ENGLEWOOD HEALTH

Vascular Fellowship Program Manual

Curriculum: Goals and Objectives

ENGLEWOOD HEALTH
350 ENGLE STREET
ENGLEWOOD, NEW JERSEY 07631

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Contents

Curriculum: Goals and Objectives

Foreword

It is our hope that your training at Englewood Health will enable you to develop the skills necessary to become a practitioner in vascular medicine and surgery and to foster the development of a personal program of learning that allows continued professional growth. As a House Staff Officer at Englewood Hospital, you will be participating in safe, effective, and compassionate patient care under the clinical supervision of faculty. You will also be given the opportunity to participate, as appropriate, in other related activities.

As you fulfill these responsibilities, it is important that you remain aware of the practices, procedures, and policies of the institution. This Manual is designed to familiarize you with Medical Center policies and to help you carry out your administrative and patient care responsibilities as a House Staff Officer. The program retains the right to make changes to this Manual without notice in accordance with applicable law.

Although this Manual attempts to be comprehensive, if you have a question or problem that is not covered, please feel free to contact your program director or the Medical Education Committee for guidance. If in the future you would like to see additional information included in this Manual, please let us know. *Updated versions of many of the included Hospital policies are available on Englewood Health's Intranet. Please access the Intranet to view these policies.*

We all share the common goal of providing the finest quality care to our patients. During your training at Englewood Hospital, your primary consideration should always be the patients in your charge.

We wish you success as a House Staff Officer and throughout your career. We look forward to meeting with you during your appointment at Englewood Health.

Thomas Bernik, MD, FACS, FSVS
Chief of Vascular Surgery

In Dedication to Herbert Dardik, MD
1935-2020

Herbert Dardik, MD, was one of the pioneers of vascular surgery and an Englewood Health luminary and leader for nearly five decades. Dr. Dardik was a founding father of the field and pioneered many modern developments. A passionate educator and mentor, he also founded our vascular surgery fellowship program, our vascular surgery research lab, and enrichment and education programs for high school students.

He joined Englewood in the late 1970s, serving as Chief of Surgery for over 40 years and Chief of Vascular Surgery for over 25 years. He retired from clinical practice in 2017.

As a surgeon, Dr. Dardik specialized in diagnosing and treating vascular conditions such as peripheral vascular disease, as well as limb salvage and lower extremity surgical techniques. He also helped develop new techniques to assist carotid artery surgery, popularized a variety of vascular tools and instruments that led to limb preservation, launched one of the first wound care centers in the region, and was one of the founders and longtime leaders of the bloodless medicine and surgery program.

Dr. Dardik held seven patents and three copyrights, including the first tissue-engineered bypass graft used to prevent gangrene and save lower limbs. Prior to this approach, which Dr. Dardik developed here in the 1970s, amputation was often the only option for patients who required vascular reconstruction but lacked suitable veins, or in whom a prosthetic graft would likely fail. With this technique, Englewood saw extraordinary growth in the number of limb salvage cases, leading to the creation of the vascular surgical service in 1976. Two years later, Dr. Dardik founded the first vascular surgery fellowship program at Englewood, which became a well-known and respected training program for 30 years, graduating several current Englewood Health surgeons. After a hiatus, the program was revived last year thanks in part to Dr. Dardik's resolute commitment to medical education. Under his leadership, Englewood's vascular surgery service and research laboratory maintained an esteemed regional, national, and international reputation and trained countless residents, pre-medical students, and high school students.

Dr. Dardik was the recipient of many prestigious awards and honors, including the Lifetime Achievement Award from the Society for Vascular Surgery in 2017 for his tireless contributions over many decades to the specialty as a physician, surgeon, teacher, researcher, clinician, community practitioner, and academician. In 2019, he was inducted into the American College of Surgeons Academy of Master Surgeon Educators. He also received the Humanism in Medicine Award from the Arnold P. Gold Foundation and the Touchstone Award from the Englewood Health Foundation.

Despite his highly regarded clinical and scientific reputation, Dr. Dardik will mostly be remembered for his warm spirit and the relationships he developed over many years. He was a kind, supportive, and patient mentor who held a lifelong passion for fostering the growth of not only the medical field, but of the lives of generations of colleagues, students, patients, and the community. He enriched our medical institution greatly and immeasurably enriched the lives of those who had the privilege of working with him.

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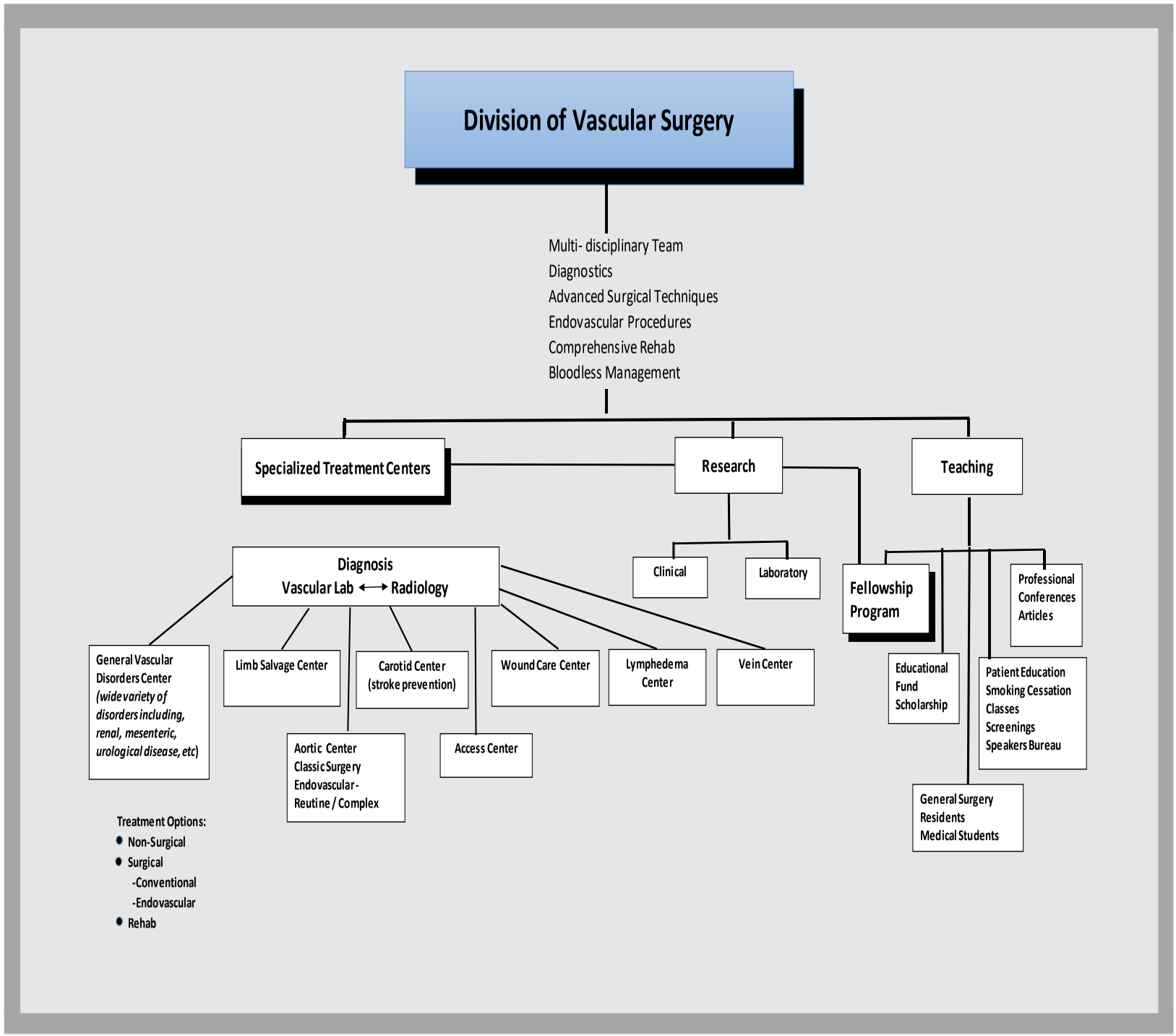
Division of Vascular Surgery
Multi- disciplinary Team
Diagnostics
Advanced Surgical Techniques
Endovascular Procedures
Comprehensive Rehab
Bloodless Management
Specialized Treatment Centers
Research
Teaching
Diagnosis
Vascular Lab ⟷ Radiology
Clinical
Laboratory
Fellowship Program
Professional Conferences Articles
General Vascular Disorders Center (wide variety of disorders including, renal, mesenteric, urological disease, etc)
Limb Salvage Center
Carotid Center (stroke prevention)
Wound Care Center
Lymphedema Center
Vein Center
Educational Fund Scholarship
Patient Education
Smoking Cessation Classes
Screenings
Speakers Bureau
Aortic Center
Classic Surgery
Endovascular - Reutine / Complex
Access Center
General Surgery Residents
Medical Students
Treatment Options:
Non-Surgical
Surgical
-Conventional
-Endovascular
Rehab

Englewood Hospital & Medical Center is a non-profit and non-sectarian community hospital. The Board of Englewood Health is committed to the following Vision and Mission Statements:

Vision Statement:

Englewood Health will be the regional leader in providing state-of-the-art compassionate care in a humanistic environment.

The Mission of Englewood Health is to:

- Provide comprehensive, state-of-the-art patient services. Emphasize caring and other human values in the treatment of patients and in relations among employees, medical staff and community.
- Be a center of education and research.
- Provide employees and medical staff with maximum opportunities to achieve their personal and professional goals.

Consortium for Graduate Medical Education

Englewood Health participates in the Hackensack University Medical Center Consortium for Graduate Medical Education (GMEC) that is dedicated to centralizing, enhancing, and monitoring the quality of the education provided to House Staff in all programs at all participating institutions. The Graduate Medical Education Office works with affiliated institutions in the Consortium to meet the new demands and responsibilities inherent in maintaining quality residency education.

Core Competencies

Fellowship programs require their residents to obtain competency in the six areas tabulated below, as well as open and endovascular skills / vascular ultrasound so that the trainee is competent to practice independently by the completion of training. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

I. *Patient Care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
II. *Medical Knowledge* about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

III. *Practice-Based Learning and Improvement* that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
IV. *Interpersonal and Communication Skills* that result in effective information exchange and teaming with patients, their families, and other health professionals.
V. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
VI. *Systems-Based Practice*, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Commitment to Diversity

Englewood Health supports full and meaningful implementation of equal opportunity policies and objectives that will enhance the quality of our work life, the productivity of our workforce and learning environments, and will meet the needs of the diverse body of students, house officers, faculty, staff, and communities we serve. Our commitment to these goals goes well beyond meeting legal requirements and directives of equal opportunity. We are convinced that the personal uniqueness of each employee is an asset of incalculable worth and are dedicated to creating an environment within Englewood Health that is free of discrimination and where all employees are afforded the opportunity to develop, perform, and advance to their maximum potential, without regard to race, color, creed, religion, cultural background, sex, age, national origin, marital status, citizenship status, sexual orientation, disability, or veteran status.

