Ongoing Professional Practice Evaluation (OPPE)
for Advanced Practice Providers

Dear Advanced Practice Provider:

In accordance with applicable accreditation standards, Kettering Health (KH) is required to perform Ongoing Professional Practice Evaluation (OPPE) on all providers at each KH hospital where the provider is granted privileges. A copy of the KH Medical Staffs' OPPE Policy can be found on the KH Intranet under Policies and Skills.

Enclosed you will find the Advanced Practice Provider OPPE form to be completed at each KH hospital where the provider is granted privileges for the annual OPPE review period of January 1 – December 31 and returned no later than December 31st.

Return the completed APP OPPE form to:

Kettering Health Main Campus
3535 Southern Blvd.
Attn: Michelle Severino
Kettering, OH 45429
Fax: 937-395-8357
Email: MedicalStaffServices@ketteringhealth.org

Thank you for your cooperation with this quality improvement process. Should you have any questions regarding the enclosed documents, please contact our office at 937-395-8323.

Enclosure: APP OPPE Form

KH Main Campus/Miamisburg/Troy APP Ongoing Professional Practice Evaluation

APP NAME:

TYPE of APP *(select one)*:
❑ Certified Nurse Midwife (CNM) ❑ Certified Nurse Practitioner (CNP) ❑ Certified Registered Nurse Anesthetist (CRNA)
❑ Clinical Nurse Specialist (CNS) ❑ Physician Assistant ❑ Surgical Assistant (*e.g.,* RNFA, CSFA, *etc.*)
❑ Other type of APP granted privileges *(specify, if other)*: _____

APP OPPE Evaluation Period: Annual (July 1 – June 30)
Specify applicable year covered by evaluation period: _____

KEY:
1 = meets standard of care
0 = does not meet standard of care (explain if "0")
NA = not applicable

HOSPITAL ACTIVITY: APP's supervising/collaborating Practitioner to complete the form below based upon patient encounters at KH Main Campus/Miamisburg/Troy during the OPPE period. If no patient encounters, indicate below.

❑ No patient encounters at KH Main Campus/Miamisburg/Troy during the OPPE period.

Evaluate care provided in terms of the type of provider:	**Patient #1**	**Patient #2**
Basic Medical/Clinical Knowledge		
Professional Performance		
Professional Judgment		
Professional/Ethical Conduct		
Competence - Clinical Skills		
Appropriate clinical care provided and documented within the provider's scope of practice and consistent with the privileges granted including but not limited to, as applicable, initial/ongoing patient assessment, patient rounding and progress notes, *etc.* Includes assessment of medical history and physical examinations completed by a PA/CNP/CNS/CNM.		
Appropriate patient management, as applicable to the provider's scope of practice and consistent with the privileges granted. Includes appropriateness of the diagnosis/treatment plan for a PA/CNP/CNS/CNM.		
Appropriate use of medications, as applicable, within the provider's scope of practice and consistent with the privileges granted. Includes appropriateness of medication orders/prescriptions and prescribing decisions/patterns (including schedule II prescribing) for a PA/CNP/CNS/CNM.		
Appropriate use of orders and order sets per policy and/or protocol, as applicable, within the provider's scope of practice and consistent with the privileges granted.		
Competence - Technical Skills		
Appropriate use of techniques, as applicable, within the provider's scope of practice and consistent with the privileges granted.		
Appropriate use of universal precautions including handwashing, exposure, infectious substances, *etc.*		

Citizenship:

Cooperative, professional, and able to work with others in a collegial manner? ❑ **yes** ❑ **no** *(If no, please explain)*

Timely, complete, and accurate preparation of medical record documentation? ❑ **yes** ❑ **no** *(If no, please explain)*

Efficient use of hospital resources? ❑ **yes** ❑ **no** *(If no, please explain)*

Positive interpersonal/communication skills with patients, hospital staff, colleagues? ❑ **yes** ❑ **no** *(If no, please explain)*

What are the provider's strengths/weaknesses?

Is there anything this provider needs to change to be a better clinician?

Is the provider able to competently exercise the privileges granted with or without a reasonable accommodation? ❑ **yes** ❑ **no** *(If no, please explain)*

❑ Provider is performing within established expectations.
❑ Provider is not performing within established expectations: ❑ quality concern ❑ conduct concern ❑ impairment concern ❑other *(please explain)*

CONTINUE TO PAGE 2
Proceed to next page (OPPE Case Evaluations) and complete.

Privileged and confidential peer review document pursuant to Ohio Revised Code §§2305.25, *et seq.* Peer review documents are not to be copied or distributed to unauthorized individuals or entities.

KH Main Campus/Miamisburg/Troy APP Ongoing Professional Practice Evaluation
Case Evaluations

Maintain HIPAA compliance – Please do not list patient name.

Note: The medical records selected for review must be from patient encounters at KH Main Campus/Miamisburg/Troy during the OPPE evaluation period.

PATIENT 1 MEDICAL RECORD #: DIAGNOSIS: PROCEDURE (if applicable):
Case evaluation/comments:
PATIENT 2 MEDICAL RECORD #: DIAGNOSIS: PROCEDURE (if applicable):
Case evaluation/comments:

Applicable to Physician Assistants (PA), Certified Nurse Practitioners (CNPs), Clinical Nurse Specialists (CNS), and Certified Nurse Midwives (CNM)

Is PA practicing according to PA's supervision agreement(s) and System/Hospital policies? ❑ **yes** ❑ **no** *(If no, please explain)*

Is CNP/CNS/CNM practicing according to CNP's/CNS's/CNM's standard care arrangement(s) and System/Hospital policies ❑ **yes** ❑ **no** *(If no, please explain)*

Does PA or CNP/CNS/CNM obtain consultation regarding complex cases and are patients referred as clinically appropriate? ❑ **yes** ❑ **no** *(If no, please explain)*

Have PA and supervising Physician(s) [or Podiatrist(s), as applicable] discussed new medical developments (including pharmaceuticals) relevant to practice? ❑ **yes** ❑ **no** *(If no, please explain)*

Have CNP/CNS/CNM and collaborating Physician(s) [or Podiatrist(s), as applicable] discussed new technologies relevant to practice? ❑ **yes** ❑ **no** *(If no, please explain)*

COMPLETED BY SUPERVISING/COLLABORATING PRACTITIONER

Signature: _____ Date: _____

STOP!
The completed form MUST be submitted to Medical Staff Services at:
3535 Southern Blvd., Kettering, Ohio 45429
Email: MedicalStaffServices@ketteringhealth.org
Fax: (937)395-8357

FOR MEDICAL STAFF USE ONLY
Reviewed by Responsible Medical Staff Leader/Signature: _____ Date: _____

Title of Responsible Medical Staff Leader: _____

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