Date: December 17, 2025

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

Location: Ring Central

Topic	***Discussion***
General Comments	Rodney ● As we come to the end of the year, the county is really pushing some pap smears as they need to get a certain number. So they will be pushing the pap smears to express care as much as possible. MSC will be affected the most. ○ If a patient comes into the clinic for a sick visit, but the nurses notice that the patient needs a pap smear, the nurses will talk to the patient. If the patient agrees they want a pap smear, the nurses will come to the providers and let them know. That way we help and hit their numbers. ○ I think they are 6 people short at MSC, so we should be able to help them hit their number. The other clinics are doing them anyway. ● I want to give a shout out to the party committee for a fantastic Christmas party. Everyone was really engaged. I had a blast. It has been a long time since I have been to one of our Christmas parties, so thank you very much for putting the time and energy into it all around. I thought it was great. Dr. Mesisca was smiling a lot. We got to talk about it and we both enjoyed it. Thank you all for all the work you did for that. Mesisca

	● Just to echo what Rodney shared, the Holiday party was awesome. You guys did a phenomenal job. It was a lot of fun. I like the fact that everybody was fancy and the culture was very family-like, which is profound. ○ It was really cool to kind of see everyone interact, which I shared with the administration, friends, and even my wife. ○ We had 112 people RSVP and about 100 people showed up, which is awesome. ○ Five years ago, none of those people of the 100, including you all, worked for the express cares. It is nice to pull everybody together and get appreciation. ● Most of the time we are all at one of the clinics or one of the locations. And in that, you do not always get the gravity of the magnitude of the impact that we are having. ○ We talk about 65,000 patients in a year, and it is hard to kind of wrap your mind around a stadium full of people, which is amazing. We get to see the impact on an individual patient basis. ● As I hit the end of the year, I kind of like to reflect and look backward. In meetings like this we are always wanting to fix problems, so we tend to spend 90% of our time doing so. It is our personality and it is who we are as leaders. It is what makes us good at our jobs, as we are always trying to refine and get better. ● We are in a CQI mode of, like, continuous quality improvement. If we are good, we want to be great. But it is super important to kind of pause along the way and look back and go, “wow, this is really exceptional” and you have all been a part of this for varying levels. ○ I think we had one person, I think it was Jonathan, that had worked one shift? So, it goes all the way from, Tiffany and Vivian, who were with us from day one to somebody that has worked a single shift, and they are just as much a part of the story and the journey, which is awesome. ○ I hope that that is just sort of worth sharing and reflecting on, because the daily work is really tough. Like those of you that are working today, you are going to go in and see anywhere from 20 to 45 patients and you are making an impact on an individual basis, but

	that is the necessary part. Those are the building blocks to a much bigger story of creating access.
Volume	Mesisca ● We had a meeting with the RUHS executive team kind of looking at volumes and finances on the hospital side. I think they are very pleased with the role that express care is having and the very positive impact that it is having throughout the entire health system. ○ In terms of getting access for patients, getting them linked to specialty care, getting higher acuity patients to the emergency room, it is all deeply appreciated by the hospital CEO and the CFO, they are great people. ○ You guys kind of see me and Rodney as your bosses, but our bosses are kind of looking and validating the work, the great work that you all are doing. We want to be able to come back and share that with you. ● One of the opportunities that came from there too is we added clinic hours and we have expanded a lot of them to where they are open now for 12 hours or seeing new patients for 11 hours. In this coming year, we will be focusing on doing things like pap smears and hospital discharge follow-ups. ○ We are really aiming to try and improve some of the volumes, particularly, the weekend volumes at Palm Springs and Lake Elsinore, and there are some strategies around that. ● We want to kind of share with you the things that are most important to us and to the health system. And that is both on access and cost and quality - things that the clinics get measured around - we want to maintain the quality of care, but we also want to increase the volumes. ● I think a good number in the back of your head, and I do hesitate to say this, because when I would say this to advanced providers in the emergency room, it would always create some anxiety of counting patients. But what we are really interested in is the number across the system. ○ Some days you are going to see 45 patients, which is 4.5 patients per hour, and other days, the clinic might be slower and you might see 15-16. ○ But on average, we are really kind of hoping to exceed that like 2.5, 25 patients a shift.