We believe that diversity in health professions benefits every aspect of health care. Addressing the needs of our increasingly multicultural and ethnically diverse patient population at Englewood Health makes it essential that patients have increased access to physicians who share their ethnic heritage, background, and belief. Further, interacting with a diverse peer group is important for students, house staff, and faculty for effectively managing cross-cultural patient presentations and for having a beneficial impact on health outcomes.

The success of the equal employment opportunity program depends considerably on the support and positive direction given by managers and supervisors. We all lead by example, and we must set the right kind of example in this critical area. We urge you to join us in an active commitment to the principles of equal opportunity in their fullest sense. With your support and participation, we know we can turn workforce diversity from a leadership challenge into one of our greatest strengths. In so doing, Englewood Health will earn recognition as both a great place to work and a place that does great work.

Section Two:
Employment at Englewood Hospital
&
Medical Center

HOUSE STAFF ELIGIBILITY AND PROCESSING

Employment Eligibility Verification

Post graduate vascular training requires the completion of a certified five year general surgical program with General Surgery Board eligibility or certification. This process includes verification of the preparatory training and a personal interview. Selection of a candidate is based on credentials, references, interview, past achievements and assessment of work ethic and compatibility with the hospital work-force and care of patients.

International medical graduates (IMGs) may not begin their training until they have obtained an appropriate visa. If an appropriate visa is not obtained in a timely fashion, IMGs will not be permitted to begin training and their contract will become null and void.

Medical Licensure

Medical Center policy requires that all graduates of US and International medical schools appointed to the House Staff must become registered with the New Jersey State Board of Medical Examiners. IMGs must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) and must present a valid copy of their Certificates. All fellows are required to apply for a NJ State Medical Board Permit, which will allow them to continue training in the State of NJ until they complete their training.

CPR Qualifications

The following trainings are **mandatory** during Englewood Health's orientation for all House staff with patient-care responsibilities. Recertification is required every two years.

Basic Cardiac Life Support (BCLS) (Initial Course)

Advanced Cardiac Life Support (ACLS)

Employee Health Service

- The Employee Health Service (EHS) is located at 286 Engle Street, front entrance (corner of Engle St and Glenwood Rd). It operates solely for the care of Englewood Hospital & Medical Center employees and applicants for employment and volunteer positions. The EHS staff also administers and reviews mandated annual employee health assessment questionnaires.

Services provided directly to employees include state-mandated OSHA tests and immunizations (measles, rubella and hepatitis B), administration of influenza vaccine, and return-to-work clearance (only in cases involving Workers' Compensation).

Mandated, routine, and periodic screening for tuberculosis (involving skin-testing and/or chest X-rays) is performed on all employees. Employees requiring tuberculosis prophylaxis are placed on a treatment and surveillance program managed by EHS staff.

On-the-job accidents, injuries, and exposures are evaluated, treated, and reported to the appropriate agencies. These include blood and body fluid exposures, animal bites, neuro-musculoskeletal injuries, falls, excoriations, and simple lacerations.

Employees must go to the Emergency Department for follow-up of these occurrences at times when EHS is closed.

For follow-up of all other illnesses and medical conditions, House Staff Officers should see their primary care providers.

Physician Wellness

Resident Mental Health Services

Resident physicians may seek further assistance or advice regarding any significant physical or mental health issues by contacting the Englewood Health Medical Staff Health Committee through its Chair, Dr. Miguel Sanchez, at 201 894-3423. The Health Committee's mission is to advise and assist Medical Staff members with physical, psychiatric, and emotional illness and to facilitate diagnosis, treatment, and rehabilitation for members who suffer from a potentially impairing condition. In addition, please visit the Human Resources Department page located on the Englewood Health ePortal or call Human Resources at (201) 894-3025 for additional information regarding the Englewood Health's Employee Assistance Program.

Malpractice Insurance

All members of the House Staff are covered by the Hospital for medical professional liability insurance under a group policy for work performed within the scope of their employment by the Hospital. In case of unanticipated and/or serious sequelae to any diagnostic or therapeutic procedure, a report of the incident is to be made promptly by telephone to the Office of Risk Management at x3719.

Should any patient or family member express dissatisfaction regarding the quality of patient care that has the potential to become a professional liability matter, it should be reported promptly to Risk Management.

Vacation

House staff are entitled to 10 work days of vacation leave each year, which accrues at the beginning of each academic year. Vacation leave must be scheduled and pre-approved by the Program Director. Unused vacation hours may be carried over from year to year.

Leave Time

House staff are entitled to 12 work days of sick leave each year, which accrues at the beginning of each academic year. Unused sick leave hours may be carried over from year to year.

Stipend

Pay Rates as of July 1, 2020

PGY6	$72,080
PGY7	$74,963

FACILITIES

Housing

Englewood does not provide housing for house staff. Incoming fellows may contact their departmental program coordinator for assistance locating apartments prior to moving to Englewood.

Food Service

Retail food service is available at reasonable rates on campus as follows:

The Drapkin Family Café

(Daily Menu Information at x6368)

Weekdays 6:30am–7:30pm

Weekends, Holidays 7:00am-9:00am, 11:00am–3:00pm

(Hours are subject to change)

The program provides meal tickets on a monthly basis.

Vending machines are available 24 hours each day in the Cafeteria and in various locations throughout the Medical Center. Kosher meals are available daily and are prepared in the Kosher Kitchen under the supervision of the Orthodox Union.

Englewood Health Dr. Walter Phillips Health Sciences Library

The Englewood Hospital Health Sciences Library is located on the first floor of the Learning Center. The library is open Monday through Friday, 8:00 AM to 4:00 PM, with full librarian services. Information on the services provided is available at www.englewoodhealth.org/for-healthcare-professionals/health-sciences-library. The library remains open for independent study and research on weeknights until 10:00 PM, based on demand. In addition, multiple computers throughout the hospital have access to UpToDate and other point-of-care clinical reference sources.

On-Call Rooms

On-call rooms are available for members of the House Staff whose clinical departments require them to work in direct clinical care at night. The call rooms are located on the 4th floor and 8th floors in

the main building (see below). Cooking or keeping food in on-call rooms is not permitted in compliance with fire and sanitation safeguards. Each House Staff Officer is expected to regard the House Staff on-call room as s/he would his or her own home and to follow accepted rules of conduct. See your Department Administrator for additional information.

4th floor on call rooms
Room# 4171- **ICU Attending**
Room# 4159- **Surgery Residents and All Students**
Room# 4155- **IM Residents**
The code for room 4159 is 412.
The new room is equipped with lockers for belongings. Room has a computer, a designated work area, attached bathroom and shower.

Telephone and Paging Systems

The Hospital maintains an internal dialing system for interoffice calls. All house staff are provided with key telephone numbers during orientation. Certain telephones have direct outside lines that may be reached by dialing "9" and waiting for a dial tone. These lines only accept calls within the area code 201. For calls outside the area, contact the hospital operator for assistance placing the call.

The Hospital has a public address page system and a dial-access radio receiver system. Many physicians and other key hospital personnel may be reached by dialing x3501, then the pager identification number, followed by "#". You will hear the current status of the person you are paging. If the person is available for paging, the system will ask you to enter your call-back number.

The overhead voice page can generally be heard throughout the Dean wings of the hospital. To place a public address page or request information on a dial-access radio page or receiver, dial x3311

Pagers are assigned to new House Staff by the departments during Orientation. The number assigned is stamped on the case. *Handle with Care:* The pocket pager is a valuable instrument and requires careful handling to work properly. The best precaution against damage is to carry it clipped to a belt or inside pocket. The Hospital expects pagers to be guarded against carelessness and abuse. An individual will be held responsible for loss or damage through negligence.

Pager Coverage: There should not be a place within the confines of the Medical Center, including yard areas, where one cannot receive a page. House Staff should not place the paging unit on or near metal desks or metal equipment, as this impedes reception. If reception is poor, the Telephone Services Supervisor should be notified promptly.

Safety

Englewood Health is committed to providing a safe environment for the people it serves: patients, staff, employees, students, and visitors. To meet these needs, the Medical Center requires the completion of an Annual Hospital Mandatory Exam, a comprehensive safety training online course with modules covering:

- **Safety Education and Training**
- **Employee Accident Management**
- **Hazardous Materials Management**
- **Emergency Preparedness**
- **Life Safety Management**
- **Equipment Management**
- **Utility Management**
- **Violence Prevention Committee**
- Annual CAPRA Self-Evaluation
- COVID-19 policy
- Wellness-Fatigue
- Diversity/ Tolerance/ Inclusivity
- Human Trafficking
- CITI Course modules (IACUC) to work in the Animal Research Lab

If a House Staff Officer observes a safety problem, s/he should call X2222.

SECURITY

Identification Cards

To be worn at all times and available for inspection.

Escorts

Security escorts are available within the Medical Center as well as to parking lots on the hospital property. 10 minutes before departure, please call Security at x3225 to arrange for an escort.

Parking

Available with assistance of program coordinator.

Uniforms and Laundry

Uniforms and white coats will be provided by and laundered by the Medical Center.

INTERNET RESOURCES

Internet-based resources vary on a departmental basis. Contact your program coordinator for details.

National Practitioner Data Bank

The National Practitioner Data Bank was created in accordance with federal law and serves as a national clearinghouse for information concerning physicians, dentists and other health care providers.

For House Staff, the Hospital must consider reporting to the Data Bank instances where the license to practice medicine or dentistry has been revoked or limited. Malpractice insurers including the Hospital (for its self-pay portion) must also report to the Data Bank any payments made on behalf of a House Staff Officer.

Hospitals are required to query the Data Bank when performing credentialing and privileging functions. This requirement does not generally apply to House Staff; however, if a House Staff Officer moonlights for the Hospital in another capacity (i.e., in the Emergency Room), the Data Bank is queried.

Under the law, a House Staff Officer may have access to his or her own Data Bank File. Requests for information should be directed through the National Practitioner Data Bank website**.**

Section Three:
Policies and Procedures

Fellow

Definition: Title assigned to qualified physicians or dentists appointed for approved training in either ACGME-approved specialty programs or non-ACGME-approved programs that have received institutional approval.

Condition: Fellow appointments to ACGME-approved programs will have a salary level commensurate with their PGY. Fellow appointments to non-ACGME-approved positions will carry no fixed salary (compensation) level. A compensation rate for each appointment shall be established pursuant to funds available to the training program director and confirmed to the appointee in a letter/contract of appointment. Fringe benefits are available comparable to those provided House Staff Officers.

Contracts

I. Each House Staff Officer shall, prior to his or her employment, receive a written Medical Resident Training Agreement which shall set forth Englewood's commitment to the House Staff Officer and the House Staff Officer's responsibilities to the Hospital.

