Date: January 21, 2025

Attendees: Rodney Koenig, Michael Mesisca, Tiffany Mendoza, Vivian Acevedo, Kelly Medina, Alexis Martinez, Bushra Hasan, Chance Thepmontrynhep, Christine Paley, Frank Nguyen, Himelda Churchill, James Bailey, Jocelyn Le, Katie Alexander, Kimberly Sales, Krista Harris, Kurt Harris, Lawrence Gates, Maerah Ahmed, Matthew Keane, Magen Costilla, Meagan Ponciano, Nichole Sayegh, Rebecca Rimka, Rosilyn Kattiyaman, Lauren Campos

Location: Ring Central

Topic	***Discussion***
Volume	Rodney ● Starting with volume, Vivian tracks all volume per day, per site ● 2025 total patient encounters: 66,286 ○ Includes all seven Express Care sites ○ Banning opened in the summer, making this strong volume ● 2026 volume goal: 75,000 patient encounters ○ Will require increased outreach, which will be scheduled for end of this month through early February ○ Partnering with RUHS to help drive volume ● Goal is to increase overall volume and have a minimum of two providers per day at each site ○ Hitting this depends on meeting volume targets ○ This will be a focus for the year
ED Transfers	Rodney ● If you're at MSC and transferring a patient: ○ You must put a sticker on the log ○ You must document the transfer ● All patients need to be escorted to the ED

	● Exception: only if there is a really good reason not to ○ Example: toe pain, patient wants an MRI or a procedure we don't do ■ In those cases, the patient can go to the ER on their own ● MAs can now do escorts ○ It does not have to be an RN or LVN if the patient is stable ● There will be a discussion, or staff may ask if an MA can take the patient ● We want to avoid sending patients by themselves, otherwise, stable patients tend to become unstable once they hit the elevator or get downstairs ● We want to avoid Code MET calls on patients we already know are stable ● Escorting patients provides a good handoff for us ● There are some issues about delays ● MSC nurses are texting in real time when there are significant delays in the ED ○ Dr. Mesisca and I have worked with leadership in the ED, however, there will still be occasional speed bumps every now and then ● If there is a delay, identify why the delay is happening, so it can be addressed appropriately ● Kurt: If there is an obvious dislocation and no X-ray (e.g., finger dislocation), do they need to be wheeled over? ● Rodney: Yes, they should be brought over ● The main concern is when the patient gets lost in the ED system and we are going to avoid that ● Patient goes over, no questions ○ The nurse will take the patient over ● Patients are going to be wheeled over and handed off regardless of how minor the issue seems ● Mesisca: Does "wheeled over" mean escorted, even if they can walk? ○ Rodney: Yes, escorted. They do not have to be in a wheelchair if ambulatory ● Kurt: Can patients be given the option to take themselves? ● Rodney: No. There will be no gray area. ○ The concern is lack of handoff and the ED not knowing why the patient is there

	● If there is a rough handoff, attitude issue, or other problem: it should be escalated in real time so Dr. Mesisca and and Lisa can address it ● There needs to be a change in culture. Staff making things difficult for patients and staff need to be held accountable. If it's not reported in real time, it can't be fixed. ● Patients do better when we bring them over ○ It leads to happier patients for both the medical center and Express Care ○ This has been proven repeatedly Kurt ● Is it reasonable for simple cases (e.g., finger injury) to be taken to triage instead of bedside? ○ It is reasonable for Express Care nursing to discuss this with the ED nurseED may ask for the patient to be brought to triage ● Mesisca: We want patients to be routed to ED2. There is extra staffing there that is sometimes underutilized. ● The default should be: ○ Can this patient go to ED2? If not, do they need a bed? ○ The last place they should go is back to the lobby or internal waiting room ● Ideally: Someone at MSC will take the patient from Express Care to ED2 ○ This is being discussed further in an upcoming meeting Kelly ● Had 2 back-to-back ER transfers during a busy time with multi-traumas and no one was available for warm handoff and told to call back in 30 minutes. I do not want to delay care (for example, a possible PE, tachycardic patient), so I sent a message to the attendings. Can we do that? ● Rodney: Those are extenuating circumstances. If there is a significant delay: ○ Send the patient with the nurse, Secure chat the ED, and Document the transfer ○ ED can call back if they have questions ○ This is appropriate and doesn't happen often ○ A few minutes' delay is okay, but not more than 5–10 minutes when patients need care ● Bushra: Are we going to get extra staffing so we don't get backed up?

