# NAHQ.CPHQ.v2025-03-07.q337

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**NEW QUESTION: 1**
Which of the following tools would best display nosocomial infection rates over time?
**A.** scatter gram
**B.** Pareto chart
**C.** histogram
**D.** run chart
**Answer: (SHOW ANSWER)**
A run chart is a graph that displays observed data in a time sequence1. It is often used to visualize trends or patterns over time1. In the context of healthcare quality, a run chart would be the most suitable tool to display nosocomial infection rates over time1. This is because it allows for the tracking of changes in the data over time, which can help in identifying any trends or shifts in the process1. This can be particularly useful in monitoring infection rates, as it can help in identifying periods of increase or decrease, which can then be investigated further1.
References:
https://brainly.com/question/37261274

**NEW QUESTION: 2**
___________ accounts for the different types of patients in institutions. Adjustments should be considered when hospital survey results are being released to the public.
**A.** Bias or mode effects
**B.** Proxy response
**C.** Case-mixed adjustment
**D.** Recall base
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 3**

In preparation for a provider organization accreditation survey, the most effective method for identifying training needs for staff is
**A.** conducting a gap analysis with an interdisciplinary team.
**B.** benchmarking with other organizations.
**C.** engaging a consultant to identify areas needing improvement.
**D.** comparing competency requirements with other facilities.
**Answer: A (LEAVE A REPLY)**
The most effective method for identifying training needs in preparation for an accreditation survey is conducting a gap analysis with an interdisciplinary team. A gap analysis compares the current state of staff competencies and organizational processes with the standards required for accreditation.
Involving an interdisciplinary team ensures that all aspects of care and service are considered, leading to a comprehensive identification of training needs across different roles and departments.
Benchmarking with other organizations (B): While benchmarking can provide useful comparisons, it may not directly identify the specific training needs of your staff.
Engaging a consultant to identify areas needing improvement (C): A consultant can be helpful, but an internal gap analysis is more effective in creating ownership of the process and addressing specific accreditation requirements.
Comparing competency requirements with other facilities (D): This can be part of benchmarking but does not provide the direct, internal insights that a gap analysis offers. Reference NAHQ Body of Knowledge: Accreditation Preparation and Gap Analysis NAHQ CPHQ Exam Preparation Materials: Identifying Training Needs for Accreditation

**NEW QUESTION: 4**
The most effective data collection tools follow the _____________ of patient care and medical record documentation, whether the data are collected retrospectively or prospectively.
**A.** Actual flow
**B.** Registration system
**C.** Chart review
**D.** Data analysts
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 5**
Which of the following is an example of using human factors engineering to improve patient safety?
**A.** performing a root cause analysis on events of harm
**B.** providing simulation training for high-risk patient care tasks
**C.** having a second person check medication calculations
**D.** using checklists to complete complicated tasks
**Answer: D (LEAVE A REPLY)**

Human factors engineering focuses on designing systems and processes that account for human capabilities and limitations to improve safety and performance. Using checklists to complete complicated tasks (Answer D) is a prime example of applying human factors engineering to enhance patient safety.
Checklists help ensure that critical steps in a process are not overlooked, reducing the likelihood of errors, especially in high-risk, complex tasks such as surgical procedures or medication administration.
The other options, while important for patient safety, do not specifically represent human factors engineering:
Performing a root cause analysis on events of harm (A) is an investigative process for identifying underlying causes of errors, not a human factors engineering intervention.
Providing simulation training for high-risk patient care tasks (B) is an educational approach to improving skills and preparedness, not directly related to system design.
Having a second person check medication calculations (C) is a safety double-check but is more of a verification process than a systemic design change.
Reference: National Association for Healthcare Quality (NAHQ) - Certified Professional in Healthcare Quality (CPHQ) Study Materials.
Human Factors Engineering in Healthcare, NAHQ Documentation.

**NEW QUESTION: 6**
The preferred culture in promoting patient safety
**A.** audits standards and promotes learning from mistakes.
**B.** uses anonymous reporting and audits standards.
**C.** promotes learning from mistakes and fosters collaboration.
**D.** fosters collaboration and uses anonymous reporting.
**Answer: (SHOW ANSWER)**
The preferred culture in promoting patient safety is one that promotes learning from mistakes and fosters collaboration. This is because a culture that promotes learning from mistakes encourages a non-punitive environment where individuals feel safe to report errors and near misses. This openness allows for the identification of systemic issues that can be addressed to prevent future errors1.
On the other hand, fostering collaboration is crucial in patient safety as it encourages open communication and teamwork among healthcare professionals. Collaboration ensures that all team members can contribute their expertise to patient care, which can lead to improved patient outcomes23.
Reference: Clinical nurse competence and its effect on patient safety culture: a systematic review1 Patient safety culture: a systematic review by characteristics of Hospital Survey on Patient Safety Culture dimensions2 Key drivers of promoting patient safety culture from the perspective of3

**NEW QUESTION: 7**

An interdisciplinary team met to review readmission rates at a health system. Issues were identified with communication across care providers. The team is interested in improving the coordination of care process and is now reviewing four candidates to serve in the role of process champion:

| Indicator | Candidate A | Candidate B | Candidate C | Candidate D |
| --- | --- | --- | --- | --- |
| Involvement with current process | High | Some | None | Some |
| Level of interest | High | High | Some | Low |
| Authority to mobilize resources | None | Low | High | High |
| Respected opinion leader | Low | High | Some | Some |

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Of the four candidates, which represents the most effective choice to serve as a process champion?

**A.** Candidate A
**B.** Candidate B
**C.** Candidate C
**D.** Candidate D

**Answer: (SHOW ANSWER)**

Candidate B is the most effective choice to serve as a process champion. This candidate has a high level of interest, is respected as an opinion leader, and has some involvement with the current process. Although their authority to mobilize resources is low, their influence and interest in the project make them well-suited to champion the process. A process champion needs to have respect and credibility within the organization, which Candidate B has, along with sufficient involvement to understand the challenges and drive change.

* Candidate A (A): While Candidate A has high involvement and interest, they lack authority and are not a respected opinion leader, which are critical qualities for a process champion.
* Candidate C (C): Although Candidate C has high authority, their low involvement, interest, and moderate respectability make them less effective as a champion.
* Candidate D (D): Candidate D has some involvement and respectability but lacks interest and authority, making them less suitable for the role.

References

* NAHQ Body of Knowledge: Selecting Process Champions for Quality Improvement
* NAHQ CPHQ Exam Preparation Materials: Characteristics of Effective Process Champions

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**NEW QUESTION: 8**

The Baldrige criteria were originally developed and applied to business; however, in 1997, healthcare- specific criteria were created to help healthcare organizations address challenges such as focusing on core competencies, introducing new technologies, reducing costs, communicating and sharing information electronically new alliance with healthcare providers, and

maintaining market advantage. The Baldrige healthcare criteria are built on the set of interrelated core values and concepts.
Which of the following is NOT out of those values and concepts?

**A.** Visionary leadership
**B.** Focus on the present
**C.** Valuing of staff and partners
**D.** Agility
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 9**

An emergency department's quality improvement report for the first quarter showed the following data:

| | January | February | March |
|---|---|---|---|
| Total patients treated | 1,000 | 1,100 | 1,350 |
| Treated and admitted | 100 | 100 | 150 |
| Treated and discharged | 900 | 1,000 | 1,200 |
| Charts reviewed for quality | 1,000 | 1,100 | 1,350 |
| Misinterpreted x-rays | 20 | 10 | 8 |
| Problems associated with history and physical | 10 | 6 | 4 |
| Problems associated with treatment | 4 | 4 | 19 |

What was the approximate overall problem rate for March?

**A.** 1%
**B.** 2%
**C.** 15%
**D.** 18%
**Answer: B (LEAVE A REPLY)**

To find the problem rate, divide the total number of problems by the total number of patients treated in March:
* Total problems in March: 8+4+19=318 + 4 + 19 = 318+4+19=31
* Total patients treated in March: 1,3501,3501,350
* Problem rate: (31/1,350)×100=2.3%(31 / 1,350) \times 100 = 2.3\%(31/1,350)×100=2.3%, approximately 2%.

References:CPHQ materials emphasize calculating problem rates as a standard method for quality analysis.

**NEW QUESTION: 10**

To assess compliance with quality standards, a healthcare organization needs

**A.** a dedicated standards assessment team.

**B.** an electronic data analysis program.
**C.** approval by the governing body.
**D.** standardized data collection methods.
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 11**
A quality professional Is the leader of a team in the storming phase of development.
Which of the following should the quality professional be prepared to do?
**A.** Direct and provide role clarification.
**B.** Be willing to share leadership responsibilities.
**C.** Redirect conflict to energize the team.
**D.** Move to a more supportive leadership style.
**Answer: A (LEAVE A REPLY)**
The storming phase is the second stage of team development, where conflicts and differences in opinions may arise12. During this phase, the team is still figuring out how to work well together1. The leader's role is crucial at this stage. They need to provide clear direction for the project and help individuals on the team get to know and accept each other3. This involves directing the team and providing role clarification3, which aligns with option A.

**NEW QUESTION: 12**
There is an increased incidence of type 2 diabetes among patients living near a healthcare organization as compared to the state.
Considering social determinants of health, which of the following strategies can be used to address this problem?
**A.** Educate newly diagnosed patients on diabetes disease management.
**B.** Set up a community-based education program about blood glucose monitoring.
**C.** Review evidence-based diabetes management protocols with primary care providers.
**D.** Collaborate with local farmers' markets to make fresh produce more widely available.
**Answer: D (LEAVE A REPLY)**
Addressing the increased incidence of type 2 diabetes through the lens of social determinants of health involves addressing broader factors that impact health. Collaborating with local farmers' markets to make fresh produce more widely available is a strategy that addresses the social determinants of health by improving access to healthy food options. This approach can help reduce the risk of diabetes by making it easier for community members to make healthy dietary choices, thereby addressing one of the root causes of the increased diabetes incidence.
Educate newly diagnosed patients on diabetes disease management (A): While important, this strategy focuses on managing diabetes after it occurs rather than addressing the social determinants that contribute to its onset.
Set up a community-based education program about blood glucose monitoring (B): This is also important for management but does not directly address the social determinants that lead to the higher incidence.

