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Don't rely too much on data bank as major source for credentialing info

Latest assessment shows NPDB incomplete, not reliable enough

The National Practitioner Data Bank (NPDB) may be a good tool for peer review professionals, but it can be a trap if you rely on it too much. The research shows that the NPDB is incomplete at best, and health care providers who depend on it may find that they aren't getting the whole story.

Peer review standards require that you query the NPDB when credentialing physicians, so it's not a question of whether to use the data bank. The question is what else you use.

Health care providers should be careful to use the NPDB as only one of several sources of information when credentialing physicians, says **Janet Brown**, RN, CPHQ, head of JB Quality Solutions consulting in Pasadena, CA.

"We can assume that it's less than 100% accurate from the beginning," Brown says. "You have to assume that it's considered to be incomplete and inaccurate, so you have to cover your bases. That means looking to other resources and doing some of your own leg work."

Brown says the most recent report from the federal government confirms what many peer review professionals have suspected for a while. According to the report, the data bank is alarmingly incomplete, and managed care companies, in particular, seem lax about reporting information.

Most managed care plans have never reported

The Health and Human Services Office of Inspector General (OIG) recently released a report that said, among other criticisms, that 84% of managed care organizations have never reported an adverse action against a health care practitioner to the data bank.

The report went on to conclude that the low rate of reporting may adversely affect patient safety. The OIG urges hospitals, physician groups,

and state licensure boards to report doctors who pose a threat to patients, but it says many health plans rarely report to the data bank because they devote little attention to clinical oversight. The health plans' heavy use of contracted panels of physicians, rather than salaried doctors, is blamed for much of the problem.

The OIG noted that health plans also depend on hospitals, physician group practices, and state licensure boards to monitor and report questionable physicians, a practice that the OIG says may be ineffective.

Federal law requires hospitals and health plans to inform the government of any disciplinary action taken against a physician for incompetence or misconduct. The OIG report, however, revealed that over the past 10 years, 84% of health plans and 60% of hospitals have never reported even a single adverse action.

The OIG noted that this finding is particularly surprising in the wake of the recent furor over medical errors, in which research suggested that tens of thousands of people die each year from errors, and at least some of those deaths are attributable to a doctor's mistake.

The OIG report is the result of an 18-month study. Between 1990 and 1999, health plans reported only 715 adverse actions, even though they became the dominant form of health care during that period, covering 100 million people. Physician groups reported 60 adverse events.

The American Association of Health Plans in Washington, DC, responded to the OIG report by saying that health plans do identify quality problems and take action, but that action does not always result in a report to the NPDB. Many situations require further review by medical groups, hospitals, and medical boards, so the health plan does not report the physician and expects those other groups to do so if warranted.

Other studies also have raised questions about the reliability of the NPDB. **(For more on research about the data bank, see related story, p. 108.)** In addition, physicians' groups have criticized the NPDB for being incomplete and inaccurate.

The latest research brought disapproval.

"The OIG report confirmed what we've been saying all along about the NPDB — that it's flawed, incomplete, and not reliable," says **Robert Mills**, a spokesman for the American Medical Association (AMA) in Chicago.

He says the group has opposed the NPDB for years because it provides an incomplete picture of disciplinary action and other incidents.

An earlier report from the General Accounting Office (GAO) reached a conclusion similar to that of the OIG. The Nov. 17, 2000, report stated, "While the [NPDB] is presently the nation's only central source of medical malpractice payment information, it is not clear that all such data are being properly reported.

"While GAO sampled one month's submissions, its review suggests that NPDB information may not be as accurate, complete, or as timely as it should be. Inaccuracies in the way reported information was coded could confuse or mislead querying organizations about the severity of actions taken against practitioners. Additionally, duplicate reports overstate the amount of information the NPDB has on a particular practitioner," the report added.

Thomas R. Reardon, MD, immediate past president of the AMA, says the government reports confirm the AMA's view that the NPDB is "seriously flawed."

He says the data bank is "riddled with duplicate entries, inaccurate data, and incomplete and inappropriate information. In addition, many of the medical malpractice citations name the patient as well as the practitioner — raising a serious red flag regarding patient privacy."

According to Reardon, the NPDB "is clearly struggling to fulfill its mandate."

Data bank managers not happy with trends

The NPDB is managed by the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS) in Chantilly, VA. HRSA has made it clear that health care providers are not reporting information as they should.

