



Hackensack
Meridian *Health*
Jersey Shore University
Medical Center

JSUMC Midlevel Provider (AHP) FPPE

Medical Staff Policies & Procedures

Document Owner: Medical and Dental Staff of JSUMC

Date Approved by MEC: 11/13/2012

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Proctoring. All initial Allied Health Professional applicants to the JSUMC Medical/Dental Staff must be proctored by a supervising physician to verify competency in requested privileges. The supervising physician oversees the Allied Health Professional performing a procedure and is prepared to intervene, if necessary, for successful patient outcome.

- a. The supervising physician teaches the procedure to an inexperienced Allied Health Professional by demonstration and co-performance of the procedure and through direct observation of the Allied Health Professional.
- b. The supervising physician directly observes an experienced Allied Health Professional performing the procedure.

Case Logs and Evaluations. All Allied Health Professionals are required to submit case logs to the Medical/Dental Staff Office when requesting privileges for procedures performed at JSUMC. Supervising physicians are required to submit periodic -Allied Health Professional evaluations.

- a. New Allied Health Professional applicants to the JSUMC Medical/Dental Staff may request privileges for procedures to be approved under supervision pending demonstration of competency. A proctoring physician evaluation must be received by the JSUMC Medical/Dental Staff Office after 90 days. Supervised privileges will become unsupervised privileges upon receipt of a proctoring physician recommendation and completed case log. If these items are not received the privilege will remain under direct supervision.
- c. Allied Health Professionals re-applying to the JSUMC Medical/Dental Staff must provide a recent case log during the previous two year interval to maintain procedure privileges. The supervising physician must submit an annual Allied Health Professional evaluation.

**JERSEY SHORE UNIVERSITY MEDICAL CENTER
FOCUSED PROFESSIONAL PRACTICE
EVALUATION**

(TO BE COMPLETED BY THE PRIMARY SUPERVISING or COLLABORATING PHYSICIAN)

Practitioner: _____

Specialty: _____

Privileges that are being reported on ALL Privileges

Specific Privilege(s). Please indicate

1. Has this practitioner completed All aspects of his/her FPPE?
If No, please explain YES NO

2. Based on this information, does this practitioner demonstrate current
Clinical competence? If no please explain YES NO

3. Were there any reports of this practitioner:
 - a. Being uncooperative with colleagues, nurses or other hospital staff?
 YES NO
 - b. Showing signs of unacceptable behavior? YES NO
 - c. Not abiding by any of the Departmental R&Rs YES NO
 - d. Being Unavailable or non-responsive to calls YES NO
 - e. Showing signs of physical or mental health
Limitations YES NOIf YES to any of the above, please explain

COMMENTS:

RECOMMENDATION of Supervising/Collaborating Physician. Based on the above I recommend to:

CONCLUDE FPPE and Begin OPPE on ALL privileges Specific privilege(s) Please indicate

CONTINUE FPPE - IMPROVEMENT PLAN RECOMMENDED ON:

ALL Specific Privilege(s) _____

Signature-Supervising/Collaborating Physician

Date

Jersey Shore University Medical Center
FOCUSED PROFESSIONAL PRACTICE EVALUATION PLAN
ALLIED HEALTH PROFESSIONAL

Practitioner: _____

Primary Supervising/Collaborating Physician _____

Department _____

Section/Specialty _____

This Section To be completed by the Primary Supervising/Collaborating Physician

1. Is this practitioner coming with a documented record of performance of the privilege and its associated outcomes?
 ___Yes ___No If Yes, a Log of the practitioner's procedures must be attached to this form. Based on this information the following FPPE Plan is being recommended:

