Date: April 15, 2026

Attendees: Rodney Koenig, Michael Mesisca, Tiffany Mendoza, Vivian Acevedo, Sheranda McGee, Himelda Churchill, Chance Thepmontrynhep, James Bailey, Jocelyn Le, Jasmine Yuen, Katie Alexander, Kimberly Henshaw, Kimberly Sales, Kelly Medina, Krista Harris, Kristen Petti, Kurt Harris, Lawrence Gates, Magen Costilla, Meagan Ponciano, Rebecca Rimka, Lauren Campos, Karla Montes

Location: Ring Central

Topic	*Discussion*
Announcements	Rodney ● Lab orders must be placed to the correct vendor (RUHS, LabCorp, or Quest). ○ There is a recurring issue where saved "favorite" orders are being selected without verifying the correct lab vendor. ● Regarding syphilis testing orders, which have been frequently ordered incorrectly. The correct test code for RPR w/ reflex to titer is 799. In EPIC, it is "syphilis AB (RPR w/ reflex) (quest)" ○ Providers always want the tpa, but they need to make sure they are ordering the 799 and 4122 ○ The Epic order for Quest syphilis testing should be FTA-abs and "syphilis AB, (RPR w/ reflex) (quest)." ● Staff are reminded to verify they are selecting the correct order set in Epic. ● Time cards must be reviewed and signed off by Saturday night. ○ Rodney reviews time cards Saturday night or early Sunday morning to allow time for corrections. ● A frequent issue is providers are not correctly affiliating the site where work was performed. ○ It is required to select the correct site because hours are billed to the county hospital by location. ● ED transfer log compliance has improved but is still not at the expected standard.

	● The expectation is that stickers are placed in the log for transferred patients.
	  ○ Nurses may occasionally assist, but it is not their responsibility to complete this task.
	  ○ Missing log entries create issues when reviewing transferred patient charts.
	● Chart review includes verifying whether the supervising physician was consulted before transfer (not just the ED physician).
	  ○ Documentation of that discussion must be included in the chart.
	  ○ Without proper documentation, it appears patients are being sent to the ED without appropriate review, limiting quality assessment and feedback.
	  ■ Data from these logs is being tracked and will be shared to demonstrate performance and quality metrics.
	● If providers do not feel confident performing procedures such as suturing, complex laceration repair, wound care, incision and drainage of abscesses, or dental blocks, they should notify leadership.
	  ○ Training sessions or refreshers will be arranged, either one-on-one or in group sessions depending on need.
	● Providers are encouraged to communicate training needs early so planning can occur for the rest of the year.

ED Transfer Log	Kurt
	● He has reviewed the transfers through March. Providers are catching a lot of good cases and making appropriate admissions.
	● December: 100 patients were sent to the ED, 7 admitted (7% admission rate).
	  ○ Total MSC volume: 1,935. About 5.1% of total volume was sent to the ED.
	● January: 109 patients were sent to the ED, 11 admitted (10% admission rate).
	  ○ Total MSC volume: 2,012. About 5.4% of total volume was sent to the ED.
	● February: 98 patients were sent to the ED, 18 admitted (18.3% admission rate).
	  ○ Total MSC volume: 1,969. About 4.9% of total volume was sent to the ED.
	● March: 129 patients were sent to the ED, 26 admitted (20.1% admission rate).

