

Municipal Secondary Market Disclosure Information Cover Sheet

This cover sheet should be sent with all submissions made to the Municipal Securities Rulemaking Board, Nationally Recognized Municipal Securities Information Repositories, and any applicable State Information Depository, whether the filing is voluntary or made pursuant to Securities and Exchange Commission rule 15c2-12 or any analogous state statute.

See www.sec.gov/info/municipal/nrmsir.htm for list of current NRMSIRs and SIDs

IF THIS FILING RELATES TO A SINGLE BOND ISSUE:

Provide name of bond issue exactly as it appears on the cover of the Official Statement
(please include name of state where issuer is located):

\$25,040,000

Garden City Hospital Finance Authority (Michigan)

Hospital Revenue and Refunding Bonds, Series 1998A

Garden City Hospital Obligated Group

Provide nine-digit CUSIP* numbers if available, to which the information relates:

365128AE7

365128AF4

(originally assigned)

365128AJ6

365128AK3

(new - prerefunded)

365128AL1

365128AM9

(new - unrefunded balance)

IF THIS FILING RELATES TO ALL SECURITIES ISSUED BY THE ISSUER OR ALL SECURITIES OF A SPECIFIC CREDIT OR ISSUED UNDER A SINGLE INDENTURE:

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Other Obligated Person's Name (if any): _____

(Exactly as it appears on the Official Statement Cover)

Provide six-digit CUSIP* number(s), if available, of Issuer: _____

*(Contact CUSIP's Municipal Disclosure Assistance Line at 212.438.6518 for assistance with obtaining the proper CUSIP numbers.)

TYPE OF FILING:

Electronic (number of pages attached) 36 Paper (number of pages attached) _____

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Municipal Secondary Market Disclosure Information Cover Sheet

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See www.sec.gov/info/municipal/nrmsir.htm for list of current NRMSIRs and SIDs

IF THIS FILING RELATES TO A SINGLE BOND ISSUE:

Provide name of bond issue exactly as it appears on the cover of the Official Statement
(please include name of state where issuer is located):

\$46,870,000

Garden City Hospital Finance Authority (Michigan)

Hospital Revenue and Refunding Bonds, Series 2007A

Garden City Hospital Obligated Group

Provide nine-digit CUSIP* numbers if available, to which the information relates:

365128AG2

365128AH0

IF THIS FILING RELATES TO ALL SECURITIES ISSUED BY THE ISSUER OR ALL SECURITIES OF A SPECIFIC CREDIT OR ISSUED UNDER A SINGLE INDENTURE:

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Electronic (number of pages attached) 36 Paper (number of pages attached) _____

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WHAT TYPE OF INFORMATION ARE YOU PROVIDING? (Check all that apply)

A. Annual Financial Information and Operating Data pursuant to Rule 15c2-12
(Financial information and operating data should not be filed with the MSRB.)

Fiscal Period Covered: _____

B. Audited Financial Statements or CAFR pursuant to Rule 15c2-12

Fiscal Period Covered: _____

C. Notice of a Material Event pursuant to Rule 15c2-12 (Check as appropriate)

- | | |
|--|--|
| 1. <input type="checkbox"/> Principal and interest payment delinquencies | 6. <input type="checkbox"/> Adverse tax opinions or events affecting the tax-exempt status of the security |
| 2. <input type="checkbox"/> Non-payment related defaults | 7. <input type="checkbox"/> Modifications to the rights of security holders |
| 3. <input type="checkbox"/> Unscheduled draws on debt service reserves reflecting financial difficulties | 8. <input type="checkbox"/> Bond calls |
| 4. <input type="checkbox"/> Unscheduled draws on credit enhancements reflecting financial difficulties | 9. <input type="checkbox"/> Defeasances |
| 5. <input type="checkbox"/> Substitution of credit or liquidity providers, or their failure to perform | 10. <input type="checkbox"/> Release, substitution, or sale of property securing repayment of the securities |
| | 11. <input type="checkbox"/> Rating changes |

D. Notice of Failure to Provide Annual Financial Information as Required

E. Quarterly or Monthly Financial Information and Operating Data
(Financial information and operating data should not be filed with the MSRB.)

Period Covered: _____

F. Other Secondary Market Information (Specify): Hospital Consultant's Report and Recommendations

I hereby represent that I am authorized by the issuer or obligor or its agent to distribute this information publicly:

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Telephone _____ Email Address _____

**GARDEN CITY HOSPITAL OBLIGATED GROUP
6215 INKSTER ROAD
GARDEN CITY, MI 48135**

ANNOUNCEMENT

DATED: MARCH 18, 2011

In the Officer's Certificate dated January 31, 2011 and delivered in accordance with Section 5.10(b)(iii) of the Loan Agreement between Garden City Hospital (the Corporation) and the Garden City Hospital Finance Authority, dated as of February 15, 2007 (the Loan Agreement), the Corporation disclosed that the Obligated Group (of which the Corporation is the sole Member) failed to comply with the Debt Service Coverage Ratio financial covenant, as required by Section 501(b)(ii) of the Amended and Restated Master Indenture and Security Agreement between the Corporation and Wells Fargo Bank, N.A., as Master Trustee, dated as of February 15, 2007 (the Master Indenture), with respect to the Fiscal Year ended September 30, 2010. The Corporation further disclosed that it expected to cure such non-compliance by engaging a Hospital Consultant no later than February 28, 2011, as required by Section 501(c) of the Master Indenture. In an Announcement dated February 28, 2011, the Corporation announced the engagement of Care Management Solutions, LLC (CMS) as the Hospital Consultant. All capitalized terms used herein are as defined in the Loan Agreement or in the Master Indenture.

Attached hereto is the initial report and recommendations of the Hospital Consultant, as required by Section 501(c) of the Master Indenture. The Corporation commenced the implementation of CMS' recommendations shortly after the delivery of this report. The implementation of Phase I has been completed. Implementation of Phase II began today, and is expected to be completed in mid-May. Implementation of Phase III is expected to commence thereafter, with its completion scheduled for approximately two months thereafter. Though not formally adopted by the Corporation's governing board, Corporation management represents that the governing board is fully aware that CMS' recommendations are being implemented. To conclude compliance with Section 501(c) of the Master Indenture, the Corporation will deliver a follow-up report of CMS after Phase III has been completed.

Garden City Hospital

**ASSESSMENT OF
CARE STATUS DETERMINATION
AND
REVIEW OF CLINICAL DOCUMENTATION
IMPROVEMENT PROCESS**

Prepared by

CARE MANAGEMENT SOLUTIONS

October 29, 2010

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I. EXECUTIVE SUMMARY

Executive Summary

In September of 2010, Garden City Osteopathic Hospital engaged Care Management Solutions, LLC to assess and evaluate the Hospital's care status determination practice and outcomes. Secondly, GCH was interested in a brief review of its current Clinical Documentation Improvement process. The executive leadership team also had concerns about Inpatient length of stay and several solutions to improve patient throughput were being explored.