COMING IN FUTURE MONTHS

- New York's report card on health care
- Hospital provides secure access to patient records
- Hospitalist programs improving peer review
- Joint Commission surveys: What to expect
- Your responsibilities with ORYX

"HRSA continues to be concerned about the low level of clinical privileges actions reported by hospitals and other clinical privileges reporters such as health maintenance organizations," the agency said recently in a public statement.

The level of reporting is "unreasonably low. Nationally over the history of the NPDB, there are 3.9 times more licensure reports than clinical privileges reports. Moreover, 52.5% of the hospitals currently in 'active' registered status with the NPDB have never submitted a clinical privileges report. Clinical privileges reporting seems to be concentrated in a few facilities, even in states which have comparatively high overall clinical privileging reporting levels," the agency added.

That means peer review professionals must turn to other sources, Brown says. Many hospitals already use credential verification organizations (CVOs) — private companies that query the NPDB and make other inquiries on behalf of the hospital.

Those services can save you a lot of work, but Brown cautions that those using that kind of service must be familiar with how the particular CVO works. If the CVO only queries the NPDB and doesn't do much else, users are not getting enough for their money. Whether hospitals do it themselves or pay a CVO, a good credentialing program must include queries to state medical boards and insurance companies.

"If you're using CVOs, make sure they're doing everything you would do if you had the time," Brown says. "They're supposed to be a convenience, a way to make the process efficient. Don't just turn it over to them without asking exactly how they're going to get the job done."

State systems may provide another option

Patti Higginbotham, RN, CPHQ, FNAHQ, vice president of quality management at Arkansas Children's Hospital in Little Rock, has similar advice. She also is concerned about the reliability of the NPDB.

"It's required that we query the [NPDB] for credentialing, so we absolutely do that for each one. But we look at it more as a compliance issue," she says.

"You can't query too many sources, and if the data bank has information, you want it," she points out. "But it's one source among many, not necessarily the definitive source."

Higginbotham says she doesn't expect any one source to be complete and serve all of her needs, so in that sense, she is not critical of the NPDB. But she recommends that health care providers consider the NPDB no more authoritative than other sources, and she worries that not everyone does that.

"The data bank only tells you if there has been action again a practitioner," she says. "It doesn't tell you what is pending, and it doesn't verify any data for you. We query, and if something turns up, fine.

"But if nothing comes out of the data bank, we

Arkansas state licensing agency offers verification

Arkansas's Centralized Credentials Verification Service (CCVS) was created in 1995, making Arkansas the first state in the nation to base a credentials verification service with the licensing agency.

A new state law allowed the Arkansas State Medical Board to release, with a practitioner's written authorization, credentialing information needed by credentialing / health care organizations. The credentialing information furnished by the board to a credentialing / health care organization is to be used solely for the purpose of credentialing and the renewal of credentials.

The applicable state law was updated in 1999 to change the CCVS service from optional to mandatory. The new law mandates that health care organizations use the CCVS for credentialing.

However, this mandate will not be effective until the program does the following:

- ✔ holds certification by the National Committee for Quality Assurance as a certified credentials verification organization;
- ✔ demonstrates compliance with the principles for credentials verification organizations set forth by the Joint Commission on the Accreditation of Healthcare Organizations;
- ✔ documents compliance with the Arkansas Department of Health rules and regulations applicable to credentialing. ■

don't consider that a stamp of approval," she adds.

Higginbotham says she is more excited about a program that is unique to Arkansas. The state's Centralized Credentials Verification Service (CCVS) was created in 1995, apparently the first credentials verification service provided by a state licensing agency. Higginbotham says the system is very reliable, even though it still is in its early stages.

When she queries the CCVS about a physician seeking credentials, the system provides information about disciplinary action similar to what should be in the NPDB, but it also verifies information about the physician's education, certification for foreign medical schools, and similar matters. **(For more on the CCVS, see related story, p. 107.)**

"It gives us all the information that we would get if we had to go through and do a primary verification on each item," she says. "And it's a tremendous value to the physicians because they don't have to submit verification for each little thing."

NPDB shortcomings put burden on you

Brown notes that, though it has always been a good idea to search beyond the NPDB, the latest research creates more of an obligation. With more evidence mounting to show that the NPDB is incomplete, hospitals risk greater liability if they don't go the extra mile in credentialing, she adds.

"We have to put the risk management hat on with the quality hat. Patient safety is such a huge issue that when it comes to the competency of our medical staff, we should look at that as the most basic element of patient safety," she says. "This recent study has to raise a red flag and make us realize that, even if we suspected this all along, there's no denying it now, and that puts the responsibility back on us."