II. The House Staff House Officers will be reappointed to the next level of training at the Program Director's sole, reasonable discretion. The Program Director will base the reappointment and promotion determinations on the House Staff Officer's successful completion of his/her training and the absence of pending disciplinary action against the House Staff Officer. House Staff Officers will be notified in writing at least four months before the expiration of their appointments (no later than March 1 for appointments commencing July 1) if their contracts are not to be renewed for the next year of a given residency program or if they will not be promoted to the next postgraduate year of training. Notifications of nonrenewal or nonpromotion will include the reasons for the action and are subject to the hearing rights specified below in "Disciplinary Action."

III. Training Agreements must be returned within two (2) weeks of the time a House Staff Officer receives the Agreement. Failure to return a contract will result in a suspension of privileges.

House Staff Evaluation & Promotion

All House Staff are regularly evaluated by faculty and the program director. Formal feedback concerning a House Staff Officer's performance by the program director or his/her designee occurs at periodic intervals that may vary with the specific program, but occurs no less than semiannually. The criteria for promotion will be provided on a departmental basis to all House Staff.

The program director or his or her designee will meet with each House Staff Officer at least twice a year to review his or her performance.

All House Staff are to be provided access to their evaluations upon request.

House Staff Officers must also have the ability to submit to their program director an anonymous written evaluation of faculty, clinical rotations, and the residency program at least on an annual basis.

All evaluations are submitted electronically in New Innovations Residency Management Suite (RMS), or by the program's procedure. House Staff may view evaluations of their performance and evaluate faculty, rotations, and the program on the New Innovations RMS site. New Innovations RMS also covers evaluations of procedures. House Staff may obtain their logon and password from the Residency Coordinator.

Promotion criteria to the next PGY level are based on mastery of the six core competencies at each level of training. House Staff are usually evaluated on a scale of 1-5 with 3 being satisfactory progress toward independent practice in competency-based training. Performance at a level below 3 may result in a remediation program or probation as described herein.

Interventions based on evaluations may include academic remediation, probation or some form of disciplinary action, up to and including termination. In the event that academic deficiencies are identified:

1. The Program Director or designee shall counsel the House Staff Officer. If a designee conducts counseling, the Program Director shall be informed of the content of such counseling in writing by the designee.

2. If such counseling results in a plan of remediation, the Program Director shall document, in writing, the conversation held with the House Staff Officer and outline corrective measures,

including criteria and time frame for correction of the deficiency (ies). A copy is to be placed in the House Staff Officer's file and a copy is to be given to the House Staff Officer.

3. The Program Director shall evaluate compliance with corrective actions as established in the remediation plan. If performance is restored to a satisfactory level, the Program Director will indicate this orally to the House Staff Officer as soon as it has occurred. A written notation of this interaction will also be placed in the House Staff Officer's file and a copy given to the House Staff Officer.

4. If the House Staff Officer fails to correct the identified academic deficiency (ies) to the satisfaction of the Program Director within the specified time frame, the Program Director may, in his or her sole and exclusive discretion, either (a) extend the remediation period, using the same procedure as for an initial remediation effort, (b) may place the House Staff Officer on a probation period or (c) terminate the House Staff Officer from the Program. The House Staff Officer may grieve a probation or termination decision to the Englewood Health Medical Education Committee. Please see the Grievance Procedure section below for details.

5. Copies of all documentation regarding academic deficiencies of the House Staff Officer should be provided to the Englewood Health Director of Medical Education (DME) and to the Graduate Medical Education Consortium's Designated Institutional Official (DIO) for all programs under the supervision of the GMEC.

Advancement Policy

Criteria for Promotion from one Fellow Level to the Next

Advancement from Year 1 to Year 2 requires:

1. Completion of all scheduled rotations with evaluations of 3 or greater in all competencies. Achievement of at least Level 2 in the ACGME / ABS Vascular Surgery Milestone Project in at least 75% of Milestone categories.
2. Completion of the online Sleep and Fatigue Module.
3. Completion of the Intuitional Review Board HIPAA and Human Subjects Research (CITI) online modules.
4. Conference attendance of at least 75%. See policy on Conference Attendance
5. Completion of an appropriate number of surgical cases in the designated year, as determined by ACGME requirements and the Program Director and Clinical Competency Committee.
6. Unanimous support among the Program Director and members of the Clinical Competency

committee that the trainee is at an appropriate level to move into Year 2.

Graduation from the Program requires:

1. Successful completion of all schedule rotations with evaluations of 4 or greater in all competencies. .
2. Complete and accurate procedure log to substantiate future credentialing.
3. Designated numbers of surgical procedures, as required by the ACGME completion of defined categories.
4. Completion or satisfactory progress demonstrated in a meaningful research effort.
5. Current and complete portfolio and CV on file.
6. Return of all keys, lab coats, pagers, etc. at the completion signoff by the GME office. The Program requires that graduating trainees also leave contact information for future communications
7. Achievement of at least Level 4 in the ACGME / ABS Vascular Surgery Milestones Project in at least 90% of Milestone categories. Graduation with lesser grades is at the discretion of the Program Director and the Clinical Competency committee, typically based upon demonstrated Improvement, and / or ongoing compliance with a remediation or probation plan
8. Unanimous support among the Program Director and members of the Clinical Competency Committee that the trainee is at an appropriate level to graduate.

Termination:

In the event of severe academic deficiency(ies) or continued failure to successfully remedy previously identified academic deficiency(ies), the Program Director may make the determination that the House Staff should be terminated from the program.

The Program Director shall outline the indications for the disciplinary action to the program's Clinical Competency Committee (CCC) or other similar committee. The House Staff Officer's faculty advisor will have the opportunity to speak on his/her behalf at the meeting.

The Program Director is to outline the indications for the disciplinary action. Following the presentation, the House Staff Officer's advisor may set forth whatever information the House Staff Officer wishes the Committee to consider as reasons to vacate the decision to endorse the adverse action or to dismiss the House Staff Officer. After the presentations, the CCC shall provide an advisory opinion to the Program Director on whether the disciplinary action should be carried out. The decision to carry out the disciplinary action is at the discretion of the Program Director.

Once the Program Director has made the decision to terminate a House Staff from the program, the DME and DIO shall be advised about the circumstances in writing.
The Program Director shall notify the House Staff Officer in writing of the termination. Copies of this notice shall be provided to the DME and to the DIO. Termination shall ordinarily become effective not less than two weeks after the receipt of the written notice. The Program Director may remove the House Staff from clinical duties without pay during this period if, in the judgment of the Program Director, continuance of the House Staff in the program during the notice period poses risk of danger to patients, or risk of harm or damage either to the program itself or to other Englewood Health personnel. The notification shall include the following:

a. Reasons for dismissal;
b. Effective date of dismissal;
c. Process for appealing the dismissal as outlined in the Grievance Procedure section below.

House Staff Supervision

Supervision of house staff varies by clinical setting. Supervision policy by setting is as follows:

1. Ambulatory (including Emergency) Medicine: House staff at all PGY levels must precept with a faculty member and obtain signature (on paper or electronic) of supervising faculty in the clinic chart. The faculty member should be present for the key portion of the encounter as required by the specialty's ACGME Residency Review Committee (RRC) or other accreditation council's requirement. The ratio of residents to faculty preceptors should comply with the requirements of a specialty's RRC. Faculty members should not have additional direct patient care responsibilities while supervising residents, unless specifically allowed by that specialty's RRC. Faculty supervision of residents performing procedures should follow the requirements of each specialty's RRC.

2. Inpatient Medicine: All patients in the hospital must have an attending physician who sees and writes notes on the patient on a daily basis and either rounds with, or verbally communicates with the house staff team responsible for the patient's care. The faculty member should be present for the key portion of the encounter as required by the specialty's ACGME (or other accreditation council) Residency Review Committee (RRC). Faculty supervision of residents performing procedures should follow the requirements of each specialty's RRC. Fellow supervision has many components and many objectives as outlined below:

Tools and assessment Used for Supervision

a) Direct oversight by faculty on the ward, outpatient setting, and
b) Operating room
c) Skills laboratory - direct faculty oversight and assessment of
d) Competence in the simulation setting.
e) Competency curriculum- Objective structured clinical examination (OSCE). The OSCE's, used to evaluate progress through the Competency Curriculum, are evaluated by the faculty and report cards reviewed with fellows.
f) VSITE (American board of Vascular Surgery In-Training Examination) yearly examination to assess medical knowledge. The VSITE Examination is a combination of both vascular and general surgery medical knowledge questions. Because of the extensiveness of the exam examinees are allowed seven hours to complete the examination.
g) New Innovations- web-based evaluations of each fellow by faculty, other fellows, other healthcare team members, and the fellows themselves. The teaching faculty is also evaluated by fellows in an anonymous fashion.
h) Scope of Practice- a list of all procedures (Invasive and non-invasive) that specifies level of supervision necessary per fellow year. The CCC determines the Scope of Practice every Three months based on the observation and clinical advancement of the fellow.
i) Procedural competency log in New Innovations include non-operative invasive procedures which are supervised and assessed by faculty members on the clinical competency committee who determine level of competency. This will allow for an individualized, fellow-specific scope of practice.

3. Critical Care Units: All patients in the Critical Care Units must have an attending physician who sees and writes notes on the patient on a daily basis and either rounds with, or verbally communicates with the house staff team responsible for the patient's care. The faculty member should be present for the key portion of the encounter as required by the specialty's ACGME (or other accreditation council Residency Review Committee (RRC). Faculty supervision of residents performing procedures should follow the requirements of each specialty's RRC.

4. Level of Supervision: Fellows in vascular surgery are to be supervised directly (supervising physician is physically present with the fellow and patient), or indirectly with direct supervision immediately available (supervising physician is physically within the hospital

or other site of patient care, and is immediately available to provide direct supervision). For many aspects of patient care, the supervising physician may be a more advanced resident or fellow.

Specific Policies for Supervision

Levels of Supervision

PGY 6 fellows should be supervised directly or indirectly with direct supervision immediately available. Fellows must communicate with supervising faculty on the service regarding the transfer of patients to the Intensive Care unit and end of life issues. To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:

1. Direct supervision- the supervising physician is physically present with the fellow and patient
2. Indirect Supervision:
    a) With direct supervision immediately available - the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available to provide Direct Supervision.
    b) With direct supervision available - the supervising physician is not physically within the hospital but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
3. Oversight - The supervising physician is available to provide review of procedures/ encounters with feedback provided after care is delivered.

5. Chain of Command: Residents must communicate with appropriate supervising faculty members when there is a major change in a patient's clinical status, such as transfer of a patient to an intensive care unit, or when end-of-life decisions are made. This includes end-of-life situation, ICU utilization and institution or reversing DNR orders.

Junior Fellow should request assistance from their senior supervising fellow if there is concern as to a patient's status, or if there is a situation in which a patient or family member requests evaluation by a senior member of the team. The fellow should call the Attending Physician to discuss the patient, and provide information regarding the current status of the patient. Should the resident(s) or attending feel that a specialty consultation is needed, they should determine the urgency of the consultation and contact the consultant. If there is disagreement between the consultant and the requesting team regarding the

urgency with which the patient needs to be seen, the attending physician should speak directly to the consultant if needed.