	○ Our initial target was around 3 patients per hour, but that was when we kind of stepped into this thinking that it was like traditional urgent care. And as we have done more and more primary care preventive care, I think probably a sweet spot when Rodney and I sort of talk and think about it is around that 2.5 patients per hour. ○ We are at about the last fiscal year ending in June. The numbers that we have, we finished at around 2.1. And that was because we added a lot of training shifts and expanded clinics. When we start new clinics, the volumes are lower. ● So, I just kind of share that with you all as sort of a barometer. I do not want people stressing about how many patients they saw daily and thinking Dr. Mesisca and Rodney are going to be upset. That is not the message I am trying to communicate, but I do kind of want you all to have a sense of how we are moving patients. ○ I do not want us to be anxious about low acuity patients moving from the express care side to primary care. If they want to pull patients to hit their numbers, that is fine. We are looking for a healthy system, but within that, we are going to set our own internal target. ● I want you to be aware of it in a sense where you guys can have ideas at your individual sites to draw volume and hit those numbers. ● I sort of sensed a little internal, healthy competition and some of the awards that came out. There is a lot of pride at each of your sites. ○ Maybe what I am trying to stoke is some pride at your site. Like, is your site hitting that productivity number? And if not, what can you do as a team to help strategize on some of that? ○ Rodney has driven past some of the clinics and it looks like they are closed on the weekend and there is no signage on the building. I think Banning was one that you would not know was there. ■ We are working with the clinic manager and the marketing team. We have gone out to elementary schools, but that is sort of the strategy. Lawrence ● Do we track the acuity of patients that were moving on a regular basis through express care?

	○ Mesisca: That is a good question. I do not know that we have a good metric for doing that. It is not like the emergency room and the reimbursement is not tied to acuity. It is just based on visit because you have to hit the care gaps. ■ A sore throat is going to bill and collect at the same rate that a hospital discharge follow-up is. ○ There probably is a mechanism to pull that data, but I do not know that there is. ■ I feel like that would be valuable data in making these goals, because I feel like the acuity that I regularly see seems to be a whole lot more than what primary care would normally be considered. And I think we have a team that is not going to cut them off at two or three complaints, as well, and I think that should be a factor in setting these goals. Mesisca ● There are some strategies that we have talked about. I think you are not going to cut a patient off, but I also think if it is super busy, it is totally not inappropriate to have them come back even in a couple days to express care. You can prioritize the visit. ○ Example: Say they have uncontrolled hypertension and diabetes and a couple other things, you can address the diabetes and hypertension and then justify bringing them back in a couple days to see if their hypertension's better and then begin to address their thyroid and some other things. ○ So the system is sort of designed in a way that incentivizes having multiple touches on the patient and not trying to get it all done at one time. ○ If you worked for Kaiser, they would want you to get it all done at one time because they are both the payer and the provider. This is something a little bit different, in that we are not the payer, the federal government is. And so, I am not asking for an abuse by any means, and I do not know if that strategy is helpful, Lawrence, but I think we can look at the acuity. The numbers are the numbers because that is how the finances are tied. ● The different clinics will balance themselves out.

