**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/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 (January 1 – December 31)
Specify applicable year covered by evaluation period: _____

***KEY:***
***2 = meets***
***1 = partially meets***
***0 = does not meet***
***NA = not applicable***

**HOSPITAL ACTIVITY:** Peer Evaluator to complete the form below based upon patient encounters at KH Main/Miamisburg/Troy during the OPPE period. If no patient encounters, indicate below.

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

| *Evaluate in terms of completeness, accuracy, and appropriateness for 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 within the provider's scope of practice and consistent with the privileges granted including but not limited to, as applicable, history and physical exam, initial/ongoing patient assessment, rounds/progress notes, *etc.* | | |
| Appropriate patient management, as applicable, within the provider's scope of practice and consistent with the privileges granted. | | |
| Appropriate use of medications, as applicable, within the provider's scope of practice and consistent with the privileges granted. | | |
| 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 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.**

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

**Maintain HIPAA compliance – Please do not list patient name.**

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

| |
|---|
| PATIENT 1 MEDICAL RECORD #:<br>DIAGNOSIS:<br>PROCEDURE (if applicable): |
| **Case evaluation/comments:** |
| PATIENT 2 MEDICAL RECORD #:<br>DIAGNOSIS:<br>PROCEDURE (if applicable): |
| **Case evaluation/comments:** |

**SIGNATURE OF PEER EVALUATOR**

Completed by Peer Evaluator/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: _____

**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.**