The engagement approach included data analysis, clinical record review, and structured interviews with process participants and key stakeholders. This report includes the findings of the assessment along with summary conclusions, recommendations for performance improvement, and detailed financial projections.

Our assessment findings demonstrate the Hospital's opportunity to significantly improve financial performance. Financial projections indicate the Hospital is likely forfeiting two point three million dollars in Medicare reimbursement annually due to over-utilization of Outpatient bed assignments (Observation & Extended Surgical Recovery). Furthermore, there is a potential for GCH to increase its Medicare Case Weight Index by implementing a comprehensive Clinical Documentation Improvement (CDI) model. We estimate the addition compliant Medicare revenue associated with a successful CDI approach would surpass one point four million dollars annually.

The Hospital's Inpatient length of stay is almost twenty-five percent (25%) longer than would be anticipated. Success in CDI endeavors may mitigate this disparity somewhat, but certainly not fully. While the Hospital's medical model, availability of diagnostic services, and medical decision making practice may all contribute to extended lengths of stay, the Hospital will need to look at optimizing patient care progression systems and Case Management services to overcome barriers to timely patient discharge.

Specifically we are recommending a three (3) phase approach to accomplishing the Hospital's stated goals. They are Patient Access, Concurrent Coding and Clinical Documentation Improvement, and Patient Care Progression and Length of Stay Management. The phases are prioritized based upon the anticipated impact on Garden City Hospital's mission effectiveness, and financial and compliance objectives. Phases are sequenced in a "building block" design so that the outcome of each objective brings forth the requisite inputs for the next phase.

II. DETAILED FINDINGS

A. DATA ANALYSIS

Study Period:

Patient discharges occurring between October 1, 2009 and June 30, 2010 (FY 2010 – Q1 through Q3)

Study Population:

All Medicare Primary Payer patient discharges including Inpatients, Medical Observation, and Post-Surgical Extended Recovery

Data Elements:

Patient identifier, attending physician, primary payer, referral source, diagnosis / procedure codes / text, associated charges, actual reimbursement, and length of stay

Analysis Findings:

MEDICARE INPATIENT

During the nine (9) month study period, Garden City Hospital discharged three thousand, one hundred and fifty-one (3,151) Medicare Inpatients. Seventy-nine percent (79%) of these patients were discharged with Medical DRGs and twenty-one percent (21%) were discharged with Surgical DRGs. This medical / surgical ratio is within the range typically reported by community hospitals.

Eight percent (8%) of total Inpatients were discharged with one day length of stay (excluding deaths, AMA, and transfers to other short term acute care hospitals). The occurrence of these one day stays (ODS) in the medical population was five point four percent (5.4%). The incidence of ODS discharges at GCH declined from seven point four percent (7.4%) in Q3 FY 2007 to four point five percent (4.5%) in Q2 FY 2010 while the statewide median remained relatively flat at ten point five and ten point six percent (10.5-10.6%) respectively. The statewide eightieth percentile is fourteen point four percent (14.4%).

Medicare One Day Inpatient Stay – Comparative Data

	Q3 FY 2007	Q2 FY 2010	Change
Garden City Hospital	7.4%	4.5%	-2.9%
Statewide Median	10.5%	10.6%	+0.1%
Statewide 80 th Percentile	14.4%	14.4%	0

In Q2 FY 2010, which is the most current available comparative data, GCH ranked in the statewide third percentile for percent of medical discharges with ODS. This indicator is highly reflective of the Hospital’s care status determination practice. It means that ninety-seven percent (97%) of Michigan hospitals are reporting a larger proportion of ODS discharges. These metrics indicate the likelihood that GCH is substituting Observation care for medically necessary short stay Inpatient admissions.

Comparative data related to Medical AND Surgical discharges in totality are similar. However, the occurrence of ODS Surgical cases is highly dependant on each hospital’s book of surgical business (i.e., extracranial, percutaneous vascular, and back procedures). In Q2 FY 2010, which is the most current available comparative data, GCH ranked in the statewide second percentile for percent of ALL Medicare discharges with ODS.

The Center for Medicaid and Medicare Services (CMS) has issued concerns about medically unnecessary three (3) day Inpatient stays which result in Skilled Nursing Facility (SNF) placement. Hospitals have been looking carefully at these volume statistics to predict potential Recovery Audit Contractor (RAC) risk.

Medicare Inpatient Three Day LOS Transferred to SNF – Comparative Data

	Q3 FY 2007	Q2 FY 2010	Change
Garden City Hospital	13.3%	12.9%	-0.4%
Statewide Median	17%	20.4%	+3.4%
Statewide 80 th Percentile	29.5%	28.7%	-0.8%

GCH ranked in the statewide eighth percentile for percent of three (3) day Inpatient stays which resulted in Skilled Nursing Facility (SNF) placement. This means that ninety-two percent (92%) of Michigan hospitals are reporting a larger proportion of Inpatient three (3) day stays transferred to SNF upon hospital discharge. Again, these indicators raise questions about the Hospital’s care status determination practice. Namely, “Are the Medicare beneficiaries served able to appropriately access SNF benefits?”

MEDICARE OBSERVATION

During the nine (9) month study period, Garden City Hospital discharged five-hundred and ninety-four (594) Medicare Observation patients. Ninety-eight percent (98%) of these cases were referred from the Emergency Department. The Hospital’s August 2009 ED Admission Report indicates thirty-four percent (34%) of total ED admissions were assigned to Outpatient beds.

Observation cases represented nineteen percent (19%) of the total Hospital *Medical* discharge volume. Hospitals with effective care status determination systems are reporting values less than or equal to twelve percent (12%).

The LOS range associated with this population was two (2) hours to one-hundred and ninety-four (194) hours. Almost one-half of these cases had LOS greater than twenty-three (23) hours. See Appendix A.

Medicare Medical Observation – Length of Stay Distribution

	2-23 hours	24-48 hours	Greater than 48 hours
Volume	311	226	57
Percent	52%	38%	10%

As stated in the CMS Manual System, Pub 102 Medicare Benefit Policy, Transmittal 42, December 16, 2005 (Implementation Date January 3, 2006), “In the majority of cases the decision whether to discharge a patient from the Hospital following resolution of the reason for the observation care or to admit the patient as an Inpatient can be made in less than 48 hours, usually less than 24 hours. In only rare and exceptional cases do reasonable and necessary Outpatient services span more than 48 hours.” The volume of GCH extended Observation LOS indicates the likelihood that GCH is substituting Observation care for medically necessary Inpatient admissions.