	○ Like, you bring somebody back for a pulmonary nodule on an x-ray to talk to them about getting a CT scan and linking them to their primary. That is probably not a long visit. ■ That probably the strategy is if we have a lot of complex hospital discharge follow-ups, then as a group, we need to look at bringing in pap smears and other things that are a little less time intensive at the sites that have really high acuity to help offset that. ● Lawrence: Yeah, I totally think that those kinds of things will help the numbers. I am not here to move numbers. I am here to give quality care and I think that should be the primary focus. And I get really anxious when you start talking about numbers, that is going to get lost. ○ Mesisca: I do not think it is one or the other. It is a combination of the two and that is just the reality of the business of medicine. ○ The productivity also has to do with the output too and that patient satisfaction is also tied to how long people are waiting. ○ And so, you know, I think that is the balance, right? You have to spend enough time with patients to address those concerns. ■ I guess that is kind of where I am giving you permission to bring them back. I think there is a very polite way to do it, in a way that does deliver the quality, but express that you have been doing this a long time. I think it is harder even on the newer people because you are really worried you are going to miss something, and we do not want people cutting corners. ■ I think those are reasonable targets, but I confess, I am a little removed from what you all are doing, but those are numbers that we have talked with Tiffany, Vivian, and Rodney. The 3 patients per hour when we started, I think we have sort of come to realize as a picture. Rodney ● There was an adjustment because we were at 3 patients an hour, and with the acuity and the level of primary care we are handling, that is why it has been able to drop to 2.5. ○ Which again, it is not one of those numbers that you have to hit, 2.5 is just one of the goals.

	○ We have the goal to provide high quality care, provide access to the patients, do all things primary care, and things in terms of filling in that gap they can not give. ○ The ask is, see anything that comes in that is appropriate for us to take care of. And we will drive good volume that way. ○ If we get to a point where volume is pushing the higher numbers, then we can look at staffing appropriately, but we do not cut off like primary care does. So you guys can not do much about the volume at this point in time, we just ask you to see whatever comes in and be efficient and give good quality care. Mesisca ● Let's take a business model, when we see 8 patients on a weekend day in an established clinic like at Palm Springs or Lake Elsinore on a Sunday, the system is losing a significant amount of money. ● Now there are ways during the week, if you can justify a recheck on somebody and bring them back on a Saturday or Sunday, or Katie can route some of these virtual visits to be in-person visits on those days, and the leadership team has been looking at load leveling. ○ So the biggest opportunity is just trying to avoid the sites that we are already established in, that are having these episodic, significant goals in particular on the weekend. ○ Usually, with time and good service, the word gets out and most of our growth, which has been exponential, is by internal referrals of people sending family members and others to see you.
Holiday Hours	Bushra ● The clinic's staffing did not know that holiday hours were different, and if we can have management put some signs in the clinic that we have different hours on Christmas Eve and New Year's Eve. That would be helpful. ○ Mesisca: So whenever the staff comes to you guys about hours or the clinic operations, refer them right back to their clinic manager. They are the ones who set the rhymes for that, but they are working on signage. Mesisca

	● I did get the impression from an announcement that Janelle made recently that in the coming months, if not the next year - you can validate this if you know more - it sounds like they are probably not going to keep the express care open on the county holidays. ● We have had some we have kept them open, and I think it has a combination of cost and union issues. ● I think our preference would be to stay open, because I think it just creates a bottleneck that then makes the day after the holiday super challenging. You all might have mixed feelings. It is probably nice to have the day off, but I think that is probably what they are looking at. ○ Rodney: Yeah, they will stay closed on the major holidays. They were looking at opening like we have before on some of the soft holidays, but if anything happens again, it will most likely just be MSC and another clinic on a soft holiday, but it will not be for the first part of this year.
Reminders	Katie: ● Sent an email regarding in baskets ● The providers are doing the work for in-baskets on the weekends. It has very slim pickings on Monday, but we are not putting them on the schedule appropriately, and we are kind of utilizing a lot of the non-billable tools to follow up in our in-baskets, which is not giving the clinic the credit it deserves or you guys. So, the flow is going to change a little bit, but it is not really going to affect you guys as much. ○ If you see anything that you would call a patient about, just send it to Katie or leave it in the in-basket. And then the weekend providers, the patients that I cannot contact over the week, will be getting an Epic message. ○ We will send out all the MRNs and will attach the team leads that are on that weekend to kind of help. And then you have to add them to the schedule on the weekend, so that we can start getting some credit for the work that you guys are doing. So these are things that you would be calling the patient to do an intervention for.