Review evidence-based diabetes management protocols with primary care providers (C): This improves care quality but does not address the social factors contributing to the disease.
Reference
NAHQ Body of Knowledge: Addressing Social Determinants of Health in Quality Improvement
NAHQ CPHQ Exam Preparation Materials: Strategies for Managing Social Determinants of Health

**NEW QUESTION: 13**
An improvement project was implemented to expand utilization of primary care services in a rural area where only 5% of residents sought primary care. The team established a goal of 20% of residents using primary care.
The table below shows the results for the four months following implementation of the improvement:
% Residents Using Primary Care Time | %
Baseline | 5% Month 1 | 15% Month 2 | 20% Month 3 | 21% Month 4 | 22%
Which of the following should the quality professional recommend to the organization?
**A.** Implement another improvement cycle.
**B.** Monitor for sustainment.
**C.** Assess patient satisfaction with providers.
**D.** Disband the improvement team.
**Answer: (SHOW ANSWER)**
The improvement project successfully increased the utilization of primary care services from a baseline of 5% to 22% by the fourth month, surpassing the initial goal of 20%. At this point, the quality professional should focus on ensuring that this improvement is sustained over time.
Monitoring for sustainment involves tracking the ongoing performance to confirm that the increased utilization is maintained and identifying any potential declines or issues early.
Continuous monitoring helps to determine if the implemented changes have become fully integrated into routine practices and are producing the desired outcomes consistently.
Implement another improvement cycle (A): This is unnecessary at this stage, as the goal has been met and even exceeded. Further improvement cycles should only be considered if the current gains are not sustained or if new goals are established.
Assess patient satisfaction with providers (C): While assessing patient satisfaction is important, it is not the immediate priority after meeting the primary utilization goal. Satisfaction assessments could be part of a broader quality strategy but do not address the current need for ensuring the sustainability of improvements.
Disband the improvement team (D): Disbanding the team could be premature, as their role in monitoring sustainment is crucial. The team may still be needed to support ongoing improvements or address any emerging issues.
Reference
NAHQ Body of Knowledge: Quality Improvement Processes

NAHQ CPHQ Exam Preparation Materials: Sustaining Improvements NAHQ Guide to Measuring Healthcare Outcomes

**NEW QUESTION: 14**

Which of the following are the three primary quality management activities?

**A.** define goals, assessment, and review results

**B.** measurement, assessment, and Improvement of outcomes

**C.** assessment, improvement, and strategic planning

**D.** review trends, assessment, and stakeholder accountability

**Answer: B (LEAVE A REPLY)**

Quality management is a critical aspect of healthcare, and it involves various activities to ensure that healthcare services meet the desired standards. The three primary quality management activities are:

* Measurement: This is the first step in quality management. It involves defining and collecting data on various aspects of healthcare service delivery. This could include patient outcomes, process efficiency, or other relevant metrics. The goal is to establish a baseline for understanding the current state of quality.

* Assessment: Once data has been collected, it needs to be analyzed to assess the quality of healthcare services. This could involve comparing actual outcomes against desired outcomes, identifying gaps in service delivery, or looking for trends and patterns in the data.

* Improvement of outcomes: Based on the assessment, targeted interventions are designed and implemented to improve outcomes. This could involve changes to processes, training for staff, or other interventions. The effectiveness of these interventions is then measured and assessed, creating a continuous cycle of quality improvement.

References: The information is based on standard quality management principles and practices, which are widely recognized and utilized in the healthcare industry123.

**NEW QUESTION: 15**

A nursing director for a unit in a cancer hospital Is reviewing and assessing outcomes data in the following scatter diagram:

The relationship between the incidence of infection and the decrease in staffing targets is

**A.** strong and positive.

**B.** weak and negative.

**C.** weak and positive.

**D.** strong and negative.

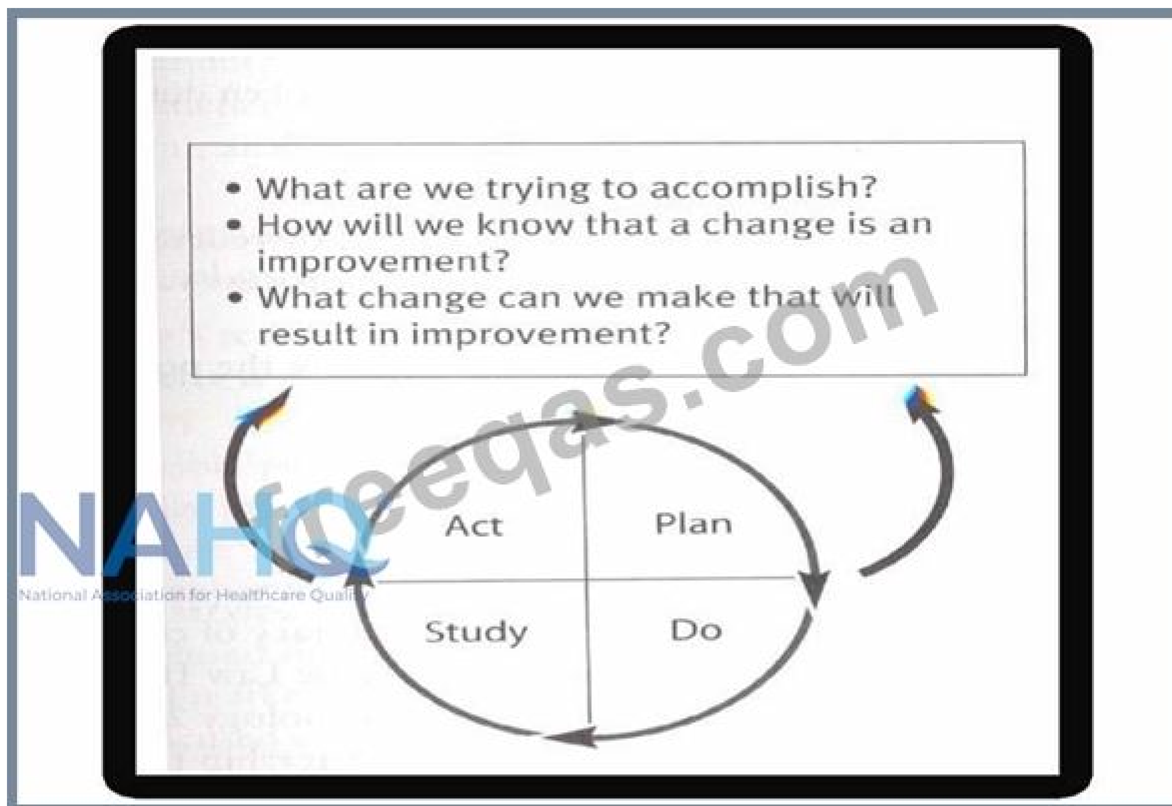
**Answer: D (LEAVE A REPLY)**

The scatter diagram shows that as the decrease in staffing targets becomes more significant (moving right on the horizontal axis), the incidence of infection goes up (moving up on the vertical axis). This indicates a negative relationship because as one variable increases, the other one decreases. The relationship appears to be strong because the points lie closely to an imaginary line that slopes upwards from left to right, which suggests a consistent trend across the data points.

References:In healthcare quality improvement, it is critical to use data to inform decision-making. Scatter diagrams are a common tool used for this purpose. The NAHQ Healthcare Quality Competency Framework emphasizes the importance of analyzing and utilizing data in decision-making, as indicated in the Performance and Process Improvement domain. A strong negative relationship in this context could indicate that decreased staffing levels are associated with higher infection rates, which is a significant finding for a nursing director assessing outcomes and considering quality improvement initiatives.

**NEW QUESTION: 16**

The following diagram shows:




**A.** None of these
**B.** API Improvement model
**C.** Quality improvement
**D.** Baldrige criteria for improvement
**Answer: B (LEAVE A REPLY)**

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**NEW QUESTION: 17**
Organizations with a positive safety culture are best characterized by
**A.** mutual trust.
**B.** self-directed teams.
**C.** anonymous reporting.
**D.** efficient staff.
**Answer: (SHOW ANSWER)**
Organizations with a positive safety culture are characterized by communications founded on mutual trust12345. This is because trust forms the basis of open and effective communication, which is essential for maintaining safety standards and procedures. In such organizations, there

is a shared perception of the importance of safety, and confidence in the efficacy of preventive measures12345. This shared perception and confidence stem from the mutual trust among the members of the organization. Therefore, mutual trust is a key characteristic of organizations with a positive safety culture.

**NEW QUESTION: 18**
A performance Improvement team has been formed and assigned to reduce wait time from clinic check-In to seeing a provider. Which tool would be most useful for the team to create at the first meeting?
**A.** storyboard
**B.** flowchart
**C.** force field analysis
**D.** Gantt chart
**Answer: (SHOW ANSWER)**
A performance improvement team's goal is to reduce the wait time from clinic check-in to seeing a provider. To achieve this, the team needs to understand the current process and identify areas of improvement1. A flowchart is a tool that can help the team visualize the current process, identify bottlenecks, and plan improvements1.
A flowchart is a diagram that represents a process, showing the steps as boxes of various kinds, and their order by connecting them with arrows1. This diagrammatic representation can give a step-by-step solution to a given problem1. It is particularly useful in understanding a hierarchical structure of processes and how they are interconnected1.
In the context of the team's goal, a flowchart can help map out the entire process from patient check-in to consultation with the provider1. This visual representation can help the team understand where delays are occurring and where improvements can be made to reduce wait times1.
While the other tools mentioned (storyboard, force field analysis, Gantt chart) can be useful in certain scenarios, they don't specifically address the need to visualize and understand a process23. Therefore, the flowchart is the most appropriate tool to recommend in this situation1.