The most frequently encountered diagnosis in this population was Chest Pain representing twenty-six percent (26%) of the total. Forty-five percent (45%) of these cases had LOS greater than twenty-three (23) hours. “Best Practice” hospitals are reporting Observation care LOS ranges of eight (8) to eighteen (18) hours for this diagnosis and have achieved this level of performance using standardized Chest Pain protocols.

Syncope and Collapse was the second most frequently reported Observation diagnosis representing six percent (6%) of the total. As would be expected, diseases and disorders of the Circulatory and Gastrointestinal system represented the highest volumes of Observation diagnoses. The volume of Injury, Poisoning, and Toxic Effects of Drugs diagnoses was higher than would be expected representing seven percent (7%) of total Observation cases. This may, in part, be related to the Hospital’s stated difficulty in transferring patients to psychiatric care hospitals from the Emergency Department.

MEDICARE EXTENDED SURGICAL RECOVERY

During the nine (9) month study period, Garden City Hospital discharged three-hundred and forty-four (344) Medicare Extended Surgical Recovery patients. Eighty-four percent (84%) of these cases were scheduled surgeries referred from Surgical Recovery. The remaining sixteen percent (16%) were referred by the Emergency Department for unscheduled surgical procedures. Extended Surgical Recovery cases represented thirty-three percent (33%) of the total Hospital *Surgical* discharge volume.

The LOS range associated with this population was three (3) hours to one-hundred and thirty-one (131) hours. Almost three quarters of these cases had LOS greater than twenty-three (23) hours. See Appendix B.

Medicare Extended Surgical Recovery – Length of Stay Distribution

	2-23 hours	24-48 hours	Greater than 48 hours
Volume	94	197	52
Percent	27%	57%	15%

The Hospital routinely boards scheduled surgical cases with Extended Surgery Recovery care status. Medicare only recognizes Inpatient Surgery (DRG) and Outpatient Surgery (APC) status for surgical cases. The need for post-operative recovery beyond the reasonable and customary period of four (4) to six (6) hours can only be determined following the operative episode. Typically this occurs in surgical cases due to nausea, inability to void, or uncontrolled pain. As such, the need for Outpatient bed assignments in the Medicare population following surgery is typically five to ten percent (5%-10%) and LOS is rarely exceeds eighteen (18) hours.

Cases reported in this population included Hysterectomy, Mastectomy, large Ventral Hernia Repair, and Open Reduction-Internal Fixation of fractures. The volume of GCH Surgical Extended Recovery cases, surgical procedures performed, and LOS distribution indicates the likelihood that GCH is substituting Outpatient Surgical bed assignments for medically necessary Inpatient Surgery admissions.

COMPARATIVE PUBLIC DATA

Garden City Hospital leadership chose St. Mary Mercy Hospital in Livonia and Botsford Hospital in Farmington Hills as comparative hospitals. While the volume of Inpatient admissions increased at these hospitals during the time period of FY 2007 to FY 2009, GCH admissions decreased.

Inpatient Admission Volume – Comparative Public Data

	FY 2007	FY 2008	FY 2009	Change
Garden City Hospital	8,997	8,594	8,395	-6.7%
St. Mary Mercy Hospital	14,620	15,536	15,261	+4.4%
Botsford Hospital	15,543	16,516	16,628	+7%

With the transition to Medicare Severity Diagnosis Related Groups (MS-DRGs), CMS anticipated hospitals' Case Weight Index would increase over time due to a natural learning curve. The "Behavioral Offset" (4.8% over three years) was designed to mitigate increases in hospital reimbursement related to coding and documentation improvement over the initial three year period. During this time period, GCH's Case Weight Index decreased by four percent (4%) while the comparative hospitals increased in excess of the "Behavioral Offset" amount.

Case Weight Index – Comparative Public Data

	FY 2007	FY 2008	FY 2009	Change
Garden City Hospital	1.49	1.45	1.43	-4.0%
St. Mary Mercy Hospital	1.33	1.37	1.42	+6.8%
Botsford Hospital	1.34	1.37	1.42	+6.0%

In both FY 2008 and FY 2009, Garden City Hospital's Inpatient LOS Index was higher than any other hospital in the Detroit – Livonia – Dearborn MSA. Only three (3) hospitals in the state reported higher values.

Inpatient Length of Stay Index – Comparative Public Data

	FY 2007	FY 2008	FY 2009	Change
Garden City Hospital	1.15	1.24	1.24	+8.0%
St. Mary Mercy Hospital	1.09	1.12	1.08	-1.0%
Botsford Hospital	1.12	1.13	1.06	-5.4%

REIMBURSEMENT IMPACT

On average, the Hospital receives seven-thousand, two-hundred and one dollars (\$7,201) per Medicare Inpatient Medical discharge and one-thousand, sixty-three dollars (\$1,063) per Medicare Observation discharge. See Appendix C.

Medicare Medical per Case Reimbursement

	Average Charge/Case	Average Payment/Case	Reimbursement as a % of charges
One Day Medical Inpatient Stay	\$7,001	\$5,554	79%
Observation ≤ 24 hours	\$4,717	\$1,063	23%
Inpatient Medical Discharge	\$15,106	\$7,201	48%
Observation Discharge	\$5,571	\$1,134	20%

Assuming a fifty percent (50%) cost to charge ratio, the Hospital's Medicare reimbursement is covering less than one-half of the cost of care for the Observation patient population.

Medicare Surgical per Case Reimbursement

On average, the Hospital receives eighteen-thousand, three-hundred, and fifty-seven dollars (\$18,357) per Medicare Inpatient Surgical discharge and three-thousand, six-hundred, fifty-one dollars (\$3,651) per Medicare Extended Surgical Recovery discharge.

	Average Charge/Case	Average Payment/Case	Reimbursement as a % of charges
One Day Surgical Inpatient Stay	\$18,052	\$9,548	53%
Extended Surgical Recovery ≤ 24 hours	\$5,259	\$1,554	29%
Inpatient Surgical Discharge	\$32,934	\$18,357	56%
Extended Surgical Recovery Discharge	\$10,794	\$3,651	34%

Again, the Hospital's reimbursement for Surgical Outpatient bed assignments is likely falling short of actual costs.

B. CLINICAL RECORD REVIEW

Study Population:

All *Medicare Primary Payer* patient discharges including Inpatients, Medical Observation, and Post-Surgical Extended Recovery for the period of October 1, 2009 through June 30, 2010.

Sampling Method:

The goal of the Outpatient bed assignment case selection was identification of cases where the patient's diagnosis / procedure or length of stay was not consistent with that which would be expected. As such, the results of this Clinical Record Review CAN NOT be extrapolated to the total population. Fifteen (15) Observation cases and fifteen (15) Extended Surgical Recovery cases were selected for review.

Inpatient cases were selected to evaluate the medical necessity for Inpatient one-day stays and the clarity, consistency, and completeness of clinical record documentation. Seven (7) one-day Inpatient stay cases were selected along with three (3) other Inpatient cases with LOS five (5) to twelve (12) days.