Fellows should contact their senior fellow, attending physician, Program Director, or Department Chief if they have any problems or concerns regarding chain of command issues as soon as these develop.

Englewood Hospital Medical Education Committee
Resident Policy for COVID-19 Exposure (March 2020)

I. Description

The ACGME provided the following guidance about the conduct of GME in the circumstances of the clinical care of patients potentially infected with COVID-19.

- Residents should be aware of and able to respond to this viral disease.
- Any resident, fellow, and faculty member providing care to patients potentially infected with COVID-19 will be fully trained in treatment and infection control protocols and procedures adopted by their local health care setting.
- Any resident or fellow who provides care to patients will do so under the appropriate supervision for the clinical circumstance and the level of training of the resident/fellow.

II. Policy

A. Inpatient Admission of Suspected Patients

Given the risk of exposure to certain groups, pregnant and immunocompromised residents are restricted from interacting with COVID-19 suspected or confirmed patients.

Medical/Surgical Units

In order to limit provider exposure, patients suspected of COVID-19 infection at the time of presentation will be admitted to the non-teaching Hospitalist or Private Attending services for Internal Medicine. Should patients develop symptoms while they are admitted to a teaching team, the involved resident can continue to see the patient for continuity or the teaching attending can make the decision to see and manage the patient alone to limit PPE use and exposure.

Each department will set its specific policy on how residents will be involved in the admission and care of inpatients with confirmed or suspected COVID-19 infection. If a resident is required in the care of the patient, the goal will be to limit the number of residents involved in the care of the patient each day and over the course of the admission.

Rounding: Teams will minimize the number of residents or fellows who enter the room of an inpatient with confirmed or suspected COVID-19 infection over the course of a patient's hospital stay. Residents who are caring for a COVID-19 patient need to limit the number of times they enter the patient's room each day, i.e. "cluster" the patient's care. This will both minimize the number of exposures, and limit the use of PPE, which is a finite resource. An

example will be to have the same resident round on the patient for as many days as possible.

ICU

Patients admitted to the ICU will be assigned no more than three residents that will be designated for each suspected or confirmed COVID-19 patient. If the patient is admitted from the Emergency Department, transportation of the patient to the ICU will be done by the admitted or receiving unit in full PPE. A security guard will be present to clear the hallways to prevent exposure.

B. Emergency Codes: RRT/Code Blue

RRT

When responding to rapid responses for COVID-19 patients, only one resident and one nurse should be in direct contact with the patient. Healthcare providers should use standard PPE as trained and fill out the log book to be contacted by employee health as per protocol.

Code Blue

When responding to code blue, we will still plan to limit provider exposure by limiting the number of providers in the room to 2-4 people if possible.

- PGY3 leader to stand at the foot of the bed or at the door
- PGY2 on-call to stay outside the room and help with other tasks
- PGY1 doing compressions until the LUCAS is in place
- Patient's nurse in the room to manage access and medications
- Respiratory Therapist in the room to ventilate the patient if not intubated. If the patient is intubated and on the ventilator, the Respiratory Therapist should NOT break the circuit and can stand outside of the room in this case.
- RRT nurse to stand outside and record

C. Managing Complications

Patients with COVID-19 are at risk for developing acute hypoxic respiratory failure/ARDS and cardiomyopathy. In most cases, these patients will require supplemental oxygenation, bronchodilators and in some cases vasopressor support. Please have a low threshold to consult the ICU.

Oxygenation

To reduce droplet exposure, we discourage the use of non-invasive ventilation with BiPAP. The following are acceptable forms of supplemental oxygen for COVID-19 patients:

- Nasal cannula
- High-flow Nasal cannula WITH a surgical mask
- Endotracheal intubation

Medications

- Inhalers and NOT nebulized medications
- Minimize IV fluids to maintain a negative fluid balance. If the patient develops hypotension and does not respond to the initial 30ml/kg bolus, have a low threshold to start peripheral vasopressors.

D. Resident Exposure: Monitoring

Known (with PPE)

Standard hospital practices for monitoring will apply here. Residents will be contacted by Employee Health at the phone number that is left in the COVID-19 patient log book, for patients with confirmed COVID-19 infection. *Rotating residents must write "rotating resident" next to their name to facilitate communication.* Residents will be informed to take their temperatures twice daily (>8h apart and without antipyretics) and report their symptoms and temperatures to Employee Health. If residents become symptomatic (respiratory symptoms and/or T>100.0), they will require screening. If you notice these symptoms, notify Employee Health and a department representative (your liaison chief and/or department faculty) immediately so that you can be tested.

- Positive Test: self-quarantine for 14 days or longer if symptoms persist
- Negative Test: stay home until afebrile for 24-hours before returning to work

Unknown (without PPE)

There may be cases of patients testing positive for COVID-19 after provider exposure without PPE. In this instance, Employee Health and Infection Control with work retrospectively to track all exposed personnel for standard monitoring as previously mentioned above.

E. Resident Self-Monitoring:

Residents should follow institutional guidelines for self-monitoring. This is defined as taking your temperature twice per day (every 12 hours, once before reporting to work) without Tylenol, Motrin, or aspirin, and monitoring for temperature of 100F or above, OR any symptoms such as cough, sore throat, or shortness of breath. Any team member who has a temperature of 100F or above or symptoms must stay home and report their absence to their manager AND contact Employee Health by calling 201-894-3112, email **COVID19EHS@ehmchealth.org** or text 551-238-2715.

F. Time Off for Quarantine/Illness

If you are sick or quarantined, you will follow institutional policy regarding using sick time and possibly disability as indicated for time off.

G. Travel
We will continue to follow the institutional policy on travel.

H. Conferences
We will continue to follow the institutional policy on conference attendance.

Well Being

The vascular fellows and general surgery residents are a diverse group of individuals who support each other in and out of the operating room. Outside of work, the program promotes health and wellbeing. This includes taking a break from the hospital by exploring local restaurants, encouraging participation in hospital organized events, fundraisers and a sponsored day at a private golf course outing. The hospital also provides discounts to local fitness and gym memberships.

Work Hours

Englewood Health is in compliance with current Accreditation Council for Graduate Medical Education (ACGME) common program requirements (CPR's) as related to work hours. The Englewood Health policies as listed below are in compliance with the July, 2017 ACGME resident work hour requirements. The terms "clinical experience and education," "clinical and educational work," and "work hours" replace the terms "duty hours," "duty periods," and "duty." This change was made to emphasize that residents' responsibility to the safe care of their patients supersedes any duty to the clock or schedule.

Resident duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. Residents must be scheduled for a minimum of one day in seven, free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. Residents should have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. In rare circumstances, after handing off all other responsibilities, a resident, on their

own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; humanistic attention to the needs of a patient or family; or, to attend unique educational events. These additional hours of care or education will be counted toward the 80-hour weekly limit. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. Clinical work hour exceptions may be granted by the Review Committee to support specialty-specific rotations approved by the institution, for up to a maximum of 88 hours based on sound educational rationale.

All ACGME-accredited residency programs in the United States must comply with the ACGME's Duty Hours Standards. These standards, which apply to House Staff in all specialties, are meant to balance the needs of patient care, resident well-being, and academic and clinical education. Programs that fail to comply with the standards will face adverse accreditation action, possibly including loss of accreditation.

The ACGME monitors compliance with work hour standards through multiple methods, including confidential resident surveys; interviews with program directors, staff, and residents during accreditation site visits; and ACGME Monitoring Committee assessment of the performance of Residency Review Committees for all specialties in applying and enforcing the accreditation standards. The ACGME communicates with all residents in accredited programs, informing them that it takes the new standards seriously and plans on rigorous monitoring and enforcement. RRCs will keep resident complaints about work hour violations, like all resident complaints, confidential.

Monitoring of work hours is done on a quarterly basis at Englewood Hospital. All residents enter daily work hours for a four week period into the New Innovations residency software management system, or through another system as determined by the program. Results of the work hour reporting are reviewed internally by the Program Director, and are provided to Englewood's Medical Staff Office (for submission to the Medical Board) and to the Hackensack Meridian School of Medicine at Seton Hall

University GMEC Designated Institutional Official (DIO). Any corrective action needed regarding work hour compliance is reported to the Englewood Health Medical Educational Committee, as well as to the Hackensack Meridian School of Medicine at Seton Hall University GME Committee.

Alertness Management/Fatigue Mitigation

It is the responsibility of the Program Director and supervising faculty within each program to monitor and observe residents for signs of fatigue and to intervene appropriately even if the residents are working within the guidelines. Residency programs at Englewood Hospital educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation. The programs educate all faculty members and residents in alertness management and fatigue mitigation processes. This education is provided during new resident orientation and through online teaching materials in the New Innovations system.

Residents who feel too fatigued to safely return home should seek assistance with their transportation. If they are unable to obtain a ride home with another resident in a timely manner, they should contact the Security Department at x3225. Security will call for a taxi ride home if the hospital shuttle van is not available to transport the resident home. The resident's department will pay for/cover the cost of the taxi.

Fatigue Mitigation Policy

I. Policy purpose

In 2010, the Accreditation Council for Graduate Medical Education (ACGME) set new standards for house Staff Officer Well-being on recommendations made by the Institute of Medicine (IOM). One of the new standards was the need to set more specific requirements for alertness management and fatigue mitigation strategies designed to ensure continuity in both patient care and resident safety.

II. Applicability of the Policy

Applies to House staff Officers enrolled at Englewood Hospital specialty and sub-specialty training programs.

III. Definitions (if applicable)

A. GME - Office of Graduate Medical Education

B. ACGME - Accreditation Council for Graduate Medical Education

C. IOM - Institute of Medicine

IV. Policy

A. The GME Training Program must:

a. Educate all faculty members and House Staff Officers to recognize the signs of fatigue and sleep deprivation

i. This education must be given to all program faculty members and house staff officers via the Sleep Alertness and Fatigue Education in Residency (SAFER) module. This will partially satisfy the ACGME requirements.

b. Educate all faculty members and House Staff Officers in alertness management and fatigue mitigation process;

ii. All House Staff officers and program Faculty, must complete the SAFER online tutorial on Sleep Alertness and Fatigue.

c. Adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

B. Each program must have a formal process to ensure continuity of patient care in the event that a House Staff Officer may be unable to perform his/her patient care duties. This process must be communicated to program trainees and faculty.

C. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for House Staff Officers who may be too fatigued to safely return home.

Vascular Surgery Fatigue Back up Plan:

The program has put in place the following back up plan for when a fellow calls in sick or is unable to show up as scheduled due to fatigue. It is the responsibility of the faculty and peers to recognize when a colleague or trainee is fatigued. Self-recognition is also very important. The program will provide coverage by reassigning a surgery resident who is on elective rotation and the on call attending physician.