**NEW QUESTION: 19**
Measurement of variation in health care and its application to quality improvement must begin with the identification and articulation of:
**A.** Understanding true variation versus artifact or statistical error
**B.** Assignable variation
**C.** What is to be measured?
**D.** The standard against which is to be compared a process based on extensive research, trial and error and collaborative discussion
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 20**

An organization notices an Increase In medication errors In threepatient care areas. Which ofthe following concepts will be most effective when Improving medication administration workflows?
**A.** elimination of wait time from the pharmacy
**B.** Improvement of staff training on safe medication practices
**C.** delivery of medications in batches each shift
**D.** design of mistake-proof systems
**Answer: (SHOW ANSWER)**
The most effective concept when improving medication administration workflows in the context of increased medication errors would be the design of mistake-proof systems1234.
* Understanding the Problem: The first step is to understand the problem, which in this case is an increase in medication errors in three patient care areas1.
* Standardizing and Safeguarding Medication Administration: Standardizing and safeguarding medication administration is a key strategy in reducing medication errors1. This involves confirming medication details using tools like the rights of medication administration or "read back" strategies1.
* Designing Mistake-Proof Systems: Mistake-proofing the system involves the use of technology such as bar-coding systems and electronic medication administration records2. These technologies have been shown to improve medication administration safety4. However, it's important to implement these technologies carefully to avoid unintended consequences2.
* Continuous Improvement: After implementing the changes, it's important to evaluate the effectiveness of the solutions. This can be done using Plan-Do-Study-Act (PDSA) cycles3. In these cycles, small tests of change are planned, implemented on a small scale, performance-measured compared to the current state, and changed to adjust the process3.
By designing mistake-proof systems, the organization can significantly reduce the risk of medication errors, thereby improving patient safety and care quality.

**NEW QUESTION: 21**
When reporting infection control indicators to a governing body, a healthcare quality professional should demonstrate improvement with which of the following tools?
**A.** run chart
**B.** frequency plot
**C.** pie chart
**D.** scatter plot
**Answer: A (LEAVE A REPLY)**
When reporting infection control indicators to a governing body, a healthcare quality professional should use a run chart to demonstrate improvement. A run chart is a simple, yet powerful tool for tracking data points over time and identifying trends or patterns. It can effectively illustrate changes in infection control indicators, showing whether performance is improving, declining, or remaining stable. This is particularly useful for demonstrating the impact of quality improvement efforts to a governing body.

* Frequency plot (B): This is used to show the distribution of data points but does not effectively demonstrate trends over time.
* Pie chart (C): Pie charts show proportions of categories at a single point in time and are not useful for showing changes over time.
* Scatter plot (D): Scatter plots show relationships between two variables but are not ideal for demonstrating changes in infection control indicators over time.

References
* NAHQ Body of Knowledge: Data Visualization in Quality Improvement
* NAHQ CPHQ Exam Preparation Materials: Tools for Demonstrating Improvement in Quality Data

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**NEW QUESTION: 22**

_____________ allows for more in-depth exploration of the causes of dissatisfaction and can provide excellent ideas for reengineering services. In addition, its videotapes can be effective at changing the attitudes and beliefs of staff members because the stories participants tell animate the emotional effect of excellent service as well as service failures.

**A.** Walk-throughs
**B.** Patient and family advisory councils
**C.** Complaint letters
**D.** Focus group

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 23**

Universities often evaluate applicants for admission on the basis of, among other things, the applicants' scores on standardized tests. The scores are thus one of the criteria by which program judge the Quality of their applicants. However, although two programs may use the same criterion - scores on a specific standardized examination-to evaluate applicants, the programs may differ markedly on standards: One program may consider applicants acceptable if they have scores above the 50th percentile, whereas the score above the 90th percentile may be the standard of acceptability for the other program.
This example clearly defines the difference between:

**A.** Processes and outcomes
**B.** Criteria and standards
**C.** Efficacy and equity
**D.** Sources and structure

**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 24**

A social service department regularly monitors the number of inappropriate referrals, the timeliness of discharge

planning, and the number of days of discharge delays. What additional monitor should be added to evaluate the
appropriateness of social service interventions?
**A.** Number of social service referrals from nursing
**B.** Attainment of social service goals
**C.** Timeliness of referrals to social services
**D.** Inadequacy of documentation in progress notes
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 25**
Knowledge about _______ is crucial to making valid judgments about quality of care using either process or outcome measures. If we know that a given clinical intervention was undertaken in circumstances that match those, under which the intervention has been shown to be efficacious, we can be confident, that the care was appropriate and, to the extent of good quality.
**A.** Outcomes
**B.** Efficacy
**C.** Processes
**D.** Structure
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 26**
A study was performed to compare quality outcomes between case/care managed groups and non-case/care managed groups tor elective coronary artery bypass. The results are as follows:

CASE/CARE MANAGED

| Case # | Length of stay (LOS) | Readmission Days | Adverse Outcomes |
|---|---|---|---|
| 1 | 6 | 0 | 1 |
| 2 | 4 | 1 | 2 |
| 3 | 5 | 0 | 0 |
| 4 | 7 | 2 | 1 |
| 5 | 3 | 0 | 1 |

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NON-CASE/CARE MANAGED

| Case # | Length of stay (LOS) | Readmission Days | Adverse Outcomes |
|---|---|---|---|
| 6 | 7 | 0 | 3 |
| 7 | 7 | 5 | 0 |
| 8 | 8 | 3 | 1 |
| 9 | 9 | 4 | 2 |
| 10 | 19 | 0 | 0 |

What is the median length of stay (or non-case/care managed patients?
**A.** 10
**B.** 9
**C.** 8
**D.** 7
**Answer: B (LEAVE A REPLY)**
The median is the middle value in a data set when the values are arranged in ascending or descending order.

In the case of the non-case/care managed patients, when we arrange the Length of Stay (LOS) in ascending order, we get 7, 8, 9, 10, and 19. Since there are 5 data points, the median is the third value, which is 9.

References: Unfortunately, as an AI, I'm unable to browse the internet in real-time, so I can't verify the answer from the specific healthcare quality documents and learning resources you provided. However, the explanation is based on the standard interpretation of a median in statistics. For more detailed information, please refer to the provided resources.

**NEW QUESTION: 27**

Which of the following is the most effective means of communicating commitment to patient safety?

**A.** CEO presenting most recent medication error rates to the governing body

**B.** articles by a CEO in the employee newsletter

**C.** posters and bulletin boards on units displaying up-to-date patient falls data

**D.** senior leaders having discussions on units with front-line staff

**Answer: D (LEAVE A REPLY)**

Effective communication in healthcare is paramount for patient safety. It is the accurate transfer of information between two or more providers1. Communication fails when it is incomplete, ineffective, or inappropriate, resulting in patient harm1. Good teamwork and effective communication rely on mutual respect, problem-solving, and sharing of ideas1.

Senior leaders having discussions on units with front-line staff is a direct and effective means of communication. It allows for immediate feedback, clarification of doubts, and a better understanding of the situation on the ground2. This direct interaction can foster a culture of safety, encourage the sharing of ideas, and promote problem-solving1.

In contrast, the other options (A, B, and C) are less direct and may not effectively communicate the commitment to patient safety. For example, presenting error rates or displaying data on bulletin boards (options A and C) are important but may not lead to immediate action or feedback. Similarly, articles in a newsletter (option B) may not reach all staff or may not be read thoroughly.

References: 1, 2

https://psnet.ahrq.gov/perspective/approach-improving-patient-safety-communication

**NEW QUESTION: 28**

The comparative norm (e.g. expected rate) in the comparison analysis is the ____________ if the measure is risk adjusted and the comparison group mean if the measure is not risk adjusted.

**A.** Proportion measure

**B.** Risk free rate

**C.** Predicted rate

**D.** Continues variable measure

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 29**

A nursing home has established a quality indicator to accomplish a 5% reduction in falls. A guideline has been developed and implemented. After six months, the goal has not been reached. The next action steps should include

**A.** revising annual evaluations to include compliance with fall prevention guidelines.

**B.** providing feedback on a weekly basis rather than displaying data over time.

**C.** measuring employee competency on understanding and use of the guideline.

**D.** continuing to measure outcomes monthly and re-evaluate every three months.

**Answer: C (LEAVE A REPLY)**

When a nursing home has not met its goal of a 5% reduction in falls despite implementing a guideline, the next action should be to measure employee competency on understanding and use of the guideline.

Here's why:

Assessing Competency: The effectiveness of the guideline depends on how well the staff understands and applies it. Measuring competency ensures that all employees are aware of the guidelines and know how to implement them in their daily work.

Identifying Gaps: If staff members are not fully competent, this could explain why the goal has not been achieved. By identifying gaps in knowledge or skills, the organization can provide targeted training and support to improve compliance and effectiveness.

Enhancing Implementation: Understanding how well the guidelines are being followed can help the organization refine its approach, ensuring that staff are equipped to prevent falls more effectively. Linking Competency to Outcomes: By focusing on employee competency, the organization can establish a direct link between staff education and patient outcomes, ensuring that guidelines are not just implemented, but are done so correctly and consistently.

Reference: (Based on Healthcare Quality NAHQ documents and resources)

NAHQ CPHQ Study Guide, Section on Employee Training and Competency Evaluation.

Quality Improvement in Healthcare, Article on Linking Competency to Patient Outcomes.