Stratification Methodology:

For Inpatient cases, numeric risk classification of zero (0) to three (3) was assigned to each case based upon the likelihood of payment "take back" based upon CMS/RAC audit findings. For Observation and Extended Surgical Recovery cases (Outpatient bed assignments), numeric risk classification of zero (0) to three (3) was assigned to each case based upon the likelihood of payment "take back" if the case had been assigned to Inpatient status and subsequently selected for audit by CMS/RAC.

The Stratification definitions were based upon application of InterQual Criteria.

Risk Stratification Key:

0 = Met InterQual criteria for Medical Necessity of Inpatient Admission

1 = Signs / symptoms and treatment plan Met Severity of Illness and
 $\frac{2}{3}$ Intensity of Service

-OR-

Met Intensity of Service and narrowly missed Severity of Illness

2 = Met Severity of Illness

-OR-

Intensity of Service

3 = Did not meet Severity of Illness

-OR-

Intensity of Service

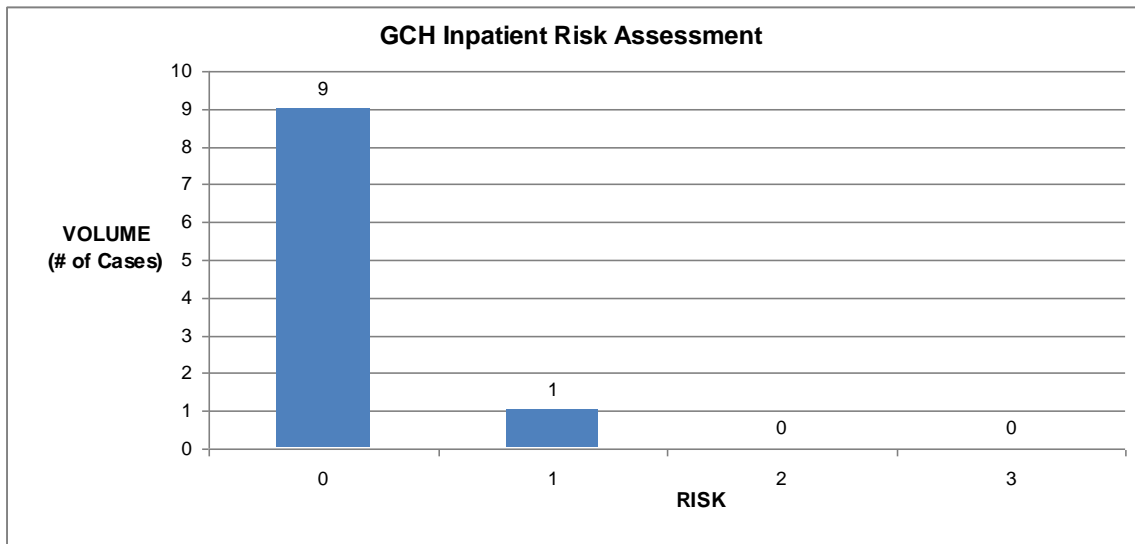
Cases assigned to Risk Level One (1) have a low propensity for payment “take back” upon audit / appeal while those assigned to Risk Level Three (3) would likely fail determination of medical necessity for Inpatient admission. For planning purposes, we estimate one-half of Risk Level Two (2) cases could be successfully appealed upon audit.

Review Findings:

MEDICARE INPATIENT

Ten (10) cases were selected representing less than one percent (1%) of total Inpatient discharges and three percent (3%) of Inpatient one-day stays. Ninety percent (90%) of the cases reviewed clearly met InterQual ISD Criteria for medical necessity of admission. Only one (1) case was classified as a Risk Level one (1) because the IV fluid rate was seventy (70) cc's per hour rather than seventy-five (75). The likelihood of failure to successfully appeal a payment denial for this case is very low.

The reviewer noted disclarity and incomplete documentation of CC's, MCC's, and Present on Admission (POA) indicators. In one (1) case, the coded discharge disposition was not correct.

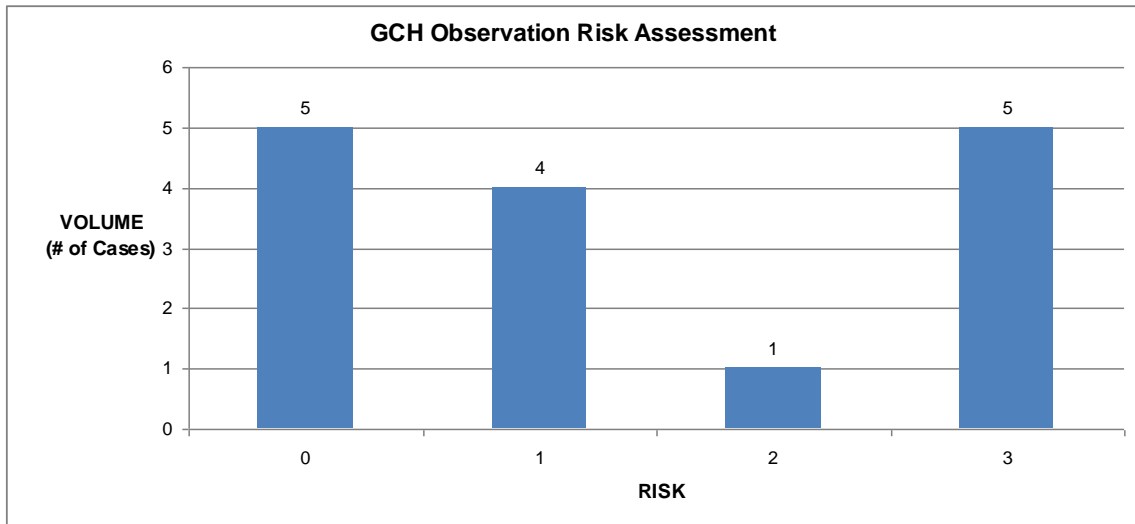


See Appendix D for detailed case review findings.

Based upon Data Analysis and clinical record review, GCH RAC risk for medical necessity of Inpatient admission is extremely low.

MEDICARE OBSERVATION

Fifteen (15) cases were selected representing two point five percent (2.5%) of the total population. The reviewer found the physician’s order for care status to be unclear in three (3) cases. In two (2) cases, the physician order was for Inpatient status. One of these cases was classified as risk level zero (0) while the second was classified as risk level one (1). In summary, the physician ordered care status was not consistent with the billed care status in one-third of the cases reviewed. In two (2) cases, the initial Inpatient order was changed to Observation. One of these cases clearly met InterQual ISD criteria for medical necessity of admission.