"Moonlighting"

Not permitted

Disciplinary Action

I. ***Disciplinary Action:*** A resident's Program Director, Department Chief, or the Hospital's Human Resources Director may take disciplinary action, up to and including termination, against any

House Staff Officer who:

A. Fails to demonstrate an acceptable level of professional competence, clinical judgment in the treatment of patients, or professionalism.

B. Commits an act that constitutes professional misconduct or a breach of professional ethics.

C. Fails to abide by the By-laws, Rules and Regulations, or policies of the Hospital or the Medical Staff.

D. Engages in any activities that are a threat to the welfare or safety of patients, employees, other physicians, or the Hospital. The House Staff Officer will be sent written notice of the disciplinary action together with a statement of the reasons therefore. If no request for a grievance procedure (see below) is made by the House Staff Officer, the disciplinary action shall become effective and final.

Grievance Procedure

A grievance shall be defined as a dispute regarding (a) the written interpretation or application of the terms of the individual contract or its conditions; or (b) a question regarding the non-renewal of the appointment of a House Staff Officer; or (c) application or interpretation of Hospital policies and procedures; or (d) a decision by the Program Director to place a House Staff Officer on probation; or (e) a decision by the Program Director to terminate the House Staff Officer from the residency training program. A grievance may be brought by an individual House Staff Officer and shall follow the following grievance procedure:

A. Within ten (10) calendar days of the occurrence giving rise to the grievance, the House Staff Officer (Grievant) must present the grievance in writing to the Program Director (A grievance regarding a suspension or termination may be brought immediately by the Grievant to Step B within the above referenced time frame). A grievance meeting will be held for the Grievant to discuss the grievance with the Program Director. The Program Director will issue a written decision within fourteen (14) calendar days of the grievance meeting. If the grievance is not resolved satisfactorily in Step A, the Grievant may proceed to Step B.

B. The grievance must be submitted to Step B by the Grievant, signed and in writing, to the

Medical Education Committee ("MEC") within 7 calendar days from the response at Step A. Once submitted, the MEC will schedule a meeting to consider the grievance within fourteen (14) calendar days, or as soon as possible thereafter. The Chair of the MEC, or his/her designee, will respond to the grievance, in writing, within fourteen (14) calendar days of the Step B grievance meeting. *The decision of the Medical Education Committee is final and binding.*

Failure on the part of the Grievant to process the grievance within the above time limits will be deemed to establish agreement with the resolution in the prior steps or waiver of the grievance.

Harassment

To be reported to the Departmental Chair.

Dress Code

Protective attire, including scrub suits, must not be worn beyond restricted areas. Gowns used as covering must be tied securely in back. Long lab coats used as a cover-up must be buttoned. *At no times are scrub suits to be worn outside the Medical Center.*

Section Four:
Patient Care

PATIENT CARE GUIDELINES

Patient Safety

It is the policy of Englewood Health to report and document any event in the hospital or on the premises that is not consistent with routine patient care or operation of the facility. House Staff Officers are required to report any occurrence that has the potential to adversely affect or threaten the health, life or comfort of a patient, visitor, staff, volunteer or other individual. Please review the above policy including the Reportable Occurrence Table carefully on which events require reporting and the proper procedures for doing so.

The requisite mechanism for reporting occurrences i**s through Englewood Health's online Safety Reporting System which can be accessed through the E-portal on the hospital's intranet. House Staff Officers can log in to the system using their hospital computer login username and password. Further review of this system will be provided during orientation.**

House Staff Officers with questions or concerns regarding an event should speak with the clinical unit's Nurse Manager and activate the Chain of Command as per Policy 300.46 whenever necessary. They may also contact Risk Management at x3081 during weekdays, or the Administrator On Call at night or on weekends.

Patient Experience

Patients' satisfaction with their experience at Englewood Health is a high priority for the organization. Patient experience is important with respect to the quality of care we provide, and impacts upon reimbursement that Englewood Health receives from payers related to our performance in patient satisfaction.

Key survey questions that patients and/or their family members may be asked to answer include:

- Did the doctor **listen carefully** to you?
- Did the doctor treat you with **courtesy and respect**?
- Did the doctor **explain things understandably**?
- Were you told what the **medications were for**?
- Was your doctor **clear about your discharge**?
- Was there good **communication between your doctor and your nurse**?

Strategies to improve patients' care experience at Englewood Health include **sitting down** when speaking with patients, and using the "**AIDET**" communication techniques:

ACKNOWLEDGE - Make a great first impression

- Always knock AND ask permission to enter a room
- Acknowledge patient AND family by name

INTRODUCE - Let the patient know you are someone who can help

- Tell patient your name, title, and role
- "Manage up" yourself (establish your credibility)
- "Manage up" rest of care team (e.g. "Our nursing team is nationally recognized.")

DURATION - Keep patients informed to help set expectations. Let them know:

- How long you will be in the room
- When you will be back
- When you will have results for them

EXPLANATION - Help reduce patients' anxiety by explaining what you are doing

- Tell them what you are going to do AND why
- Ask them if they have concerns or questions--listen without interrupting
- Let them know THERE IS A PLAN

THANK YOU - Let patients know you care

- Thank them for choosing Englewood Health
- Thank them for allowing you to care for them
- Thank their family for caring enough to be there

Sitting down while speaking with patients and their families, and saying "thank you" are two of the most effective ways that we can improve their patient experience.

We want to emphasize to patients that we ALWAYS strive to meet their needs and answer their questions.

Englewood Health has two Patient and Family Engagement Coordinators Lorraine Johnson, RN, ext 2175, and Maryellen Jahnke, RN, ext 2171, who are located in the Main Building, Room 1016 next to the Physicians' Lounge. They are calling patients after discharge to follow up on patients' clinical status, and to answer patient or family questions or concerns. They are a valuable resource, and are happy to speak with residents or other Englewood Health staff.

House Staff Role in Length of Stay

Englewood Hospital recognizes the importance of managing the length of stay (LOS) of patients admitted to the inpatient service. Not only does reducing the LOS increase the efficiency of medical care and improve the quality of care provided, it also assures revenue availability to the Hospital for program development. Throughout the Hospital, mechanisms are in place to reduce LOS. All Hospital personnel must be cognizant of this pressing issue. Care coordinators and social workers are actively involved in discharge planning and are routinely available on the patient floors for consultation with the medical staff. House Staff are encouraged to interact with these individuals and, wherever possible, bring to administration's attention any areas where intervention could play a part in reducing LOS.

Orders on the Teaching Service

Admission orders and daily changes are to be written by the medical or surgical residents. Suggestions for changes should be stated in the Attending's admission note or Progress notes. Whenever possible, these suggestions should be discussed with the residents. The residents should review charts at regular intervals during the day and their sign out to pick up and read attending physicians' and consultants' notes and suggestions. Attendings may write orders when a resident is not immediately available. However, the resident must be notified and given an opportunity for discussion and explanation. The policy for order writing by residents applies to consultants as well as the primary attending.

Discharge Planning

An integral component of all patient care, Discharge Planning is mandated by federal and State regulations, and is an essential element of Utilization Management. Optimally, such planning begins at the time of admission. The goal of Discharge Planning is to enable the patient to complete his or her care in the Hospital and to return home or to transfer to another facility with arrangements for the continuing care s/he may require.

It is the responsibility of the patient care team to work together to establish a target LOS for the patient, and to work with the patient and family to establish an appropriate discharge plan working toward this goal.

The physician is responsible for thinking about the discharge plan and probable date of discharge as soon as the patient is admitted, and for communicating alterations in that plan and date to other health care team members. S/he is also responsible for the final discharge determination and writing of the discharge orders. It is essential that physicians communicate with other team members regarding the patient's needs and readiness for discharge.

The Care Coordination Department is responsible for coordinating discharge planning for patients having complex needs for post-Hospital care. To identify such patients, RN Case Coordinators or social workers employ a high-risk screening program when patients are admitted and collaborate with other health professionals during Hospital stays.

Early referral by physicians of patients with complicated psychosocial or health care needs is a further impetus to initiate planning efforts as early as possible. Current application procedures and eligibility criteria for all services, whether institution- or home-based, are quite complicated. The care coordination staff members explain these to the physician as they affect individual situations and expect cooperation in completing necessary applications and summaries.

Consultations

In general, the decision to request a consultation should be made with the knowledge of the patient or family and the attending physician. The House Staff Officer should discuss the role of consults from other services with the patient's primary attending. Either the House Staff Officer or the attending of record may contact the consulting service. An order for the consultation must be placed in the medical record. It should be noted that the House Staff Officer of the teaching service rather than the consulting

service has the responsibility for ordering routine tests. If the consultant orders tests, the consultant should notify the House Staff that orders have been placed.

Emergencies: Medical and Surgical

Emergency Preparedness: Emergency Management

The Hospital's Emergency Management plan is aimed at prompt and efficient handling of any community or Hospital emergency. The plan is designed as an "all hazards plan." The Hospital uses the Hospital Emergency Incident Command System, which defines chain of command and operations objectives. The Emergency Operations Center is the site from which response efforts are coordinated by an Incident Commander. Drills are performed and evaluated throughout the year. This provides staff the opportunity to reinforce their knowledge of the plan while providing the Hospital an opportunity to make improvements to the plan. Participation is mandatory for all employees in departments involved in a drill.

If the Emergency Management Plan is activated, it will be announced by overhead loudspeaker. House Staff may receive a page from Hospital operators or their departments. After the House Staff Officer ensures his or her safety and that of his or her patients, s/he should contact a direct supervisor for further instructions. House Staff should not attempt to respond to the scene of the incident or the Emergency Department unless directed to do so by a supervisor, or unless it is the responsibility of the House Staff Officer under the Emergency Management Plan. A copy of the Plan can be found in the Nursing Units, in Department Administrators' Offices, and on the Englewood Health Intranet.

House Staff should make sure that their departments have their current contact information so that professional staff availability may be assessed in emergencies.

Code Blue: In-Hospital Resuscitation

See Medical Staff Policy 100.04: Code Blue.

Ethics: Clinical Dilemmas

See Medical Staff Policy 100.05: Ethics Consultation.

Capacity Assessment

The more significant the consequences of refusal, the more certain House Staff should be that the patient has decisional capacity. They should assess whether the patient:

- *Understands* and *appreciates* the diagnosis, prognosis, likelihood of risks and benefits, and the treatment alternatives.
- *Makes* and *communicates* a choice.
- Articulates a *reason* for the refusal that is consistent with patient's values.

House Staff should elicit the patient's reasons for refusal:

- "Help me understand why you decided to refuse _____."
- "Tell me what makes _____ seem worse than the alternatives."
- "What do you believe will happen if you don't have _____?"

It should also be determined whether the patient has a related mood disorder or other distortion of judgment (e.g., depression, fear, or anxiety). When a patient lacks decisional capacity, a surrogate (e.g., health care proxy, or guardian, or next of kin) may make decisions on behalf of the patient.