**NEW QUESTION: 30**

When allocating limited resources to meet strategic objectives, management decisions should be driven by

**A.** accreditation standards.

**B.** local competition.

**C.** consultant recommendations.

**D.** outcome data.

**Answer: D (LEAVE A REPLY)**

When allocating limited resources to meet strategic objectives, management decisions should be driven by outcome data. This is because outcome data provides evidence-based results that reflect the effectiveness and impact of a particular strategy or intervention. By focusing on outcome data, management can ensure that resources are being used in the most effective and efficient manner to achieve the desired results. This approach aligns with the principles of

healthcare quality, which emphasize the use of data to inform decision-making and improve performance.
Reference: Resource allocation is the process of identifying and assigning available resources to an initiative. Effective allocation of resources helps maximize the impact of project resources while still supporting your team's goals.
Gathering and recording as much information as possible is the key to making good resource allocation decisions. In short, knowing everything you possibly could about your resources, their availability, and the projects in most need of them lets you effectively match needs with resources.
What Is Resource Allocation? Here's How to Allocate Resources [2024] * Asana Resources | Project planning | What is resource allocation? Learn how ... What is resource allocation? Learn how to allocate resources Julia Martins January 15th, 2024 8 min read Summary Project managers and teams can struggle to make balanced resource allocation decisions, often opting for too much or too little. But the key to navigating this delicate balance is continuous adjustment and real-time responsiveness to project needs. This approach ensures that resources are optimally utilized, preventing both surplus and shortfall and steering towards project success with precision and efficiency.

**NEW QUESTION: 31**
Health plan databases are valuable because they contain detailed information on all care received by health plan members.
These databases are commonly used to identify patients who have not received preventive services such as:
**A.** Immunization
**B.** Colon cancer screening
**C.** A, B and C
**D.** Mammograms
**Answer: C (LEAVE A REPLY)**

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**NEW QUESTION: 32**
A nursing director for a unit in a cancer hospital Is reviewing and assessing outcomes data in the following scatter diagram:

The relationship between the incidence of infection and the decrease in staffing targets is

**A.** strong and positive.

**B.** weak and negative.

**C.** weak and positive.

**D.** strong and negative.

**Answer: D (LEAVE A REPLY)**

The scatter diagram shows that as the decrease in staffing targets becomes more significant (moving right on the horizontal axis), the incidence of infection goes up (moving up on the vertical axis). This indicates a negative relationship because as one variable increases, the other one decreases. The relationship appears to be strong because the points lie closely to an imaginary line that slopes upwards from left to right, which suggests a consistent trend across the data points.

References:In healthcare quality improvement, it is critical to use data to inform decision-making. Scatter diagrams are a common tool used for this purpose. The NAHQ Healthcare Quality Competency Framework emphasizes the importance of analyzing and utilizing data in decision-making, as indicated in the Performance and Process Improvement domain. A strong negative relationship in this context could indicate that decreased staffing levels are associated with higher infection rates, which is a significant finding for a nursing director assessing outcomes and considering quality improvement initiatives.

**NEW QUESTION: 33**

An organization has a goal to increase profitability of services covered under bundled payments. Which of the following aspects of quality should a healthcare quality professional recommend as a starting point for an analysis?

**A.** efficiency

**B.** safety

**C.** access

**D.** equity

**Answer: A (LEAVE A REPLY)**

To increase profitability of services covered under bundled payments, the healthcare quality professional should recommend starting with an analysis of efficiency. Bundled payments provide

a single payment for all services related to a treatment or condition, incentivizing providers to deliver care more efficiently.
Analyzing efficiency can help identify areas where resources can be used more effectively, reducing costs while maintaining or improving quality, which is critical for profitability under bundled payment models.
Safety (B): While crucial, safety alone may not directly impact profitability under bundled payments.
Access (C): Improving access is important but may not directly influence profitability in the context of bundled payments.
Equity (D): Equity is essential for quality care but is not the primary focus when aiming to increase profitability under bundled payments.
Reference
NAHQ Body of Knowledge: Efficiency and Cost Management in Healthcare
NAHQ CPHQ Exam Preparation Materials: Analyzing Quality in Bundled Payment Models

**NEW QUESTION: 34**
The hospital administration has requested data to support an initiative to reduce barriers to healthcare In the community. Which of thefollowing Information Ismost appropriate for the quality professional to provide for initial planning?
**A.** top 10 admission diagnoses and readmission report
**B.** community planning maps showing transportation routes
**C.** reports from the public health department showing pediatric obesity rates
**D.** demographic data showing occupations and housing types of the area
**Answer: (SHOW ANSWER)**
When planning an initiative to reduce barriers to healthcare in the community, it's important to understand the demographic makeup of the area. This includes information about occupations and housing types, which can provide insights into socioeconomic status, access to transportation, and other factors that may affect healthcare access.
Community planning maps showing transportation routes (Option A) could be useful in later stages of planning, particularly when considering the location of healthcare facilities or services. However, this information is not as fundamental as demographic data for initial planning.
Reports from the public health department showing pediatric obesity rates (Option C) could be relevant if the initiative specifically targets pediatric health or obesity. However, for a general initiative to redu

**NEW QUESTION: 35**
The most important determinant of quality improvement success is
**A.** organizational culture.
**B.** monetary resource allocation.
**C.** the CQI model selected.
**D.** the type of organization.

**Answer: A (LEAVE A REPLY)**
The most important determinant of quality improvement success is organizational culture.
Organizational culture refers to the collective values, beliefs, and norms that shape the behavior and practices within an organization. In the context of healthcare, a culture that emphasizes continuous improvement, teamwork, and a commitment to patient safety is crucial for the success of any quality improvement initiative.
Organizational Culture as a Foundation: A strong organizational culture supports the principles of Continuous Quality Improvement (CQI), including open communication, a non-punitive approach to error reporting, and a focus on learning from mistakes. This creates an environment where staff feel empowered to contribute to quality improvement efforts.
Influence on CQI Success: Without a supportive culture, even well-designed CQI models may fail. Organizational culture directly influences employee engagement, collaboration across departments, and the overall commitment to improvement efforts, making it a critical factor in the success of quality initiatives.
Monetary Resources and Models: While monetary resource allocation (B) and the specific CQI model selected (C) are important, they are secondary to culture. Adequate resources and the right CQI model are necessary but not sufficient without a culture that prioritizes quality.
Type of Organization: The type of organization (D) is also less critical than culture. Regardless of the organization's size, type, or specialty, a culture that prioritizes quality and continuous improvement is essential for the success of any initiative.
Reference: National Association for Healthcare Quality (NAHQ) documents and resources emphasize the importance of organizational culture as a primary determinant of quality improvement success, highlighting that a supportive culture is foundational for any CQI efforts.

**NEW QUESTION: 36**
Patient and family advisory council is one of the most effective strategies for involving families and patients in the design of care.
Council responsibilities may include input on or involvement in:
**A.** Marketing plan or practice services
**B.** Staff evaluation
**C.** Planning for major renovation or the design of a new building or service
**D.** Program development, implementation, and evaluation
**Answer: A,C,D (LEAVE A REPLY)**

**NEW QUESTION: 37**
The main goal of a clinical pathway/guideline Is lo
**A.** assistindocumentation of care.
**B.** document practitioner variances.
**C.** guide the patient's care toward identified outcomes.
**D.** ensure precise treatment plans are followed.
**Answer: C (LEAVE A REPLY)**

* A clinical pathway/guideline is a tool that helps healthcare providers to deliver evidence-based, patient-centered, and standardized care for a specific condition or population12.
* The main goal of a clinical pathway/guideline is to improve the quality and consistency of care, reduce unnecessary variations, optimize outcomes, and enhance patient satisfaction123.
* A clinical pathway/guideline is not meant to assist in documentation of care (option A), although it may include documentation requirements as part of the quality improvement process1.
* A clinical pathway/guideline is not meant to document practitioner variances (option B), although it may allow for deviations from the recommended care based on individual patient needs and preferences, clinical judgment, and resource availability12. Variances should be monitored and evaluated for their impact on outcomes and quality1.
* A clinical pathway/guideline is not meant to ensure precise treatment plans are followed (option D), although it may provide recommendations for specific interventions, tests, or medications based on the best available evidence12. A clinical pathway/guideline should be flexible and adaptable to the local context and the patient's situation12. References: 1: Clinical Pathways 2: NICE clinical guidelines 3: Clinical Practice Guidelines

**NEW QUESTION: 38**
Because of the goals of care can be defined broadly, outcome measures have come to include the costs of care as well as patients' satisfaction with care.
In formulations that stress the technical aspects of care, however outcome typically refers to:
**A.** Special set of clinical activities
**B.** Appropriate and potentially harmless care
**C.** Desired results
**D.** Health status-related indicators such as whether the pain subsided
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 39**
Crossing the Quality Chasm provided a blueprint for the future that classified and unified the components of quality
through six aims for improvement, chain of effects, and simple rules for redesign of healthcare. The six aims for
improvement, viewed also six dimensions of quality. Which of the following is NOT out of those dimensions?
**A.** Care centered
**B.** Effective
**C.** Efficient
**D.** Safe
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 40**

During improvement in healthcare system, because of a combination of technical complexity, system fragmentation, a tradition of autonomy, and hierarchical authority structures, overcoming the "daunting barrier to creating the habits and beliefs of common purpose, teamwork and individual accountability" necessary for spread and sustainability will require:
**A.** Right time
**B.** Continual focus
**C.** Focus to maintain benchmark levels
**D.** Commitment
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 41**
Which management accountability action should be Implemented to ensure continuous readiness tor accreditation survey?
**A.** Identify variation between policy and practice.
**B.** Convene multidisciplinary workgroups prior to the survey.
**C.** Initiate rounding on units previously cited.
**D.** Delegate survey coordination to subject matter experts.
**Answer: A (LEAVE A REPLY)**
Continuous readiness for an accreditation survey is a crucial aspect of healthcare quality management. It involves a series of actions to ensure that the healthcare organization meets the standards set by the accrediting body. Among the options provided, identifying variation between policy and practice is a key management accountability action. This involves comparing the organization's current practices with its established policies and procedures. Any discrepancies or variations are identified and addressed, ensuring that the organization is adhering to its own standards and those set by the accrediting body.
This process helps to maintain a state of continuous readiness for an accreditation survey.
Reference: Tips for Continuous Joint Commission Readiness1
Tips to achieve continuous compliance readiness2
8 strategies for bringing greater accountability to your workplace3