	● Rodney: No, if it becomes an operational issue: ○ Kim is paying close attention. She came in yesterday and noticed a massive delay due to there not being enough rooms. Noticed Daryl had not requested extra rooms ● If there are significant delays with nurses taking patients over: ○ That is why Rodney is being notified, so it can be relayed to Kim ● Ideally, extra help would keep flow moving, however, this is a county decision ● Data on delays will continue to be shared, but it unlikely that staffing will be added at this point Rodney ● Make sure you are documenting in your chart that you spoke with an attending and who you spoke with ● This ties into quality review ● Transfers are reviewed for: ○ Necessity and ensuring the documentation supports the transfer ● The chart must clearly state: Patient transfer to the emergency department ● In the plan that is built in for us ○ Remove patient discharged home ○ Add “patient transfer to the emergency department, escorted with Express Care nursing” ● Otherwise, it looks like a pre-completed note and will not do well in court as there are two different plans in there
Time Cards	Rodney ● On time cards, the hours must be associated with the correct site ○ There was improvement noted this pay period ○ You must manually select the site when clocking in and out ○ This is required for accurate county invoicing where we show the hours worked and where ● Deadline:

	○ Time cards must be reviewed by Saturday night at the latest. It can be done earlier if a Saturday shift is not being worked ○ Cards are signed Sunday morning and it provides time to fix any errors or missing entries ○ If time cards aren't signed or correct, it escalates to Dr. Mesisca ● Signing your time card means you are authenticating that it is accurate ○ Rodney then authenticate your authentication ○ Payroll issues arise if this process breaks down ● You may now clock in 10 minutes before your shift ● Katie is handling follow-ups and actionable items, so in baskets have been going very well ○ The only thing you would look at an in basket for is a red alert for a critical that needs to be addressed immediately (e.g., hyperkalemia) ○ You do not need to review non-critical in basket items before your shift ○ Katie will go through actionable items on Monday, Wednesday, Friday ○ On Tuesday/Thursday: check only for critical items ○ Banning clinic is covering in baskets on weekends ■ Mondays have improved significantly as a result Katie ● An actionable item is anything that requires an order ● Examples: Referrals (e.g., positive Cologuard), Medication changes, Positive STI results (noted as common recently) ● Have had a few cases requiring in-person evaluation ○ If a physical exam is needed, bring them in ■ For example, if you have a patient forming soft tissue abscess without recent exam or antibiotics, call them and send them to clinic ○ Do not wait for Katie to be on with cases like this ○ If it is not something that needs a physical exam, call Rodney ● If you do not know how to use the system to make a phone call to the patient and document in the chart, reach out to Katie, Tiffany, or Vivian.

	● We do not want to miss an opportunity to be able to create a billable visit for a patient that is legal and necessary ● If you are still unclear what that looks like, reach out to Katie. She is an expert on it at this point.
Advanced Imaging	Rodney ● Consider whether advanced imaging is truly needed urgently versus if they could have followed up with primary ○ There should not be difficulties in getting them PCP appointments ● If you're gonna order an advanced image, Discuss with the supervising physician before ordering to make sure that the patient needs it that soon, and they could not have waited for the PCP ● If imaging can wait, have the team schedule that patient with PCP follow-up within 1–2 weeks ○ If that cannot be done, secure chat Rodney with the MRN so it can be addressed to Kim to find out why they are blocking appointments ● We are getting some studies back late for an MRI that was ordered two months prior, and everyone was trying to figure out why. I got radiology talking about a CT that was ordered in October, but performed in January for an abscess. ○ One of the problems is the length of the study that has been ordered ○ Anybody that is getting a study should have that study within a week. An MRI can be harder to get a closer appointment, so it should not be longer than 1 month. They have to get it done within a month or it expires. ● Labs should be completed within 1 week unless it is a care gap ● Care gaps can have at least a month, but anything longer is sitting there and then all of a sudden it pops up and nobody knows why it was ordered Kurt ● Ortho clinic is really good at getting people in and usually see patients within 2 weeks ● Rodney: They often determine themselves if an MRI is needed ● For a lot of these ortho follow ups, ortho gets them in before they even schedule the MRI ● If ortho asks the provide to order the MRI, that is documented in the chart to explain why it was ordered

