMF") Nos. 1, 3.) This class was held in a training room that contained a padded floor, weights, and other exercise equipment. (UMF No. 4.) Plaintiff was completing a relay race about 30 minutes into the class when she was injured. (UMF Nos. 5-6.) Participants were instructed to run forward as fast as they could, run backwards, then shuffle sideways one way, and shuffle back sideways the other way. (UMF No. 7.) The participants were instructed not to cross their feet. The entire exercise took under a minute to complete. (UMF No. 10.) Plaintiff was completing the last sideways shuffle when she was injured. (UMF No. 12.)

LEGAL STANDARDS

In reviewing a motion for summary judgment, courts must apply a three-step analysis: "(1) identify the issues framed by the pleadings; (2) determine whether the moving party has negated the opponent's claims; and (3) determine whether the opposition has demonstrated the existence of a triable, material factual issue." ([Hinesley v. Oakshade Town Center \(2005\) 135 Cal.App.4th 289, 294.](#))

"[T]he initial burden is always on the moving party to make a prima facie showing that there are no triable issues of material fact." ([Scalf v. D. B. Log Homes, Inc. \(2005\) 128 Cal.App.4th 1510, 1519.](#)) A defendant [*4] moving for summary judgment or summary adjudication "has met his or her burden of showing that a cause of action has no merit if the party has shown that one or more elements of the cause of action ... cannot be established, or that there is a complete defense to the cause of action." ([Code Civ. Proc., § 437c, subd. \(p\)\(2\).](#)) A moving defendant need not conclusively negate an element of plaintiff's cause of action. ([Aguilar v. Atlantic Richfield Co. \(2001\) 25 Cal.4th 826, 854.](#))

To meet this burden of showing a cause of action cannot be established, a defendant must show not only "that the plaintiff does not possess needed evidence" but also that "the plaintiff cannot reasonably obtain needed evidence." ([Aguilar, supra, 25 Cal.4th at p. 854.](#)) It is insufficient for the defendant to merely point out the absence of evidence. ([Gaggero v. Yura \(2003\) 108 Cal.App.4th 884, 891.](#)) The defendant "must also produce evidence that the plaintiff cannot reasonably obtain evidence to support his or her claim." (*Ibid.*)¶ The supporting evidence can be in the form of affidavits, declarations, admissions, depositions, answers to interrogatories, and matters of which judicial notice may be taken. ([Aguilar, supra, 25 Cal.4th at p. 855.](#))

"Once the defendant ... has met that burden, the burden shifts to the plaintiff ... to show that a triable issue of one or more material facts exists as to the cause of action or a defense thereto." [*5] ([Code Civ. Proc., § 437c, subd. \(p\)\(2\).](#)) The plaintiff may not merely rely on allegations or denials of its pleadings to show that a triable issue of material fact exists, but instead, "shall set forth the specific facts showing that a triable issue of material fact exists as to the cause of action." (*Ibid.*) "If the plaintiff cannot do so, summary judgment should be granted." ([Avivi v. Centro Medico Urgente Medical Center \(2008\) 159 Cal.App.4th 463, 467.](#))

EVIDENTIARY OBJECTIONS

Plaintiff's Evidentiary Objections

Plaintiff's evidentiary objections are not objections to the admissibility of the evidence, but rather a dispute over the facts that the evidence purports to support. Accordingly, Plaintiff's objections are OVERRULED.

Defendant's Evidentiary Objections

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The court needs to rule only on evidence that it considers dispositive to the motion. ([Code Civ. Proc., § 437c, subd. \(q\).](#)) With that in mind, the court rules on Defendant's evidentiary objections as follows:

Objection No. 16: SUSTAINED.

Objection No. 18: SUSTAINED.

Objection No. 19: SUSTAINED.

Objection No. 21: SUSTAINED.

DISCUSSION

Express Assumption of Risk: Membership Agreement and Member Services Agreement

Defendant claims that Plaintiff signed a membership agreement on April 5, 2016. Defendant argues that this agreement contains a valid release.

A release may negate the duty element [*6] of a negligence action." ([Benedek v. PLC Santa Monica \(2002\) 104 Cal.App.4th 1351, 1356.](#)) "In the absence of extrinsic evidence, the scope of a release is determined by the express language of the release." ([Id. at p. 1357](#) (citation omitted).)¶ A waiver and release must "be clear, unambiguous and explicit in expressing the intent of the parties." ([Paralift, Inc. v. Superior Court \(1993\) 23 Cal.App.4th 748, 755.](#)) Waiver and release forms are to be strictly construed against the defendant. Such a form is simply a written assumption of a known risk, i.e. a risk reasonably anticipated by the plaintiff. ([Leon v. Family Fitness Center \(# 107\), Inc. \(1998\) 61 Cal.App.4th 1227, 1234, 71 Cal.Rptr.2d 923.](#)) To be operative, the defendant's negligence which results in plaintiff's injury must be reasonably related to the object or purpose for which the release is given. ([Id., at p. 1235](#); [Paralift, Inc. v. Superior Court](#), supra, 23 Cal.App.4th at p. 757.)

Defendant identifies two provisions within the membership agreement which it contends act as a waiver/release of liability:

(2) MEMBER RISK. Member and Member's guests shall hold Crunch harmless from any loss, theft, cost, claim injury, damage or liability ("Damages") incurred as a result of the use of a Crunch facility and any other membership activities, except such Damages which result from the willful misconduct or gross negligence of crunch, its affiliates, agents or employees.

(2.5) Activity Risk. Any strenuous athletic or physical activity involve [*7] certain risks. Member and Member's guest assume the risk of any and all accidents or injuries of any kind that may be sustained by, or in connection with, use of the facilities and release, hold Crunch harmless, discharge and absolve Crunch, its agents and employees from any and all Damages or responsibility except if such accident or injury is the result of the willful misconduct or gross negligence of Crunch, its affiliates, agents or employees.

(Def.'s Ex. 3, p. 3.) Defendant argues this language is sufficient to release them from liability for Plaintiff's injury and cites to [Sanchez v. Bally's Total Fitness Corp. \(1998\) 68 Cal.App.4th 62](#). The Sanchez court of appeal held that a health club was relieved of liability even though the exculpatory clause was not set out in large or italicized letters and did not include the term "negligence." ([Id. at p. 68.](#))

The Sanchez court further explained that the visual characteristics of the printed words are irrelevant because the plaintiff failed to show that she was unaware of the exculpatory language or was otherwise misled. ([Id. at p. 65.](#)) Importantly, in Sanchez the plaintiff admitted in her deposition that she signed it and read it and was aware that she was entering into a contract at the time. ([Id. \[*8\] at p. 66.](#)) The Sanchez court also noted that plaintiff was a senior real estate officer who understood the importance of reading and understanding contracts. ([Ibid.](#))

Here, Defendant claims that Plaintiff read and signed the Membership Agreement, which was introduced as Exhibit 3 in Plaintiff's deposition. Defendant cites to Plaintiff's deposition transcript at 111:6-25 and 112:1-4 wherein

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defense counsel asked whether Plaintiff read the agreement before signing it and Plaintiff said, "Correct." (Def.'s Ex. 2, 112:1-4.) Furthermore, Plaintiff's injury was sustained while participating in an activity reasonably related to the object for which the release was given. (See e.g., *Benedek v. PLC Santa Monica*, supra, 104 Cal.App.4th at p. 1361; *Lund v. Bally's Aerobic Plus, Inc.* (2000) 78 Cal.App.4th 733, 739.)

Defendant has met its moving burden to establish a prima facie case that Plaintiff's action is barred by the release contained in her membership agreement. The burden now shifts to Plaintiff to show that a triable issue of material fact exists.

In opposition, Plaintiff argues that the agreement has not been authenticated because it has only been used at Plaintiff's deposition. This makes no sense. Plaintiff admitted in deposition that she signed the membership agreement and recognized her signature on the membership [*9] agreement which was introduced as an exhibit at her deposition. (Def.'s Ex. 2, 112:1-4.)