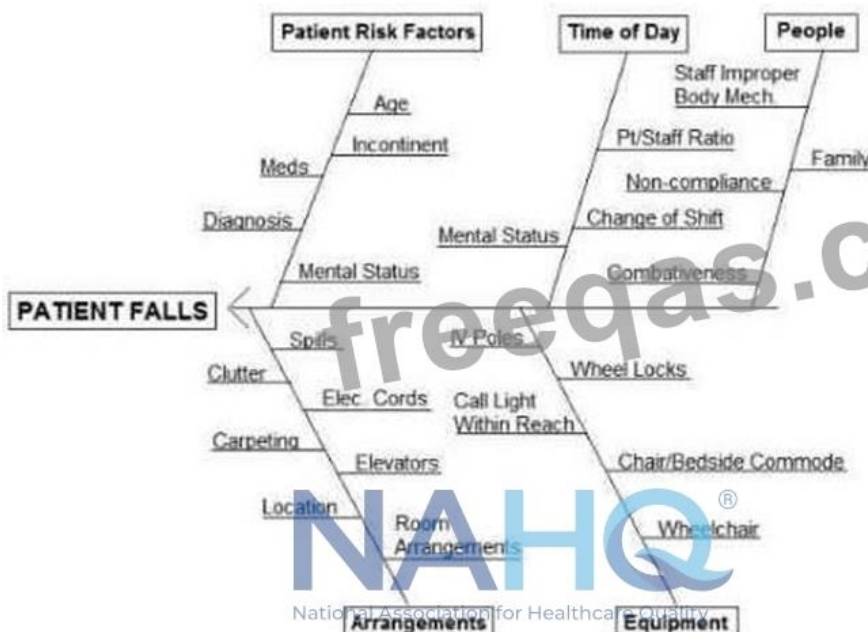
**NEW QUESTION: 42**
The quality of amenities of care refers to the characteristics of the setting in which the encounter between patient
and clinician takes place, such as:
**A.** Comfort, care and access
**B.** Comfort, convenience and privacy
**C.** Comfort
**D.** Responsive to patient preferences
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 43**

Quota sampling was developed in the late 1930s and used extensively by the Gallup organization.
Babbie (1979) describes the steps involved in developing a quota sample.
All of the following are out of those steps EXCEPT:
**A.** All persons in a given cell are then assigned a weight appropriate to their proportion of the total
**B.** When all the sample elements are so weighted, the overall data should provide a reasonable representation of the majority of the samples
**C.** Develop a matrix describing the characteristics of the target population. This may entail knowing the proportion of male and female; various age, racial and ethnic proportions; as well as the education and income levels of the population
**D.** Once the matrix has been created and a relative proportion assigned to each cell in the matrix, data are collected from persons having all the characteristics of a given cell
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 44**
A patient safety manager is asked to recommend the best action to reduce medication errors at a hospital.
Which of the following is the most appropriate next step?
**A.** Re-educate the nursing staff on correct medication administration procedures.
**B.** Conduct research on implementation of a bar code medication administration system.
**C.** Ask the unit managers to counsel staff following medication errors.
**D.** Drill down on the data to identify trends before making recommendations.
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 45**
Which of the following should the team do next?
Due to an increase in the number of patient falls, a quality improvement team has created the following diagram:



**A.** Evaluate patient risk factors.
**B.** Collect frequency data on the causes of the falls.
**C.** Conduct an in-service for housekeeping staff.
**D.** Refer this issue to the safety committee.
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 46**
The term __________ brings in mind that indicator panel on an automobile, which is most useful when t he car is
moving as a way for t he driver t o monitor key performance metrics such as speed, fuel level, engine performance,
temperature and direction from digital display units.
**A.** Dashboard
**B.** Charts
**C.** Scoreboard
**D.** Scanners
**Answer: A (LEAVE A REPLY)**

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**NEW QUESTION: 47**
A clinic is implementing a new medication dispensing system. The vendors of three products are on site with staff interacting with the products prior to purchase. Which of the following best describes this type of safety intervention?
**A.** Forcing function
**B.** Standardization
**C.** Usability testing
**D.** Independent backup
**Answer: C (LEAVE A REPLY)**
Detailed Explanation:
Usability testing involves having end-users interact with a product to identify potential issues and ensure that it meets user needs effectively.
Option C: Usability testing
Allowing staff to interact with products before purchase is a form of usability testing to ensure the system's safety and effectiveness.

References:
CPHQ and human factors literature describe usability testing as essential for ensuring that new systems meet the practical needs of end-users in healthcare settings.

**NEW QUESTION: 48**
Which type of data could best be used to help identify health-determinant information in a patient population?
**A.** payor claims
**B.** preventive care checklist
**C.** patient satisfaction
**D.** event reporting
**Answer: B (LEAVE A REPLY)**
A preventive care checklist is best suited to help identify health-determinant information in a patient population. This type of data includes information on preventive health measures, such as screenings, vaccinations, and lifestyle interventions, which are crucial determinants of overall health. By analyzing this data, healthcare organizations can identify gaps in preventive care and address social determinants of health that may impact patient outcomes.
* Payor claims (A): These primarily provide financial and utilization data, not health determinants.
* Patient satisfaction (C): This measures perceptions of care quality but does not provide health determinant information.
* Event reporting (D): This focuses on adverse events and safety issues, not on determinants of health.
References
* NAHQ Body of Knowledge: Population Health Management and Social Determinants of Health
* NAHQ CPHQ Exam Preparation Materials: Data Sources for Health Determinants
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**NEW QUESTION: 49**
The focus of Lean methodology is a "ba to basics" approach that places the needs of customer first through five steps.
Which of the following is NOT out of those steps?
**A.** Let the customer pull the product
**B.** Identify the value stream
**C.** Define value as determined by the customer
**D.** Make value identifying steps
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 50**
The term __________ brings in mind that indicator panel on an automobile, which is most useful when the car is moving as a way for the driver to monitor key performance metrics such as speed, fuel level, engine performance, temperature and direction from digital display units.

**A.** Charts
**B.** Scoreboard
**C.** Dashboard
**D.** Scanners
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 51**
Which of the following is an example of using human factors engineering to improve patient safety?
**A.** performing a root cause analysis on events of harm
**B.** providing simulation training for high-risk patient care tasks
**C.** having a second person check medication calculations
**D.** using checklists to complete complicated tasks
**Answer: D (LEAVE A REPLY)**
Human factors engineering focuses on designing systems and processes that account for human capabilities and limitations to improve safety and performance. Using checklists to complete complicated tasks (Answer D) is a prime example of applying human factors engineering to enhance patient safety. Checklists help ensure that critical steps in a process are not overlooked, reducing the likelihood of errors, especially in high- risk, complex tasks such as surgical procedures or medication administration.
The other options, while important for patient safety, do not specifically represent human factors engineering:
* Performing a root cause analysis on events of harm (A) is an investigative process for identifying underlying causes of errors, not a human factors engineering intervention.
* Providing simulation training for high-risk patient care tasks (B) is an educational approach to improving skills and preparedness, not directly related to system design.
* Having a second person check medication calculations (C) is a safety double-check but is more of a verification process than a systemic design change.
References:
* National Association for Healthcare Quality (NAHQ) - Certified Professional in Healthcare Quality (CPHQ) Study Materials.
* Human Factors Engineering in Healthcare, NAHQ Documentation.
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**NEW QUESTION: 52**
To effectively communicate performance indicator results, information should be disseminated to the
**A.** Medical Executive Committee.
**B.** department heads.
**C.** Quality Council.
**D.** entire staff.

**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 53**

An orthopedic surgery practice has been working on Improving patient safety for the last 3 years.
The following data table is available:
Which of the following Is the most appropriate conclusion about patient safety outcomes?

**A.** The patient safety culture has remained consistent.
**B.** The safety event rate has remained stable
**C.** Patient safety outcomes have improved.
**D.** The increase in "lime-outs" has reduced patient harm.

**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 54**

Practice guidelines should be based on

**A.** cost-benefit analysis.
**B.** scientific evidence.
**C.** computer-generated data.
**D.** utilization review criteria.

**Answer: B (LEAVE A REPLY)**

Practice guidelines should be based on scientific evidence. This ensures that the guidelines reflect the best available knowledge and research, leading to recommendations that are both effective and reliable.
Evidence-based practice guidelines help improve patient outcomes by ensuring that clinical decisions are informed by rigorous and up-to-date research findings.
Cost-benefit analysis (A): While important in decision-making, it is not the primary basis for developing practice guidelines.
Computer-generated data (C): This can assist in analyzing data but is not a substitute for evidence- based research.
Utilization review criteria (D): These criteria are more focused on managing healthcare services rather than forming the foundation of clinical guidelines.
Reference
NAHQ Body of Knowledge: Evidence-Based Practice Guidelines
NAHQ CPHQ Exam Preparation Materials: Foundations of Practice Guidelines

**NEW QUESTION: 55**

A healthcare organization has been providing cardiac care to patients. Leaders are interested in seeing how their outcomes compare with other organizations that are providing similar care.
Which of the following types of programs should this organization consider participating in?

**A.** registry
**B.** network
**C.** research

**D.** certification

**Answer: A (LEAVE A REPLY)**

A healthcare organization interested in comparing its cardiac care outcomes with other organizations should consider participating in a registry. A registry collects and stores data on specific patient populations, treatments, and outcomes from multiple organizations, allowing participants to benchmark their performance against others. This comparison can help identify areas for improvement and validate the quality of care provided.