Brown raises other questions about the reliability of the NPDB, suggesting that a full-scale audit is warranted.

There are so many variables in the reporting process, she says, that hospitals can't judge the reliability of the NPDB without delving into exactly how information gets there. How is the data transmitted from a hospital or medical board? Who receives the information at the NPDB? Does someone have to re-enter the data and risk typing mistakes? Are all the physician numbers entered perfectly?

"My laundry list of questions gets pretty long," Brown says. "The impact of these questions can be pretty scary, because people have become so dependent on the data bank as a central source. But I guess that's the message: You shouldn't be." ■

Previous research casts doubt on value of NPDB

The latest report from the federal government questions the value of information in the National Practitioner Data Bank (NPDB), but it is not the first time doubts have been raised. One study in 1999 suggested that the data found in the data bank were incomplete.

The authors of the study noted that the NPDB is believed to be an important source of information for peer review activities by the majority of those who use it.[1]

The researchers conducted a retrospective cohort study of privileges action reports to the NPDB between 1991 and 1995, linked with the 1992 and 1995 databases from the Annual Survey of Hospitals conducted by the American Hospital Association.

A total of 4,743 short-term, nonfederal, general medical/surgical hospitals throughout the United States were continuously open between 1991-1995 and registered with the NPDB.

The researchers investigated how many hospitals reported one or more privileges actions during the five-year study period, as well as privileges action reporting rates (numbers of actions reported per 100,000 admissions).

They found that hospitals reported 3,328 privileges actions between 1991 and 1995; 34.2% reported one or more actions during the period. The range of privileges action reporting rates for these hospitals was 0.4 to 52.27 per 100,000 admissions, with an overall rate of 2.36 per 100,000 admissions. The proportion of hospitals reporting an action decreased from 11.6% in 1991 to 10% in 1995.

After adjustment for other factors, urban hospitals had significantly higher reporting than rural hospitals. There were notable regional differences in reporting, with the east south central region having the lowest rate per 100,000 admissions (1.49).

"The results of this study indicate a low and

declining level of hospital privileges action reporting to the NPDB," the researchers concluded. "Several potential explanations exist, one of which is that the information reported to the NPDB is incomplete."

Reference

1. Baldwin LM, Hart GL, Oshel RE, et al. Hospital peer review and the National Practitioner Data Bank. *JAMA* 1999; 282:349-355. ■

Hospitals must start to collect ORYX data now

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, recently reminded accredited hospitals that they are expected to begin collecting data now on the first sets of the ORYX core performance measures.

The Joint Commission long has sought to implement standardized core measures as part of the ORYX initiative, which is designed to integrate outcomes and other performance measurement data into the accreditation process.

Deadline was extended six months

The July 1, 2002, deadline was an extension of six months from the original target date. The Joint Commission says this timing is intended to allow hospitals and performance measurement systems sufficient time to plan and budget for activities related to the collection of core measure data.

These are some important dates in the Joint Commission's implementation schedule for ORYX:

- **October 2001:** The Joint Commission will release final technical specifications for initial measure sets.
- **November 2001 through June 2002:** Hospitals will formally select core measure sets based on the health care services that they provide.
- **July 2002:** Hospitals will begin data collection.
- **January 2003:** The Joint Commission will receive the first core measure data for the July 1 to Sept. 30, 2002 quarter. The due date is four months from the end of the last month of the reporting quarter. ■

Project targets medical waste left on food trays

Group effort eliminates problem

When the nutrition and food services employees at Park Nicollet Health Services in St. Louis Park, MN, complained that food trays were being returned with medical waste and sharps on them, the director of quality resources tackled the problem as a process improvement project. Six months later, the problem was virtually eliminated.

The problem had been simmering for a while, but in February, it was brought to the attention of **Judy Wilson**, RN, CPHQ, director of quality resources at Park Nicollet, an integrated care system that includes Methodist Hospital, Park Nicollet Clinic, Park Nicollet Foundation, and Park Nicollet Institute.

Park Nicollet Health has more than 6,800 employees, including more than 485 physicians on staff. Methodist Hospital is a 426-bed facility with 2,600 employees. Representatives from nutrition and food services came to Wilson and said staff were concerned about syringes and other potentially dangerous medical waste being left on the food trays when they were returned after meals.

"A lot of the items were oral syringes that patients had used and then just discarded on the trays, but some were syringes with needles that posed a potential hazard for needlesticks," Wilson says.