Plaintiff also cites to her deposition testimony and claims in a declaration that she was never asked to confirm whether she read the agreement or signed it. The deposition transcript clearly states otherwise; Plaintiff confirmed that she read the agreement before signing it. (Def.'s Ex. 3, 112:1-4.) Plaintiff also attempts to create a triable issue of material fact by emphasizing that she did not sign the third page and could not confirm that her signature was on the fourth page.

These arguments are specious. First, there is no signature line on the third page. Second, Plaintiff does not introduce evidence showing that she didn't sign the agreement. Plaintiff must introduce evidence in order to establish a triable issue of fact and cannot rely on speculation.

Next, Plaintiff relies on the expert declaration of Michael Vredenburg to support her argument that Defendant was grossly negligent. Vredenburg opines that "the Personal Training room was inappropriate for the L.E.F.T. test exercise." However, there is no evidence showing that the L.E.F.T. test exercise was conducted. In support of this statement, [*10] Vredenburg cites to pages 56 and 58 of the deposition transcript of Adele Albano, the trainer who led the class, but the portions of her deposition which were submitted do not include these pages. Therefore, Vredenburg's opinion is based on an assumption of fact without evidentiary support. (*Borger v. Department of Motor Vehicles* (2011) 192 Cal.App.4th 1118, 1122.)

Request for Continuance and Submission of Supplemental Evidence

In the alternative, Plaintiff requested a brief continuance to conduct additional discovery. Plaintiff argued that the missing evidence will show that Defendant's employees acted in a grossly negligent manner. For example, Plaintiff claimed that the instructor of the exercise class and the instructor's supervisor could testify that trainers were not supposed to use running exercises in the small room. Plaintiff also claimed that Marvin Warner, one of the employees who led Plaintiff's class, needs to be deposed to testify about the preparations were made ahead of the class; if there were no preparations, Plaintiff argues that this would lend itself to gross negligence. Plaintiff further claimed that she has only recently found an expert without conflicts who can opine on fitness-specific questions such as the lighting and flooring [*11] of the gym.

On July 14, 2021, after Defendant filed its reply, Plaintiff filed a "Supplemental Separate Statement" and the expert declaration of Neal Pire ("Pire"). While timely, these filings do not create a triable issue of material fact. (*Code Civ. Proc.*, § 437c, subd. (b)(2) [opposition must be served not less than 14 days prior to the scheduled hearing].)

Pire has more than 30 years of experience in designing, managing, and consulting for fitness and training centers and gyms. (Pire Decl., ¶ 1.) He opines that the Personal Training Room in which the exercise took place was not appropriate and that the design of the class significantly increased the risk of injury to participants. (Pire Decl., ¶ 6.) Pire understands that Plaintiff was injured during a class that took place in a personal training studio. (Pire Decl., ¶ 5.) Like Vredenburg, Pire states without evidence that the incident occurred during a Lower Extremity Functional Test (L.E.F.T.) that was turned into a relay race type competition. (Pire Decl., ¶ 6.) He describes the purpose of this test and how it should be administered. (Pire Decl., ¶ 6.)

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Specifically, Pire states that the L.E.F.T. is designed to test movement efficacy to assess an athlete's readiness [*12] to return to play after an injury to the lower extremity. (Pire Decl., ¶ 6.)

Like Vredenburg, Pire provides no evidentiary support for his assumption that Plaintiff was engaging in a L.E.F.T. He explains that the L.E.F.T. should be done mindfully and is used to assess unilateral balance and movement efficiency, and to biomechanical compensations and dysfunctions. (Pire Decl., ¶ 6.) He continues to describe the L.E.F.T. as an activity that is not meant to be performed in a small space with multiple participants.

Pire's opinion is irrelevant not only because there is no evidence supporting the fact that a L.E.F.T was even involved, but for the additional reasons that the purpose of the exercise class is to "burn calories and increase [one's] heart rate to get [] in better shape." (Plaintiff's Supplemental Material Fact No. 76.) The class is not meant to assess any of the participant's capacity for movement. Therefore, how the L.E.F.T. should be executed or administered is not probative of whether hosting the relay race constitutes gross negligence.

CONCLUSION

In light of the foregoing, the motion for summary judgment is GRANTED.

Moving party to give notice.

END OF TENTATIVE

Motion is [*13] heard, argued, and taken under submission.

Clerk to give notice of ruling once it becomes available.

After an in-chambers review, the Court makes the following ruling:

The tentative ruling is adopted as the Order of the Court, which is incorporated herein the minute order this date.

The Motion for Summary Judgment , OR IN THE ALTERNATIVE SUMMARY ADJUDICATION; filed by Crunch Holdings, LLC on 02/19/2021 is Granted.

Certificate of Mailing is attached.

EXHIBIT 11

CURRICULUM VITAE

Farrokh Reza Farrokhi, M.D.**PROFESSIONAL ADDRESS:**

Virginia Mason Medical Center
 1100 Ninth Avenue
 PO Box 900
 Seattle, WA 98101
 206-223-7525

EDUCATION

B.A. Biophysics, John Hopkins University, Baltimore, Maryland	1990-1994
M.D., Baylor College of Medicine, Houston, Texas	1994-1998

INTERNSHIP AND RESIDENCY

Residency in General Surgery, University of Texas Health Science Center San Antonio, Texas	1998-1999
Residency in Neurosurgery, University of Texas Health Science Center San Antonio, Texas	1999-2003
Chief Residency in Neurosurgery, University of Washington Seattle, Washington	2003-2005
Fellow in Pediatric Neurosurgery, Children's Hospital Seattle, Washington	2005-2006

POSITIONS

Attending Neurosurgeon - Virginia Mason Franciscan Health	2006 – present
Medical Director of Quality, Chairman - Quality Council	2015 - present
Section Head, Department of Neurosurgery	2014 - 2020
Chair of Functional Neurosurgery, VMFH Center for Neurosciences	2023 - present

LICENSURE

Washington (Active), Texas (inactive)	2005 – present
---------------------------------------	----------------

BOARD CERTIFICATION

Board Certified, American Board of Neurological Surgery	2013 – present
---	----------------

EXHIBIT 1
Farrokhi, MD
10/3/2025

Tami Lynn Vondran
 CRR, RMR, CCR# 2157

MEDICAL SOCIETY AND PROFESSIONAL MEMBERSHIPS

Board Director , Global Nutrition & Empowerment	2025 - Present
Peer Review Consultant , Washington Hospital Services - WSHA	2024 - Present
Expert Reviewer , Washington Medical Commission	2024 - Present
Board Director , Foundation, Washington State Medical Association	2024 - Present
Delegate , Washington State Medical Association, House of Delegates	2024 - Present
Delegate , King County Medical Society	2024 - Present
Local Arrangements Chair , Western Neurosurgical Society	2019 - Present
Fellow , American Association of Neurological Surgeons (AANS)	2013 - Present
Chairman , Quality Assessment Committee, Virginia Mason Medical Center	2011 - Present
Board Director , Nepal Spine Foundation	2021 - Present
Examiner , American Board of Neurological Surgery	2019 - 2021
Member , Washington State Bree Collaborative, Lumbar Fusion Design Committee	2014 - 2016
President , Washington State Association of Neurological Surgeons	2008 - 2017
Chairman , Medical Advisory Committee Northwest Parkinson's Foundation	2014 - 2018
Board Member , Northwest Parkinson's Foundation	2012 - 2014
Member , High Value Healthcare Collaborative Spine Care Team	2013 - 2017
Member , IIMAC Cervical Spine Committee, Washington State Department of Labor & Industries	2013 - 2014
President , House Staff Council, University of Texas Health System	2001 - 2003
Member , Washington State Medical Society (WSMA)	2006 - Present
Member , King County Medical Society (KCMS)	2006 - Present
Member , Congress of Neurological Surgeons (CNS)	2006 - Present
Member , Movement Disorders Society (MDS)	2006 - Present
Member , Washington State Medical Association (WSMA)	2006 - Present
Member , Society for Neuroscience (SFN)	1999 - 2003
Member , Bexar County Medical Society (BCMS)	1998 - 2003
Member , Texas Medical Association (TMA)	1998 - 2003
Member , American Medical Association (AMA)	1994 - present