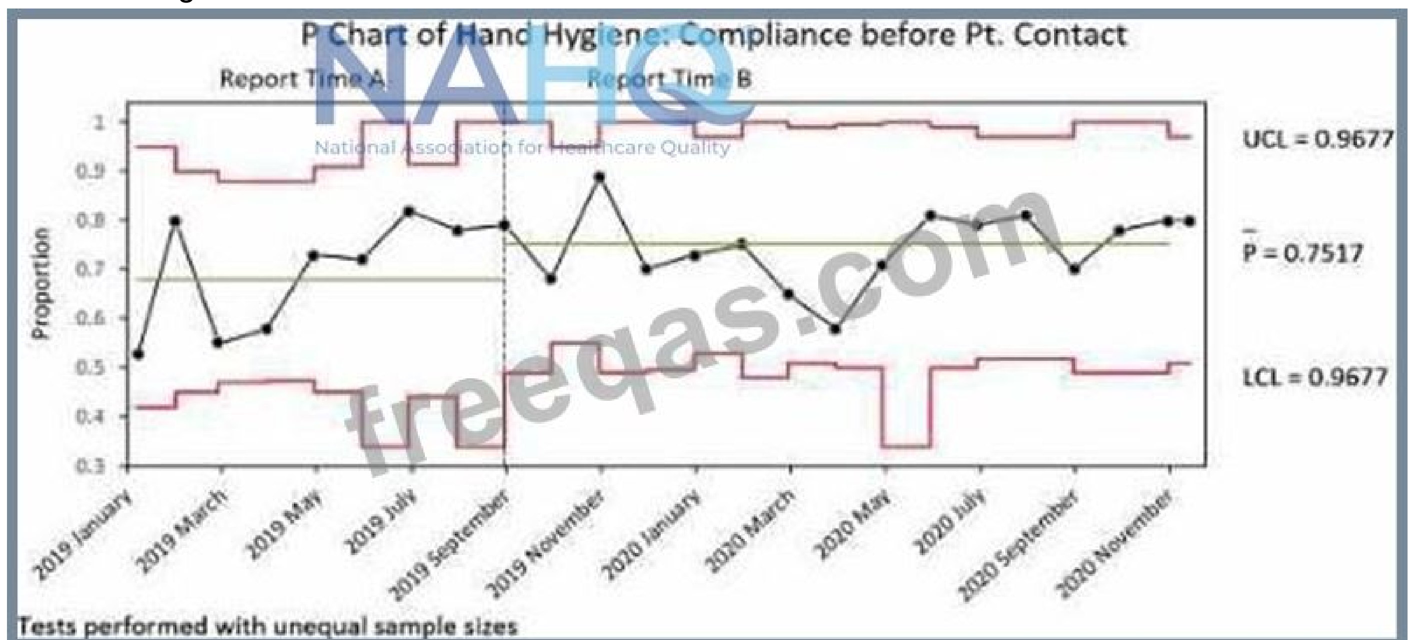
* Network (B): A network might facilitate collaboration or sharing best practices but does not provide the detailed comparative data that a registry offers.
* Research (C): Participating in research could help generate new knowledge, but it is not specifically designed for benchmarking outcomes.
* Certification (D): Certification ensures that an organization meets specific standards but does not provide comparative outcome data.

References

* NAHQ Body of Knowledge: Data Analytics and Benchmarking in Quality Improvement
* NAHQ CPHQ Exam Preparation Materials: Using Registries for Outcome Comparisons

**NEW QUESTION: 56**

The following data are known:




Which of the following accurately describes this chart?

**A.** The lower control limits were the same in Report Time A and B.

**B.** The mode was 0.7517 In Report Time B.

**C.** There was one outlier in Report Time A.

**D.** There were no special cause variations.

**Answer: (SHOW ANSWER)**

The chart you've provided is a P chart, which is used to measure the proportion of nonconformities in a process over time, in this case, hand hygiene compliance before patient

contact. This type of control chart is particularly useful for analyzing the performance of processes in areas like healthcare compliance.
From the visual analysis of the chart:
Upper Control Limit (UCL) and Lower Control Limit (LCL) are clearly labeled and appear consistent across both Report Time A and B at 0.9677. This addresses option A, indicating that the lower control limits remain unchanged between the two reporting periods.
Central Line (P), which represents the average proportion across the data set, is also consistent across both periods at 0.7517.
Outliers and Special Cause Variations would typically be indicated by points falling outside the control limits or showing non-random patterns that suggest shifts or trends.

**NEW QUESTION: 57**
A facility Is reviewing their quality program for compliance with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation. Which of the following Is the most Important factor in program compliance?
**A.** 12 months of data for each project
**B.** Integration into each department and service of the facility
**C.** poor improvement outcomes monitored for an additional 12 months
**D.** coordination by a full-time healthcare quality professional
**Answer: (SHOW ANSWER)**
The Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) are health and safety standards that healthcare organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs1. These standards are the foundation for improving quality and protecting the health and safety of beneficiaries1.
The CMS CoPs cover a wide range of areas, including emergency preparedness, physical environment, patients' rights, nurse staffing, medical records, lab and radiological services, and utilization review2. They also include requirements for policies and procedures that identify when a patient is in distress, how to initiate an emergency response, how to initiate treatment, and recognizing when the patient must be transferred to another facility to receive appropriate treatment3.
Given this broad scope, it is clear that compliance with the CMS CoPs requires integration into each department and service of the facility. This is because all these areas need to work together to ensure the health and safety of patients and to improve the quality of care. Therefore, the most important factor in program compliance with the CMS CoPs is likely to be B. Integration into each department and service of the facility.
While the other options (A, C, and D) are also important aspects of a quality program, they are not as comprehensive as option B. For example, having 12 months of data for each project (option A) and monitoring poor improvement outcomes for an additional 12 months (option C) are important for tracking performance and making improvements, but they do not cover all the areas required for compliance with the CMS CoPs. Similarly, coordination by a full-time healthcare quality professional (option D) is important for managing the quality program, but it does not

ensure that all departments and services of the facility are integrated and compliant with the CMS CoPs.
Therefore, based on the information available, the most important factor in program compliance with the CMS CoPs is likely to be B. Integration into each department and service of the facility. However, it is important to note that this is a complex issue and the actual decision should be made by the healthcare quality professional considering all relevant factors and resources.

**NEW QUESTION: 58**
Examples of administrative data sources are all of the following EXCEPT:
**A.** Health information management or medical record system
**B.** Hospital or physician office billing systems
**C.** Nursing management system
**D.** Health plan claim databases
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 59**
Through ___________ the data collection staff can spot patient trends as they develop rather than receive the information after the patient have been discharged.
For instance, the incidence of ventilator-associated pneumonia sooner, or it may spot an increase in the rate of aspiration in stroke patients as it occurs.
**A.** Scanners
**B.** Data collection forms
**C.** Prospective chart review
**D.** Medical record review (Retrospective)
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 60**
The comparison chart interpretation will result in one of the following scenarios, regardless of the type of measure EXCEPT:
**A.** Favorable outliner: Actual performance is better than the expected performance
**B.** Incomplete data: Data cannot be analyzed because of complexity
**C.** Unfavorable outliner: Actual performance is worse than the expected performance
**D.** No outliner: Actual performance is within the expected range
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 61**
An interdisciplinary learn met to review readmission rates at a health system. Issues were identified with communication across care providers. The team is interested in improving the coordination of care process and is now reviewing four candidates to serve in the role of process champion:

| Indicator | Candidate A | Candidate B | Candidate C | Candidate D |
|---|---|---|---|---|
| Involvement with current process | High | Some | None | Some |
| Level of interest | High | High | Some | Low |
| Authority to mobilize resources | None | Low | High | High |
| Respected opinion leader | Low | High | Some | Some |

Of the four candidates, which represents the most effective choice to serve as a process champion?

**A.** Candidate A

**B.** Candidate D

**C.** Candidate C

**D.** Candidate B

**Answer: A (LEAVE A REPLY)**

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**NEW QUESTION: 62**

Overproduction

Inventory

Repairs/rejects

Motion

Processing

Waiting

Transport

These are the types of _____________ identified by Taiichi Ohno.

**A.** Continuous improvement

**B.** Quality controls

**C.** Areas to be focused during production

**D.** Waste (activities that do not add value to the process)

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 63**

Which of the following is true regarding critical values?

**A.** defined by law

**B.** determined by the organization

**C.** provided by accrediting agencies

**D.** specific to nursing units

**Answer: B (LEAVE A REPLY)**
Critical values are specific test results that fall significantly outside the normal range and may indicate a life- threatening situation. These values are determined by the organization based on clinical judgment and the specific context of the healthcare setting. Each organization is responsible for defining what constitutes a critical value for various tests, ensuring that these values are communicated promptly to the responsible clinician.
* Defined by law (A): Critical values are not universally defined by law; they are established by individual organizations based on their clinical needs and practices.
* Provided by accrediting agencies (C): While accrediting agencies may provide guidelines on how to manage critical values, they do not define the specific values.
* Specific to nursing units (D): Critical values are not specific to nursing units but are applicable across the organization and require prompt communication.
References
* NAHQ Body of Knowledge: Critical Values in Laboratory Management
* NAHQ CPHQ Exam Preparation Materials: Managing Critical Values in Healthcare
=========

**NEW QUESTION: 64**
The approach to medical record review involves well-conceived steps, beginning with the development of a data collection tool and ending with:
**A.** Compilation of collected data element into a register or physical record system
**B.** Compilation of collected data element into a registry or electronic database software for review and analysis
**C.** Execution of the future activities on the finding of this record review
**D.** Implementation of the analysis of collected data set
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 65**
A healthcare quality professional works in a primary care setting and has been asked to develop a patient safety program.
The first step in program development is to
**A.** complete a literature search.
**B.** survey patients.
**C.** visit similar organizations.
**D.** define the scope.
**Answer: D (LEAVE A REPLY)**
When developing a patient safety program, the first step should be to define the scope of the program.
Here's why:
Establishing Boundaries:

Defining the scope helps clarify what the program will cover, such as specific patient safety concerns, the population it will serve, and the settings in which it will be implemented.
Guiding Program Development:
A well-defined scope provides a clear direction for the subsequent steps in the program development process, such as conducting literature searches, surveys, or visits to similar organizations.
Resource Allocation:
By clearly defining the scope, the organization can better allocate resources, including time, personnel, and finances, ensuring that the program is feasible and aligned with the organization's goals.
Stakeholder Alignment:
Defining the scope at the outset helps align stakeholders, ensuring everyone understands the objectives and limitations of the patient safety program.
While completing a literature search, surveying patients, and visiting similar organizations are important steps in the process, they should occur after the scope has been defined to ensure that all efforts are focused and relevant.
Reference: NAHQ Guide to Developing and Implementing Patient Safety Programs NAHQ Healthcare Quality Competency Framework: Program Development

**NEW QUESTION: 66**
An organization with a focus on population health may use data to
**A.** identify high-risk patients.
**B.** determine the voice of the customer.
**C.** identify high-risk low-volume processes.
**D.** determine high-cost procedures.
**Answer: (SHOW ANSWER)**
In the context of population health, data is essential for identifying high-risk patients who may benefit from targeted interventions.
Here's why:
Targeted Interventions:
Identifying high-risk patients allows healthcare providers to allocate resources more efficiently and design interventions that are specifically tailored to those most in need, improving overall population health outcomes.
Preventive Care:
By focusing on high-risk patients, the organization can implement preventive measures that reduce the likelihood of adverse health outcomes, which is a key objective in population health management.
Data-Driven Decision Making:
Data enables the identification of patterns and trends within the population, helping to stratify patients based on risk and prioritize care for those at the highest risk of complications or poor outcomes.