	○ So sureswabs, changes in antibiotics, patients with chronic imaging issues that have not been referred to PT or have not done any of the conservative care, H. Pylori, or anything that is not going to harm your patient in the next week or so. ○ If there are things that you can send and you are on the fence about something and you do not really know what to do with it, send it to me and I can work on that. ● We are really trying to make sure that you guys are getting credit for all the work that you are doing. ● Adding those video visits is going to help with those numbers. During the week, I am also able to look to see if those patients need care gaps like pap smears and things like that, where I can get them visits on the weekend to come back in. ○ Kurt had asked specifically because they added a camera at banning on how to actually connect to a video visit through your desktop computer, so for patients that are on your schedule for video visits, that is how you can do that. You can always send me a text or an email and I will try to walk you through it the best I can. ● If you are really OCD about your in-basket and you like to keep it neat and you do not want to worry about me fishing through it, just send it to me, and it is out of your hair. ● Documenting a telephone encounter ○ I only utilize these notes when I try to call a patient and I get a voicemail. ○ Or the patient has one of our insurances that the ACC will not add to the schedule, because they are not contracted with us, or it is a Medicare patient, and we do not get billed for it. ○ So those are two types of patients that I would use this telephone visit for and use the little blurb. ○ You can use the regular telephone icon above your in-basket, but it looks really messy and is sometimes really hard because it attaches the whole encounter and you have to kind of fish through it to figure out what happened. ○ The providers are not doing anything wrong, we just want to make sure you guys and the clinics are getting credit for it. Chance

	● I had a patient that had a positive BV. I had the nurses check to see if I could add them into the schedule and they were fine. I had added them into the schedule and I tried calling using the video visit, but they did not pick up on either of that. I called later and I was able to get him on the phone. Do we still get credit if I contact them and I was not able to get them through the video visit? ○ Katie: Yes, there should be a way for you to document that as well. We have the telephone note and video visit in our templates. ○ This happens to me a lot with patients when I call them. I ask them if they want to switch to video and they decline. I just document that the patient was offered a video visit and declined, and then I just make sure that in the attestation that they do I also put "patient declined video visit and proceeded via telephone per patient preference". ● So you want any type of video visit or phone call that we do on results to be on the schedule? ○ Katie: Yes, as long as we can get credit for it and the patient is eligible to be added Chance ● A lot of times during the weekend I am capturing them because during the week, you guys are super busy. So it is sometimes a lot easier to just call the patient, throw in the telephone note, and do your intervention, but we do not get credit for that. So you want us to send it to you, so that way you can look over and schedule them for us? ○ Katie: Yes, I will contact and help with the intervention that way we are getting the credit for it because you guys are busy seeing in person patients. ○ If something comes up in your basket and you are like, I do not know what to do with this, just send it to me anyway, and I will reach out to the supervising doctors. ○ When there are weird labs and stuff like that, we can definitely figure it out. Do not feel bad if you do not feel like it has something that is not actionable. Katie ● The only other big thing that I forgot to mention is we are all still responsible for any criticals that show up in our in-basket because I will only be checking these Monday, Wednesday, Friday. ● Make sure that you are also checking your in-basket and at least browse it during your shift to make sure that there are no criticals, meaning patients that need to be called ASAP to either come into the