HONORS/AWARDS/CERTIFICATES

Executive Program: AI Business Implications (MIT Sloan School of Management)	2021
Clinical Research Chair, Neuroscience Institute	2017
Best Poster Award, International Society for the Study of Lumbar Spine (ISSLS)	2016
Leadership Development Intensive, Virginia Mason	2014
First Place Clinical Excellence Award, AORN Congress	2012
Virginia Mason Production System for Leaders Training (Lean Certified)	2012
Best Basic Science Research Presentation, First Place, Aust Surgical Society	2002
House Staff of the Year, University Hospital, University of Texas Health System	2002
National Resident Leadership Award, American Medical Association	2001
Best Clinical Research Presentations, Aust Surgical Society	2000
Novarius Award for Outstanding Community Service, Baylor College of Medicine	1997

EDUCATION/TEACHING/MENTORSHIP APPOINTMENTS

Research Supervisor, Elson S. Floyd College of Medicine Washington State University, Spokane, Washington	2023-Present
Summer Research Mentor, UW School of Medicine University of Washington, Seattle, Washington	2023-Present
Undergraduate Mentor Program Seattle Pacific University, Seattle, Washington	2012-Present

Acting Clinical Instructor, Department of Neurosurgery University of Washington, Seattle, Washington	2005-2006
Neuroanatomy Lab Instructor, Department of Cellular and Structural Biology Research Elective in Neurosurgery – Instructor, Neurosurgical Research Laboratory University of Texas Health Science Center, San Antonio, Texas	2001-2003
General Chemistry Lab Instructor, Department of Chemistry Johns Hopkins University, Baltimore, Maryland	1992-1994

COMMITTEES

Mentorship Committee , Western Neurosurgical Society	2024 - Present
Utilization Management Committee , Virginia Mason Medical Center	2024 - Present
Neuroscience Collaborative , Common Spirit	2024 - Present
Finance Committee of NSC , Common Spirit	2024 - Present
Member , Medical Executive Committee, Virginia Mason Medical Center	2011 – Present
Member , Medical Staff Committee, Virginia Mason Medical Center	2011 - 2014
Member , Metrics Committee, Spine Surgical Care and Outcomes Assessment Program	2010 - 2015

PUBLICATIONS

Journals

1. Yekuno K, Funk D, Marsans M, Roberts J, **Farrokhi F**, *Renaming Twiddler's syndrome: an argument for change to reflect a diverse set of aetiologies, patients and devices*. *BMJ Case Reports CP2025*;18:e263681.
2. Basner L, Smit JV, Zeitler DM, Schwartz SR, Krause K, Bansal A, **Farrokhi F**. *Deep Brain Stimulation for Primary Refractory Tinnitus: A Systematic Review*. *Brain Sci.* 2024 Apr 30;14(5):452.
3. Sharma MR, Bohara S, Shrestha DK, Joshi DR, Singh S, Lamsal R, Acharya SB, Kafle P, Pradhanang AB, Sedain G, **Farrokhi F**, Grant GA; *Clinical Characteristics and Outcome of Patients With Intraoperative Aneurysm Rupture: A Retrospective Cohort Study From Nepal*; *Neurosurgery Practice* 5(1):e00083, March 2024.
4. Louie PK, Alostaz M, Bansal A, Drolet CE, Gyawali P, Khan N, Vivel N, **Farrokhi F**. *A Tubular-Mounted Digital Camera (TMDC) versus Optical Surgical Microscope (OSM) for Minimally Invasive Lumbar Decompression Surgery: The impact on Operative Times, Ergonomics, and Workflow*. *World Neurosurgery*. Accepted 5 Jan 2024.
5. Pant A, **Farrokhi FR**, Gyawali P, Yekuno K, Shah O, Singh S, Sharma MR; *Global Research Trends in Central Nervous System Tuberculosis — A Bibliometric Analysis*; *Journal of Clinical Tuberculosis and Other Mycobacterial Diseases*; Jan 2024
6. Pant A, **Farrokhi F**, Krause K, Marsans M, Roberts, J. *Ten-Year Durability of Hypothalamic Deep Brain Stimulation in Treatment of Chronic Cluster Headaches: A Case Report and Literature Review*. *Cureus* 15(10):October 19, 2023.
7. Sharma MR, Sedain G, Kafle P, Pradhanang AB, Sapkota S, Niyaf A, **Farrokhi F**, Garozzo D, *Academic neurosurgery in Nepal: Present status and future directions*; *Brain Spine*. 2023 Jul 19;.
8. Thapa P, Bhattarai M, Paude B, Sharma P, Kunwar P, Poudel S, Koirala S, Pradhanang A, Klein B, **Farrokhi F**; *Early experience with percutaneous balloon kyphoplasty for treatment of osteoporotic vertebral compression fracture in Nepal: A case report*; *Clinical Case Reports*; 27 August 2023.
9. Buchlak QD, Tang CHM, Seah JCY, Johnson A, Holt X, Bottrell GM, Wardman JB, Samarasinghe G, Dos Santos Pinheiro L, Xia H, Ahmad HK, Pham H, Chiang JI, Ektas N, Milne MR, Chiu CHY, Hachey B, Ryan MK, Johnston BP, Esmaili N, Bennett C, Goldschlager T, Hall J, Vo DT, Oakden-Rayner L, Leveque JC, **Farrokhi F**, Abramson RG, Jones CM, Edelstein S, Brothie P.; *Effects of a comprehensive brain computed tomography deep learning model on radiologist detection accuracy*; *Eur Radiol*. 2023 Aug 22.
10. Khan N, Drolet C, **Farrokhi F**, Nemani V, Leveque JC, Krause K, Friedman A, Bansal A, Louie PK. *Clinical Guidelines for the Evaluation and Treatment of Lumbar Disc Herniations: How Accurate is the Internet?* *World Neurosurgery*. Acc. 31 Jul 2023