Resource Optimization:
Identifying high-risk patients helps in optimizing the use of healthcare resources by focusing efforts on those who require the most attention, leading to more effective management of the population's health.
While determining the voice of the customer, identifying high-risk low-volume processes, and determining high-cost procedures are valuable, the primary use of data in population health is to identify high-risk patients for targeted interventions.
Reference: NAHQ Guide to Population Health Management
NAHQ Healthcare Quality Competency Framework: Data Analytics and Risk Stratification

**NEW QUESTION: 67**
The primary purpose of an emergency preparedness program is to
**A.** Provide evaluations of semi-annual evacuation drills
**B.** Manage the consequences of disasters that disrupt the facility's ability to provide care
**C.** Conduct evaluations of emergency training
**D.** Prevent internal disasters that disrupt the facility's ability to provide care and treatment
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 68**
Many organizations establish condition-specific patient registries for their more sophisticated quality improvement
projects because they do not have a reliable source of clinical information. The use of patient registries is
advantageous for the following reasons EXCEPT:
**A.** They can collect all the data that the physician or health system determines are most important
**B.** They are not subject to short comings of review records
**C.** They can be used for quality improvements and research purposes
**D.** They are rich source of information because they are customized
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 69**
Which of the following actions will most effectively promote safety activities within an organization?
**A.** Discuss safety events with managers at the unit level.
**B.** Ensure staff are aware of psychological safety concepts.
**C.** Empower staff to take ownership of unit-based safety issues.
**D.** Encourage patients to participate in the advisory council.
**Answer: C (LEAVE A REPLY)**
Detailed Explanation:
Promoting safety within an organization is best achieved by empowering staff to take responsibility for safety on their units:

Option C: Empower staff to take ownership of unit-based safety issues
This fosters a proactive safety culture, where staff feel accountable and involved, leading to more effective safety practices.
Option A: Discuss safety events with managers at the unit level
While this is beneficial, it's less effective than direct staff empowerment.
Option B: Ensure staff are aware of psychological safety concepts
Psychological safety is important but needs to be paired with empowerment to drive action.
Option D: Encourage patients to participate in the advisory council
Patient participation is valuable but indirect for internal safety promotion.
References:
CPHQ emphasizes staff empowerment and engagement in quality improvement initiatives as critical for a sustainable safety culture.

**NEW QUESTION: 70**
Licensing and accrediting bodies have relied heavily on structural measures of quality not only because the measures are relatively stable and thus easier to capture but:
**A.** They reliably identify physicians
**B.** They reliably identify providers who demonstrably la means to deliver high quality care
**C.** They reliably identify providers who are cheap
**D.** They can never la the means to deliver high quality care
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 71**
For cheing the outcomes our focus of attention is blood pressure of patients with diabetes.
Its criteria and standard can be respectively:
**A.** Criterion: Sugar level in blood on daily basis and Standard: How many times sugar level rises and how many times it declines in a week
**B.** None of these
**C.** Criterion: Percentage of patients with diabetes whose blood pressure is at or below 130/85 and Standard: At least 50% of patients with diabetes have blood pressure at or below 130/85
**D.** Criterion: Percentage of post heart atta patients prescribed beta-bloers on discharge and Standard: At least 96% of heart atta patients receive a beta-bloer prescription on discharge
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 72**
The most important determinant of quality improvement success is
**A.** organizational culture.
**B.** monetary resource allocation.
**C.** the CQI model selected.
**D.** the type of organization.
**Answer: A (LEAVE A REPLY)**

The most important determinant of quality improvement success is organizational culture. Organizational culture refers to the collective values, beliefs, and norms that shape the behavior and practices within an organization. In the context of healthcare, a culture that emphasizes continuous improvement, teamwork, and a commitment to patient safety is crucial for the success of any quality improvement initiative.
* Organizational Culture as a Foundation: A strong organizational culture supports the principles of Continuous Quality Improvement (CQI), including open communication, a non-punitive approach to error reporting, and a focus on learning from mistakes. This creates an environment where staff feel empowered to contribute to quality improvement efforts.
* Influence on CQI Success: Without a supportive culture, even well-designed CQI models may fail.
Organizational culture directly influences employee engagement, collaboration across departments, and the overall commitment to improvement efforts, making it a critical factor in the success of quality initiatives.
* Monetary Resources and Models: While monetary resource allocation (B) and the specific CQI model selected (C) are important, they are secondary to culture. Adequate resources and the right CQI model are necessary but not sufficient without a culture that prioritizes quality.
* Type of Organization: The type of organization (D) is also less critical than culture. Regardless of the organization's size, type, or specialty, a culture that prioritizes quality and continuous improvement is essential for the success of any initiative.
References: National Association for Healthcare Quality (NAHQ) documents and resources emphasize the importance of organizational culture as a primary determinant of quality improvement success, highlighting that a supportive culture is foundational for any CQI efforts.
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**NEW QUESTION: 73**

An organization that demonstrates a culture of safety

**A.** has a balanced scorecard.

**B.** penalizes reporting of errors.

**C.** learns from errors.

**D.** generates a low number of incident reports.

**Answer: C (LEAVE A REPLY)**

An organization that demonstrates a culture of safety is one that learns from errors (Answer C) rather than penalizing them. In such an environment, errors are viewed as opportunities for learning and improvement, with the aim of preventing future occurrences. This approach fosters openness and encourages staff to report incidents and near misses without fear of retribution, leading to a safer and more resilient healthcare system.
The other options describe aspects that are either contrary to a safety culture or unrelated:
* A balanced scorecard (A) is a strategic management tool and does not directly indicate a culture of safety.

* Penalizing reporting of errors (B) would create a culture of fear, which is the opposite of a safety culture.
* Generating a low number of incident reports (D) might suggest underreporting rather than a true reflection of safety, especially if it results from a punitive environment.
References:
* National Association for Healthcare Quality (NAHQ) - Certified Professional in Healthcare Quality (CPHQ) Study Materials.
* Culture of Safety in Healthcare, NAHQ Documentation.
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**NEW QUESTION: 74**
A criterion is considered valid if it
**A.** consistently yields the same results.
**B.** does not change with changes in technology.
**C.** is applicable to many groups and settings.
**D.** measures what it is intended to measure.
**Answer: D (LEAVE A REPLY)**
A criterion is considered valid if it measures what it is intended to measure. Validity refers to the accuracy of a measure, meaning the criterion accurately reflects the concept or outcome it is supposed to assess.
For example, if a criterion is designed to measure patient satisfaction, it should accurately capture patients' perceptions of their care.
Consistently yields the same results (A): This describes reliability, not validity.
Does not change with changes in technology (B): This is not related to validity.
Is applicable to many groups and settings (C): This refers to generalizability, not validity.
Reference
NAHQ Body of Knowledge: Measurement Principles in Quality Improvement
NAHQ CPHQ Exam Preparation Materials: Validity and Reliability in Quality Measures

**NEW QUESTION: 75**
______________ testing method provides useful information on respondents' perceptions of the response task, how respondents recall and report events, and how they interpret specified reference periods.
**A.** Cognitive
**B.** Biometric testing
**C.** Psychographic testing
**D.** Psychometric testing
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 76**

Evaluating data to determine high utilizers of emergency departments and their related characteristics is a strategy that can best help with

**A.** hospital throughput.

**B.** culture of safety.

**C.** population health management.

**D.** high reliability.

**Answer: C (LEAVE A REPLY)**

Evaluating data to determine high utilizers of emergency departments and their related characteristics is a strategy that best helps with population health management. Population health management involves identifying and managing the health outcomes of specific groups, including those who frequently use healthcare services like the emergency department. By understanding the characteristics of high utilizers, healthcare organizations can develop targeted interventions to manage chronic conditions, improve care coordination, and reduce unnecessary ED visits, ultimately improving health outcomes for these populations.

Hospital throughput (A): This refers to the efficiency of moving patients through the hospital but is not the primary focus of managing high utilizers.

Culture of safety (B): While important, culture of safety is more about ensuring a safe environment for patients and staff, not directly related to managing high utilizers.

High reliability (D): High reliability focuses on consistent performance and error reduction, rather than managing specific patient populations.

Reference

NAHQ Body of Knowledge: Population Health and High Utilizer Management

NAHQ CPHQ Exam Preparation Materials: Strategies for Population Health Management

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**NEW QUESTION: 77**

Which of the following presents a set of high-level measures grouped into learning and growth, customer, internal business, and financial?