"Even if the item had no needle and represented little risk of exposure, the staff in nutrition and food services couldn't know which was which. So they ended up with a lot of anxiety [about] these items, no matter what they were," she adds.

Other waste items caused concern

Syringes weren't the only items of concern. Nutrition and food services staff routinely found various other medical waste, such as gauze dressings and swabs.

"This had bothered them for some time, and they finally came and asked for help," she says. "I was glad they did. I thought we could go through a root-cause analysis and solve this."

To get things started, Wilson invited nurse managers from each care unit to meet with her

and representatives from nutrition and food services. They discussed the problem and discovered that most people viewed the food tray as a convenient disposal area.

Patients, especially those self-administering medications, had no qualms about putting trash on the food tray because they figured that everything on the tray would just be discarded.

Patients about to be discharged were especially likely to view the tray as a convenient place to put trash. They assumed that the entire room would be cleaned after their departure, so they thought it didn't much matter where they put a particular item of trash.

> *The tray was flagged with a pink slip and sent back to the nursing station. "The idea was to make it a very visible reminder. I'm sure it was a little annoying to have the tray sent back to the nurses, but that was sort of the idea. It made them much more aware."*

Clinical staff had a higher level of awareness that leaving medical waste on the tray was improper, but they often saw it as only minor deviation from good practice.

In addition, staff often left items on the trays accidentally after setting them there temporarily for convenience and forgetting to remove them. The 90-minute discussion and root-cause analysis revealed these other root causes:

• The food trays came with a white paper place mat that sometimes made it hard to spot white gauze and other items.

• Fewer staff were around at meal times because employees took their meal breaks at about the same time. That meant that volunteers or other nonclinicians might pick up the trays and were less likely to spot the inappropriate materials.

• Staff often thought that nonsharps items could safely be left on the tray. If the staff member saw the item as harmless, he or she was more likely to leave it on the tray, even while being careful not to leave sharps.

• Sharps containers were not located as conveniently as needed in the rooms. Also, there was some inconsistency about where the containers were located in different rooms.

This often caused the clinician to put the item on the food tray because it was conveniently located right in front of the patient, intending to pick it up and take it to the sharps container before leaving.

• Overworked nurses often had to multitask and became too busy to pay attention to proper procedures.

• Medications given at mealtimes increased the likelihood that medical wastes would be put on the trays.

Education plan makes a difference

Once the committee members identified the root causes, they worked out a number of solutions. The most important need was educating staff.

"We put out the word that it was the staff's responsibility to scan all trays and remove all foreign objects and patient care materials before sending them downstairs," Wilson says.

"We had staff meetings with an educational story board put together by a manager in nutrition and food services, and they used a visual aid: a clear container full of all the things coming down with the food trays. They passed that around, and that was very effective," she explains.

These were some other educational initiatives:

• The nutrition supervisor put a reminder in the hospital newsletter.

• Flyers were posted on each nursing unit with the theme: "If it didn't come up on the tray, it shouldn't come down on the tray."

• The nursing director sent e-mail reminders to nurse managers.

Staff were receptive and eager to help once they heard how much the patient care materials bothered employees in nutrition and food services, Wilson says. Other measures were instituted to minimize the problem and track the process improvement.

The dietary aide who loads the used trays on a dumbwaiter to be sent down to food services was instructed to scan all the trays before loading them, she explains. If the aide spotted any patient care materials that the nurses had missed, he or she was not to remove them, she explains. Instead, the tray was flagged with a pink slip and sent back to the nursing station.

"The idea was to make it a very visible reminder," Wilson says. "I'm sure it was a little annoying to have the tray sent back to the nurses, but that was sort of the idea. It made them much more aware."

The nutrition and food services department kept

track of how many trays were flagged with a pink slip, plus how many trays made it down to their department with foreign materials.

The committee also recognized that patients should be educated about why patient care materials should not be put on food trays, but members decided to let the nurses tackle that goal informally. If the other measures did not yield good results, more formal patient education might be the next step.

Other possible improvements were put on hold, too. The white place mats could be switched for a color that would make it easier to see white items, but the committee decided that change would be too expensive.

It reached the same conclusion about the sharps containers. Even though they weren't ideally located in each room, moving them would be a very expensive project.

"It's still something we could do, but we wanted to put that on hold until we saw whether these other changes would help," Wilson says.

Simple changes seemed to do the trick

All indications are that those more expensive changes won't be necessary. Right after the root-cause analysis, nutrition and food services reported about seven instances a week of medical waste on trays, somewhat fewer than before, though no one was keeping records then. The next week, the number of incidents fell to three or four, and then dropped to one or two instances per week.