11. Sharma MR, Sedain G, Kafle P, Pradhanang AB, Sapkota S, Niyaf A, **Farrokhi F**, Gorazzo D; *Academic Neurosurgery in Nepal: Present status and future directions*. Brain and Spine, V3, 2023.
12. Zeitler DM, Buchlak QD, Ramasundara S, **Farrokhi F**, Esmaili N; *Predicting Acoustic Hearing Preservation Following Cochlear Implant Surgery Using Machine Learning*: Laryngoscope 2023 Jul 15.
13. Boudreaux H, **Farrokhi F**, Krause KL, Louie PK. *The Surgeon Ergonomic Impact of a Tubular-Based Digital Camera to Perform a Seated Posterior Cervical Foraminotomy*. World Neurosurgery. 2022 Dec 21;171:19-24.
14. Buchlak QD, Milne MR, Seah J, Johnson A, Samarasinghe G, Hachey B, Esmaili N, Tran A, Leveque JC, Farrokhi F, Goldschlager T, Edelstein S, Brotchie P. *Charting the potential of brain computed tomography deep learning systems*. J Clin Neurosci. 2022 May;99:217-223. Epub 2022 Mar 12
15. Bohl M, Kakarla UK, Chang SW, Sethi R, **Farrokhi F**, Leveque JC, *Establishing a Reference Procedure Length for Anterior Cervical Fusions: The Role for Standards in Surgical Process Improvement*. Cureus 14(2): e22615. doi:10.7759/cureus.22615, 22 FEB 2022.
16. Buchlak QD, Esmaili N, Bennett C, **Farrokhi F**. *Natural Language Processing Applications in the Clinical Neurosciences: A Machine Learning Augmented Systematic Review*. Acta Neurochir Suppl. 2022;134:277-289.
17. Almosnino G, Sikora MJ, **Farrokhi FR**, Schwartz SR, Zeitler DM. *Tumor-Related and Patient-Related Variables Affecting Length of Hospital Stay Following Vestibular Schwannoma Microsurgery*. Ann Otol Rhinol Laryngol. 2021 Jul 1.
18. Buchlak QD, Esmaili N, Leveque JC, Bennett C, Piccardi M, **Farrokhi FR**. *Machine learning applications to neuroimaging for glioma detection and classification: An artificial intelligence augmented systematic review*. Journal of Clinical Neuroscience, 2021-5.
19. Winocour SJ, Xue EY, Bohl MA, **Farrokhi F**, Davis MJ, Abu-Ghname A, Ropper AE, Reece EM. *Vascularized Occipital Bone Grafting: Indications, Techniques, Clinical Outcomes, and Alternatives*. Semin Plast Surg. 2021 Feb;35(1):14-19.
20. Bohl MA, Reece EM, **Farrokhi F**, Davis MJ, Abu-Ghname A, Ropper AE. *Vascularized Bone Grafts for Spinal Fusion-Part 3: The Occiput*. Oper Neurosurg (Hagerstown). 2021 Apr 15;20(5):502-507.
21. Bohl MA, Wright AK, Holekamp TF, Mecklenburg RS, **Farrokhi FR**, Leveque JC, Friedman A, Sethi RK. *Is there bias in the treatment of degenerative spine disease? Analysis of anonymous voting via a multidisciplinary conference*. Journal of Clinical Neuroscience, 2020-12-01.
22. Buchlak QD, Esmaili N, Leveque JC, Bennett C, Piccardi M, **Farrokhi FR**. *Ethical thinking machines in surgery and the requirement for clinical leadership*. Am J Surg. 2020 Jul 8.
23. Buchlak QD, Esmaili N, Leveque JC, **Farrokhi F**, Bennett C, Piccardi M, Sethi RK. *Machine learning applications to clinical decision support in neurosurgery: an artificial intelligence augmented systematic review*. Neurosurg Rev. 2020 Oct;43(5):1235-1253.
24. **Farrokhi FR**, Buchlak QD, Sikora M, Esmaili N, Marsans M, McLeod P, Mark J, Cox E, Bennett C, Carlson J. *Investigating Risk Factors and Predicting Complications in Deep Brain Stimulation Surgery with Machine Learning Algorithms*. World Neurosurgery 2019 Oct 18. S1878-8750(19)32681-6.
25. **Farrokhi FR**, Marsans MT, Sikora M, Monsell SE, Wright AK, Palmer M, Hoefer A, McLeod P, Mark J, Carlson J. *Preoperative smoking history increases risk of infection in deep brain stimulation surgery*. J Clin Neurosci. 2019 Nov; 69:88-92. doi: 10.1016/j.jocn.2019.08.026. Epub 2019 Aug 21.
26. Buchlak QD, Kowalczyk M, Leveque JC, Wright A, **Farrokhi FR**. *Risk stratification in deep brain stimulation surgery: Development of an algorithm to predict patient discharge disposition with 91.9% accuracy*. J Clin Neurosci. 2018 Aug 28. S0967-5868(18)30497-1.
27. Puchalski RB, **Farrokhi FR**, et al, Foltz GD. *An anatomic transcriptional atlas of human glioblastoma*. Science. 2018 May 11; 360(6389):660-663.
28. Yanamadala V, Kim Y, Buchlak QD, Wright AK, Babington J, Friedman A, Mecklenburg RS, **Farrokhi F**, Leveque JC, Sethi RK. *Multidisciplinary Evaluation Leads to the Decreased Utilization of Lumbar Spine Fusion: An Observational Cohort Pilot Study*. SPINE. Sep 2017.
29. Martin BI, Lurie JD, **Farrokhi FR**, McGuire KJ, Mirza SK. *Early effects of Medicare's Bundled Payment for Care Improvement (BPCI) program for lumbar fusion*. SPINE. Sep 2017
30. Bradywood A, **Farrokhi F**, Williams B, Kowalczyk M, Blackmore CC. *Reduction of Inpatient Hospital Length of Stay in Lumbar Fusion Patients with Implementation of an Evidence Based Clinical Care Pathway*. SPINE. Feb 2017.

31. Lee MJ, Shonnard N, **Farrokhi F**, Martz D, Chapman J, Baker R, Hsiang J, Lee C, Gholish R, Flum D. *The Spine Surgical Care and Outcomes Assessment Program (Spine SCOAP): a surgeon-led approach to quality and safety. Spine SCOAP-CERTAIN Collaborative.* Spine. 2015 Mar 1;40(5):332-41.
32. Martin BI, Lurie JD, Tosteson AN, Deyo RA, **Farrokhi FR**, Mirza SK. *Use of bone morphogenetic protein among patients undergoing fusion for degenerative diagnoses in the United States, 2002 to 2012.* Spine J. 2015 Apr 1;15(4):692-9.
33. **Farrokhi FR**, Gunther M, Williams B, Blackmore CC. *Application of lean methodology for improved quality and efficiency in operating room instrument availability.* Journal for Healthcare Quality Sept-Oct 2015.
34. Kerby JD, Sainz JG, Zhang F, Hutchings A, Sprague S, **Farrokhi FR**, Son M. *Resuscitation from hemorrhagic shock with HBOC-201 in the setting of traumatic brain injury.* Shock 2007 Jun; 27(6):652-6.
35. Stelzer KJ, Mesiwala AH, **Farrokhi FR**, Silbergeld DL. *Posterior Cerebral Artery Compression and Subsequent Infarction after Implantation of Gliasite Balloon.* The Internet Journal of Oncology 2007;4(1).
36. Natarajan SK, Sekhar LN, Wright DC, **Farrokhi FR**, Schessel D. *Patient Outcomes at Long-term Follow-up after Aggressive Microsurgical Resection of Petroclival Meningiomas.* Neurosurgery 2006. Aug;59(2):489.
37. North RB, Kidd DH, **Farrokhi F**, Piantadosi SA. *Spinal cord stimulation versus repeated lumbosacral spine surgery for chronic pain: a randomized, controlled trial.* Neurosurgery. 56(1):98-106, 2005.
38. North RB, Kidd DH, Olin J, Sieracki JM, **Farrokhi F**, Petrucci L, Cutchis PN. *Spinal Cord Stimulation for Axial Low Back Pain: A Prospective, Controlled Trial Comparing Dual With Single Percutaneous Electrodes.* Spine. 30(12):1412-1418, 2005.
39. Sainz, JG, Sprague S, Son M, Kerby J, Zhang F, **Farrokhi, FR.** *Resuscitation of Hemorrhagic Shock with HBOC-201 Following Traumatic Brain Injury.* Critical Care Medicine. 32(12) Supp:A32, December 2004.
40. North RB, Kidd DH, **Farrokhi F**, Piantadosi SA. *Spinal cord stimulation versus repeated lumbosacral spine surgery for chronic pain: a randomized, controlled trial.* Neurosurgery. 56(1):98-106, 2005.
41. Zhang F, Sprague SM, **Farrokhi F**, Henry MN, Son MG, Vollmer DG. *Reversal of attenuation of cerebrovascular reactivity to hypercapnia by a nitric oxide donor after controlled cortical impact in a rat model of traumatic brain injury.* Journal of Neurosurgery. 97(4):963-69, 2002
42. **Farrokhi FR**, Wernstein A, Brownell I: *Curriculum Evaluation by Student Run Focus Groups*, Academic Medicine, 72(5):412-3 May 1997.