	express care for splinting or to the emergency room due to critical labs. Those are kind of the big things that you should be focusing on when you look in your in-basket.
MSC	Tiffany ● The end of the year is coming, so make sure you guys use your CME if you have not already for part time and full time people. Some people are doing re-appointment with the emergency department or express care in general, so just make sure you are handling that. ● If you need any peer references or anything like that, you can always utilize me. Just send me a text message and I will do it. ● For all of the clinics, make sure we are ordering lidocaine if we are using it for any procedure. I know most clinics do not make us order it, but there are one or two that are pretty insistent that we put the order in. So make sure that you are putting in a separate order for lidocaine. It will have you put in an amount that you are going to give. ● Usually in the ER it will come in like 5 mL vials. So if you want to round up by like 1mL, usually we know about how much we are going to put in, but if you need to put in more, that is okay. ● They are going to give you the whole vial like they already do, it is not the 5mL ones. It is the regular vials. So if you end up using more, you can adjust that or you can add onto it. So just make sure you are putting the order into epic. It should be a clinic administered medication.
ED Tracker	Tiffany ● I know we have our tracking system for the emergency department, so just make sure that whenever you are sending patients to the ER, that we are putting a sticker on the sheet. ○ It was moved from the door onto the wall. ● You just need to put the reason or what you are concerned for, what you are ruling out, and your initials on there. That is going to help us with our own internal quality. ● I have had a lot of people ask if we are sending too many patients? Are we sending something that is wrong?

	○ I have been telling everyone it is not punitive. There is no thing that someone was doing wrong or anything like that. We are always constantly looking at quality and what we are doing, and how to increase education. ○ I think that when we started express care, that was one of the pillars of importance, continual growth and continual learning, because none of us know everything. ○ Sometimes we will have cases where we did not even know what happened. And we can use those for presentations and we can pass that information along to Mesisca when they are in their meetings. I think it just shows how great and amazing our team is. ■ Rodney: I think you captured it well. The only thing is it also allows me to go in and look if there is a question about a case to make sure that we consulted either our on-call attending or the emergency department attending. So any patient getting sent over needs to be consulted with either your on-call position and the ED. It captures a lot of positive things.
XR Techs	Rodney ● There was one day at MSC where they did not have enough radiology techs that day in the outpatient radiology on the first floor. So we actually did not have walk-in x-ray for patients that day, so we handled it how we would at the outside clinics. ● If a patient needed immediate imaging, then we sent them either to the emergency department, or we would tell them they can come back the next day for walk-ins. ● It does not sound like it has happened again, but if you guys happen to be on shift and that does happen, can you please let me know? ○ It is something I would like to keep tabs on the frequency with which it is happening. ○ This has only happened one time in the 3 years that we have been at that site.
General Comments	James ● A patient was sent to me last night from pediatrics for a well child exam for a three week old. I just want to make sure we are not doing well child exams.

	○ Rodney: It is not a well child, so see the kid, do a physical and have our team schedule them with pediatrics for a formal well child exam. ○ Nursing staff will sometimes push back and say they can or can not do anything and they have not actually run it up the chain. So just send anything that they say they can not do to me, and I will confirm. James ● I had a kid yesterday that expressed HI to me yesterday. I spoke with Dr. Despujos about it and was told to send him to the ER for evaluation. The ER social worker sent me a really nasty message on Epic saying to use the clinic social worker first. ● Rodney: That aggravated me. Send the MRN number to me and we can look into it and we can escalate it to Dr. Mesisca. There might just be a lack of understanding from the social worker. ○ So if the attending recommends that, because we do not always have the social worker available at the MSC or the clinic, keep doing what you are doing.
Patient Awareness	Jocelyn ● There have been a group of patients coming from the Franklin Residential Care for Beaver Health Patients. These patients usually arrive for medication refills and they have a packet with a medication list with them and the instructions for us are to refill the highlighted medications. ● The concern is that some patients do not know why they are there or why they are taking certain medications. ● Most of these patients are alone in the room, and this should change. ● We learned that patients arriving by bus are accompanied by a nurse. ● At Neighbourhood, the nurse was told to wait in the lobby with the driver. ● If a patient is not equipped to answer basic healthcare questions, providers should reach out to the nurse who accompanied them or a nurse from Franklin Residential Care. ● The nurse's phone number should be posted on the board by the main provider computer at Neighborhood. ● This information can be emailed to everyone, and Nikita at Neighborhood can help as well.