"Now we're having no reports at all," Wilson says. "The tracking system is good, and it looks like we're not seeing any more materials make their way down to nutrition and food services."

Though it seems the problem has been whipped, she says, the staff intend to keep focusing on it. The committee presented its findings at the hospital's leadership day, after which the employee health and infection control departments asked to join the effort.

With those departments on board, the committee reconvened in April and decided at that point to wait on relocating the sharps containers, Wilson adds.

"We'll keep tracking it through the summer at least," she says. "We've got some people coming and going with staff changes, so we want to make sure everyone gets the word. After that, we'll probably spot check it once a quarter and take corrective action if we start seeing the problem again." ■

Patients should receive pain management info

A statement from the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) is adding more pressure on health care providers to improve their pain management programs. Health care facilities already were facing pressure from the Joint Commission on Accreditation of Healthcare Organizations' new pain management standards.

CMS' action is not new, but the agency recently released an opinion underscoring what it has expected from health care providers all along. The CMS opinion stated that information about pain management must be conveyed to patients. The opinion came in as an answer to a petition to CMS from a coalition of patient advocacy groups.

To clarify CMS' position, on pain management, **Jeffrey L. Kang**, MD, MPH, director of the Office for Clinical Standards and Quality at CMS, wrote that patients have a right to be informed of all aspects of their medical care, including pain management. Not only is pain management included under medical care, but it is a "critical aspect of care." He said the agency's surveyors will discuss pain management as part of their survey to assess compliance with state and federal laws.

The petition came from a coalition that includes Americans for Better Care of the Dying, the American Academy of Pain Management, the American Pain Foundation, Compassion in Dying, the Medicare Rights Center, and Partnership for Caring (which was formerly Choice in Dying).

The coalition petitioned CMS to amend its Patient's Rights Conditions of Participation to require Medicare and Medicaid providers to:

- inform patients of their pain management rights;
- identify pain management as a critical aspect of medical care;
- explicitly acknowledge that patients have the right to make informed pain management decisions;
- inform patients of any pain management rights they may have under state law.

CMS denied the requests made in the petition but made clear that it supports the effort to improve pain management. The only reason it rejected the petition, Kang wrote, was that CMS already considers pain management "a critical

aspect of care." No change in policy is necessary, he added.

Kathryn Tucker, JD, director of legal affairs with the Compassion in Dying Federation in Seattle, says the CMS letter means that all health care providers in the United States are operating under equivalent pain management requirements. Prior to CMS' clarification, the coalition was concerned that some facilities not accredited by the Joint Commission would not be held to the same pain management standards.

Tucker says the CMS clarification should urge all health providers to manage pain effectively. Joint Commission-accredited organizations risk losing their accreditation by not complying, and others that are not accredited risk losing their Medicare and Medicaid financing by not complying with CMS' expectations.

Kang wrote in his letter that the *Hospital Interpretive Guidelines* (issued June 2000), "explicitly direct the surveyor to ask if the patient has been notified of his / her right to be informed of his / her health status; be informed of his / her prognosis; be involved in care planning and treatment, including pain management; and request or refuse treatment. We believe that pain management is included under medical care as it involves the mitigation and treatment of pain, and that by including it in our interpretive guidelines, we have identified it as a critical aspect of care."

When surveyors look at whether facilities meet applicable state and federal laws, including the Patient Self-Determination Act (PSDA), "pain management should be discussed.

"We also believe that it is the clear intention of the PSDA to allow each individual state the flexibility to determine the most effective manner to comply with its own laws regarding the right of each patient to request or reject the use of effective pain management," he wrote. ■

Two studies confirm value of quality improvement

Two major studies recently provided more support to the work done every day by peer review and quality professionals at hospitals across the country. Both studies showed that quality improvement significantly and directly improves the quality of patient care. In the first study, *Improving Quality Improvement Using Achievable Benchmarks For Physician Feedback,* Catarina Kiefe, MD, PhD, and other researchers found that context performance feedback and benchmarking can be effective (*JAMA* 2001; 285: 2,871-2,879).

They noted that while they are common tools for health care improvement, such feedback and benchmarking rarely are studied in randomized trials. "Achievable benchmarks of care . . . are standards of excellence attained by top performers in a peer group and are easily and reproducibly calculated from existing performance data." Kiefe, et al, conducted a group-randomized controlled trial in December 1996, with follow-up through 1998. The research involved 70 community physicians and 2,978 fee-for-service Medicare patients with diabetes mellitus who were part of the Ambulatory Care Quality Improvement Project in Alabama. Physicians were randomly assigned to receive a multimodal improvement intervention, including chart review and physician-specific feedback or an identical intervention plus achievable benchmark feedback.