INVITED EXTRAMURAL POSTER AND ORAL PRESENTATIONS

1. **Farrokhi FR**, Palermo C, Pant A, *Value-Based Care Innovations in Neurosurgery: Same Day Discharge Deep Brain Stimulator Surgery*, Health Finance Management Association Annual Conference, Denver, CO, June 23-25, 2025.
2. **Farrokhi FR**, *Is it time to say goodbye to the drill?* Mazama Spine Summit, Winthrop, WA June 20, 2025
3. **Farrokhi FR**, *Piezo Spine Surgery*, Mectron International Annual Meeting, Charleston, SC; January 28, 2025.
4. **Farrokhi FR**, *Spot on Stereotaxy*, Northwest Primary Care Medical Conference, Virtual Meeting, December 6-7, 2024
5. **Farrokhi FR**, *ACD vs. PCF: The Votes Are In.* Spine Week Conference 2024, Tribhuvan University Teaching Hospital, Kathmandu, Nepal, Nov 4, 2024.
6. **Farrokhi FR**, *Say Goodbye to Drills. Piezo Spine Surgery.* Spine Week Conference 2024, Tribhuvan University Teaching Hospital, Kathmandu, Nepal, Nov 4, 2024.
7. Pant A, Palermo C, **Farrokhi FR**, *Same Day Discharge Pathway for Deep Brain Stimulation Electrode Placement. DBSA Case for Innovation in Rapid Recovery After Neurosurgery.* Congress of Neurological Surgeons, Annual Conference, Houston, TX, September 30, 2024
8. Basner L, Smit JV, Zeitler DM, Schwartz SR, Krause K, Bansal A, **Farrokhi F.** *Deep Brain Stimulation for Primary Refractory Tinnitus.* Movement Disorders Society Congress, Philadelphia, PA, Sep 29, 2024
9. **Farrokhi FR**, *Same Day Discharge After DBS: A Case for Innovation in Rapid Recovery After Neurosurgery.* Western Neurosurgical Society 70th Annual Conference, San Diego, CA, September 6, 2024
10. **Farrokhi FR**, *Global Surgery Panel*, University of Washington, Global Surgery Student Alliance, Seattle, WA June 4, 2024

11. **Farrokhi FR**, *Translating QI Initiatives into Value Based Care*, Mayo Clinic Neurosurgery QI Education Lecture, Rochester, April 1, 2024
12. **Farrokhi FR**, *The VMPS Journey*; Fairbanks Memorial Hospital, Fairbanks AK, March 5, 2024
13. **Farrokhi FR**, Bick SK, Konrad PE, Paulo DL, Falowski S, Bretscher BM, Stromberg K, Weaver TW; *Infection Prevention with an Antibacterial Envelope: A large Prospective Global Evaluation of DBS-Related Infections*; North American Neuromodulation Society 2024 Annual Meeting, Las Vegas, January 19, 2024.
14. **Farrokhi FR**, *Good News! You can go home after brain surgery*. American Association of Neuro Nurses, Seattle, January 30, 2024.
15. Louie PK, **Farrokhi FR**, et al. *A Tubular-Mounted Digital Camera (TMDC) versus Optical Surgical Microscope (OSM) for Minimally Invasive Lumbar Decompression Surgery: The impact on Operative Times, Ergonomics, and Workflow*; CNS/AANS Spine Summit, Las Vegas, NV, Feb 2024.
16. **Farrokhi FR**, *Stand Alone Lateral Fusion: Who Needs Backup*. Spine Week Conference 2023, Tribhuvan University Teaching Hospital, Kathmandu, Nepal, Dec 9, 2023.
17. **Farrokhi FR**, Schwartz S, *Surgical Approaches to the CPA*; VMFH Skull Base Visiting Professor Grand Rounds; Seattle, WA November 2023.
18. **Farrokhi FR**, *Safety First! Complication Avoidance in DBS Surgery*; Maldives Brain Spine 2023, Male, October 2023.
19. **Farrokhi FR**, *Building a Deep Brain Stimulation Program: Needed Tools, Technology and Expertise*; Maldives Brain Spine 2023, Male, October 2023.
20. Pant A, **Farrokhi FR**, et al; *Same Day Discharge Pathway in DBS Electrode Surgery*; Movement Disorders Congress, Copenhagen, Denmark August 2023.
21. Gyawali P, **Farrokhi FR**, et al; *Deep Brain Stimulation for MS Tremor*; Movement Disorders Congress, Copenhagen, Denmark August 2023.
22. Yeakuno K, **Farrokhi FR**, et al; *Staged Unilateral vs. Simultaneous Bilateral Electrode Placement*; Movement Disorders Congress, Copenhagen, Denmark August 2023.
23. **Farrokhi FR**, *History of Neurosurgery In Nepal*; Washington State Association of Neurological Surgeons, Annual Meeting, Suncadia, WA; June 2023
24. Morelli N, Singer A, Sannelli C, Mure H, Martinez K, Oyama G, Falowski S, Bick S, Schiess M, **Farrokhi F**, Witt T, *Real-World Local Field Potential Recordings in Patients with Parkinson's Disease: Peak Detection and Influence of Patient-Related Factors*, American Academy of Neurology 2023 Annual Meeting, April 22 to April 27, 2023 in Boston, MA.
25. **Farrokhi FR**, *Lateral Lumbar Interbody Fusion Techniques and Patient Selection*. November Spine Week 2022 Conference, Tribhuvan University Teaching Hospital, Kathmandu, Nepal, November 10, 2022.
26. **Farrokhi FR**, *Camera Based Tubular Spine Surgery*, Maldives Brain and Spine Conference 2022, Crossroads, Maldives, September 20, 2022.
27. **Farrokhi FR**, *Current Update in Treatment of Vestibular Schwannomas*. Keynote for Tribhuvan University Teaching Hospital, Current Opinion in Neurosurgery-Annual Conference, Kathmandu, Nepal, Mar 5, 2022.
28. **Farrokhi FR**, *Medical Volunteerism*, Virginia Mason Grand Rounds, March 11, 2022.
29. **Farrokhi FR**, *Artificial Intelligence in Neurosurgery*. American Association of Neuroscience Nurses Annual Conference, San Diego Jan 7, 2022.
30. **Farrokhi FR**, *Deep Brain Stimulation: Who, When, How and WOW!* American Association of Neuroscience Nurses Annual Conference, San Diego Jan 7, 2022.
31. **Farrokhi FR**, *Advantages of the Camera Based Fusion Surgery*. Spine 2021 Conference, Tribhuvan University Teaching Hospital, Kathmandu, Nepal, November 22, 2021.
32. **Farrokhi FR**, *Eliminating the microscope in spine surgery*. Spine 2021 Conference, Tribhuvan University Teaching Hospital, Kathmandu, Nepal, November 20, 2021.
33. **Farrokhi FR**, *Introduction to Camera Based MIS Spine Surgery*. Spine 2021 Conference, Tribhuvan University Teaching Hospital, Kathmandu, Nepal, November 18, 2021.
34. **Farrokhi FR**, *Artificial Intelligence and Machine Learning in Neurosurgery*. Tribhuvan University Teaching Hospital, Kathmandu, Nepal, October 16, 2020
35. **Farrokhi FR**, Schwartz, S, Zeitler, D, *The Eighth (nerve) Wonder of the World! Vestibular Schwannomas Will Make Your Head Spin*. Grand Rounds, Virginia Mason, Seattle, WA, April 3, 2020
36. Buchlak QD, **Farrokhi FR**, *Augmenting clinical decision-making and patient safety with artificial intelligence: Case studies in deep brain stimulation surgery*. Grand Rounds, Virginia Mason, Seattle, WA, February 7, 2020

