Spring 2021

Lompoc Healthcare District Medical Staff Newsletter

LOMPOC VALLEY MEDICAL CENTER
Lompoc Healthcare District

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CMO Perspective

With Spring upon us and having dealt with over a year of the COVID pandemic, most everyone is looking to a brighter future. Instead of focusing on the pain and suffering brought on by the pandemic, it is a pleasure to talk about the resilience and accomplishments of the LVMC staff and the changes brought about both at the hospital and the Lompoc Health Clinics.

With the COVID vaccination process going on daily in the hospital, there is a palpable feeling of hope among patients and staff. Many people vaccinated in the over 75-year-old group explained how they had felt isolated and could not wait to see grandchildren and other family members. Teachers expressed excitement about returning to the classroom with the added protection of vaccination. All the LVMC staff who have stepped up in the vaccination effort are being treated to an air of hope and excitement. The vaccination process has only gotten smoother as we have gained experience. We now have an "ultra-low temperature" freezer which will allow us to keep the Pfizer vaccine up until its expiration date and make us less dependent on other facilities for storage.

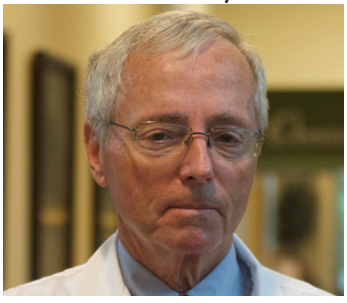
The pandemic also brought on the need to embrace telehealth technology at the Lompoc Health Clinics. Although the number of telehealth visits has markedly declined, this technology has established itself as part of our clinical practice. We also implemented online registration for office visits at the Lompoc Health Clinics to allow patients to avoid time in the waiting rooms. As this process evolved, patients are now able to register for visits, complete a health questionnaire and make copayments from their phone, tablet, or computer. This technology was obviously coming, but the pandemic certainly advanced the timeline. It was impressive to see how the IT team (Mr. Jim White and Ms. Katie Lopez), registration (Mr. Bob Ondrizek), and the clinical team (Director Paul Fry, Ms. Lennaya Smith, Ms. Sue Nooney and Ms. Nancy Hummer) came together to put this process in place.

Our physicians and nursing staff have gained a good deal of experience in treating these most severely ill patients. Thanks to Chief of Quality Improvement Melissa DeBacker and CNO Yvette Cope and their staffs, infectious disease practices are firmly established and will stand us in good stead as we continue to face COVID and other possible future waves of infection. As they teach in medical school, there is no substitute for actual experience, and we have certainly had a large dose.

With all this experience comes a cost to our staff in terms of stress and anxiety. I will not use the term "burn out" because this seems to have been applied to the entire adult population during this pandemic. The stresses involved with treating highly infectious, seriously ill patients are somewhat unique. The hospital has, under the direction of Chief DeBacker, implemented a "Healing the Healers" program to provide ongoing needed support to our hospital and medical staff. Again, this is another program fostered by our current circumstances that will hopefully continue.

Going forward, I feel the pandemic has taught us much that will improve the care we deliver to the community. This experience has also reinforced our need to always be looking ahead to new technologies and process improvements to deal with future health threats.

Again, thank you to all our providers and staff for everything you do for our patients and community.

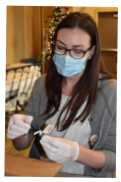


Randall Michel, MD, FACS
Chief Medical Officer

The Pharmacy Corner

COVID-19 VACCINATIONS

To date, Lompoc Valley Medical Center Pharmacy has received 7,746 doses of Pfizer-BioNTech vaccine and 6,600 doses of Moderna vaccine. These figures include doses allocated as second doses.
We now have an Ultra-Low Temperature Freezer! This allows us to store the Pfizer-BioNTech vaccine between -80°C and -60°C (-112°F and -76°F).



UPDATES TO THE FORMULARY

Additions:

Emend IV formulation (fosaprepitant) has been added to the formulary for postoperative nausea and vomiting.

Ryanodex (dantrolene) has been added to the formulary for malignant hyperthermia. It is suppled in 250mg vials and only requires 5 mL of sterile water to reconstitute and warming is not needed. Three vials must be kept in stock compared to 36 vials of Revonto. This will be replacing Revonto, which will be removed from the formulary.

Deletions:

Exparel (liposomal bupivacaine) has been removed from the formulary after a lack of evidence to show a clinical or statistical difference between non-liposomal bupivacaine. Liposomal bupivacaine is almost 200 times the price of non-liposomal bupivacaine.

Revonto (dantrolene) has been removed from the formulary and has been replaced by Ryanodex. Revonto is supplied in 20 mg vials requiring 60 mL of sterile water for mixing. And warming does enhance its solubility. Thirty-six vials must be kept in stock.