RADIOLOGY SERVICES

Diagnostic Radiology and Imaging Services

The Radiology Department includes diagnostic radiology, ultrasonography, computerized tomography (CT), interventional radiology, nuclear medicine, positron emission tomography (PET), magnetic resonance imaging (MRI), mammography, and early detection screening CT. The Department provides services to inpatients and emergency patients 24 hours per day and services to outpatients approximately 12 hours per day, Monday through Friday, and on a limited schedule on weekends. The range of services includes diagnostic imaging and special interventional or therapeutic procedures, utilizing ionizing and non-ionizing radiation, with and without the use of contrast media.

Request for Exams

All requests for imaging studies or interventional procedures must be electronically ordered through the electronic health record (EHR). Interventional procedures and urgent diagnostic studies should be requested by telephone as well. Final reports are uploaded to the hospital information system and are viewed online.

SOCIAL WORK SERVICES

Social work services are provided at Englewood Hospital. Patients and families are more effectively served when personal and family problems influencing health care treatment and recovery are treated simultaneously and in close relationship with the diagnosis and treatment of illness. Professionally trained and licensed social workers of the Care Coordination Department provide this needed service.

Based on the recognition that social and emotional factors are fundamental concerns in illness and can be disruptive to health and medical care, the Care Coordination Department is prepared to help patients and their families deal and cope with these related problems. Social workers can also provide consultation and technical assistance related to behavioral health issues. The referral guidelines below were developed to assist physicians and other professional staff in identifying patients or families in need of social work intervention at any point during the course of treatment. The Care Coordination Department should be contacted if any of the following situations exist:

I. Patient/family safety issues interfere with continuity of care, including:
   A. Patient with evidence of lack of sufficient care in the community.
   B. Suspicion of abuse, neglect or domestic violence.
   C. Lack of family and/or community support system adequate for care plan.
   D. Inadequate insurance or other resources for recommended levels of care.
   E. Evidence of substance abuse and/or psychiatric disorder impeding care.

II. Potential exists for extended or long-term care needs, including:
   A. Need for sub-acute or long-term placement.
   B. Need for hospice care.
   C. Need for supervised living arrangements/foster care.

D. Frail elder with multiple admissions and/or failure to thrive.
E. Homelessness.
F. Concern that patient's condition will alter his or her ability to continue present living arrangements.
G. Need for Medicaid related home care services.

III. There is evidence of patient/family coping and/or compliance issues, including:
A. Complex patient/family dynamics interfering with medical treatment plan; history of refusing needed skilled or support services at home.
B. History of discharge against medical advice (AMA) or current AMA.
C. Non-adherence to medical regimen.
D. Lack of follow-through with efforts to plan hospital discharge.
E. Need for bereavement counseling.
F. Psychosocial issues related to adjustment/adaptation to illness or medical condition.
G. Mental health issues impacting medical management.

IV. There are legal/regulatory issues, including:
A. Inability to make decisions regarding safe discharge alternatives and no surrogate decision maker.
B. Inability to access financial assets for continuing care needs.
C. Immigration issues.
D. Need for involvement of Division of Youth and Family Services [DYFS].

V. There are immediate resource concerns, for example:
A. All medically necessary transportation arrangements.
B. Financial assistance with discharge needs including prescriptions.

Social workers use high-risk criteria to determine whether to initiate intervention with patients. When physicians refer to the Care Coordination Department it is very helpful if they discuss with the patient/family the reason for referral in relation to the medical treatment plan. Interpretation of the

importance of getting assistance with emotional and social problems, as part of comprehensive health care, can be most helpful.

VASCULAR SURGERY FELLOWSHIP

CURRICULUM

GOALS AND OBJECTIVES

Vascular surgery Fellowship Curriculum
Goals and Objectives

EDUCATIONAL GOALS AND PHILOSOPHY

The goal of the Vascular Fellowship Program at Englewood Hospital is to provide training to general surgeons who, upon completion of the program, will be qualified vascular surgery specialists. This is accomplished by providing both the experiences and environment where fellows can develop the surgical skills, medical knowledge, communication, clinical skills, and professional attitudes to become physicians committed to lifelong learning, medical system integration, and excellence in the diagnosis of vascular diseases, performance of open vascular surgery, and endovascular interventions.
Whether fellows pursue an academic career or one in community practice, the goal of the Vascular Fellowship Program is to equip fellows with the ability to critically assess the medical literature, develop an understanding of research, and keep abreast of new developments. Since the acquisition of knowledge in medicine must be lifelong, general principles are emphasized throughout the duration of training.

PROGRAM OVERVIEW

Goals: The general goals of the program are to provide a learning and training environment which facilitates the development of expert vascular surgery specialists who will have the tools and abilities to be leaders in both the clinical and academic community of vascular surgeons. These goals are accomplished by providing:

- Didactic instruction and research experience in vascular physiology and pathobiology.
- Instruction and direct clinical experience with the technology, clinical applications, and professional interpretation of noninvasive vascular testing.
- Instruction and direct clinical experience in the performance and interpretation of the complete spectrum of endovascular interventions.
- Supervised performance of open vascular surgical procedures.

Following successful completion of the training program the trainee should be eligible for certification as an RVPI (Registered Physician in Vascular Interpretation) and eligible for certification in Vascular Surgery

by the American Board of Surgery. It is expected that the trainee will be a competitive candidate for the professional position of his or her choice, whether private practice, academic, or a combination of the two. Additionally, it is a goal of the program to graduate physicians competent in all aspects of vascular care, including diagnosis, medical management, endovascular and open management.

CURRICULUM OVERVIEW

The fellowship training program in Vascular Surgery at Englewood Hospital and Medical Center is a two-year program comprised of all the clinical and academic components of:

- Endovascular diagnostics and therapeutics
- Noninvasive vascular testing with ultrasound-based therapeutics
- Clinical research
- Open surgical procedures

These activities are all conducted at Englewood Hospital and Medical Center (Site 1)

Vascular Surgery Fellowship Program
Block Schedule

YEAR 1

PERIOD	1	2	3	4	5	6	7	8	9	10	11	12	13
SITE	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1
ROTATION NAME	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas
OUTPATIENT	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas
% OUTPATIENT	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
% RESEARCH	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

YEAR 2

PERIOD	1	2	3	4	5	6	7	8	9	10	11	12	13
SITE	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1	SITE 1
ROTATION NAME	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas	Vasc Surg/ OR Non-Invas
OUTPATIENT	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas	Clinic/ Non-Invas
% OUTPATIENT	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
% RESEARCH	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

GOALS AND OBJECTIVES FOR COMPETENCIES

At the completion of the training program it is expected that the fellow will be fully prepared to embark on a career as a vascular surgeon through education and successful completion in the following areas:
Medical Knowledge: Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care:

- Demonstrate appropriate general knowledge in vascular diseases.
- Know and apply the basic and clinically supportive sciences which are appropriate to the discipline of vascular surgery.
- Demonstrate competence in all surgical and technical procedures commonly performed in vascular surgery.

Patient Care: Fellows must be able to provide both inpatient and outpatient care that is compassionate, appropriate and effective for the treatment of vascular diseases and the promotion of health. Fellows are expected to:

- Establish skills in gathering accurate and essential patient data.
- Demonstrate an understanding of informed treatment plans, including up to date scientific evidence and clinical judgment.
- Demonstrate competence in pre and post-operative care, the ability to select the procedure most appropriate to the clinical situation, and to recognize his/her limitations.
- Demonstrate competence in all surgical and technical procedures commonly performed in vascular surgery.
- Demonstrate caring and respectful behaviors when interacting with patients and families.

Interpersonal and Communication Skills: Fellows must demonstrate interpersonal and communication skill that result in effective exchange of information and collaboration with patients, their families, and health professionals. Fellows are expected to:

- Communicate openly and effectively with patients, peers, healthcare professionals and ancillary staff.
- Utilize effective listening and questioning skills while providing and receiving patient information.
- Demonstrate effective exchange of information.
- Present clear and concise thoughts at conference and presentations.

Professionalism: Fellows must demonstrate commitment to carrying out professional responsibilities, and an adherence to ethical principles. Fellows are expected to:

- Demonstrate an ability to effectively utilize systematic methodology to assess practice experience and perform practice based improvement activities.

- Locate, appraise, and assimilate evidence from scientific studies related to patient's vascular problems.
- Demonstrate an ability to obtain and utilize information from patient population and the larger population from which they are drawn to enhance patient care.
- Utilize information technology to manage information, access on-line medical information, and to support their own education.
- Demonstrate an ability to utilize knowledge of study designs and statistical methods to recognize strengths and weaknesses in clinical studies and other information on diagnostic and therapeutic effectiveness.
- Facilitate the education of medical students, residents, and other healthcare professionals.

Systems Based Practice: Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Fellows are expected to:

- Demonstrate understanding of vascular issues; how they affect other health care providers, the health care organization, and society as a whole. Collaborate with healthcare professionals from other disciplines to provide optimal care.
- Exhibit an understanding of how environmental factors impact healthcare organizations and healthcare costs.
- Demonstrate ability to recognize how types of medical practices and delivery systems differ from one another, including methods of controlling health care costs and allocating resources. Utilize this knowledge to insure quality healthcare.
- Develop an appreciation for practicing cost effective healthcare and resource allocation that does not compromise patient care.
- Express knowledge of hospital and community resources in place to support patients, advocate for quality patient care and consistently assist patients in dealing with complexities of the healthcare system.

Technical Skills: Fellows are expected to demonstrate competence in all surgical and technical procedures commonly associated with vascular surgery. In particular, competence must be acquired in:

- detailed vascular anatomy and physiology.
- proper history taking and physical examination of patients with vascular problems in both the hospital and outpatient clinic setting.
- early recognition and treatment of complications of vascular surgery.
- open major vascular procedures.
- endovascular procedures.

FELLOWSHIP BLOCK SCHEDULE (4 WEEKS)

YEAR 1 & YEAR 2	PRIMARY ACTIVITY	SECONDARY ACTIVITY
BLOCK 1	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Radiation Safety Course Vascular Laboratory Interpretation
BLOCK 2	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular Laboratory Interpretation / Computerized Tutorials
BLOCK 3	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular Laboratory Interpretation
BLOCK 4	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular laboratory Interpretation
BLOCK 5	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular laboratory Interpretation
BLOCK 6	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular laboratory Interpretation
BLOCK 7	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular laboratory Interpretation
BLOCK 8	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular laboratory Interpretation
BLOCK 9	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular laboratory Interpretation
BLOCK 10	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular laboratory Interpretation

BLOCK 11	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular laboratory Interpretation
BLOCK 12	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular laboratory Interpretation
BLOCK 13	Vascular Service Open / Endovascular rotation Clinical Noninvasive Lab	Research Vascular laboratory Interpretation

GENERAL INFORMATION

Research

Fellows will be expected to become actively involved in research in vascular surgery, with the goal of completing at least 2 projects suitable for presentation and publication per year. This may be a new project, which reflects a particular interest of the fellow, although generally the fellow engages in a project that reflects ongoing interests of the vascular faculty.