37. Bradywood AC, Chua R, **Farrokhi FR**, *Global Health and Spine*, Mazama Spine Summit, Winthrop, WA January 2020.
38. **Farrokhi FR**, *Risk Reduction in Deep Brain Stimulation Lean Methodology, Logistic Regression, Artificial Intelligence and the Kitchen Sink*, Western Neurosurgery Annual Meeting, Scottsdale, AZ, November 2019.
39. **Farrokhi FR**, *Risk Reduction in Complex Spine Surgery*. NESON Spine Conference, Kathmandu, Nepal, September 20, 2019.
40. **Farrokhi FR**, *Hyper-lordotic LLIF for Sagittal Balance Correction Avoiding Osteotomy*. NESON Spine Conference, Kathmandu, Nepal, September 20, 2019.
41. **Farrokhi FR**, *Safety and Risk Reduction in Spine Surgery Multidisciplinary Conferences and Standard Protocols*, ADK Brain and Spine 2019 Conference, Paradise Island, Maldives, September 19, 2019.
42. **Farrokhi FR**, *Operating room efficiency improvements through the application of LEAN methodologies*, ADK Brain and Spine 2019 Conference, Paradise Island, Maldives, September 19, 2019.
43. **Farrokhi FR**, *Risk Prediction in Deep Brain Stimulation using Artificial Intelligence and Machine Learning*, ADK Brain and Spine 2019 Conference, Paradise Island, Maldives, September 18, 2019.
44. **Farrokhi FR**, *Awake Lumbar Spine Fusion Surgery*, ADK Brain and Spine 2019 Conference, Paradise Island, Maldives, September 17, 2019.
45. **Farrokhi FR**, Isenberg NB, *DBS for Alzheimer's disease*. Grand Rounds, Virginia Mason Medical Center. Seattle, WA. June 22, 2018.
46. **Farrokhi FR**. *Application of Deep Brain Stimulation in Movement Disorders*. Olympic Medical Center. Port Angeles, WA. May 4, 2018.
47. **Farrokhi FR**. *Neurosurgery Spine vs. Orthopedic Spine. Is there a difference?* CHI Franciscans Primary Care. Bremerton, WA May 7, 2018
48. **Farrokhi FR**, *Intracranial Hemorrhage Non-transfer Protocol*. VM Memorial Hospital. Yakima, WA. January 11, 2018
49. **Farrokhi FR**. *Deep Brain Stimulation: Common and Unique Complications*. Swedish Neuroscience Institute, Cranial Conference, Seattle, WA. November 8, 2017.
50. **Farrokhi FR**. *What makes a Neurosurgeon Nervous*. Peninsula Cancer Center. Poulsbo, WA. November 2, 2017.
51. **Farrokhi FR**. *Considering Deep Brain Stimulation: Why do it? What is available?* APDA/NWPF Hope Conference. Bellevue, WA. October 7, 2017.
52. Schiess M, et al, **Farrokhi FR**, Palfi S. *Health related quality of life as measured by EQ-5D in Parkinson's Disease with DBS Therapy: Preliminary Results from the Product Surveillance Registry*. Movement Disorders Society Annual Conference. Vancouver, BC. June 2017.
53. **Farrokhi FR**. *Waste in the OR. Optimization of OR instrumentation*. VM NSI Vesting Professor Lecture. Seattle, WA. March 2017
54. **Farrokhi FR**. *Deep Brain Stimulation and Movement Disorders*, Neuroscience Institute, Grand Rounds, Virginia Mason Medical Center, Seattle, WA. November 2016.
55. Yanamadala V, Fowler G, Buchlak QD, Wright AK, **Farrokhi FR**, Leveque JC, Sethi RK. *Perioperative Transfusion Threshold of Hemoglobin ≥ 9.0 mg/dL Results in Better Early Ambulation and Shorter Length of Stay for Patients Undergoing Complex Spine Surgery*. Poster Presentation. Wilske Symposium, Virginia Mason Medical Center, Seattle, WA, September 2016.
56. **Farrokhi, FR**. *DBS for Multiple Sclerosis Related Tremor. Oral Presentation. State-Of-The-Art Treatment of Movement Disorders*, Seattle Science Foundation, Seattle, WA. September 2016.
57. Martin BI, Tosteson ANA, Lurie JD, **Farrokhi FR**, McGuire KJ, Mirza SK. *Early effects of Medicare's Bundle Payment for Care Improvement program for lumbar fusion on episode costs, volume, and safety*. Poster Presentation. North American Spine Society (NASS), NASS2016, Boston, MA, October 2016.
58. Martin BI, Tosteson ANA, Lurie JD, **Farrokhi FR**, McGuire KJ, Mirza SK. *Early effects of Medicare's Bundle Payment for Care Improvement program for lumbar fusion on episode costs, volume, and safety*. Poster Presentation. The International Society for the Study of the Lumbar Spine, ISSLS Annual Meeting, Singapore, May 2016.
59. Pyle A, Kowalczyk M, **Farrokhi FR**. *Effectiveness of a Clinical Care Pathway on Improving Care for Lumbar Spine Fusion Patients*. Poster Presentation, Institute for Healthcare Improvement, Scientific Symposium. Orlando, FL. December 2014.
60. **Farrokhi FR**, Taylor L, Pham H. *Team approach to the care of the neuro-oncological patient*. Oral Presentation, Grand Rounds. Virginia Mason Medical Center. Seattle, WA. December 2014.

61. **Farrokhi FR**, *What to Consider When Considering DBS*. Oral Presentation, Northwest Parkinson's Foundation Support Group. Kirkland, WA. November 2014.
62. **Farrokhi FR**, *Considerations in Deep Brain Stimulation Surgery*. Webinar. Northwest Parkinson's Foundation. September 2014.
63. **Farrokhi FR**, Leveque JC, Nussbaum C. *Management of Sellar and Suprasellar Neoplasms: Endoscope vs. Microscope*, Endoscopic Skull Base Surgery Course. Seattle, WA. August 2014.
64. **Farrokhi FR**, *Neurosurgical Post-operative Care*. Oral Presentation, US Healthworks Medical Symposium. Dana Point, CA. June 2014.
65. **Farrokhi FR**, *Parkinson's Update 2014*. Oral Presentation, Northwest Parkinson's Foundation Board Retreat. Kirkland, WA. May 2014.
66. Martin BI, Lurie JD, Deyo RA, Tosteson AN, **Farrokhi FR**, Mirza SK. *Trends in the use of Bone Morphogenetic Protein among Patients Undergoing Fusion for Degenerative Diagnoses in the United States, 2002-2011*. Oral Presentation, International Society for the Study of the Lumbar Spine. Seoul, Korea. June 2014.
67. Lisse, G, **Farrokhi FR**, Alsedi, A. *Socially Responsible Practice in The Operating Room*; Oral Presentation at the Scientific Session of the ASE 2014 Annual Meeting; Chicago, IL, April 2014.
68. **Farrokhi, FR**. *Clinical Update in Parkinson's Disease*. Invited Speaker at Northwest Parkinson's Foundation Annual Board Retreat. Seattle, WA. May 2013.
69. **Farrokhi, FR**. *Surgical Management of Parkinson's Disease*, Invited Speaker at the 24th Annual Pacific Northwest Ambulatory Care Nursing Conference, Lynwood, WA. May 2013.
70. **Farrokhi, FR**. *Systems Based Practice*, Invited Speaker at Grand Rounds, Virginia Mason Medical Center. Seattle, WA. December 2012.
71. Gunther M, Nizamani R, Roubicek M, Berger J, Williams B, Blackmore C, **Farrokhi FR**, *Waste Reduction in Operating Room Instrument Supply Chain by Application of the Virginia Mason Production System*, Institute for Healthcare Improvement: 24th Annual National Forum on Quality Improvement in Health Care, Orlando, FL. December 2012.
72. Porter A, **Farrokhi F**, Narimasu J, Koehler R, Mulroy M. *Sustainable Effective Implementation of a Surgical Pre-Procedural Checklist: an "Attestation" Format for all Team Members*, Institute for Healthcare Improvement: 24th Annual National Forum on Quality Improvement in Health Care. Orlando, FL. December 2012.
73. **Farrokhi FR**. *Surgical Treatment of Parkinson's Disease, Neuroscience Update for Primary Care*, Virginia Mason Medical Center. Seattle, WA. October 2012.
74. Nizamani R, Roubicek M, Berger J, Crosby I, Holcomb L, Nilsson K; Vosburg W, Aeyung R, **Farrokhi F**. *Development of a Process to Reduce Waste in Sterile Instrumentation: A Novel Application of the Virginia Mason Production System* National Association for Healthcare Quality 37th Annual Educational Conference, Tampa, FL. September 2012.
75. Gunther M, Roberts J, Berger J, McHenry K, **Farrokhi F**. *Improving Deep Brain Stimulation Case Efficiency by Application of Virginia Mason Production System (VMPS)*. The MDS 16th International Congress of Parkinson's Disease and Movement Disorders. Dublin, Ireland June 2012.
76. Roubicek M, Berger J, Crosby I, Holcomb L, Nilsson K; Vosburg W, **Farrokhi F**. *Improving Efficiency in the Use of MIS Sets by the Application of Virginia Mason Production System*. AORN Congress. New Orleans, LA. March 2012.
77. **Farrokhi FR**. *SLADH vs CSW in Subarachnoid Hemorrhage Patients. Triple HHH and Hypertonic Saline Therapy*. Nursing CNE, Virginia Mason Medical Center. Seattle, WA. December 2011.
78. **Farrokhi FR**. *Spine Surgery Review*, Nursing CNE, Virginia Mason Medical Center. Seattle, WA. June 2007.
79. **Farrokhi FR**. *Surgical Treatment of Parkinson's Disease*, Neuroscience Grand Rounds, Virginia Mason Medical Center. Seattle, WA. October 2006.
80. Campos CV, Zhang F, Son MG, Sprague SM, **Farrokhi FR**, Vollmer DG. *Topical L-arginine, but not nitric oxide donor, restores cerebrovascular pressure autoregulation following traumatic brain injury in rats: Possible role of endothelial nitric oxide synthase*. Top finalists in the poster competition. First Joint Symposium of the 20th Annual National Neurotrauma Society & The 6th Annual International Neurotrauma Meeting. Tampa, FL. October 2002.
81. **Farrokhi FR**, Zhang F, Son M, Vollmer DG. *Mechanisms of Neuronal Nitric Oxide Inhibition and Attenuation of Cerebrovascular Reactivity*, Society for Neuroscience Annual Meeting. Orlando, FL. November 2002.