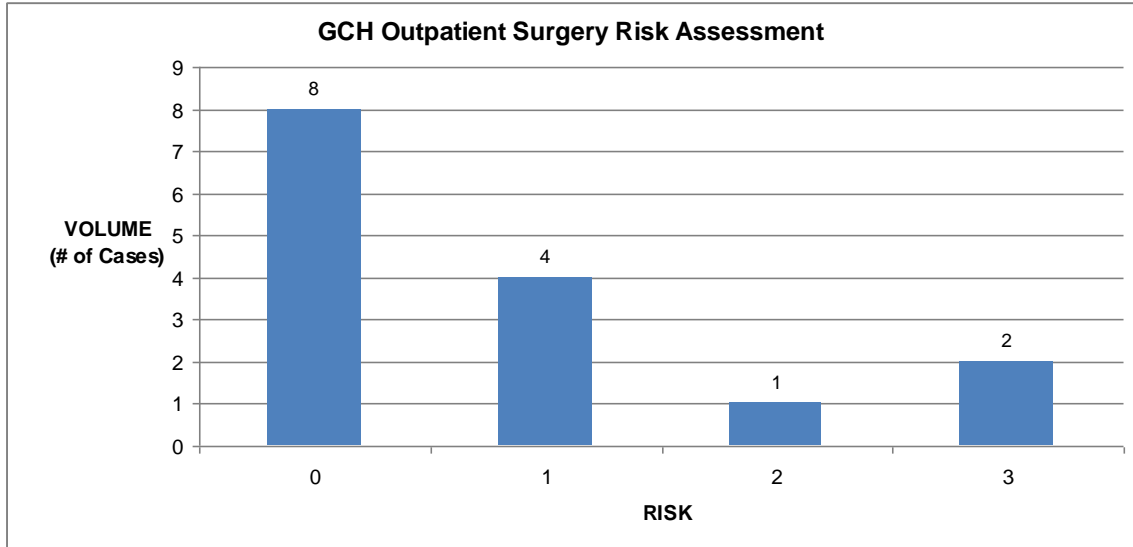


See Appendix E for detailed case review findings.

One-third of the cases reviewed met InterQual ISD criteria for medical necessity of Inpatient admission. It is likely one-half of the level one (1) cases would meet Inpatient criteria with additional documentation.

MEDICARE EXTENDED SURGICAL RECOVERY

Fifteen (15) cases were selected representing six percent (6%) of the total population. In two (2) cases, representing thirteen percent (13%) of the study population, the physician ordered care status was for Inpatient admission. One of these cases was classified as risk level zero (0) while the second was classified as risk level one (1).



See Appendix F for detailed case review findings.

Over one-half of the cases reviewed met InterQual Criteria for Inpatient admission. Only twenty percent (20%) of the cases reviewed were classified as a risk level two (2) or three (3).

C. STRUCTURED INTERVIEWS

The purpose of this component of the engagement was to:

- Determine the roles and goals of Garden City Hospital's Case Management process participants and key stakeholders
- Seek to identify any barriers to goal alignment
- Solicit data essential to the formulation of actionable solutions and recommendations

Structured interview participants included:

Name:	Representing:
Dr. Moorman	Chief Medical Officer
Dr. Ruettinger	Chair, Utilization Review Committee Past Chief of Staff
Dr. Marsh	Utilization Management Physician Advisor
Drs. Doig and Edge	Primary Care Medicine
Dr. Drouillard	Orthopedic Surgery
Dr. Kim	Emergency Medicine
Dr. Papisifakis	Cardiac Medicine
Dr. Spinale	General Surgery
Terri Kalinski	Patient Accounting
Shelley Clark and Kathy Ernst	Patient Registration
Annette Krupa	Surgical Boarding
Rosemary Schofield	Case Management
Carol Mahaney	Surgical Services / Observation Unit
Barb Coldren	Emergency Department
Andrea Merritt	Compliance and Risk Management
Donna Bellomo and Linda Collins	Health Information Management / Clinical Coding
Elizabeth Pepera	Surgical Nurse
Theresa Tannason	Observation Unit Nurse
Dee, Debbie, and Faith	Case Manager / Social Worker / UR

All interview participants were actively participative in dialogue, forthcoming with information, and eager to participate in performance improvement initiatives related to the engagement scope.

The summary of findings and overriding themes is as follows:

1. Case Management executive leadership shared five (5) priorities for the future direction of Case Management services. They are:
 - Expanding coverage to seven (7) days per week
 - Focus on the “front end” with physician documentation coaching
 - Clinical Documentation Improvement (CDI)
 - Patient flow
 - Increased collaboration between Case Management and Nursing
2. The Case Management department leadership directs staff members to focus on Inpatient LOS, Concurrent DRG coding, RAC / HDI appeals, and physician education aimed at minimizing RAC risk / payment denials for medical necessity of Inpatient admission. To that end, the Hospital’s HDI Inpatient necessity denials are less than one percent (1%) while other hospitals have experienced greater than fourteen percent (14%). Nurse Case Manager labor resources are allocated to the Inpatient units and ED. NCMs do not participate in surgical care status determination (pre-op or post-op) or Observation bed assignments.
3. Case Management is staffed by seven (7) Nurse Case Managers (NCM), four (4) Social Workers, one (1) Utilization Review Specialist, and two (2) data entry staff. One of the nurses is assigned to the Emergency Department Monday through Friday covering the evening shift hours. This nurse is largely focused on Psychiatric placements. The remaining six (6) nurses are assigned to the Inpatient care units. Review of Observation cases for care status determination is performed by the UR Specialist who is a HIM professional. This staff member also performs the UR function for obstetrical cases and assists the Case Managers with telephonic third party payer authorizations. Social Workers perform ECF, Psychiatric, and Hospice placements / referrals. One (1) NCM is on duty Saturday and Sunday during day time hours. This nurse is assigned to the ED but also assists with complex Inpatient discharges.
4. Case Managers do not reference InterQual Inpatient Criteria books when performing medical necessity case reviews. Instead they rely on clinical judgment. This is reportedly due to insufficient time to appropriately apply the criteria with the current staffing level. Case Management staff refers cases to the Physician Advisor (PA) if the Inpatient care status does not seem medically necessary. The PA then uses the InterQual Criteria book to review the case for determination of medical necessity of Inpatient admission. There is no formal referral / response process, documentation, or reporting mechanism.

5. Observation hours of care begin at the time the order is written. While Patient Accounting is aware this is not consistent with CMS guidelines which define Observation care begins at the time the patient is received in the Observation bed, the Hospital has not been able to implement a process for capturing the Observation “start time.”
6. The volume of care status changes, reportedly fifty (50) to seventy (70) per month, has presented challenges for business office functions. Bills may be dropped prior to notification of the final patient care status and thus may not coincide with the most recent physician order. Condition Code 44 reporting requirements may not be met due to ineffective inter-departmental notification processes.
7. Emergency Department visits exceed forty-four thousand per year. There is a perception that ED physicians have been instructed to utilize Observation vs. Inpatient status in order to avoid payment denials for medical necessity. There is a fear factor about adverse consequences (i.e., “getting beat up”) when the Inpatient order is later deemed to be medically unnecessary. The physician director of the ED has made requests for a copy of the InterQual criteria book for the ED. However, these requests have been declined.

