

Date: April 16, 2025

Attendees: Michael Mesisca, Rodney Koenig, Katie Alexander, Rebecca Rimka, Christine Paley, Jocelyn Le, Brenda Villareal, Tiffany Mendonza, Vivian Acevedo, Meagan Ponciano, Kimberly Sales, Kurt Harris, Krista St Onge, Eunic Tuungafasi, Bushra Hasan, Karla Montes, Kimberly Ortega, Rosilyn Kattiyaman, Amanda Diep, James Bailey, Kelly Medina
Location: Ring Central

<i>Topic</i>	<i>Discussion</i>
Central	<p>Christine Paley</p> <ul style="list-style-type: none">● Reminder about the symposium on May 6 and 7 in Irvine, the new provider experience is on May 5.● Compliance modules are coming up in June, so that is something you want to pay attention to.● The innovation grant is out for people to apply. It is money that is put out there to help you with any kind of process that you are struggling with and have a solution for. In the past it was used to create a tracker for the ER to see where the patient is in the hospital.● Amanda Diep is a relatively new site lead in the Golden Valley clinics in Central California. Golden Valley is a newer hospital system that is similar to RUHS. She is in this meeting to observe the efficiency of this group and your projects.● Shout out to Vivian for helping people with the loan repayment program.● Mesica: If you have not filled out the paperwork for this, consider doing it because there is uncertainty on how much longer this will be available for.
Care Gaps	<p>Katie</p> <ul style="list-style-type: none">● We are trying to get access to dashboards to see our improvement. We only have access to MSC gonorrhea/chlamydia, which shows we do have a small market increase. BPA-wise we are inching higher.● Rodney: We should be hitting BPA's every single time.

<p>Lake Elsinore</p>	<p>Katie</p> <ul style="list-style-type: none"> ● They are currently still interviewing to hire an LVN to be at the clinic Sunday to Wednesday. Urtha from family med is covering Mondays and Tuesdays, Attiana and Karen pick up for the other days. ● ACC is starting to turn patients away again for certain things. Remind ACCs that if they have questions or concerns they should be talking to the provider. There have been a couple instances where patients were sent to Express Care from one the three surrounding hospitals for ED follow up, but they have private insurance. Notify patients that we are still able to see them, but our referrals and other orders might not go through. <ul style="list-style-type: none"> ○ Rodney: If the patient has private insurance they will get billed, so it is important for ACC to have that conversation with the patient beforehand. If we can track which hospital(s) they came from, it may be an opportunity for Dr. Mesisca or myself to get a hold of the medical directors from those hospitals and enlighten them on what we can not do at the CHC clinics for ED follow ups. ○ Katie: It seems to be the three hospitals in the Southwest Health System. ○ Mesisca: If it is only a couple patients here and there, it might be better to come up with a list of resources and clinics where they can get follow-up with their insurance. Continue to trend the volume.
<p>Corona</p>	<p>Vivian</p> <ul style="list-style-type: none"> ● Finally hired a new RN, she will be starting her training in family med today. ● Clinic has been busy. If surge providers switch from Riverside to Corona, make sure to send scribe from Corona to Riverside so that the Riverside provider is not alone. <p>Rodney</p> <ul style="list-style-type: none"> ● If you see patients for mouth and dental related issues, remember to send patients to the dentist in Corona. ● Vivian: We do have a new dentist, as well.
<p>Riverside Neighborhood</p>	<p>Jocelyn:</p>