82. **Farrokh FR**, Brown SW, Vollmer DG, Startzell JM, Edgin W, Simmons NE. *An Anatomic Comparison of the Extended Transsphenoidal and LeFort Osteotomy Approaches*, Congress of Neurological Surgeons Annual Meeting, Philadelphia, PA. September 2002.
83. **Farrokhi F**, Zhang F, Son M, Sprague S, Campos C, Vollmer DG. *Neuronal nitric oxide synthase activity is important after traumatic brain injury: The beneficial effects of 7-nitroindazole are independent of nNOS inhibition*. Annual Meeting of the Congress of Neurological Surgeons, Philadelphia, PA. September 2002.
84. Zhang F, Son MG, Sprague SM, Campos CV, Henry MH, **Farrokhi FR**, Vollmer DG. *NO donor and L-arginine reverse the attenuation of cerebral vascular reactivity to hypercapnia following traumatic brain injury in rat: Role of neuronal NO synthase*. Annual Meeting of the Society for Neuroscience. San Diego, CA. November 2001.
85. **Farrokh FR**, Zhang F, Son M, Vollmer DG. *The Effects of 7-Nitroindazole in Traumatic Brain Injury: Mechanisms of Neuronal Nitric Oxide Synthase Inhibition and Cerebrovascular Reactivity*, Aust Surgical Society Annual Research Symposium. San Antonio, TX. June 2002.
86. Campos C, Zhang F, Son M, Sprague S, **Farrokhi FR**, Henry MN, Vollmer DG. *Role of Neuronal NOS in Cerebrovascular Response Following Traumatic Brain Injury*, Society for Pediatric Critical Care Annual Meeting. San Diego, CA. September 2001.
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89. **Farrokhi FR**, Harper G, Vollmer DG. *Traumatic Atlanto-occipital Dislocation Managed with "360°" Atlanto-occipital Fusion*, Texas Association of Neurosurgeons Annual Meeting, June 2000.
90. **Farrokhi FR**. *Surgical Management of Arachnoid Cysts*, Neurosurgery Grand Rounds. Baylor College of Medicine. Houston TX. November 1997.

Books/Book Chapters

1. Sharma MR, Dahal S, Sedain G, **Farrokhi F**; *Decision making in Pediatric Emergencies: Approach, Investigations and Treatment: Approach to Pediatric Emergencies*, 2023.
2. Buchlak QD, Esmaili N, Bennett C, **Farrokhi F**. *Natural Language Processing Applications in the Clinical Neurosciences: A Machine Learning Augmented Systematic Review* in Machine Learning in Clinical Neuroscience, VE Staartjes, L Regli, C Serra, 2022.
3. **Farrokhi FR** as Medical Editor for Joseph Keon's *The Alzheimer's Revolution: An Evidence-Based Lifestyle Program to Build Cognitive Resilience And Reduce Your Risk of Alzheimer's Disease*; Hatherleigh Press, Sep 6, 2022.
4. Kowalczyk M, Mecklenburg R, Kartunen A, **Farrokhi FR**. *Chapter 4: The Bree Collaborative: Standardizing Appropriateness and Quality in Lumbar Fusion*, in ISSSL Online Spine Textbook, Hart R, Luk K, Gunzberg R, 2020. <https://www.wheelsonline.com/issls/contents/>
5. **Farrokhi FR**, Dailey A. *Ossification of the Posterior Longitudinal Ligament*, in Surgical Anatomy and Techniques to the Spine, Kim DH, Vaccaro A, Dickman C, Cho D, Lee S. 2005.

Videos

"Deep Brain Stimulation Surgery: A New Frontier in Medicine". Patient Education Video. Virginia Mason Medical Center. 2010.

LANGUAGES

English, Farsi

EXHIBIT 12



ACADEMIC CATALOG

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User Experience (UX) and Design Thinking Graduate Certificate (UEDT-CERTD)



CIP Code: 140501

In this three course certificate program, you will learn:

- how to use latest skills and tools to create and evaluate user experience (UX);
- concepts related to UX, usability and design thinking;
- to apply the iterative process of user-centered design thinking;
- techniques related to low- and high fidelity prototype creation;
- user-interface (UI) prototyping tools such as Axure, MIT app inventor.

This certificate can be completed in one year (three semesters). Required courses in the certificate program are:

- IHE 6300 Fundamentals of Human Factors Engineering
- IHE 6320 Human-System Interaction and Design Thinking Principles
- IHE 7340 User Experience Design for Mobile Computing

Students who have completed ISE 4300 and/or ISE 4320 will be required to take one or both of the following courses to fulfill the certificate requirements:

- IHE 6830 Engineering Project Management and Applications
- IHE 7020 Systems Engineering and Analysis

Admission to this certificate program requires a completed bachelor's degree with a 2.7 or higher GPA. certificate may be earned as part of a graduate degree program or as a stand alone certificate for a non-graduate student.

For more information, visit <https://engineering-computer-science.wright.edu/biomedical-industrial-and-human-factors-engineering>.

Required Courses

- [IHE 6300 - Fundamentals of Human Factors Engineering](#) Credit Hour(s): 3
- [IHE 6320 - Human-System Interaction and Design Thinking Principles](#) Credit Hour(s): 3
- [IHE 7340 - User Experience Design for Mobile Computing](#) Credit Hour(s): 3

Alternative Courses

Students who are ineligible to take IHE 6300 and/or IHE 6320 should select one or both of these courses to fulfill certificate requirements.