By Sarah Osellame, Pharm.D. & Chad Signorelli, PharmD

Steve Popkin
Chief Executive Officer

CEO Thoughts

Greetings
Medical Staff Members,

At LVMC we have all been very busy doing what we always do every day. On top of that, as of the date I am writing this, we have administered more than 10,000 COVID-19 vaccine doses to Lompoc Valley community members. LVMC was the first vaccination provider in the County to provide vaccinations for 75+ individuals, educators, childcare workers, food workers and agriculture workers. Although this requires an immense amount of time, effort, skill and expense, we are very happy to do it. It gives so many community members, who may or may not be familiar with LVMC, a chance to see our beautiful hospital, see how we are able to run a complex operation effectively and efficiently, and experience first-hand the positivity and compassion or our staff and volunteers (which includes some medical staff members). The many, many wonderful comments, calls, cards, emails and social media postings by those receiving vaccinations have been very heartwarming.

I thought I would take a moment to provide a very brief overview of where we are on a financial and statistical basis seven months into this fiscal year.

At the hospital, utilization of most outpatient services is down from prior year due to the pandemic. This includes areas such as diagnostic imaging, emergency department and outpatient surgery. However, we have made it up on the inpatient side. Average daily census is up 42%, and discharges are up 19%. Case Mix Index, which is an indicator of the clinical intensity of our inpatients, is up 15%. Net Revenue is up 11.4% from prior year, and Income from Operations has increased 34.2% from prior year.

The census at the Comprehensive Care Center is down significantly due to the pandemic. Yet, Operating Income is $997,000 better than prior year.

At Lompoc Health, even with the pandemic, clinic visits are up 5% (excluding urgent care, which is down 3%). Net Revenue is up 3.4%, while Operating Income is down 14% compared to prior year. Patient visit volume at the clinics has normalized, and we expect good results going forward.

On a consolidated basis through seven months, Net Revenue is up 10.6%, and Net Income is $2.34 Million better than prior year.

The LVMC capital budget for the fiscal year beginning July 1 will be presented to the Board for approval in May. It includes capital expenditures for the following areas: Alternative Birthing Center, Critical Care Unit, Diagnostic Imaging, Emergency Department, Information Systems, Pathology, Physical Therapy, Plant Operations, Surgery Department, Telecommunications, Lompoc Health (various items) and CCC (various items).

Thank you to all medical staff members for your tremendous work and support!

Best regards,

Steve Popkin
Chief Executive Officer

The cities, states where physicians are paid the most

Being a physician is the fifth best overall job in the country, according to a U.S. News & World report ranking the 100 best jobs. This ranking was based on several factors, including unemployment rate, 10-year growth volume, future job prospects, work-life balance, and median salary.

According to data from the U.S. Bureau of Labor Statistics, the median salary of physicians in 2019 was $206,500. One-quarter of physicians earned $208,000 or more that year.

The best-paying city for physicians is Janesville, Wisconsin, where physicians earned a mean salary of $284,720. That was followed by Laredo, Texas ($282,730); Salinas, California ($282,640); Pittsfield, Massachusetts ($279,900); and Ocean City, New Jersey ($279,790).

The states with the highest mean physician salaries were Alaska ($258,550), New Hampshire ($257,220), Maine ($251,930), Montana ($247,720), and Wisconsin ($246,060).

Source: Credentialing Resource Center Digest

William J. Pierce, MD
Chief of Staff

A Day in the life of a CCU nurse caring for Covid patients

For the past year, as a hospital, we have been ruled by Covid-19. This has stretched us in previously unheard-of ways. The last line of defense for a sick Covid patient is the CCU. Staffed 24/7/365 it is the make-or-break area where people are either healed of the disease or they die. Much has been made of the front-line workers and rightfully so. I was wondering to myself whether most people were really aware of what caring for a CCU-level Covid patient entails. In a very small and abbreviated way, I would like to attempt to describe what Covid care is like for the CCU nurses.

The day begins with Report -- the shift change in which the out-going nurse tells the incoming nurse everything known about the patient in terms of condition, trends, critical events, medications and expectations for the coming shift. Always thoughtful and comprehensive, report provides seamless care for the patient, much like passing a baton at full speed in a relay race. What follows is the most structured portion of the day.

After report, the nurse checks the orders and labs, reports critical values to the doctor, does his or her own head-to-toe examination, gives the morning medications, rounds with doctors, Pharmacy and Case Management. A head-to-toe survey is done every 4 hours and a pain assessment, I.V. checks and repositioning done every two hours. All in all, a very busy day on all CCU patients, but when a Covid infection is added to the patient's problems, the nurses' job becomes much harder. The transfer of a Covid patient from the floor to the CCU is very involved, complex and needs to be done as quickly as possible.