Procedure	SOURCES OF DATA	WHAT IS TO BE EVALUATED	
Please list ALL Invasive Procedures Requested	Please check ALL that will Apply to this practitioner's proctoring	Time Period	# Procedures under supervision
Procedure to be evaluated: 1. _____	<input type="checkbox"/> Documented personal interaction with practitioner <input type="checkbox"/> Documentation discussion(s) with other individuals interacting with practitioner <input type="checkbox"/> Chart review by non-meridian staff <input type="checkbox"/> Chart review by physician <input type="checkbox"/> Monitoring clinical practice patterns <input type="checkbox"/> direct observation by a Physician <input type="checkbox"/> Simulation <input type="checkbox"/> External Review	<input type="checkbox"/> 1 -3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-9 months <input type="checkbox"/> 9-12 months <input type="checkbox"/> Other _____ If "other" is selected, please provide explanation	<input type="checkbox"/> 3- 5 Procedures <input type="checkbox"/> 5-10 Procedures <input type="checkbox"/> Other _____ If "other" is selected, please provide explanation
Procedure to be evaluated: 2. _____	<input type="checkbox"/> Documented personal interaction with practitioner <input type="checkbox"/> Documentation discussion(s) with other individuals interacting with practitioner <input type="checkbox"/> Chart review by non-meridian staff <input type="checkbox"/> Chart review by physician <input type="checkbox"/> Monitoring clinical practice patterns <input type="checkbox"/> direct observation by a Physician <input type="checkbox"/> Simulation <input type="checkbox"/> External Review	<input type="checkbox"/> 1 -3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-9 months <input type="checkbox"/> 9-12 months <input type="checkbox"/> Other _____ If "other" is selected, please provide explanation	<input type="checkbox"/> 3- 5 Procedures <input type="checkbox"/> 5-10 Procedures <input type="checkbox"/> Other _____ If "other" is selected, please provide explanation

Please list ALL Invasive Procedures Requested	Please check ALL that will Apply to this practitioner's proctoring	Time Period	# Procedures under supervision
Procedure to be evaluated: 3. _____	<input type="checkbox"/> Documented personal interaction with practitioner <input type="checkbox"/> Documentation discussion(s) with other individuals interacting with practitioner <input type="checkbox"/> Chart review by non-meridian staff <input type="checkbox"/> Chart review by physician <input type="checkbox"/> Monitoring clinical practice patterns <input type="checkbox"/> direct observation by a Physician <input type="checkbox"/> Simulation <input type="checkbox"/> External Review	<input type="checkbox"/> 1 -3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-9 months <input type="checkbox"/> 9-12 months <input type="checkbox"/> Other _____ If "other" is selected, please provide explanation	<input type="checkbox"/> 3- 5 Procedures <input type="checkbox"/> 5-10 Procedures <input type="checkbox"/> Other _____ If "other" is selected, please provide explanation
Procedure to be evaluated: 4. _____	<input type="checkbox"/> Documented personal interaction with practitioner <input type="checkbox"/> Documentation discussion(s) with other individuals interacting with practitioner <input type="checkbox"/> Chart review by non-meridian staff <input type="checkbox"/> Chart review by physician <input type="checkbox"/> Monitoring clinical practice patterns <input type="checkbox"/> direct observation by a Physician <input type="checkbox"/> Simulation <input type="checkbox"/> External Review	<input type="checkbox"/> 1 -3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-9 months <input type="checkbox"/> 9-12 months <input type="checkbox"/> Other _____ If "other" is selected, please provide explanation	<input type="checkbox"/> 3- 5 Procedures <input type="checkbox"/> 5-10 Procedures <input type="checkbox"/> Other _____ If "other" is selected, please provide explanation
Procedure to be evaluated: 5. _____	<input type="checkbox"/> Documented personal interaction with practitioner <input type="checkbox"/> Documentation discussion(s) with other individuals interacting with practitioner <input type="checkbox"/> Chart review by non-meridian staff <input type="checkbox"/> Chart review by physician <input type="checkbox"/> Monitoring clinical practice patterns <input type="checkbox"/> direct observation by a Physician <input type="checkbox"/> Simulation <input type="checkbox"/> External Review	<input type="checkbox"/> 1 -3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-9 months <input type="checkbox"/> 9-12 months <input type="checkbox"/> Other _____ If "other" is selected, please provide explanation	<input type="checkbox"/> 3- 5 Procedures <input type="checkbox"/> 5-10 Procedures <input type="checkbox"/> Other _____ If "other" is selected, please provide explanation

**Jersey Shore University Medical Center
FOCUSED PROFESSIONAL PRACTICE EVALUATION PLAN
ALLIED HEALTH PROFESSIONAL**

Practitioner Name: _____

The above FPPE Plan was developed between the primary supervising/collaborating physician and the applicant

Signature – Primary Supervising Collaborating Physician

Date

DEPARTMENT CHAIR REVIEW:

_____ The Department Chair Accepts the FPPE recommendation as presented without change

_____ The Department Chair Accepts the FPPE recommendation with the following modifications:

Signature – Department Chair

Date