	○ This allows all providers to be able to defend care decisions
Patient Care	Rodney ● All patients need follow up appointments scheduled before leaving the clinic ● If you are struggling to get that for them, secure chart the MRN so the challenges and barriers are being escalated ● This will reduce unnecessary Express Care visit Rodney ● If you are going to discuss a patient with colleagues or the supervising doctors, the standard expectation is to see the patient first and do your own history and physical exam. Then ask questions or seek advice. ● Colleagues will ask for clinical details and saying you have not seen the patient is a major trigger ● See the patient, do your history, do your physical, and then come ask your question
Note Templates	Rodney ● Tiffany was gracious enough to help us build these pre-completed templates and notes that have some standard things that already pop pre-populated into your note. ● You need to review your note and make sure it is accurate or it is going to burn you in court ● If the plan is pre-populated, you must change it, or update it to reflect what you actually plan to do ● Same applies to the physical exam ● If you are using a scribe, you must review the scribe's notes ○ Scribes are not medically trained ○ They are documenting what we tell them ○ Personally uses dictation as it is more efficient then going back and reviewing what the scribe wrote to make sure it is accurate ○ Scribes are fine, as long as you review the note ● They will be pulling 5 charts per provider per month, so that we can check and make sure that it's accurate ● We all make mistakes, but we want to minimize this both to protect your license, as well as the care of the patient and the contract with the county

	● If you do not know how to dictate or you want some mentoring on dictating, be is happy to demonstrate
Volume Surge	Rodney ● We will get surge volumes, MSCs, like the constant surge from the beginning to the end. A surge is a bolus of patients coming in. What's the appropriate way to see them and document? ● The limiting factor is often rooms or getting patients into a room, but we don't want the limiting factor to be providers. ● One way to avoid being the limiting factor is seeing the patient, putting in orders, and moving to the next patient. Documentation is completed in the last hour. ○ The caveat is MSC, where the last hour is spent on patient volume. Otherwise, the last hour is an opportunity to finish documentation. ● If we have downtime and are caught up, that's another opportunity to complete notes. ○ I can review volume, time cards, and resource utilization. ○ People may finish early and leave, which is fine as long as all documentation is complete. ● The last hour should be used to finish all documentation. ● Incomplete notes can trigger issues with the county. ● I can check Epic for patients seen, last check-in, and provider clock-out. ○ Leaving early without completing charts doesn't make sense. ○ Some may say they'll finish the next day, but consider efficiency and workflow
Quality Checks	Rodney ● Matt and Dr. Alkotob will look at charts for opportunities to improve. They will pull a few cases (cardiac, pediatric, and transfer cases) for review. ● Feedback will be shared with providers, including mine. ● If there is a learning opportunity that the group can learn from, it will go in the education component

	● We already hold charts and take a peek at them, and from the perspective of our supervising doctors, Rodney, Mesisica and Matt, they look pretty good. But there is always a chance for improvement.
Patient Supervision	Rodney ● There was a patient from the Emmanuel Group home, who was not cognitively equipped to answer any of the questions, and he was by himself with no social worker or nurse present. Is there a way to standardize having someone as a social worker or a nurse present? ○ We are creating a phone list to contact facilities and encourage them to provide a staff member, at least by phone. ● Chance: There was a patient dropped off at Palm Springs clinic without supervision who left. Police later arrived looking for patient ○ Secure chat MRNs should be sent to Matt and Rodney for follow-up. Lawrence ● How do I make sure patients have follow-ups when they are discharged? ○ Rodney: Providers don't need to track follow-ups as long as they document them: write the appointment on the intake form and as a nurse communication order. Kim can pull data to verify compliance. ● Can the nursing communication be turned into a hard stop or an order? Some nursing communications have been overridden ○ Rodney: Will be looked into ● Matt: The standard workflow is the discharging provider walks the patient to ACC for warm handoff if a follow-up is needed. ● Rodney: It will not happen this way at MSC. Kim wants the nursing staff to have the patients scheduled ○ This ensures the ACCs do not schedule patients 6 weeks out, when they need to be seen within 2 weeks. The patients will get appointments when the providers think they are necessary.

	Lawrence ● Why don't we have the ACC make a follow up appointment when they register the patient? ● Rodney: They don't know when the patient needs a follow up. ● Tiffany: At the bottom of our note templates, there is a built-in follow-up appointment that will include any appointments that they have coming up. So if you refresh your note before you sign it, at the very bottom, it will populate that appointment that was made for them. ○ When patients come in for easy things, to simply establish care. Sometimes the nurses will just make an appointment as they are registering the patient and rooming the patient. ○ Those are small things that can be implemented, where the patient is just there to establish care and start being seen by a provider with follow-up with primary. ○ I assume PCPs are not going to have anything available for 2 to 4 weeks at the earliest. So anything less than 2 weeks or less than a week, I am having them follow up with us.
On Call Attendings	Mesisca ● We want to close the communication a little quicker ● If the attending needs a little more time to look through the case, they are going to try and text you all back to let you know that they received the text, and they are looking through it. ○ Some of them are kind of long and by the time we end up reading through the end of it and processing you are reaching out to the next attending. ○ So we will work on getting the responses back to you later.
Audits	Katie ● RUHS is going to start auditing weekly. ● They are going to start sending the delinquent charts to us. So you might be seeing some emails about reminders and they are mainly focusing on the BMIs for adults and PEDS. ● Individual clients are trying to up their percentages Katie ● When the scribe is going through the radbinder, if they have a final read and it is something that is not normal and they run it by you and you say, “hey, this patient does not need to be called today”