	○ Total MSC volume: 2,224. About 5.8% of total volume was sent to the ED. ● Overall, we are averaging about 5% of total volume sent to the ED, though actual may be slightly higher if entries are missing from the log. ● Many of the cases being sent are appropriate and high-yield admissions. ● A trend identified from chart review is excessive copy/paste between HPI and MDM. ○ The MDM should reflect clinical reasoning, differential diagnosis, and rationale for ED transfer, not duplicate the HPI. ○ Documentation is critical because if it is not documented, it is considered not done. ● ED providers often do not have time to fully read our notes, so clear reasoning helps continuity of care. ● Notes should include who was contacted, including express care attending or ED personnel, and this must be documented. ○ Include the time of communication and the specific individual spoken to, rather than just "ED attending," since care may be handed off between providers. ● Certain templated discharge instructions are being used incorrectly. If a patient is being sent directly to the ED, the note should clearly state "send to ED now," not advisory language about going if symptoms worsen. ● Epic workflow issue: hyperlinking labs and imaging must be removed or made non-populating so outside ED results do not auto-fill into the chart. ● Use correct EKG documentation methods rather than relying solely on auto-generated reports. ● Physical exam documentation needs to be more detailed and specific. Abdominal exams should include location and findings rather than generic statements. ● Photos should be used more consistently for wounds, infections, and procedural follow-ups. ● Hospital discharge summaries should not replace the HPI. The HPI should reflect current patient presentation, not copy hospital documentation. ○ EX. Ask questions such as: Why are you in the hospital? What's going on? How are you feeling? Are you taking your medicine? Has anything changed?

	● For abnormal uterine bleeding with hemoglobin >7, pelvic exams are still important to guide decision-making and verify reported bleeding severity. ○ Discuss it with the attending, but it is important to let them know you are doing a pelvic, but there is only minimal blood. ● Providers should be refreshing their charts. Charts are not showing up with the diagnosis. ● Pregnant patients over 20 weeks with related complaints should go directly to L&D, not the ED. OB should be contacted, and L&D should be notified before transfer. ● For respiratory cases like bronchospasm, attempt appropriate treatments (e.g., nebulizers, steroids) before sending to the ED when clinically safe. ● For febrile tachycardic patients with a known source (e.g., flu positive), provide treatment such as IV fluids and PO tylenol and motrin before ED transfer when appropriate. ● Previous wound photos should be reviewed and new ones documented to track progression. Rodney ● For physical exams do not shortcut them. Document the work you did. ● MSC is probably the most problematic place, because of the volume. ● Efficiency is better than speed. So be efficient, but do not shortcut your history and your physical exam. If it takes you a little bit longer, that is fine, especially in complicated cases. It is better for the patient, but document everything you did. ○ If documentation appears incomplete and scant, it likely is incomplete and should be corrected. ● Use supervising physicians for clinical decision support when uncertain about management or disposition. ● Do not hold critically ill patients, but appropriate initial treatment should be started while arranging transfer. ● Diagnosis coding must reflect the underlying medical complaint or problem, not “medication refill”, otherwise the county cannot bill for it ○ The primary diagnosis must support billing (e.g., asthma for inhaler refill). Kurt

	● Some great catches are: ○ Jocelyn: 12-year-old admitted for mastoiditis. ○ Tiffany: 52-year-old with a foot wound admitted for gas gangrene. ○ Nichole: 55-year-old female with history of STEMI, NSTEMI, hypertension, palpitations, and bilateral hand numbness since 8:00 AM, admitted for hyponatremia. ○ Kelly: 54-year-old male with diabetes and atrial fibrillation, with vision spots for 3 weeks and a black spot for 2 days, admitted for retinal detachment. ● These cases represent patients who likely had delayed pathology. If patients have to wait for ED care or are hesitant to go to the ED, they may not present in time. ● Express care is capturing these cases earlier, helping prevent further damage or potential death. These are significant clinical good catches and highlight the importance of early identification and escalation.
Lake Elsinore	Lawrence ● Things are running pretty smoothly. I went through the stock yesterday. Everything looks good from the feet on the ground perspective. Katie ● Everything has been smooth sailing
BPAs	Kaite ● BPAs appear in the Epic chart under the plan section, often as a yellow banner when certain criteria are triggered. ● Common BPA triggers include height/weight (BMI), positive tobacco use, positive substance use screening, and missing depression screening. ○ Depression, substance use, and tobacco screenings are typically completed by rooming MA, NP, LVN, or RN. ○ Required actions from BPAs may include referrals (nutrition, behavioral health), tobacco cessation counseling, or medication interventions. ● A recurring issue is that BPAs are being completed without using the Epic SmartSet.