To assess how the patient care improved, the researchers measured pre-intervention (1994-1995) against post-intervention (1997-1998) changes in the proportion of patients receiving influenza vaccination; foot examination; and each of three blood tests measuring glucose control, cholesterol level, and triglyceride level, compared between the two groups. The proportion of patients who received influenza vaccine improved between 40% to 58% in the experimental group vs. 40% to 46% in the comparison group. The researchers concluded that use of achievable benchmarks significantly enhances the effectiveness of physician performance feedback in the setting of a multimodal quality improvement intervention.

The second study was *Qualitative Study of Increasing Beta-Blocker Use After Myocardial Infarction: Why Do Some Hospitals Succeed?* (*JAMA* 2001; 285:2,604-2,611.) In this research, Elizabeth H. Bradley, PhD, and others studied how performance measurement improvements directly improve the care of patients.

They noted evidence that beta-blockers can reduce mortality in patients with acute myocardial infarction (AMI) and studied how hospitals have initiated performance improvement efforts to increase prescription of beta-blockers at discharge.

"Determination of the factors associated with such improvements may provide guidance to hospitals that have been less successful in increasing beta-blocker use," they wrote.

The researchers gathered data from in-depth interviews conducted in March-June 2000 with 45 key physician, nursing, quality management, and administrative participants at eight U.S. hospitals chosen to represent a range of hospital sizes, geographic regions, and changes in beta-blocker use rates between October 1996 and September 1999.

The interviews revealed six broad factors that characterized hospital-based improvement efforts: goals of the efforts, administrative support, support among clinicians, design and implementation of improvement initiatives, use of data, and modifying variables.

Hospitals with greater improvements in beta-blocker use over time demonstrated four characteristics not found in hospitals with less or no improvement: shared goals for improvement, substantial administrative support, strong physician leadership advocating beta-blocker use, and use of credible data feedback. "This study provides a context for understanding efforts to improve care in the hospital setting by describing a taxonomy for classifying and evaluating such efforts," they said. "In addition, the study suggests possible elements of successful efforts to increase beta-blocker use for patients with AMI." ■

THE QUALITY - CO$T CONNECTION

Plan and execute your projects more effectively

How to brainstorm with note cards

By **Patrice Spath**, RHIT
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In today's busy health care environment, quality improvement (QI) managers often find themselves burdened with an increasing number of projects. The time demands on the people involved can be overwhelming.

The organization's leaders rely on the QI staff to assist project teams in bringing initiatives to a successful conclusion. QI staff may serve as a project team leader, facilitator, or team member. Whatever the role of the QI staff, their technical expertise in project management can greatly benefit the team. Project management involves three steps: pre-work, planning and execution, and post-project evaluation. The topic of project pre-work was covered in last month's column. The planning and execution step of a project is detailed this month. Project planning can begin once the goals are clear and the team is assembled.

During the planning process, a detailed schedule for the project is developed and implemented. The people doing the work (the project team) should be involved in designing the work that needs to be done to complete the project. Start the project by asking the team to identify the major tasks based on the stated goals.

For example, the team that is charged with improving inpatient satisfaction with pain management practices might identify three major tasks:

- gather data;
- benchmark current practices;
- recommend improvements.

Next, have the team brainstorm the subtasks that need to occur during completion of each major task.

Use a Post-it note process during the brainstorming session. Projects should be planned in layers, starting at the highest level and working down. Use 3-inch by 5-inch size notes to record major tasks. Space these across the top of the planning sheet. The 3-inch by 3-inch size note is used for subtasks. Place the subtasks below the major tasks on the planning sheet.

