**Announcements (chiefs)**

* Med Staff Dinner is 9/20/13. It is free for all residents and coverage is provided for all residents to attend (from 5 pm-12 am). Residents at CHO are excused as well.
* There will be a survey regarding work hours for inpatient residents this week. The work hours policy is attached. Possible work hour violations include: working >80 hours/week, off <10 hours in between shifts, or working >16 hour shifts (applies to interns only).
* Quick survey regarding in-basket coverage at CHO; all 2nd year residents present at the meeting agreed that it would be more helpful to have in-basket coverage while at CHO than while on nights.
* Please get your CHO badge renewed if you have not already. Thanks to all those who have!
* If you’re holding the 674 pager, please remember that surgeons will page this number 24/7 to sign out post-op patients. It is your responsibility to ensure that these patients are on the mega-board and assigned to a care team.

**Recruitment update (Geena)**

* Meeting will be held in August for those interested in pre-screening applicants to instruct you in how to do this. People interested will need to commit to reviewing applications on your own time. Email Lauren Wondolowski if you are interested in being involved.
* Email Tami if you have housing available for clerks or interviewees
* There is a new email that has been created to give feedback about applicants; please email any and all feedback to this address for review. Recruitment team will announce when this email is officially up and running.

**Forum for feedback about inpatient trials and PBL**

**PBL:**

* Given increased attendance, we need a bigger room for lectures or to divide the group into two small groups.
* Question about whether receiving an email regarding PBL topics is a sign that you are on the list of those expected to attend
* Should the Gyn-Peds resident really be required to go to PBL? This creates a 24 hour shift that seems unnecessary to some people
* People did like resident presentations as a part of PBL and are wondering if there is a way to continue this. Resident presentation at journal club was one solution raised.

**Inpatient trials:**

* Seems less efficient and repetitive
* Harder to get to OR for some people; registrar seems spread too thin
* Nice to be taught by 3rd year; helpful to present to 3rd year in front of attending (and not twice)
* Overall, folks are seeing less patients
* Confusion about the purpose of the overflow service and whether caps are strict or not
* People who are admitting patients over their caps are switching those patients to other services so there is less continuity

**RLG: Role and structure (Karen)**

* Current RLG members include director (Kristin), assistant directors (Brian, Karen and Fred), and faculty (Patty, Tai and Neil).
* A selection committee is choosing 3 new RLG members (2 general members and one recruitment chair)
* ACG is a subcommittee of RLG focusing on non-family medicine outpatient rotations; members include Karen, Cinnie Chou and Susan Feierabend.
* RLG priorities for 2013-2014 year and new members/roles TBA

**Inpatient Task Force update (Felicia/Brian)**

* History of ITF
* Trials will continue through block 3 instead of through block 4
* 24/7 in house attending supervision for med/surg and ICU patients is on the horizon although timeline not decided yet and extra resources needed
* Request for resident input so that two goals of patient safety and resident education are sustained

**Clinic schedules (Tai)**

* On March 1, all faculty primary care clinics switched to 2 week scheduling system, excluding well child checks and prenatal visits. Residency chose not to switch at that time.
* Currently, the ambulatory medical director Chris Farnitano MD is asking the residency to reconsider switching to a 2 week scheduling system
* Tai’s pros and cons were reviewed (please review the handout he gave you for further detail)
* Pros: increased continuity, higher show rate, system consistent with your preceptors, fewer patients need to be rescheduled when clinics are cancelled, easier for administrative staff to schedule clinics, clinic slightly faster because RN/LVN/MA does not have to spend time scheduling return appointments, easier to get patient back in 1-2 weeks without having to add-on patients
* Cons: Patients can be lost to follow up, difficult to ensure follow up for patients that you want to see in >2 weeks (vulnerable patient population and automated reminders to schedule appointments currently exist as possible solutions)
* Other cons discussed by residents: perceived to be less availability for hospital discharge follow up appointments (most are currently being scheduled with residents), burden for scheduling appointments now placed on patients and still very difficult to do over the phone.
* 2 week system may change type of visits (more urgent care type visits).
* There will be a survey from lead preceptors to gauge overall resident opinion which will be a major factor in the decision of whether to switch. Look for it in your email soon.

**Union update (Tai/Froyd)**

* Negotiations continue but no agreement has been reached yet
* If there is a strike vote it will either come after current round of negotiations is over, or after a subsequent fact finding session (at the earliest, in November) and would likely only include clinics (not inpatient or ED), only last 1-2 days.
* Mediation is confidential so specific negotiation play-by-play cannot be discussed in public
* Email Jon Froyd if you don’t know whether you are a voting member
* Issues in negotiation are that docs/dentists have not had a contract in 4 years; our salary is lower than other county hospitals and recruitment/retention is suffering as a result; retirement benefits are getting cut.
* Idea of a residency position statement was raised (this would be exclusively from the residents, not involving RLG). No firm decision was made.