	○ The SmartSet is accessed through the BPA prompt and ensures proper documentation and full credit for compliance. ○ If SmartSet is not used, work may be completed clinically but not properly credited for county/IEHP reporting. ○ BMI-related BPAs, especially adult and pediatric height/weight items, are frequently missed or not completed via SmartSet. ● Updated "how-to" guides have been shared with practice leads for distribution and placement in clinic sites. ● James: I have noticed over the last few days when I have been doing the tobacco screening, I am doing everything in it, and it is still in that area. ○ Katie: If BPA items appear completed but still remain visible, Epic MRNs should be sent for review in case of system error or glitch. ● Chance: I had a patient where the chart was requesting a PHQ-9 after a behavioral health referral was already placed. What does that mean? ○ Katie: PHQ-2 should be completed by staff and may trigger PHQ-9 when indicated. ○ Patients with a history of depression may trigger additional care gap reminders requiring periodic follow-up screening every 3, 6, 9, and 12 months. ○ If referrals and interventions are already completed but alerts persist, it may be a care gap reminder rather than an incomplete task. ● Nursing and MA staff are responsible for intake and pre-screening workflows, including required screenings. If these are not completed, it should be escalated so workflow gaps can be addressed. Rodney ● Rodney is working with Kim to standardize workflow across clinics. BPA and care gap completion is critical for county reporting, reimbursement, and regulatory compliance. ● Clinic performance metrics are tracked at both individual and clinic levels. The target completion rate is 100%, with an acceptable goal of 85% or higher. ○ Current performance varies, with some areas still in the 60% range, which is not acceptable.

	○ These metrics directly impact county evaluation and funding, and both underperformance and strong performance are visible. ● Ongoing monitoring and education are being conducted to improve compliance. ● Rebecca: There will occasionally be patients who have appointments with one of the PCPs, but their intake forms say "outside PCP". How do we address care gaps? ● Rodney: If the nurses do not pin the care gap, do not worry about it. ○ If care gap status is unclear or inconsistent, it should be confirmed with nursing and the ACC. If it does not apply, it can be skipped without additional documentation.
Corona	Vivian ● The current interim manager at Corona is Christina from Hemet, and she is overseeing the clinic along with Kim Booker until a new manager is hired. ○ Kim Booker will be more present, checking in with the team and providers to see if anything is needed. ● Wednesdays are typically used to work on supplies because there are 3 MAs and 3 LVNs, so staffing is higher that day. ○ For supplies, Jamie maintains the list and provides it to the person ordering, but requests can also be given to Vivian for ordering. ● Volume was a little low last week due to spring break, but it has been busy this week. Rodney ● Appreciation was given to Hamelda and the team for organizing supplies. ● Kim Booker will be present at Corona due to the clinic manager turnover. ● Some issues were identified, including primary care taking patients to fill their schedule; some cases were appropriate and some were not, and this is being addressed. ○ It was discovered that some ACCs stopped taking patients at 7:30 p.m. instead of 8:00 p.m., which was not previously known and will be addressed. ○ The clinic is expected to take patients until 8:00 p.m. ● The reduced hours may have contributed to lower volume, along with a lack of marketing.

	● Over the next month and a half, outreach will be done to local schools and community centers to rebuild relationships. ● Kim will ensure the new clinic manager understands the importance of maintaining these relationships. ● The minimum goal is 45 patients per day at Corona, with a target goal of 60 patients per day.
Riverside	Rodney ● There is no construction in neighborhood at this point. There is no additional space there, but the team is doing a good job with the limited space. ○ Roxie is very vocal and helpful with that, and operations will continue as usual. ● There are plans to drive more pediatric volume to the clinic. Some local schools, including a new school that opened, are sending patients there. ● There was a question about supplies; do not engage in supply discussions regarding numbers or ordering issues, as it does not work that way. ○ Refer supply-related questions directly to Rodney, as there has been confusion and Kim is working on cleaning it up. ○ Supplies can be obtained through the medical center, and any mention of an HC number should be ignored.
Moreno Valley	Magen ● They are still without an RN, and there are no other major updates; overall, it varies each time you go. Rodney ● Vanik has been very helpful. ● One of the main pain points is space, as there are only four rooms available. It is important to ensure that nurses are using all four rooms. ● At the start of each shift, ask nurses if they have checked with Gilbert about any additional rooms that may be available. ○ This helps get patients prescreened by nurses and improves productivity and patient flow.