The goal of the research component is to enhance the residents understanding of research methodology, to stimulate translational research, and to enhance the understanding of vascular biology and cellular mechanisms of disease.

This experience includes project selection, literature review, experimental design, data collection, analysis, presentation skills and manuscript preparation.

At the conclusion of the second year the fellow will have completed and submitted research initiated during the first year which is suitable for publication and presentation.

In addition to research activities, the fellow will become familiar with non-invasive vascular diagnosis. This will take the form both of directed reading in the basic science and physical principles on non-invasive testing, as well as a hands-on experience. This experience is distributed among all the major types of vascular diagnosis, including cerebrovascular, aortic, mesenteric, hemodialysis, peripheral arterial and venous duplex examinations.

RPVI - Registered Physician in Vascular Interpretation

The Registered Physician in Vascular Interpretation (RPVI) certification, developed in response to requests from physicians in the vascular surgery and vascular medicine community, documents the highest attainable standard in vascular ultrasound interpretation.

The RPVI certification programs is accredited by ANSI to the International Organization for Standardization (ISO) 17024 Standard. Earning the RPVI certification is a requirement to sit for the American Board of Surgery's Vascular Surgery Qualifying Examination. Additionally, the RPVI certification is required for completion of many vascular surgery fellowship programs.

Earning the RPVI Certification

The RPVI certification is earned by passing the Physicians' Vascular Interpretation (PVI) examination. The content of the PVI examination reflects current noninvasive vascular laboratory practice. To learn about how the PVI examination is written, go to APCA.org/PVI

Qualifications to sit for the RPVI Exam

Applicants must maintain a patient log or other record of interpretation experience with a minimum of 500 vascular laboratory studies. This documentation must be maintained for at least three years following the date of application approval as case logs are subject to audit. Case logs must include at a minimum the date of the case, the testing area of the case, and whether the case was simulated/didactic or clinical. Additionally, the case log must include the name of the supervising physician/medical director and clinical site (i.e. hospital name, clinic or private practice) with contact information. For a sample patient case log, please visit **APCA.org/SampleLetters**.

RPVI Exam covers the following subjects:

- Carotid duplex ultrasound (extracranial cerebrovascular).
- Transcranial Doppler (intracranial cerebrovascular).
- Peripheral arterial physiologic testing (excludes Ankle Brachial Index (ABI) and single level exams).
- Peripheral arterial duplex ultrasound.
- Venous duplex ultrasound.
- Visceral vascular duplex ultrasound.

Fellow needs to complete the 500 case log requirement by Year 1. Fellow should register and sit for the RPVI exam during first quarter of Year 2 (July/August/Sept). RPVI Certification should be attained by second quarter of Year 2.

Didactic Experience

The fellow is responsible for choosing case presentations and topics for the weekly main Vascular Conference, and coordinating preparations and topics of educational material for discussion. Topics will be reviewed with the Program Director at the beginning of each year. The fellow is also responsible for presenting at the Vascular Mortality and Morbidity conference and attending the joint conference with general surgery residents. Fellows are expected to attend and present at the plenary session of the yearly Vascular Symposium of the Vascular Society of New Jersey.

Clinical Rotations

The goal of the clinical experience in vascular surgery is an intense, concentrated and focused experience in the diagnosis, surgical, non-surgical management, and follow-up care of the entire spectrum of vascular surgical diseases. The fellow is not expected to take in-house call, but is expected to be available on a first-call basis for vascular emergencies, 6 days of every week, excluding vacation weeks. The fellow is responsible to and under the supervision of the various attendings whose patients he/she is caring for, and ultimately to the Vascular Program Director.

Fellows will be monitored for their continued competence in medical knowledge, patient care, communication, professionalism, practice based learning and improvement, systems based practice and technical skills throughout training as outlined in goals and objectives for competencies.

During clinical rotations, the fellow is expected to participate in the pre, peri, and post –operative care of vascular patients of the full-time faculty. He/she is also responsible for assigning junior residents to surgeries, which he/she is not planning to do. All junior residents on the service are under the supervision of the fellow, and the fellow makes rounds, sees consults, and is responsible for tall management decisions on the service. The fellow participates at least weekly in the outpatient offices.

The fellows split weekend clinical coverage. He/she is expected to attend and participate in all didactic and clinical conferences of the division, including Department of Surgery Grand Rounds, and Vascular Case Conference.

Evaluations

Fellows will be monitored and evaluated for their continued competence in the six core competencies of medical knowledge, patient care, communication, professionalism, practice based learning and improvement, systems-based practice and technical skills throughout training.

Supervision

Refer to Supervision Policy in the House Staff Manual.

YEAR I FELLOW CURRICULUM

Endovascular training

Endovascular procedures are typically performed in the angiography suite or in a hybrid room located in the main operating room suites. In the first year, the vascular resident masters basic endovascular skills and begins to learn advanced skills.

At the conclusion of the first year rotation, the fellow will be knowledgeable in endovascular management including basic and advanced catheterization skills, principles of diagnostic and therapeutic procedures including angioplasty, atherectomy, stenting, thrombolytic therapy, embolization and aortic endo-grafting including the thoracic and abdominal aorta using simple and branches grafts.

Non-invasive Vascular Laboratory

During this rotation, the fellow will read basic texts on vascular noninvasive imaging, review all studies performed at the listed site which are done on a daily basis. He/she will review his interpretation with the reading faculty for the week and will document interpretation.

At the conclusion of the first 6-month rotation, the fellow will:

- be able to deal with ultrasound-guided interventions.
- have acquired knowledge of ultrasound physics as it applies to current established techniques of vascular diagnosis.
- be familiar with all major forms of instrumentation associated with routine noninvasive vascular diagnosis, including plethysmography, continuous-wave and pulsed Doppler, and Color-flow duplex ultrasound scan technology.
- be able to perform and interpret the results of noninvasive testing modalities performed for major non-cardiac vascular disorders.
- have a basic knowledge of ultrasound physics.

Diagnostic Angiography

Fellows will perform all diagnostic and therapeutic angiograms with the vascular faculty. Fellows will have already completed the radiation safety course. Fellows will select 2-3 cases to present at weekly vascular rounds.

At the conclusion of this rotation, the fellow will:

- be comfortable with diagnostic endovascular procedures, including aortograms and runoff as well as venograms and fistulograms.

Open Cases

During this first year rotation, the fellow will participate in open cases. He/she is expected to participate in the pre, peri and post-operative care of vascular patients of the faculty. The fellow also participates in the care of patients from voluntary faculty. He/she is also responsible for assigning junior residents to surgeries, which he/she is not planning to do. All junior residents on the service are under the supervision of the fellow, and the fellow makes rounds, sees consults, and is responsible for all management decisions on the service.

At the conclusion of the rotation, the fellow will be comfortable with:

- AV access
- basic LE bypass
- Carotid Endarterectomy (CEA)
- Transcarotid Artery Revascularization (TCAR)

Outpatient Clinic

The fellows participate at least weekly in the outpatient offices of the faculty. He/she should begin to learn the evaluation of patients with aneurysmal and/or peripheral arterial disease with regard to medical management testing preoperative preparation. The fellow should become familiar with evaluation of patients with venous disease and TOS.

Wound Care Integrated experience (see Wound Care Curriculum: Goals and Objectives)

Endovascular Procedures

During the year the vascular fellow performs diagnostic and therapeutic angiography.

- A substantial number of aortic endograft procedures and thoracic endograft will be performed. Aortic and peripheral stent graft procedures are performed routinely at our training site. Trainees have experience with all FDA approved endograft and stent graft devices available including fenestrated grafts.
- Upon completion of the training program, the vascular fellow will have both the skills and the experience to qualify for independent performance of all approved percutaneous interventions and aortic endografting based upon all current established credentialing guidelines.

Inpatient Management

The vascular fellow serves as a supervisory resident in the clinical management of all inpatients on the teaching Vascular Surgery service.

YEAR II FELLOW CURRICULUM

During the second year of training, the fellow will participate in open major vascular procedures, thoracoabdominal aneurysms, and thoracic outlet procedures as well as procedures for venous disease, and traumatic vascular injuries. The fellow will participate in complex endovascular procedures including fenestrated aortic endografting and brachial endograft techniques.

During the last 6 months of the second year of training, the fellow will have increased independence with primary responsibility for the entire management of the Vascular Surgery Service. This includes performing both as a primary surgeon and teaching assistant on appropriate cases, seeing all consults to the vascular surgery service and supervising a weekly ½ day clinic. The fellow will be expected to make all primary management decisions independently, including decisions regarding type and timing of surgical procedures, with consultation from the attending staff. Ultimate authority for clinical decisions remains with the attending staff. The fellow again is involved with endovascular procedures under the guidance of full time faculty.

The fellow should be able to complete all procedures, both endo and open with minimal to no assistance required from faculty. It is expected that the fellow be able to take a junior resident through simple cases. The vascular fellow performs all categories of major vascular surgical procedures under the direct

supervision of the attending staff. Surgical case totals are generally balanced with regard to case mix (e.g. carotid, aortic, extremities) and will meet defined category requirements.

It is expected that at the end of the second clinical year, the fellow:

- Will have met all requirements for diagnostic angiography and is comfortable performing these procedures.
- Is comfortable with more complex endovascular procedures such as subintimal angioplasties and stenting.
- Will have an understanding of the evaluation and testing required for patients undergoing aortic, cerebrovascular, and peripheral vascular procedures.
- Will be competent with the treatment of venous disease insufficiency and varicose veins.
- Will be competent with the evaluation and treatment of thoracic outlet diseases.
- Diagnose and recommend management for open aortic intervention.
- Define options for managing ruptured aortic aneurysms.
- Discuss complex vascular disorders such as carotid body tumors, thoracic aortic diseases.
- Understanding diagnosis and treatment of children with vascular diseases.
- Communicate effectively with patients and patient's families regarding care.
- Complete documentation on a timely basis for patient care
- Be comfortable with operative note dictation.
- Communicate with referring physicians and consultants regarding patient care.
- At the conclusion of the second year the fellow will have completed and submitted research initiated during the first year which is suitable for publication and presentation.

Regional and National Conference Participation

Annual UCLA Symposium (Moore Course) Year 2 Participation
This is a 4-day course which provides an in-depth, comprehensive, and current review of vascular and endovascular surgery, and it is co-sponsored by the Society for Vascular Surgery. It covers four significant categories of topics including open surgery, endovascular procedures, medical management and diagnostic and non-invasive imaging. It is particularly useful for those taking the vascular board examination and therefore the all fellows are to attend this course.

Veith Symposium (Year 1 and 2 participation)
The Veith Symposium is a 5-day annual vascular event that represents the cutting edge, comprehensive, and well-attended meeting in the field of vascular surgery. It is setup in a series of 5-minute rapid-fire presentations that run the full successively the full duration of each day. It is geared towards all practitioners involved with vascular surgeries, procedures or interventions. All vascular fellow are required to attend at least one day of the meeting, at during each year of their training.