The patient’s Admitting physician has the final authority to give a verbal order for the care status, however, they typically agree with the ED physician. Initial orders for care are written by the ED attending and completed by the Intern on duty who also performs the History and Physical examination. If a Resident Physician is assigned to the case, additional orders may be written prior to the initial visit by the Admitting / Attending physician. As such, there is an opportunity for multiple care status and treatment plan changes due to multiple patient encounters by different physicians.

8. Physician documentation requirements for Inpatients include a “full” H&P as well as a discharge summary. Outpatient bed assignments do not require a discharge summary or “full” H&P. While some perceive this as a driver for over-utilization of Observation and Extended Surgical Recovery, we were not able to validate this with the medical staff participants involved in Structured Interviews.
9. The CMO and PA hold case conferences twice weekly to review cases with LOS four (4) to eleven (11) days. Case Management team meetings, which include Case Management staff, the CMO, Physical Medicine, and a rotating Nurse Manager, are held to formulate plans for Inpatients with LOS of eleven (11) or more days. Nursing holds inter-disciplinary team meetings on the patient care units. It was reported that Case Managers are, “too busy to attend.” The Nursing division would like to pursue opportunities for increasing Nursing collaboration with Case Management.

10. Clinical Coding and DRG assignment for the Inpatient population is accomplished by 3.6 FTE Coder. One (1) Coder is assigned to concurrent Inpatient coding and CDI. The remaining staff works from home. Based upon the GCH *August 2010 Concurrent Coding Report*, Case Managers and the concurrent Coder collaborated to generate one-hundred and thirty-nine (139) physician queries which resulted in the “potential” assignment of higher weighted (HW) DRGs. The report does not compare the working DRG to the *final* DRG. Instead, the working DRG is compared to the *new* DRG for quantification of financial impact.

In four (4) cases, all with very large financial impact, the working DRG was reassigned to a pre-MDC DRG. This type of change is typically related to performance of a tracheotomy rather than additional physician documentation. As such, the reported potential financial impact of over three-hundred twenty-six thousand dollars (\$326K) may be overstated by as much as one-hundred forty seven thousand dollars (\$147K).

11. Widespread confusion exists about the concept and purpose of Outpatient bed assignments. The Medical staff is eager to adopt the necessary changes to ensure the Hospital captures the compliant revenue associated with the care provided.
12. The Utilization Review Committee (URC) is a committee of the medical staff and reports to the Medical Executive Committee. The URC is chaired by the former Chief of Staff. This committee is looking to further define its purpose, prerogative, and process. Valid and reliable data reporting will be required in lieu of general statement of attribution and blame in order for the Committee to be maximally effective and efficient.

III. SUMMARY CONCLUSIONS

A. Patient Care Status Determination

Garden City Hospital's current care status decision making strategy and tactical approaches have been focused on Inpatient payment denial avoidance. To these ends, the Hospital has accomplished this goal. The Detailed Findings of this report indicate that, in doing so, the Hospital's Medicare compliance, mission effectiveness, and the receipt of compliant revenue have been compromised.

Medicare beneficiaries are entitled to medically necessary Inpatient care as well as the appropriate assignment of financial responsibility for care rendered. Inpatient care is a Medicare Part A benefit. Professional fees and Outpatient care fall under the Medicare Part B benefit plan. The Hospital's decision to provide care in Outpatient bed assignments in lieu of medically necessary Inpatient care is not consistent with Medicare guidelines. Claims that are not billed as per the physician ordered care status present additional compliance concerns.

Short term acute-care community hospitals exist to provide local access to medically necessary Inpatient care. The practice of classifying and billing Medicare patients as Observation or Extended Surgical Recovery when Inpatient medical necessity is apparent has resulted in the Hospital forfeiting as much as three and one-third million dollars annually.

See Appendix G for detailed financial projections.

B. Clinical Documentation Improvement

GCH's Case Weight Index (CWI) trend is downward trending over the past three (3) years, while other hospitals have experienced upward trends. The tendency across the industry for increasing CWI is a result of the learning curve associated with the CMS FY 2007 transition to MS-DRGs. Unless the Hospital's CWI increases in proportion to the CMS "behavioral offset," per case reimbursement will decline even if the CWI trend is flat.

Full implementation of an efficient and effective Concurrent Coding and Documentation Improvement initiative would position the Hospital to, at the very least, achieve the 4.8% "behavioral offset" increase in CWI along with the associated reimbursement. Changes in care status determination practice may infuse lower acuity Inpatients into the DRG population which will tend to dilute additional CWI increases. Increasing the CWI by the amount of the behavior offset represents over one point four million dollars in incremental Medicare reimbursement annually.

C. Inpatient Length of Stay Management

The current approach to Inpatient length of stay management has not been effective. Attribution for extended Inpatient LOS is likely due to multiple factors. The Hospital's medical model, availability of diagnostic services, and medical decision making may all play a role. Still and all, the Hospital will need to look at optimizing patient care progression systems and Case Management services to overcome barriers to timely patient discharge.

The Hospital's Inpatient LOS is twenty-four percent (24%) over that which would be anticipated. Success in CDI endeavors may mitigate this disparity somewhat, but certainly not fully. The Concurrent Coding approach will, however, provide predictive LOS metrics on a case by case basis during each patient's Inpatient encounter. By mobilizing the inter-disciplinary care team, ensuring collaboration between Nursing and Case Management services, and empowering the URC with actionable data, GCH will surely make strides in decreasing Inpatient LOS.

IV. RECOMMENDATIONS

Phase I – Patient Access

In this initial Phase, the Hospital will need to configure Case Management (CM) roles, goals, and staff labor allocation to achieve the desired outcomes of the function. Leadership responsibility will need to be determined. CM position descriptions should be aligned with “staff” and “operational” responsibilities. We are recommending that the Hospital clearly differentiate the Case Management nurse’s roles associated with payment authorization and clinical documentation improvement from those assigned to patient care progression, LOS management, and post-Hospital care planning.

Based upon Garden City Hospital’s goals and culture, we are proposing the following staff roles, FTE complement, and organizational alignment:

- Four (4) FTE’s Nurse Utilization / Data Coordinator assigned to all points of patient access for care status determination, third party payer admission / continued stay authorization, and clinical documentation improvement associated with care status determination and DRG assignment. These nurses would be scheduled to provide seven (7) day per week coverage. Initially, these nurses should focus on skill development and tactical approaches to facilitate care status decision making. Once that is accomplished, the clinical component of the concurrent CDI / DRG optimization initiative can be added to the role.