	Rodney ● What if nurses were automatically in the room with these patients? ● When the provider enters, they can confirm with the patient that it's okay for the nurse to stay. ○ This would prevent delays caused by going back and forth to locate the nurse. ● The goal is efficiency and avoiding interruptions in workflow. ○ Jocelyn: The nurse stated she did not enter the room because she gives patients the option of whether they want her present. ● If the nurse is not in the room, at minimum, she should be stationed outside the room. ● Providers often need to ask the nurse questions anyway, so having her nearby improves efficiency. ● Follow-up will be provided once the patients return.
Scheduling	Vivian ● April scheduling is in progress, and the first half of April is already busy with vacation requests. ● No additional vacation requests will be accepted for the first half of April. ● Providers who have not submitted time off can request dates in the second half of April. ● Vacation requests must be submitted before booking non-refundable plans and must be approved first. ● Providers will be informed whether their request is first or second choice, and dates can be adjusted if needed. ● The scheduling policy will be resent as a reminder. ● March scheduling is complete, and April will be finalized soon.
E-consults	Katie ● Providers should check and respond to e-consults regularly. ● When logging in, ensure there are no pending e-consult messages. ● Charts must be signed so billing can be completed. ● If there are questions, providers should contact a lead or practice lead for help. ● Providers should review emails daily, including RUHS and Vituity emails. ● While working, providers should also monitor secure chats and consult messages.

Malpractice	Lawrence: ● In what situations would malpractice coverage not apply? ○ A patient was triaged who belonged to a primary care team but presented for a worker's comp injury. ○ The patient could not be seen for worker's comp, but the patient needed first aid. ● Wanted to document and provide care. To what extent do we need to document to be able to have coverage in these cases? Mesisca ● Vituity's internal malpractice coverage ("the Mutual") does not apply to most RUHS sites. ● RUHS contracts are covered by county malpractice insurance, which can be broader in some respects. ● Under the Mutual, if there is no chart or encounter, there is no malpractice coverage. ● Any care provided without documentation is considered uncovered. ○ Phone conversations and any rendered care must be documented in the medical record. ● County coverage shifts most liability to the county rather than the individual provider. ○ Provider accountability is more focused on peer review and quality review. ● If something is not documented, legally it is considered not done. ● Without documentation, patients may extrapolate or fabricate details if legal action occurs. ○ Any professional care provided should be documented, including care for family or friends. ○ There are appropriate ways to document those encounters if they occur. ○ Any care tied to Express Care services must be documented in the chart. ● Providers should focus on delivering care, not financial responsibility. ● Billing issues can be addressed later by clinic management or registrars. ● Patients with commercial insurance must decide whether to pay out of pocket or seek care elsewhere. ● Clinics are not bound, so patients may decline care based on cost. ○ Registrars typically handle financial discussions if the patient has not entered the system.

	● In worker's comp cases, if the patient has a secondary medical issue, they may still be seen for that issue. ○ Example: a patient with anxiety and a worker's comp injury could be seen for anxiety. ○ If a splint is adjusted during that visit, it does not mean the worker's comp issue was fully addressed. ● The general rule is: if you are treating a patient, document it in the medical record. James ● We do not do any work comp cases, right? Because sometimes I will get some patients that walk through that are work injuries, and I just want to make sure that we are not addressing those. We normally recommend they go to their employer or to the ER if they had an injury? Rodney ● The patient presents, and makes it into the clinic, and it has a non-RUHS work comp, then we can see them and then refer them to their own work comp clinic. We can see non-RUHS work comps. If the ACC's clear them and they put them in the room. ● Generally it becomes more comp after we see them because if they have Medi-Cal and Medicare, that is what we are seeing them under. And then we have them follow up under their work comp case.
Case Presentation	Meagan ● Link

Meeting called to order: 8:00a; Meeting adjourned 9:15a