	<ul style="list-style-type: none"> ● Alexis, our full time MA, is nearing the end of her training. She will be starting Sunday to Wednesday soon. <p>Rodney</p> <ul style="list-style-type: none"> ● There is some large space that is not being utilized in the back of the clinic. I will help Dr. Schiller, Melissa, and Kim to figure out how to occupy that space for primary care so that we could potentially take some of the other rooms. ● A middle school will be opening in August, so that will drive business in the neighborhood.
MVC	<p>Rodney</p> <ul style="list-style-type: none"> ● Construction is done for the most part. There are two places for providers to work: one is in the room with the nurses and the other is separate from the staff. ● Vernon Olson is the acting clinic manager at this time. ● Staff can still utilize some of the pods. If we are busy, ask the nurses to use the pods. ● ACCs are allowed to start registering patients into Express Care 20 minutes prior to opening.
MSC	<p>Tiffany</p> <ul style="list-style-type: none"> ● Alejandra the MA will be leaving, so the clinic will be a person down. ● We have been running out of a lot of supplies. Send me a text message about things that are running low so that I can start compiling a list. ● Tickets are in for the keyboards in the provider room to be fixed. There are post-its on the walls for the keyboards that need to be fixed. <p>Rodney</p> <ul style="list-style-type: none"> ● There have been several changes to the intake form. All information should be getting filled out now. <ul style="list-style-type: none"> ○ We have to sign at the bottom so nurses know who is assigned to the patient. ○ Staff will be circling whether the patient asked for a work/school note. ○ Staff will write down the patient's pharmacy at the bottom. <p>Tiffany</p>

- There are also changes to the bins. One bin is “nursing tasks” and the other is “zero nursing tasks” (straight discharge). Make sure to write in the box “discharge” and verbally notify them that you want the patient discharged.
 - Rodney: staff will be moved to where ECM is located right outside of the provider room, so this will become easier to do later.

Rodney

- Kim Boker is acting manager, she has had multiple meetings with staff and me.
 - We need to discuss the results with the patient before we leave the room. If we forget, the staff will give us a gentle reminder.
 - Medications are not being explained to the patient before discharge. If a patient tells staff that you did not explain medications, go in with the nurse and have that conversation with the patient.
 - Make sure you complete the plan, AVS, and prescriptions before changing patients to green for discharge and putting their chart on the rack.
 - We need to sign all pending orders so that nurses can sign their chart.
 - Make sure you check the in-take form and complete the work note prior to putting the patient up for discharge.
 - Patient rooming will start at 9 AM, but they cannot put a patient in a room without a provider in the clinic. Make sure you are physically clocking in on time. Nurses will let the county know if we are not there at 9 AM.
 - Sometimes the rooms have to be cleaned. We are getting flags on the walls to identify the rooms that are ready.
 - Notify staff to move the wound care cart in front of the room.
 - When doing procedures, make sure you throw away sharps before leaving the room. Verbalize “sharps are gone” when leaving the room.
 - Room should be restocked at the end of the day. If you don't see rooms being properly stocked, let staff know.
 - Staff should be verbally telling us any abnormal vitals.

	<ul style="list-style-type: none"> ○ Staff should be handing EKGs directly to a provider (doesn't matter if the provider is not assigned to the patient, a provider needs to initial for stemi). ○ Spotfire automatically populates into the chart—staff will be adding estimated time of completion of results on the chart. ○ When you cancel care gaps you don't need, don't blanket cancel all of them. ○ We are working on getting an in-person translator. ○ Tiffany: There is a sticky note on the wall in the provider room on how to access a translator from the clinic. When you call them, give them the name of one patient they can translate for and they will usually stay with us for a while. ○ Rodney: We will be getting a translator assigned to Express Care, so that will make things a lot easier for us. ○ Rodney: Take only one chart at time to not disrupt workflow. ○ Bushra: Let's say if people come in for pelvic problems, do nurses have to ask us to tell the patient to undress? Or should the nurses be telling them automatically and set up for a pelvic? ○ Rodney: First go see the patient and get the history to determine if the pelvic is necessary. If you need to do a pelvic, put in the nursing order, "set up for pelvic." ○ Lara: If it is a busy day, is it fine if I take 3 charts and place them in the bin one at a time? <ul style="list-style-type: none"> ■ Rodney: They just ask that if you do take multiple charts, make sure you have all orders in before placing that chart in discharge. We should try to move out of the ED mindset, aim to take one chart at a time because the staff is not ER trained. If it is really busy, it should be fine if you have finished all orders and tasks for the patient before you give nurses orders to discharge. I have been asking staff how the flow is. If the workflow is not being efficient, let me know so that we can continue working on things.
Palm Springs	Rodney