Society for Vascular Surgery, Eastern Vascular Society, Society for Clinical Vascular Surgery, etc. (Year 1 and 2 participation)

There are numerous opportunities for the vascular residents to attend one of the many other vascular meetings. These additional opportunities will be granted on an individual basis with priority given based on seniority and to those individuals who have abstracts/papers that are accepted to the meeting.

SilkRoad (Year 2 participation)

– TCAR Fellow Course in Chicago. Training covers pre-case planning, procedural technique, communication with OR staff, procedural supplies (NPS, Stent, Wires, Balloons, ACT)

Annual UCLA/SVS Symposium: A Comprehensive Review and Update of What's New in Vascular and Endovascular Surgery **in October** at The Beverly Hilton, Beverly Hills, CA**. (Year 2 participation)**

Non-Invasive Vascular Laboratory Conference (list topics for a complete academic year)			
Who is in charge of the conference:			Dr. Adam Sagarwala
Frequency of conference: **Monthly**			Thursday(s)
Presenter			**Title of presentation**
Name	**Faculty/ Fellow/ Resident**	**PGY**	
Walsky	Faculty		Vascular Hemodynamics
Walsky	Faculty		Viscosity Shear, Stress + Strain
Walsky	Faculty		Basic Concepts, Hemodynamics, Physics
Lotrario / Sagarwala	Faculty Faculty		Upper Extremity; Hemodialysis (Live Demo)
Walsky	Faculty		Hepatic + Visceral Ultrasound Standards
Walsky	Faculty		Renal + Updated Ultrasound Standards
Lotrario/ Rao	Faculty Fellow	7	Renal + Mesenteric (Live Demo)/ Updated Ultrasound Standards
Elias	Faculty		Practical Venous Ultrasound
Walsky	Faculty		Non-Vascular Pathology EVAR
Elias	Faculty		Venous Insufficiency
Lotrario Cho	Faculty Fellow	7	Bypass Surveillance (Endo + Open)
Walsky / Cho	Faculty Fellow	7	Extremities; Pulse Volume Recording (PVR), Ankle-Brachial Index(ABIs), Toe-Brachial Index (TBIs) and Wrist-Brachial (WBI)
Rao/ Lotrario	Fellow Faculty	7	Live Demonstration of Abdominal Duplex Ultrasound: Celiac, SMA + Renal Visceral Vasculature

Basic Science Lecture (list topics for a complete academic year)			
Who is in charge of the conference:			Dr. Thomas Bernik / Senior Fellow
Frequency of conference: **Monthly**			Thursday(s)
Presenter			**Title of presentation**
Name	**Faculty/ Fellow/ Resident**	**PGY**	
Dr. Jane Kim	Resident	PGY 1	Embryology of the Vascular System
Dr. Jessica Wassef	Resident	PGY 1	Basic Science of Vascular Hemodynamics
Dr. Severjia Saladziute	Resident	PGY 1	Basic Concepts of Hemostasis and Thrombosis
Dr. Jae Hee Cho	Fellow	PGY 6	Vascular Exposure + Anatomy
Dr. Fung	Resident	PGY 1	Diabetes and the Vascular Patients with PAD
Dr. Saladziute	Resident	PGY 1	Formation of Atherosclerosis/Formation of Plaque
Dr. Jane Kim	Resident	PGY 1	Hemodialysis Access
Dr. Ashina Choudhary	Resident	PGY 1	Amputations of Lower Extremities
Dr. Tarokh	Resident	PGY 1	Basic Science Behind DVT
Dr. Jae Hee Cho	Fellow	PGY 6	Criteria Upper Extremity Vein Mapping
Dr. Nakul Rao	Fellow	PGY 7	Pre-Op planning Thoraco-Abdominal Coral Reef Calcification
Dr. Kristin Sheppard	Resident	PGY 1	Common Bleeding Disorders/ Coagulopathies
Dr. Jessica Wassef	Resident	PGY 1	Pathophysiology of Renal Hypertension
Dr. Nakul Rao	Fellow	PGY 7	Nomenclature Consensus: SVU/SVM Guidelines

Educational Journal Club /Guest Speaker Lectures/ New Technology Presentations		
Who is in charge of conference: Dr. Thomas Bernik / Senior Fellow		
Frequency of conference: **Bi Monthly on Thursday(s)**		
Presenter Name	**Journal / Guest Speaker/ New Tech**	**Title of presentation**
Dr. Pergolizzi	Guest Speaker	Molecular Biology: Clinical use of Embryonic Stem Cells
Dr. Kondapaneni	Guest Speaker	Thrombosis in the Pandemic
Dr. Nakul Rao PGY 7	New Technology Presentation	Clotreiver and Flowtriever System Data
Dr. Nakul Rao PGY 7	Journal	Catheter-directed thrombolysis versus suction thrombectomy in the management of acute pulmonary embolism:
Dr. Jae Hee Cho PGY 6	Journal	A Randomized Trial of the Optimum Duration of Acoustic Pulse Thrombolysis Procedure in Acute Intermediate-Risk Pulmonary Embolism: The OPTALYSE PE Trial
Dr. Pergolizzi	Guest Speaker	Molecular Biology: Molecular Genetic of Atherosclerosis summary
Dr. Ofer Burshtain	Guest Speaker	(Pediatric Anesthesiologist) topic: Introduction to Anesthesia summary
Dr. Thomas Bernik	New Technology Presentation	ALTO graft presentation
Dr. Nakul Rao, PGY 7	Journal	A systematic review and meta-analysis of long-term reintervention after endovascular abdominal aortic aneurysm repair
Dr. Jae Hee Cho, PGY 6	Journal	Type II endoleak with an enlarging aortic sac after endovascular aneurysm repair predisposes to the development of a type IA endoleak
Dr. Pergolizzi	Guest Speaker	Molecular Biology: Stem Cells in Transplantation Medicine
Dr. Nakul Rao, PGY 7	Journal	The impact of contralateral carotid artery stenosis on outcomes after carotid endarterectomy

Dr. Jae Hee Cho, PGY 6	Journal	Severe contralateral carotid stenosis or occlusion does not have an impact on risk of ipsilateral stroke after carotid endarterectomy
Dr. Thomas Bernik	New Technology Presentation	Association of Adaptation of Trancarotid Artery Revascular With Center – Level Perioperative Outcomes
Dr. Pergolizzi	Guest Speaker	Molecular Biology: Trans-splicing as a Genetic Therapy
Dr. Michael Cioroiu	Guest Speaker	HBO: The Evidence and Value of Early Application
Dr. Nakul Rao, PGY 7	Journal	A prospective, randomized, controlled clinical trial on the efficacy of a single-use negative pressure wound therapy system, compared to traditional negative pressure wound therapy in the treatment of chronic ulcers of the lower extremities
Dr. Jae Hee Cho, PGY 6	Journal	Vascular Assessment Enters the 21st Center
Dr. Nakul Rao, PGY 7	New Technology Presentation	S + N Negative Pressure A simple, comprehensive NPWT portfolio, suitable for incisional, acute and chronic wounds[1-3]

CURRICULUM/GOALS AND OBJECTIVES IN WOUND CARE Experience

Goals:

To familiarize the vascular fellows with the concept of advanced treatment of chronic wounds and when to refer to the advanced healing center.

Become familiar with the principal etiologies of chronic wounds as well as patient and wound assessment.

Become familiar with Physiological wound healing, as well as the pathophysiology of chronic wound healing and factors influencing the outcome of proper treatment.

Become familiar and know proper indications/utilization of advanced would treatments (skin substitutes, NPWD and Cellutome)

OBJECTIVES:

1. Understand the anatomy and physiology of skin and pathophysiological implications
2. Understand the phases of wound healing
3. Understand initial patient assessment and wound assessment.
4. Become familiar with diagnosis and treatment of arterial wounds, venous wounds, diabetic foot neuropathic wounds, and pressure injuries wounds, and lymphedema.
5. Importance of clinical pathways and evidence based medicine in wound healing
6. Clinical approach and option of treatment in atypical wounds (sickle cell diss., spider bites, pyoderma gangrenosum, calcinosis cutis i.e.)
7. Become familiar with different types of debridement and hemostasis
8. Infected wounds versus contaminated wounds and the treatment approach
9. Become familiar with Wound dressings, specific for different types of wounds and application of topicals.
10. New technologies in advanced wound treatment (skin substitutes, genetic engineered skin substitutes, stem cell treatment and HBO)
11. Associated factors for successful outcomes in wound treatment (nutrition, pain management, edema control).

UPDATED 7/1/21

VASCULAR SURGERY FELLOWSHIP PROJECT PLANNER / TIMELINE YEAR

YEAR 1
YEAR 2

ACADEMIC YEAR _____- _____

		QUARTER #1			QUARTER #2			QUARTER #3			QUARTER #4		
TASK/PROJECT	#/YEAR	1	2	3	4	5	6	7	8	9	10	11	12
		JULY	AUGUST	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY	JUNE
		DUE	DUE	DUE	DUE	DUE	DUE	DUE	DUE	DUE	DUE	DUE	DUE
CASE LOGGING (ACGME)	WEEKLY												
DUTY HOURS LOGGING (NEW INNOVATIONS)	WEEKLY												
M+M/INTER CASE CONFERENCES	WEEKLY												
ULTRASOUND/BASIC SCIENCE CONF	MONTHLY												
JOURNAL REVIEW (DINNERS)	BI-MONTHLY												
RPVI (APCA REGISTRATION) CLINIC -ULTRASOUND CASE LOGS (500)	YEAR 1 WEEKLY												
RPVI EXAM SCHEDULED	YEAR 2-Q#1												
QUALITY IMPROVEMTENT PROJECT	YEARLY				QI TOPIC		QI OUTLINE			PRELIM REPORT		Q1-FINAL REPORT	
PUBLICATION ARTICLE PROJECT	BI-ANNUAL				TOPIC - INTRO	OUTLINE	BACKROUND	METHODS	RESULTS	CONCLUSION	FIRST DRAFT/EDIT	SUBMISSION	
ABSTRACT PRESENTION (S)- SYMPOSIUMS	TBD												
POSTERS													
SUTURE LABS	BI-ANNUAL			LAB 1							LAB 2		
EVALUATIONS (NEW INNOVATIONS) SELF/ATTENDING/FACULTY/PROGRAM	QUARTERLY												
PEC(PROGRAM EVALUATION COMMITTEE)	BI-ANNUAL												
RESEARCH LAB *REQ IACUC CERT	YEAR 1												
UPDATED CV	TRIANNUAL												
COMMITTEE MEMBERSHIPS													
SAFETY PROJECT PRESENTATION													

Thank you

For any questions or additional information, please contact our vascular program coordinator at 201-894-3141 or email elis.tossounian@ehmchealth.org.