Admission: The patient typically arrives from the floor when they have failed all attempts at conservative methods of maintaining an adequate oxygen saturation. They are exhausted from the effort and are usually in need of urgent endotracheal intubation. The nurse attends the patient from the first moment and then for the next two to three hours, nonstop.

Preparations are made to sedate and chemically paralyze the patient for intubation and placement of the intravenous and arterial lines and feeding tube. This involves setting up a multi-channel iv pump to handle up to 5 or 6 medications simultaneously, helping Respiratory Therapy if needed to set up the ventilator, all while also monitoring the patient and administering whatever medications the patient may urgently need.

This would be taxing enough, but it all has to be done in full N95 protective gear. Every time the nurse enters a room, they must don the mask, hair covering, gown, face shield and gloves. The advent of the positive pressure PAPRs has simplified this somewhat, but they are available in limited supply. It is really like suiting up for

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a football game except that it is done 10-12 times per shift.

With everyone assembled, the nurse gives the medications to enable the doctor or CRNA to intubate the patient. These medications often cause the blood pressure to drop, requiring an immediate response. The placement of the central venous access is next followed by placement of the arterial line, which monitors blood pressure. Both are sterile procedures requiring the nurse and doctor working in close concert. Lastly, the nurse places the feeding tube. He or she then assists the radiology tech with placement and removal of the x-ray plate behind the patient to verify correct placement of the lines and tubes. These x-rays are typically shot through the glass door from outside the room with the nurse moving into the bathroom to avoid x-ray exposure.

Once in N95 gear, it is prohibitively difficult to leave the room for medications or supplies. So, when a nurse is not actually in the room, he or she is just outside acting as an extension of the nurse in the room. The EKG tech/unit clerk often serves in this capacity as well.

Then there is the issue of "proning" the patient to help better ventilate other areas of the lung. This is an "All Hands on Deck" event and must be done quickly and correctly as the patient can decompensate rapidly. Typically, this is done once per day. The set-up for proning is elaborate and time consuming but the execution takes just seconds. There are other elements of caring for Covid patients that are unique, but the difference is not limited to the time in the hospital.

Routines vary, but many frontline Covid care providers have their home lives disrupted, as well. This may take the form of taking clothes off in the garage, showering at work or as soon as they get home before seeing the family, or even living apart from their loved ones in a hotel or RV or another part of the house. Voluntarily, these workers were especially isolated so as to minimize the threat of infecting others.

This short account does not do any real justice to the effort put forth by the CCU nurses caring for critically ill Covid patients. We have endured multiple major waves of Covid here at LVMC and the contributions of the nursing staff cannot be overstated. Everyone here has put in a herculean effort to see us through our corner of the pandemic but, in my opinion, none more so than the nurses in the CCU, and of course the nurses on Med-Surg. But, that's another story.

REMINDER

Regular Medical Staff Business Meetings & CMEs

Tuesday, April 27 - Tuesday, May 25 - Tuesday, June 29

7am - Ocean's Seven Cafe

HIM Hints

by Barbara Frink
Director, Health Information Management
Privacy Officer

Debridement Documentation

Debridement procedures are a frequent target for audits by Recovery Audit Contractors (RAC) and all third-party payers. Inpatient accounts for debridement are often targeted for audit, as excisional debridement is a procedure that results in a surgical DRG payment. Precise documentation of all of the required elements will raise the DRG payment level for inpatients. Same Day Surgery, Observation or clinic office patient accounts are also often audited for precise documentation of the required debridement elements.

To understand the requirements for documentation for debridement, some background information in general will help with understanding why documentation for all diagnoses and procedures must now be so precise.

Since the inception of ICD-10 CM and ICD-10 PCS, the documentation for all diagnoses and inpatient procedures requires very precise documentation. Procedure coding for ICD-9CM was fairly straightforward and uncomplicated. On October 1, 2015 ICD-10 CM and ICD-10 PCS took the place of ICD-9 CM. These code sets, along with the CPT code set for outpatients, must now be used by hospitals in order to get paid. Both ICD-10 CM and ICD-10 PCS code sets require a great deal of specificity in comparison with ICD-9. Some physicians tell us that they were never asked to

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Chaplain in the house

LVMC now has a part-time Chaplain, Greg Nelson, for patient rounding to address any faith needs at LVMC and provide private sessions with staff or providers.
Chaplain Nelson can be reached by email at **chaplaingregnelson@gmail.com** or by calling **805-697-1945.**

Chaplain Nelson earned an undergraduate degree in religion and philosophy and a Master of Divinity degree from Pacific Lutheran Theological Seminary. He was ordained in 1990. Chaplain Nelson provided pastoral care, hospital chaplain services, and more for years at Cleveland hospitals and congregations. He recently retired after 20 years working with inmates at the U.S. Federal Penitentiary in Lompoc. He has continued his ministry with the Lompoc Valley homeless population and at Calvary Chapel in Lompoc.