	● Nurses are generally on board, but there can occasionally be issues. ○ There was a situation where staffing was short, and an MA was left without adequate support, leading to concerns from the LVN. ■ The volume was not too high at that time, but the issue was noted. ● Vanik is aware of these situations and is approachable if issues arise. ○ If needed, have Vanna come speak with the team, and Rodney can also be involved.
MSC	Tiffany ● MSC has a new clinic manager named Teresa, who is from the CodeMet team and has recently started after being onboarded by Kim last week and shadowing her. ○ Teresa will be present more moving forward. If she is not consistently checking in or present, that should be reported. ● Kim previously checked in on MSC once or twice daily, and that level of engagement is expected to continue. ○ If the clinic manager is not routinely checking in, it should be escalated, as leadership visibility is important for maintaining workflow and accountability. ● MSC has experienced staff fatigue at times, which can affect rooming and overall flow; when this happens, leadership support is needed to step in. ○ If rooming is slow or the clinic is several hours behind, it should be reported so leadership can intervene as needed. ● Daryl is now back as the clinic RN, so reliance on Kelly, the RN from family medicine should decrease. ○ Staff should escalate any issues to him. ● The radiology binder process is important and must be followed consistently. ● When patients complete same-day x-rays, wet reads must be documented the same day in the radiology binder. ○ Delays can result in multiple unreviewed imaging studies accumulating and potentially missing important findings.

	○ Providers should ensure imaging is reviewed before the end of shift and document wet reads appropriately. ● A dot phrase with a required field (asterisk) can be used as a reminder to prevent closing charts before completing reads. ○ This process helps prevent missed findings such as fractures or more serious conditions like pneumothorax. Rodney ● Workflow priority must always be on the sickest patients, meaning those still in the lobby waiting to be seen. ● All rooms should be kept full whenever possible, and empty rooms should be addressed immediately. ○ Staff should actively monitor the patient board and escalate delays in rooming. ○ It is acceptable to escalate concerns directly, including contacting Rodney if needed, especially if rooming delays are occurring. ● Reducing "left without being seen" patients is a priority; while some are unavoidable due to volume or staffing, avoidable delays should be addressed. ○ The goal is to move patients efficiently and safely so they are seen promptly and discharged in a timely manner. ● The lactated ringers have been delivered to all the clinics, which will be used for hydration, if or when surgery sends some patients over for hydration. ● A standard protocol will be shared outlining evaluation steps, responsibilities, and escalation pathways for hydration cases. ○ Tiffany will ensure this is posted at all of the clinic sites. ● The nurses and providers will be starting the IVs. If the nurse cannot do it, or we do not have a nurse, the providers will have to do it. ○ If IV training is needed, reach out and it will be arranged, potentially including provider-led training sessions.

Banning	Magen ● We are still waiting for our LVN to get signed off. She was supposed to start last week or the week prior but is still not signed up yet. ● They removed one of the ACCs for express care, and Kristin is good about having primary step in when needed. ● Kristin usually texts in the morning to let Magen know if we are going to be short staffed, and I try to notify the provider right away so they can be prepared. ○ She has been good about having primary care staff help. ○ Banning will have an MA going out, but there has been good communication ● Magen is bringing some Bio-glo strips today, that she got from MSC. ○ Please use them wisely because there are only about six. ● Today, if time permits, I will go through supplies and stock to make sure everything is up to par.
Palm Springs	Magen ● There are about 10 Bio-glo stocked, so please use them wisely - Alfonso has them ● I was not able to go through stock, so if someone has time, please let me know if we need anything; the staff is good about writing everything down. ● We are getting a new Doppler; the one we have does not read or measure pedal heart tones, it only reads pulses, so it was very hard to do pedal heart tones the other day and it took longer to count them than to find the heart tone ○ A new one has been ordered and should be coming soon. ● The only issue we are really having with Palm Springs, and I think all the providers can attest to this, is staffing. ○ The latter half of the week has been pretty bad for staffing. ○ We only have one MA that is permanent to Express Care. ○ Our LVN is out and might be out for a while because she is getting shoulder surgery, ○ The clinic has not had an RN for over a year.