- [IHE 6830 - Engineering Project Management and Applications](#) Credit Hour(s): 3
- [IHE 7020 - Systems Engineering and Analysis](#) Credit Hour(s): 3

Total: 9 Credit Hours



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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL CENTER,
INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**[PROPOSED] ORDER GRANTING THE COMMUNITY HOSPITALS’
MOTION TO EXCLUDE LEAPFROG’S EXPERT WITNESSES**

This matter comes before the Court on Plaintiffs the Community Hospitals’ Motion to Exclude Leapfrog’s Expert Witnesses. The Court, having reviewed the Motion, any response thereto, and all available evidence, hereby GRANTS the Community Hospitals’ Motion. Accordingly, it is hereby ORDERED and ADJUDGED that:

1. Leapfrog’s proffered expert witness Michael Vredenburgh is barred from testifying at any trial in this matter.
 - a. The Court holds that Mr. Vredenburgh and Leapfrog violated Federal Rule of Civil Procedure 26 because they did not timely disclose “the facts or data considered” by Mr. Vredenburgh “in forming” his opinions. Fed. R. Civ. P. 26(a)(2)(B)(ii). The Court further holds that this violation is not substantially justified or harmless, and accordingly that Mr. Vredenburgh’s exclusion from any trial in this matter is an appropriate sanction under Federal Rule of Civil Procedure 37(c)(1).

- b. Mr. Vredenburgh's Opinion One is that Leapfrog's website design ensures clarity and transparency for reasonable consumers. The Court holds that Mr. Vredenburgh's Opinion One is inadmissible under Federal Rule of Evidence 702 and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), because Mr. Vredenburgh is not qualified to offer this opinion and the opinion is irrelevant, unhelpful, and unreliable.
- c. Mr. Vredenburgh's Opinion Two is that Leapfrog's website is accessible to a general audience. The Court holds that Mr. Vredenburgh's Opinion Two is inadmissible under Federal Rule of Evidence 702 and *Daubert* because Mr. Vredenburgh is not qualified to offer this opinion and the opinion is irrelevant, unhelpful, and unreliable.
- d. Mr. Vredenburgh's Opinion Three is that hospitals' scores on the Four Measures for which Leapfrog's Safety Grade methodology imputes scores are readily clear on Leapfrog's website to users with basic reading comprehension. The Court holds that Mr. Vredenburgh's Opinion Three is inadmissible under Federal Rule of Evidence 702 and *Daubert* because Mr. Vredenburgh is not qualified to offer this opinion and the opinion is irrelevant, unhelpful, and unreliable.
- e. Mr. Vredenburgh's Opinion Four is that Leapfrog's user-experience testing validates the clarity of Leapfrog's website. The Court holds that Mr. Vredenburgh's Opinion Four is inadmissible under Federal Rule of Evidence 702 and *Daubert* because Mr. Vredenburgh is not qualified to offer this opinion and the opinion is unhelpful and unreliable.

- f. Mr. Vredenburg's Opinion Five is that Google Analytics data demonstrates high user engagement with full page content on Leapfrog's website, ensuring visibility of key disclosures. Mr. Vredenburg has withdrawn this opinion and therefore the Court holds that it is inadmissible.
- 2. Leapfrog's proffered expert witness Dr. Farrokh Farrokhi is barred from testifying at any trial in this matter.
 - a. The Court holds that Dr. Farrokhi and Leapfrog violated Federal Rule of Civil Procedure 26 because they did not timely disclose "a complete statement of all opinions [that Dr. Farrokhi] will express and the basis and reasons for them." Fed. R. Civ. P. 26(a)(2)(B)(i). The Court further holds that this violation is not substantially justified or harmless, and accordingly that Dr. Farrokhi's exclusion from any trial in this matter is an appropriate sanction under Federal Rule of Civil Procedure 37(c)(1).
 - b. Dr. Farrokhi's Opinion One is that Leapfrog's Safety Grades improve hospital quality. Dr. Farrokhi has withdrawn this opinion and therefore the Court holds that it is inadmissible.
 - c. Dr. Farrokhi's Opinion Two is that Leapfrog's Hospital Survey improves hospital quality. The Court holds that Dr. Farrokhi's Opinion Two is inadmissible under Federal Rule of Evidence 702 and *Daubert* because Dr. Farrokhi is not qualified to offer this opinion and the opinion is irrelevant, unhelpful, and unreliable.
 - d. Dr. Farrokhi's Opinion Three is that hospitals can use Leapfrog's Hospital Survey to benchmark themselves against peer hospitals. The Court holds that Dr. Farrokhi's Opinion Three is inadmissible under Federal Rule of Evidence 702

and *Daubert* because Dr. Farrokhi is not qualified to offer this opinion and the opinion is irrelevant, unhelpful, and unreliable.

- e. Dr. Farrokhi's Opinion Four is that Leapfrog's Hospital Survey is a reliable methodology. The Court holds that Dr. Farrokhi's Opinion Four is inadmissible under Federal Rule of Evidence 702 and *Daubert* because Dr. Farrokhi is not qualified to offer this opinion and the opinion is unhelpful and unreliable.
 - f. Dr. Farrokhi's Opinion Five is that Leapfrog's Hospital Survey is not burdensome. The Court holds that Dr. Farrokhi's Opinion Five is inadmissible under Federal Rule of Evidence 702 and *Daubert* because Dr. Farrokhi is not qualified to offer this opinion and the opinion is unhelpful and unreliable.
3. Leapfrog's proffered expert witness Mark Rule is barred from testifying at any trial in this matter.
- a. Mr. Rule's Opinion One is that the Community Hospitals' experts did not quantify the damages incurred by the Community Hospitals. The Court holds that Mr. Rule's Opinion One is inadmissible under Federal Rule of Evidence 702 and *Daubert* because it is irrelevant and unhelpful.
 - b. Mr. Rule's Opinion Two is that Leapfrog's Safety Grade methodology is not a significant driver of the Community Hospitals' resulting "D" and "F" Safety Grades. The Court holds that Mr. Rule's Opinion Two is inadmissible under Federal Rule of Evidence 702 and *Daubert* because Mr. Rule is not qualified to offer this opinion and the opinion is irrelevant, unhelpful, and unreliable.
4. Leapfrog's proffered expert witness Dr. Anthony Harris is barred from testifying at any trial in this matter.

- a. Dr. Harris's Opinion One is that Leapfrog's Safety Grade methodology is reasonable and ethical. The Court holds that Dr. Harris's Opinion One is inadmissible under Federal Rule of Evidence 702 and *Daubert* because it is unhelpful and unreliable.
- b. Dr. Harris's Opinion Two is that nonresponse bias is real and should be accounted for in a hospital grading methodology. The Court holds that Dr. Harris's Opinion Two is inadmissible under Federal Rule of Evidence 702 and *Daubert* because it is unhelpful and unreliable.
- c. Dr. Harris's Opinion Three is that the Community Hospitals are underperformers regardless of the scores they receive on the Four Measures for which Leapfrog's Safety Grade methodology imputes scores. The Court holds that Dr. Harris's Opinion Three is inadmissible under Federal Rule of Evidence 702 and *Daubert* because it is irrelevant, unhelpful, and unreliable.
- d. Dr. Harris's Opinion Four is that the methodology used by one of the Community Hospitals' experts, Dr. Sean Nicholson, to determine what the Community Hospitals' Safety Grades would have been had they participated in Leapfrog's Hospital Survey, is flawed. The Court holds that Dr. Harris's Opinion Four is inadmissible under Federal Rule of Evidence 702 and *Daubert* because it is unhelpful and unreliable.
- e. Dr. Harris's Opinion Five is that Leapfrog's Safety Grade methodology is the closest to the truth of what non-participating hospitals' Safety Grades would have been had they participated in Leapfrog's Hospital Survey. The Court holds that Dr. Harris and Leapfrog violated Federal Rule of Civil Procedure 26 because they

did not timely disclose this opinion and the basis and reasons for it. Fed. R. Civ. P. 26(a)(2)(B)(i). The Court further holds that this violation is not substantially justified or harmless, and accordingly that exclusion of this opinion from any trial in this matter is an appropriate sanction under Federal Rule of Civil Procedure 37(c)(1). The Court further holds that Dr. Harris's Opinion Five is inadmissible under Federal Rule of Evidence 702 and *Daubert* because it is unhelpful and unreliable.

DONE AND ORDERED in the Southern District of Florida on [].

DATED _____

Donald M. Middlebrooks
United States District Judge