- They will be hiring a new MA.
- Reminder that you should only be looking at information about your patient. If staff are bringing up charts to you for patients you are not seeing or managing, do not look at it. It is a violation and people are losing their jobs over it. If you see that happen, report it to Rodney because that goes against compliance. Epic logs your activity and looks at which charts you go into.
- Mesisca: Rodney's fervor is appropriate because he is looking out for you all. Sometimes we get celebrities or high-profile patients. Epic has an AI platform that might mark someone's activity as unusual and it will send off a message. If you are a site lead and doing QA, as long as there is a business need, there might be a question, but we will have an answer for it. There is a lot of latitude for quality insurance. If there is a medical need and you are involved in the patient's care (even remotely), from an administrative standpoint, there is a lot of latitude. There is no latitude for accessing your chart, a family members chart, or for someone you don't know. Willfully choosing to access a chart and breaking a hospital policy is a one-and-done thing.
- Bushra: Is it fine to look at a chart as a case scenario and are interested in knowing how they were treated?
- Mesisca: There are two different scenarios. If you send someone to the ED and want to follow up on their care, that is appropriate because you are managing their care. If there's a patient that another provider saw while they were working with you (in other words, you are not directly involved in the care with the patient), that is a little more nuanced and might flag something. However, if you are on duty and in the department they are being seen, that might be justifiable because we do work as a team.
- Rodney: When I do that, I usually call the patient to check on how they are doing and chart it on Epic.
- James: I have a couple of questions about my shift at Corona yesterday. I had to send two patients who should not have been discharged from the ED at Corona Regional. I had to go into their charts from the hospital to see what happened, was that okay?

- Rodney: Absolutely because that is part of the care for the patients.
- James: Okay, because I had to send them to our ED even from Corona. When I called them, even they were unsure why they were discharged.
- Mesisica: Hospitals used to keep people in as long as possible, but insurance payers switched over to a bundled rate. So there is a huge goal to get people out of the hospital. That balance is often in limbo because of competing motivators. You want a low length of stay because that is good for the health system and it's good for the patient, but if you trim that too much, they keep the money and they release the patient before they are ready to go, and then they bounce back. So there is also a push to penalize hospitals for returning admissions within 30 days, but there is also data that shows that patients who have hospital readmissions less than 30 days typically do better than the ones who don't come back if their condition changes. It is a delicate balance that most institutions struggle with because of the competing interest of the patient with the finances. So, James, it probably is better to send these patients back to RUHS because there's hospitalists who are a bit more conservative than community doctors and are in the patient's interests. If you can send those cases to Rodney and I, we can take those over back to the ED directors at those hospitals.
- Rodney: I just want to let you all know that you are saving lives with these discharge visits. I met with Tracy about the scheduling of these visits, some of the points are that the patient can schedule themselves, therefore wound checks post-op need to be seen in person. When either IEHP or the patient has scheduled themselves, it's hard to fix that—except let me know you have done, so I can let Tracy know and educate IEHP on that. Dr. Mesisca and I met with trauma surgery so we're working on a way to help them with their post hospital discharge workflow. For a patient discharge that was on trauma service, they are talking and meeting with their teams to write in the plan what they want us to do in Express Care. So, continue to help us understand some of the things we see. This is the only way the county gets feedback to help improve their process. I can tell you all you've done a fantastic job and we get phenomenal reviews.

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| | <ul style="list-style-type: none">● Bushra: This is more of an MSC thing, but we're having some of the MA's at ortho send us patients who should be going to the ER.● Rodney: Whenever that happens, have Deryl text me so that we can look at it. Dr. Mesicia and I can talk to the ortho department about it. It mainly is because of convenience because we have proven that we are efficient. |
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Meeting called to order: 8:01a; Meeting adjourned 9:02a