	○ There are a couple of days toward the end of April where there is only an ACC and no MA, but Sergio is trying to address it. Rodney ● He will send another email regarding staffing and is asking Sergio to send weekly updates to himself, Kim, and Vernon about what staffing looks like. ● There has been a lack of communication to leadership about staffing, and it has been last minute, which has been a trend. ● The other piece is continuity; the goal is to have all clinics functioning relatively the same way with the same process. ● There are some nuances per clinic; for example, Palm Springs has OB, so patients can be sent to OB or seen there directly. ○ Otherwise, operationally, clinics should be running the same. ● Magen has spent the last month to month and a half comparing and contrasting what is done differently so Rodney can review and decide. ● When going to Palm Springs, there should not be differences in how things are done. ● Every patient that checks in to express care will be physically seen by a provider; the provider will go in, examine the patient, and do their job. ○ There is no such thing as a nurse visit in express care. ○ Providers must sign off because they are confirming they saw the patient. ● If anything different or out of the ordinary is noticed in express care compared to other locations, Rodney needs to know. ○ Some clinics, especially newer ones or those where the manager is not as present, may do things differently, which creates difficulty when processes are not aligned. ● Matt will be back next month, and they will make sure everyone is on the same page.
General Comments	Mesisca ● There is nothing in particular to report. I continue to hear good feedback on the escalations to the attending team.

	● The team sends great cases, and I am always impressed and intrigued by the complexity of what comes through. ○ I enjoy taking the calls because it gives me a good window into what you are seeing and managing. ○ Sometimes we go back and forth on cases, and some of them are very complex. ○ Every month something comes up that I have never seen before, which is increasingly surprising. ● It is impressive. We want to work on highlighting more of the great catches. ○ I found a few more examples this month of strong pickups by the team, including some surgical cases. ● The work being done is impactful, including the cases coming through and the lives being affected. ● While talking about care gaps and BPAs, they are surrogates of quality. Underneath that quality is the significant access to care that the team is providing. Chance ● While at mobile clinic, noticed there was lead testing being performed. Is this being done at our regular express care clinics? ○ Rodney: At the moment, clinic staff determine what needs to be done, including tests like lead testing.Regular clinics are supposed to handle that testing as part of their workflow. ○ Express care does not own that responsibility; if the clinic staff orders it, it is done, and if not, it is not something express care needs to manage. ■ There have been instances where tasks are not completed due to clinic workflow issues rather than refusal. ● Rodney will meet at the mobile unit to provide guidance and show how the process works so providers are not handling it alone. ● There was a case involving a 14 month old, dad stated she would stop breathing for a couple of seconds while she was crying. Hemoglobin was checked and found to be 6. Lead level was also checked and was normal.

	● Staff at that clinic said that lead testing is not typically done in express care and is usually handled by family medicine. There was some pushback because supplies had to be obtained from family medicine. ○ Rodney: Lead testing is available and should be done when appropriate. ○ The reason it is not commonly done at certain sites is due to needing to retrieve supplies. ○ There will follow up with clinic leadership to address this, as these are required measures tied to government standards. ○ Express care serves as a safety net when primary care cannot see patients, so these opportunities should be utilized. Rodney ● Providers are encouraged to continue sharing good catches or notable cases. ○ These should be sent to Lawrence with the MRN number to provide awareness. ● These cases are shared not only within the team but also with medical center leadership. ○ The purpose is to highlight quality work and team collaboration. ○ Sharing these examples helps demonstrate effective teamwork and positive outcomes, which are often underrecognized compared to issues.

Meeting called to order: 8:00a; Meeting adjourned 8:52a