	● You can send me those MRNs. Just make sure that the scribe is asking the provider first. The scribe should not be sending it without a provider reviewing it. ○ The scribe should not be reading these final reads and making an interpretation that way. ○ That is like a triage that they should not be doing Katie ● The in basket is open to all unless Katie is working that day. If there are 20 patients in there, feel free to pull. ● Lawrence: Should items be left in the inbox for Katie or forwarded for convenience? ● The patients are usually pulled before providers are in the clinic. ● Providers sometimes send their plan, which is appreciated. ○ If there is already a plan (for example, waiting on an X-ray before PT vs. ortho), send the item with the plan.
Care Gaps and Insurance	Rebecca ● What do we do when a patient's paperwork says outside PCP, but chart review shows recent visits with RUHS PCPs and upcoming appointments.? ● Katie: Care gaps may be due, but outside PCP status usually means gaps are not addressed. ○ Many patients are transitioning insurance, especially at the beginning of the year or month. ○ Insurance changes often occur without the patient realizing it. ○ If paperwork says outside PCP, document in the chart that care gaps were not addressed due to outside PCP. ■ This is commonly documented in discharge notes, especially at Elsinore. ● ACC verifies insurance at check-in and notifies staff if a patient is outside PCP. ● Some patients still schedule PCP visits, and fees may be absorbed. ● Care gaps should be addressed by the PCP. ● Providers are not expected to manage registration or insurance issues. ○ If paperwork and report are outside PCP, document that information. Frank

	● Hovering over insurance in Epic shows the most up-to-date information.
	● If insurance indicates outside PCP anywhere on the line, it confirms outside status.
	● If paperwork says outside PCP but Epic shows RUHS, verify with ACC.
	  ○ ACC may have circled the wrong insurance or not updated it.
	  ○ Paperwork and chart insurance should match by the end of the day
	Chance
	● If a patient is transitioning to RUHS but still has Molina or another insurance, should care gaps be ordered?
	● Katie: Recommendation is to wait until the patient is established with RUHS primary care to avoid patients receiving a bill
	  ○ Insurance transitions are handled by Medicare/Medi-Cal representatives.

Corona	Vivian
	● Corona has a new MA, Jenny, working Sunday through Wednesday.
	  ○ Jenny is learning express care workflow.
	● A new LVN is also training from 8:00–5:00, so clinic flow is slower while new staff are training.
	● Be patient during this period while everyone is learning
	  ○ You can do easy discharges to improve patient flow.
	● This is expected to last a couple of weeks.

Dot System	Tiffany
	● Follow-up on previously sent emails regarding clinic workflow.
	● The dot system must be used consistently in all clinics.
	  ○ Smaller or non-MSC clinics should follow the same process.
	● An updated alert dot guide was sent via email.
	  ○ Pink dot: medication with recheck.
	  ○ Green dot: patient ready to go.
	  ○ Blue dot: orders in place.
	  ○ There is a specific dot used for patients going to X-ray, especially at MSC.

	● Dots should be used at all times without exception. ● Nursing communication orders must be entered in the system, even if notes are written on paper. ○ Without nursing communication orders, patients may be accidentally discharged. ○ Written notes can cause confusion if timing is unclear. ○ Nursing communication orders flag nurses before discharge. ● Computer documentation is the standard and legally important. ● Stickers must be placed in correct bins to prevent accidental discharge.
General Comments	Matt ● No operational, performance, or training updates. ● The first education session of the year occurred last week. ● Education sessions will continue monthly. ○ Dates for the next lecture will be sent out Jocelyn ● The mobile mammogram unit is in the parking lot at the neighborhood clinic today. ○ If a patient comes to express care first and is due for a mammogram, an order must be placed. Rodney ● Are there any volunteer opportunities for high school students at RUHS or MSC. ○ Opportunities may be available through the main hospital volunteer program. ○ Information will be researched and shared once available.
Case Presentation	James ● Link: Kelly ● Link:

Meeting called to order: 8:00a; Meeting adjourned 9:13a