These nurses will be able to optimize their effectiveness with the assistance of one (1) FTE Utilization Review Specialist charged with telephonic third party payer payment certification and appeals management. In this model, one (1) FTE paraprofessional would be assigned to perform data entry and other clerical functions.

In order to ensure connectivity with the revenue cycle, business office functions, and compliant revenue guidelines, these roles should be aligned with the division of finance.

- Five (5) FTE's Nurse Case Manager assigned to the Inpatient population charged with patient care progression, inter-disciplinary team collaboration, and post-Hospital care planning. In this model, three (3) FTE's Social Worker would perform ECF, Hospice, and Psychiatric placements. Two (2) FTE's Social Worker would be assigned to the care units while one (1) FTE would be assigned to the ED on the afternoon shift hours to facilitate all community and psychiatric care referrals. Recently purchased information technology will likely eliminate the necessity of additional clerical support for these functions.

In order to fully integrate these Case Management and Social Work roles with Nursing care delivery, solidify the inter-disciplinary team communication, and ensure timely case finding, we are recommending these functions be aligned with the Nursing division.

Inherent to the success of the Patient Access initiative, Hospital leadership will also need to ensure the following activities are accomplished:

1. Achieve organizational clarity and consensus around the concept, purpose, and appropriate utilization of Observation and Extended Surgical Recovery care status.
2. Ensure valid, reliable data is available to the URC and provide staff / operational supports to facilitate sound medical staff decision making.
3. Develop systematic processes for PA referrals and follow through with PA decision making including formal activity tracking and reporting mechanisms.
4. Provide the requisite staff development and education to the newly defined roles.
5. Create learning venues and content for the medical and Nursing staff regarding care status decision making and documentation of medical necessity for Inpatient admission.
6. Design performance reporting templates and solicit the assistance of appropriate staff to generate monthly performance reports.
7. Consider modification of physician documentation requirements for Outpatient bed assignment cases.
8. Define performance expectations and accountability.
9. Solicit medical staff engagement and sponsorship.

Phase II – Concurrent Coding and Clinical Documentation Improvement

In the second Phase of the GCH Health Economics Project, a Concurrent Coding Model which builds upon the successes of the Hospital's Patient Access initiative should be implemented. The feasibility of assigning clinical coders to the care units will need to be explored. Venues for communication and collaboration between medical, clinical, and Health Information Management (HIM) professionals should be determined. Didactic and practicum training will need to be provided to all process participants and plans for Physician education must be established.

Success in this endeavor will improve GCH's external comparative data base performance, optimize compliant revenue, and decrease financial risk in coding audits. Once fully implemented, anticipated length of stay (LOS) for all Inpatients will be available to physicians and care providers during each patient's episode of care. Completion of Phase II will provide a platform for future LOS management initiatives.

Phase III – Patient Care Progression and Length of Stay Management

In this final Phase of the Project, a system for collaborative practice between Physicians, Nursing Staff, HIM, and Case Management will need to be established. Shared goals and accountability for outcomes should be defined. Success in this endeavor is dependent upon the outputs of Phase I and II.

Achievement of ALOS reduction requires defining the patient's acute care goal, monitoring milestones to goal attainment, and integrating each patient's plan for the day within the context of the anticipated LOS duration. While post-Hospital care planning is an essential component, the Hospital will need to expand the scope of LOS management to include care progression and patient readiness for discharge. As such, participation of Nursing staff and leadership is essential.

Tools, resources, monitoring mechanisms, and shared accountability for outcomes are requisite to sustainability of this Model. Again, Executive, Physician Advisor, and URC engagement, sponsorship, and oversight are crucial for success in this endeavor.

V. APPENDICES

Garden City Hospital
INPATIENT ONE-DAY LOS
 10/01/09 - 06/30/10

INPATIENT MEDICAL CASES									
LOS	CHARGES	PAYMENTS	VARIANCE	VOLUME	VOLUME as % of TOTAL MEDICAL	CHARGES as % of TOTAL MEDICAL	PAYMENTS as % of TOTAL MEDICAL	AVG PMT/ CASE	% CHARGE CAPTURE
Medical One (1) Day LOS*	\$ 931,126.11	\$ 738,666.69	\$ 192,459.42	133	5%	3%	4%	\$ 5,553.88	79%
All Medical LOS	\$ 37,115,627.33	\$ 17,692,207.32	\$ 19,423,420.01	2,457	100%	100%	100%	\$ 7,200.74	48%

INPATIENT SURGICAL CASES									
LOS	CHARGES	PAYMENTS	VARIANCE	VOLUME	VOLUME as % of TOTAL SURGICAL	CHARGES as % of TOTAL SURGICAL	PAYMENTS as % of TOTAL SURGICAL	AVG PMT/ CASE	% CHARGE CAPTURE
Surgical One (1) Day LOS*	\$ 830,381.69	\$ 439,198.86	\$ 391,182.83	46	7%	4%	3%	\$ 9,547.80	53%
All Surgical LOS	\$ 22,856,434.32	\$ 12,739,826.64	\$ 10,116,607.68	694	100%	100%	100%	\$ 18,357.10	56%

INPATIENT MEDICAL AND INPATIENT SURGICAL CASES COMBINED									
LOS	CHARGES	PAYMENTS	VARIANCE	VOLUME	VOLUME as % of TOTAL	CHARGES as % of TOTAL	PAYMENTS as % of TOTAL	AVG PMT/ CASE	% CHARGE CAPTURE
Med & Surg One (1) Day LOS*	\$ 2,654,665.89	\$ 1,704,443.67	\$ 950,222.22	249	8%	4%	6%	\$ 6,845.16	64%
ALL Med & Surg LOS	\$ 59,972,061.65	\$ 30,432,033.96	\$ 29,540,027.69	3,151	100%	100%	100%	\$ 9,657.90	51%

*Discharge Disposition Exclusions for One (1) Day LOS:			
Discharge Disposition	Medical	Surgical	Total
Short Term Acute Care Hospital	22	4	26
Expired	26	2	28
AMA	14	0	14
Psychiatric Hospital	2	0	2
Total	64	6	70

Garden City Hospital
MEDICAL OBSERVATION AND SURGICAL EXTENDED RECOVERY
 10/01/09 - 06/30/10

MEDICAL OBSERVATION CASES									
LOS	CHARGES	PAYMENTS	VARIANCE	VOLUME	VOLUME as % of TOTAL MEDICAL	CHARGES as % of TOTAL MEDICAL	PAYMENTS as % of TOTAL MEDICAL	AVG PMT/ CASE	% CHARGE CAPTURE
Medical Obs LOS ≤ 24 hours	\$ 1,599,044.65	\$ 360,327.74	\$ 1,238,716.91	339	57%	48%	53%	\$ 1,062.91	23%
All Medical Obs LOS	\$ 3,309,061.93	\$ 673,759.17	\$ 2,635,302.76	594	100%	100%	100%	\$ 1,134.27	20%