History of National Doctors' Day

In the United States, National Doctors' Day is a day on which the service of physicians to the nation is recognized annually. The idea came from Eudora Brown Almond, wife of Dr. Charles B. Almond, and the date chosen was the anniversary of the first use of general anesthesia in surgery. On March 30, 1842, in Jefferson, Georgia, Crawford Long, MD used Ether to anesthetize a patient, James Venable, and painlessly excised a tumor from his neck.
In 1990, President George H. W. Bush recognized the numerous contributions of physicians by formally designating March 30 as National Doctors' Day.

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document what the coder is now asking him/her to document. The Official Coding Guidelines, Coding Clinic and HIPAA regulations for preventing fraud and abuse in coding tell the coder that they have to query physicians for more specific documentation if it is not found in the chart. In addition, there are rules for queries specifically saying that coders cannot lead the physician to an answer. Coders have to construct the query as a multiple choice question or in a very indirect way so they are not leading the physician/ healthcare provider to a specific answer.

Medicare and other third party payers won't pay for most unspecified codes any longer. In addition, when auditors or third-party payers don't see key language used in the inpatient ICD-10 PCS coding book designated for procedures, they deny the claim for payment for the procedure. This means no payment to the hospital for the procedure or a request to refund payment that was made pre-audit.

There are required elements and key language that physicians/ healthcare providers must use when documenting excisional or any other type of debridement. These are listed specifically in the CMS documentation requirements for payment. Here are the specific items and key language that must be used:

1. The technique used must be documented. Each of these words has a different character or symbol added to the ICD-10 PCS procedure code. Examples to be used include: scrubbing, brushing, washing, trimming, or excisional. Saying a sharp instrument was used is not a substitute for using the term excisional in the documentation. For excisional debridement, it is important for the physician/healthcare provider to use the word excisional or excised.
2. The instrument(s) used must be documented. Examples are scalpel, scissors, curette, pulse lavage, brushes or other instrument used. This must be documented to avoid denial.
3. The nature of the tissue that was removed. Was it slough? Was it necrosis, devitalized tissue, non-viable tissue?
4. The appearance and size of the wound / and or lesion must be documented. Document the size of the wound or lesion that you are going to debride or excise. You must then document the size of the tissue excised along with the wound. CPT codes and ICD-10 PCS codes are selected based on these measurements. Without documentation to support the lesion size and the measurement of the margins debrided, a code cannot be selected. Document if there is fresh bleeding tissue or viable tissue after debridement.
5. The physician must document the depth of the debridement. There must be documentation that specifically states that the wound was debrided down to one of these levels: skin, fascia, subcutaneous tissue, soft tissue, muscle or bone. The ICD-10 PCS code set has a different character or symbol for each of those terms. CPT codes are based on these terms, as well. Without specific documentation that states the wound or lesion was debrided "down to and including" one of the levels stated above, there is insufficient documentation to support coding the procedure which jeopardizes payment received by the physician and/or hospital.

Optimizing reimbursement for any account submitted to Medicare or other payer is always dependent on good documentation. If a physician/healthcare provider documents the specifics of any procedure thoroughly and with specific details, the hospital and physician will ensure that the hospital and physician are receiving maximum payment to reflect the services rendered. Without specific documentation or without all of the required elements being documented, payment is reduced or rescinded altogether.

When the coder sends a query to the physician, it means she/ he has identified an opportunity to achieve a higher level of specificity for coding. This results in better reporting of the patient's condition and procedures for mandatory reporting. A side benefit for the physician and hospital is that full payment for actual services rendered is received.

For more information, or if you have any questions, please contact Christy Moegelin, Coder moegelinc@lompocvmc.com

Celebrating Milestones

The following physicians hit a service milestone in the beginning of 2021. We would like to recognize the following physicians for their **service and dedication to Lompoc Valley Medical Center.**

25 Years on Staff
David A. Tufenkian, MD
Emergency Medicine

10 Years on Staff
William J. Pierce, MD
Surgery

5 Years on Staff
Alex Ecarma, MD
Internal Medicine

Recent Medical Staff Appointments

Paul L. DiModica, DO
Emergency Medicine
Santa Ynez River Physicians

K. April Kennedy
Oncology/Hematology
Ridley-Tree Cancer Center
and Sansum Clinic Specialty Care

You may or may not be patient but because you are a doctor you will always have patients.

Please welcome **Leslie Sherrill**

We would like to introduce Leslie Sherrill, LVMC's **new Executive Assistant in the Administration & Medical Staff Services office.** Beth Burk remains at LVMC, but has joined the staff of the Finance Department.
Leslie is available Monday to Friday from 8:30 a.m. to 5 p.m, and can be reached at **805-737-3301** or **sherrilll@lompocvmc.com**

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