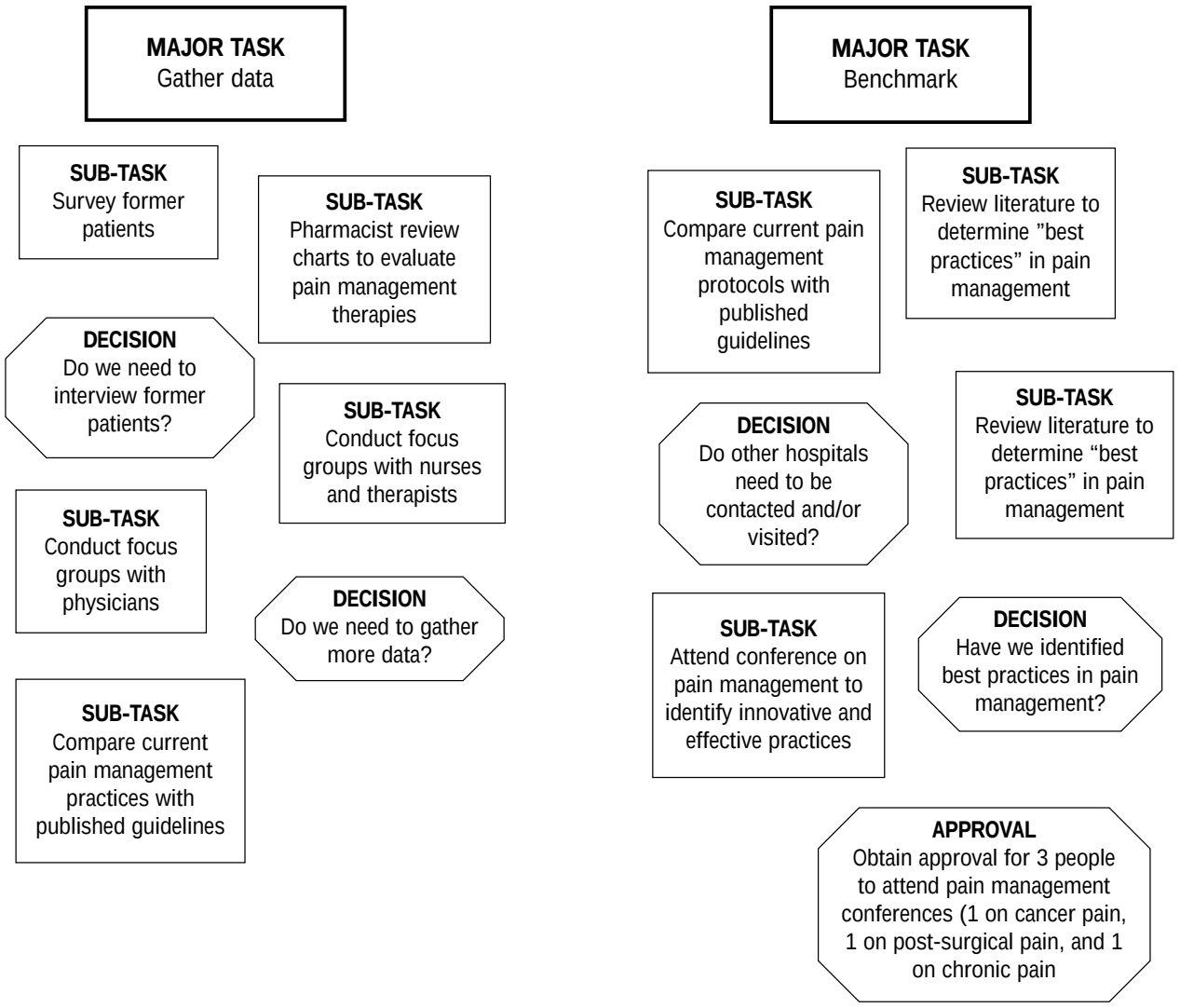
It may be necessary to spell out each subtask in considerable detail depending upon people's familiarity with the work to be done. The team also should describe any key decisions or approvals that might need to occur during the completion of major tasks. These are recorded on a 3-inch by 3-inch size note turned to the side (diamond-shaped).

At this stage in the planning, don't worry about arranging the work. Just try to get the team to identify some of the work that will be necessary for each major task. Once the team has defined a fair number of subtasks and decisions, you can begin to organize the project.

In the box on p. 114, you'll find an excerpt from the pain management project team's planning document. Two of the major tasks are shown, along with some of the subtasks, and decisions or approvals that need to occur.

Later, the team will go back to the planning sheet and use 1½-inch by 2-inch size notes to add

Excerpt from Planning Document for Pain Management Project



Source: Patrice Spath, RHIT, Brown-Spath Associates, Forest Grove, OR.

resource assignments, schedule estimates, and comments.

Once the team has defined a good number of subtasks and decisions, you can begin to apply some structure to the developing project plan. Start by arranging the brainstormed subtasks on the planning sheet to illustrate the relationship between the subtasks. Place the subtasks according to time of completion; with time running horizontally from left to right. As the team begins to layout the project subtasks, the sequence and time relationships among the subtasks will become evident. Some subtasks can begin at the same time. Place these parallel subtasks on the planning sheet in vertical sets — stacking one on top of the other.