SURGICAL EXTENDED RECOVERY CASES									
LOS	CHARGES	PAYMENTS	VARIANCE	VOLUME	VOLUME as % of TOTAL SURGICAL	CHARGES as % of TOTAL SURGICAL	PAYMENTS as % of TOTAL SURGICAL	AVG PMT/ CASE	% CHARGE CAPTURE
Surgical Ext Rec LOS ≤ 24 hours	\$ 499,563.81	\$ 146,695.11	\$ 352,868.70	95	28%	13%	12%	\$ 1,544.16	29%
All Surgical Ext Rec LOS	\$ 3,713,001.74	\$ 1,255,972.26	\$ 2,457,029.48	344	100%	100%	100%	\$ 3,651.08	34%

MEDICAL OBSERVATION AND SURGICAL EXTENDED RECOVERY CASES COMBINED									
LOS	CHARGES	PAYMENTS	VARIANCE	VOLUME	VOLUME as % of TOTAL	CHARGES as % of TOTAL	PAYMENTS as % of TOTAL	AVG PMT/ CASE	% CHARGE CAPTURE
Med Obs & Surg Ext Rec LOS ≤ 24 hours	\$ 2,098,608.46	\$ 507,022.85	\$ 1,591,585.61	434	46%	30%	26%	\$ 1,168.26	24%
ALL Med Obs & Surg Ext Rec LOS	\$ 7,022,063.67	\$ 1,929,731.43	\$ 5,092,332.24	938	100%	100%	100%	\$ 2,057.28	27%

Patient Access

Projection of Compliant Revenue Opportunity - Medicare

Summary

Financial projections were derived from data submitted by the hospital which included Medicare Inpatient, Observation, and Surgical Extended Recovery discharges during the three (3) quarter period beginning October 1, 2009 and ending June 30, 2010.

These projections are based upon external comparative data, GCH payment data, and Care Management Solutions, LLC (CMS) consultant record review findings. Incremental Medicare payment projections are annualized.

Total Incremental Medical Reimbursement = **\$2,014,687**

- Statewide Median percentile ranking = \$1,218,288
- Statewide 80th percentile ranking = \$796,399

Total Incremental Surgical Reimbursement = **\$1,352,701**

Total Medical and Surgical Opportunity = \$3,367,387

These calculations were derived at using a “Best Case Scenario” financial model. Using a conservative financial planning approach, CMS suggests capping these opportunity projections at fifty percent (50%) to seventy percent (70%) of the stated financial opportunity.

Detail

Medicare Medical Observation:

During the nine (9) month study period, one (1) day medical Inpatient stays (excluding deaths, transfers, AMA) represented 5.4% of Total Medicare Medical Discharges. According to the most recent PEPPER data, the State Median is **10.5%** and the State 80th percentile is **14%**. Garden City Hospital's percentile ranking is in the third percentile.

****Note: For the purpose of this analysis, ALL incremental IP volume was assumed to be one (1) day IP LOS. As such, future Medical Inpatient ODS as % of Total Medical Inpatient Discharges is overstated.**

Calculation A – State Median Performance

Based upon retrospective case review of Observation cases with complex diagnoses and LOS ≥ 23 Hours, sixty percent (60%) of cases were classified as “risk” level 0 or 1.

Current Medicare Medical Inpatient ODS Volume = 133

Current Medicare Medical Observation Volume >24H = 225

Proposed addition Inpatient Volume from OBV >24H = 153

Future Medical Inpatient ODS as % of Total Medical Inpatient Discharges = **11%****

Average Medicare Medical Inpatient payment = \$7,200

Average Medicare Medical OBV > 24H payment = \$1,229

Incremental Medical Inpatient per case revenue = \$5,972

Incremental revenue per 3Q = \$913,716

Incremental IP Revenue Annualized = \$1,218,288

Calculation B – State 80th percentile Performance

Medical ODS Volume = 286 (after above)

Proposed additional ODS Volume (from OBV Volume) = 133

Future Medical Inpatient ODS as % of Total Medical Inpatient Discharges = **15%****

Average Medicare Medical Inpatient ODS payment = \$5,554

Average Medicare Medical OBV ≤ 24H payment = \$1,063

Incremental Medical Inpatient per case revenue = \$4,491

Incremental revenue per 3Q = \$597,299

Incremental IP Revenue Annualized = \$796,399

Statistical Summary of Proposed Medicare Medical Case Volume Changes:

- Total Medical Inpatient Volume 3Q increase from 2,457 to 2,743 (286 cases)
- Total Medical Inpatient ODS Volume 3Q increase from 133 to 419 (286 cases)
- Medical Inpatient ODS as a % of total Medical Inpatient Discharges = **15.28%****
- Medical Observation as a percent of Total Inpatient and Observation Discharges = 10%
- **Total Annualized incremental Medicare Inpatient Medical Revenue = \$2,014,687**

Medicare Surgical Extended Recovery:

During the nine (9) month study period, one (1) day surgical Inpatient stays (excluding deaths, transfers, AMA) represented 7% of Total Medicare Surgical Discharges. Based upon retrospective case review of Extended Recovery cases with complex diagnoses and LOS \geq 23 Hours, eighty percent (80%) of cases were classified as “risk” level 0 or 1.

****Note: For the purpose of this analysis, ALL incremental IP volume was assumed to be one (1) day IP LOS. As such, future Surgical Inpatient ODS as % of Total Surgical Inpatient Discharges is overstated.**

Current Medicare Surgical Inpatient ODS Volume = 46

Current Medicare Surgical Extended Recovery Volume >24H = 249

Proposed addition Inpatient Volume from OBV >24H = 199

Future Surgical Inpatient ODS as % of Total Surgical Discharges = **27%****

Average Medicare Surgical Inpatient ODS payment = \$9,548

Average Medicare Surgical Extended Recovery >24H payment = \$4,455

Incremental Inpatient per case revenue = \$5,093

Incremental revenue per 3Q = \$1,014,526

Incremental IP Revenue Annualized = \$1,352,701

Statistical Summary of Proposed Medicare Surgical Case Volume Changes:

- Total Inpatient Surgical Volume 3Q increase from 694 to 893 (199 cases)
- Total Inpatient Surgical ODS Volume 3Q increase from 46 to 245 (199 cases)
- Surgical Inpatient ODS as a % of total Surgical Inpatient Discharges = **27%****
- Surgical Extended Recovery as a percent of Total Surgical Inpatient and Extended Recovery Discharges = 14%
- **Total Annualized incremental Medicare Inpatient Surgical Revenue = \$1,352,701**