Subtasks that must be completed in sequence are placed in a line from left to right. Subtasks that can start at different times but must be finished at the same time before the next subtask can take place are placed on the sheet, one below the other. These interval subtasks are placed in the order in which they must occur. The chart review subtasks are expected to occur at the same time, however the team wants these reviews to be done prior to patient surveys. The interval subtasks of focus group discussions do not need to be done in parallel with the chart reviews, but do need to be completed before patient surveys.

Once the major tasks, subtasks, decisions, and approvals are all mapped out on the planning sheet, a Gantt chart is developed. This chart lists

subtasks activities down the vertical axis and time along the horizontal axis.

While constructing this chart, the team will need to establish time lines and duration times. What is the overall time (start to finish) for completing the entire project? When should focus group discussions with physician start? How long should it take to complete this activity? To establish the project time lines, have the team discuss the optimistic time (if all goes well) and the pessimistic time (if everything goes wrong).

Through these discussions, the team should be able to come up with the most likely time. (In your best judgment, what is a realistic estimate of how long it will take to deliver?)

The subtasks are recorded on the left side of the Gantt chart listed in the order in which they will be accomplished.

There should be no activity on the project flowchart or the project schedule that does not have a specific individual responsible for its accomplishment. Each person's level of involvement in the accomplishment of the subtask should be defined. There are basically four levels of participation:

- **Consultation.** The consultant has information that is necessary to complete the activity, but does not need to schedule time to work on it.
- **Advisement.** The advisor should be told about the activity, specifically when it is started or completed and the ongoing progress.
- **Involvement.** One person must be involved

CE questions

5. According to a report from the Health and Human Services Office of Inspector General, what percentage of hospitals have never reported an adverse action against a health care practitioner to the National Practitioner Data Bank?
   A. 84%
   B. 60%
   C. 71%
   D. 50%

6. One of the root causes identified for the problem of medical waste left on food trays at Part Nicollet Health Services in St. Louis Park, MN, was that overworked nurses often has to multitask and became too busy to pay attention to proper procedure.
   A. true
   B. false

7. According to its implementation schedule for ORYX, when will the Joint Commission on Accreditation of Healthcare Organization release final technical specifications for initial measure sets?
   A. September 2001
   B. November 2002
   C. October 2001
   D. July 2002

8. Which of the following organizations was not part of the coalition that sent a petition to the Centers for Medicare and Medicaid Services regarding pain management?
   A. The American Academy of Pain Management
   B. The American Pain Foundation
   C. Compassion in Dying
   D. The American Hospital Association

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in the work of completing the activity; he or she must schedule time to work on the subtask and produce work output.

• **Responsibility.** One person is responsible for seeing that the activity is completed.

Talk with each of the individuals that fall into these four categories to be certain they agree to accept the role they have been assigned. Be sure that only one person is assigned the responsibility role for every subtask. Also, don't overlook assigning responsibilities to each activity on the Gantt chart. Otherwise, you may find some project subtasks not completed as expected.

The Gantt chart, which is developed as part of the planning activity, is the basis for all subsequent project planning. It is a graphic representation of the series of activities and deliverables that will lead to the accomplishment of the project goal.

By adding information to a basic Gantt chart (such as the people working on each task, notes about critical activities, etc.), the chart can be expanded to show more the of the project's flow. It is sometimes helpful (depending on the complexity or duration of the project) to construct several charts showing smaller manageable pieces of the project and to then combine these into a single chart for the total project. Your project schedule is complete and sufficiently detailed if the team is able to answer "yes" to the following questions:

• Do you know the significant deliverables throughout the project?

• Do you know what activities must be completed in order to accomplish each deliverable?

• Do you know what peripheral activities support major tasks?

• Do you know the order in which subtasks must be completed?

• Do you know which activities result in critical deliverables (those which must be completed before succeeding activities can begin)?

• Do you know who is responsible for each activity?

• Do you know the time estimate for each activity?

Successful project planning requires good leadership. Too often, teams want to jump into the initiative without a clear plan of what needs to be accomplished and the sequence of events. Even if you have to start the project before planning is completed, the team should keep planning to stay ahead of the activities. A systematic project plan helps the team stay on track and achieve project goals. ■

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• Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.

• Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and / or based on independent recommendations from clinicians at individual institutions.

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