**A.** balanced scorecard

**B.** histogram

**C.** matrix diagram

**D.** Gantt chart

**Answer: A (LEAVE A REPLY)**

The balanced scorecard presents a set of high-level measures grouped into four perspectives: learning and growth, customer, internal business, and financial. This management tool is used to align business activities with the organization's vision and strategy, improve internal and external communications, and monitor organizational performance against strategic goals. By balancing these four perspectives, the balanced scorecard helps organizations focus not just on financial outcomes but also on the drivers of future performance, such as employee knowledge, customer satisfaction, and efficient internal processes.
* Histogram (B): A histogram is a graphical representation of the distribution of numerical data, not a tool for grouping strategic measures.
* Matrix diagram (C): A matrix diagram shows relationships between different sets of data but does not group measures into strategic categories.
* Gantt chart (D): A Gantt chart is a type of bar chart that illustrates a project schedule, not a strategic measurement tool.
References
* NAHQ Body of Knowledge: Strategic Planning and Balanced Scorecard
* NAHQ CPHQ Exam Preparation Materials: Using Balanced Scorecard for Performance Measurement
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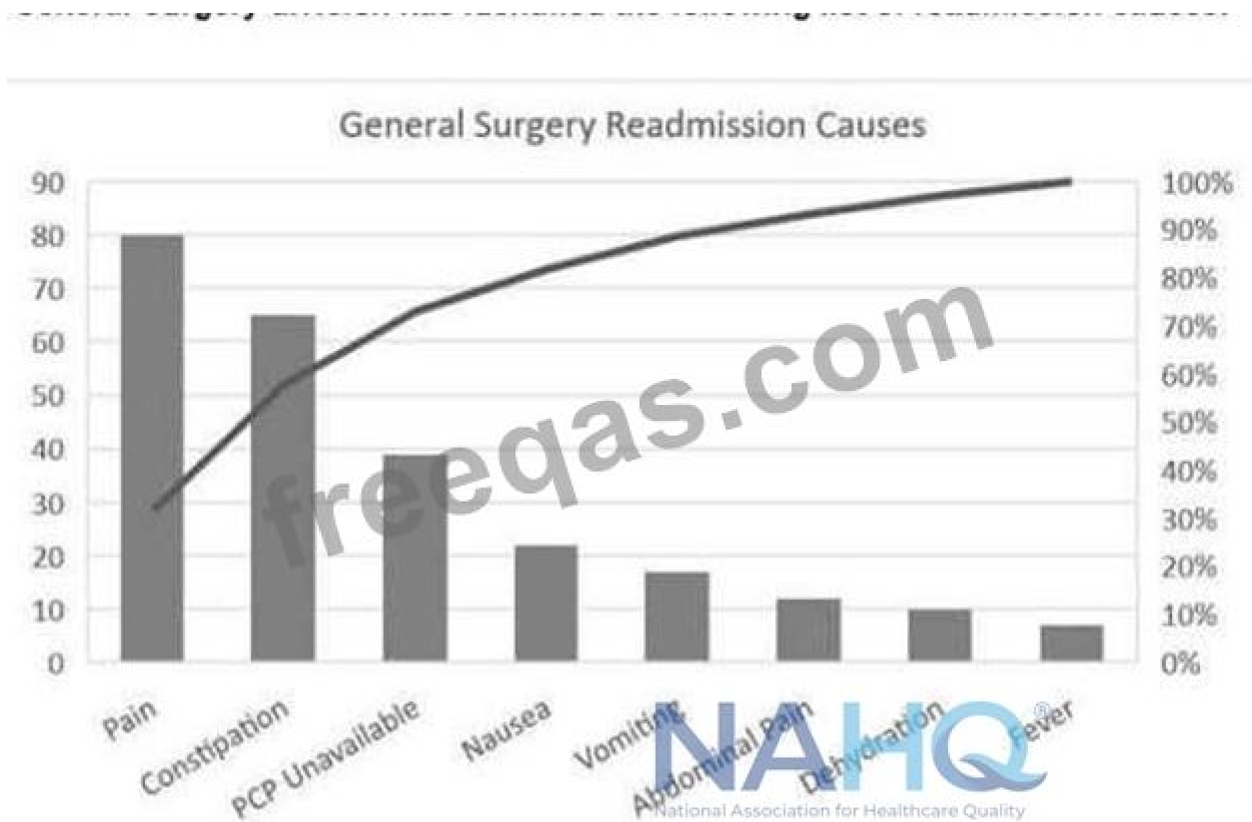
**NEW QUESTION: 78**
A performance improvement team was formed to reduce the inappropriate ordering of two expensive lab tests. The goal was to reduce the rate of inappropriate ordering of Test A by 20% and Test B by 5%.
The results of the pilot group showed a 30% drop in Test A orders and a 3% drop in Test B orders.
What additional information would be of most benefit to gain final administrative approval to implement the change organization-wide?
**A.** the cost savings resulting from the project
**B.** feedback from providers that ordered test A
**C.** the total number of Test A and Test B labs ordered
**D.** the number of providers that were educated on the change
**Answer: A (LEAVE A REPLY)**
To gain final administrative approval to implement the change organization-wide, it is most beneficial to provide information on the cost savings resulting from the project. Demonstrating cost savings is a compelling argument for scaling the project, as it directly impacts the organization's financial performance. In this case, the significant reduction in inappropriate test orders likely translates to substantial cost savings, which would be a key factor in gaining approval from administration. Feedback from providers that ordered Test A (B): While useful, feedback alone is less likely to influence administrative approval compared to cost savings.
The total number of Test A and Test B labs ordered (C): This data is relevant but needs to be linked to the financial impact to be persuasive.

The number of providers that were educated on the change (D): This is more related to implementation metrics rather than decision-making for scaling up the project.
Reference
NAHQ Body of Knowledge: Cost-Effectiveness in Quality Improvement
NAHQ CPHQ Exam Preparation Materials: Financial Impact of Quality Projects

**NEW QUESTION: 79**
When formulating medical standards, a critical decision that must be made is the _____ at which the standard should
be set.
**A.** Depth
**B.** Level
**C.** utility of measurement
**D.** Clarity
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 80**
Organizational size affects the ability to disseminate best practices
**A.** True
**B.** It depends on situation
**C.** False
**D.** Difficult to decide
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 81**
Based on the chart below, which of the following should be addressed first?




**A.** pain, constipation, PCP unavailable, nausea, and vomiting
**B.** pain, constipation, PCP unavailable, and nausea
**C.** pain, constipation, and PCP unavailable
**D.** pain and constipation
**Answer: (SHOW ANSWER)**
Based on the provided Pareto chart of general surgery readmission causes, the most significant causes should be addressed first to have the greatest impact on reducing readmissions.
Pareto Principle (80/20 Rule): The chart illustrates that a small number of causes contribute to the majority of the readmissions. The top three causes-pain, constipation, and PCP (Primary Care Provider) unavailable-account for the most significant portion of the readmissions. Prioritization of Interventions: By addressing these top three causes first, the healthcare team can potentially prevent the majority of readmissions, making the intervention more efficient and effective.
Strategic Focus: Focusing on pain, constipation, and the unavailability of PCPs aligns with the principle of focusing on the "vital few" causes rather than spreading resources thinly across many less significant issues.
Reference: (Based on Healthcare Quality NAHQ documents and resources)
NAHQ Quality Improvement and Data Analysis Modules.
CPHQ Study Guide, Section on Pareto Analysis in Quality Improvement.

**NEW QUESTION: 82**
An important responsibility of each team member working on a team project is to
**A.** complete assignments between meetings.
**B.** investigate the existing data on the project.
**C.** review team progress periodically.

**D.** teach skills to the team during meetings.
**Answer: A (LEAVE A REPLY)**
An important responsibility of each team member working on a team project is to complete assignments between meetings. This ensures that progress is made continuously, and that meetings can be focused on discussing completed work, making decisions, and planning the next steps. Regular completion of assignments is crucial for maintaining momentum and ensuring that the project stays on track.
Investigate the existing data on the project (B): This may be a task for some team members, but not the primary responsibility of all.
Review team progress periodically (C): This is typically the responsibility of the team leader or facilitator, not every team member.
Teach skills to the team during meetings (D): While sharing knowledge is valuable, it is not the primary responsibility of every team member.
Reference
NAHQ Body of Knowledge: Effective Teamwork and Project Management
NAHQ CPHQ Exam Preparation Materials: Team Roles and Responsibilities in Project Work

**NEW QUESTION: 83**
In successful implementation of performance improvement programs, use of a single improvement methodology across all improvement initiatives is critical to facilitating a cohesive and consistent approach to improvement within the organization. An organization can develop improvement methodologies internally or can adopt them from external sources.
Which of the following components is related to this strategy?
**A.** Establishment of a performance improvement oversight entity
**B.** Establishment of partnership with key stakeholder
**C.** Selection and use of a performance improvement methodology
**D.** Staff understanding
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 84**
In a quality improvement team, the primary role of the facilitator Is to
**A.** ensure that team project goals are met.
**B.** promote effective group dynamics.
**C.** provide content expertise.
**D.** design team structure.
**Answer: (SHOW ANSWER)**
In a quality improvement team, the primary role of the facilitator is to promote effective group dynamics123. The facilitator, also known as a quality improvement coach, assists practices with coordinating their quality improvement activities and helps build capacity for those activities2. This reflects a systems-level approach to improving quality, safety, and implementation of evidence-based practices2. The facilitator encourages the views and opinions of the team,

facilitates/assists with implementing QI activities, requests and uses appropriate resources, systems and support mechanisms, provides regular communication about QI activities, and reviews the progress of QI activities3.

**NEW QUESTION: 85**

Which of the following strategies promotes timely completion of a quality improvement project?

**A.** allowing the project sponsor to direct the project team's work

**B.** assigning the team leader to document overall project progress

**C.** requiring team members to devote a majority of their time to project work

**D.** focusing routine senior leader updates on project successes

**Answer: (SHOW ANSWER)**

To promote the timely completion of a quality improvement project, it is crucial to ensure that there is effective management of the project's progress and that team members are dedicated and focused on the tasks at hand.

Requiring team members to devote a majority of their time to project work: This approach ensures that sufficient time is allocated to the project, minimizing distractions from other duties and speeding up project completion. It highlights commitment and prioritizes the project among other responsibilities.

Among these, Option C is the most direct and effective strategy to promote timely completion, as it prioritizes the project within the team members' workload, ensuring dedicated efforts towards project tasks.

**NEW QUESTION: 86**

An ambulatory care practice has reviewed data to identify patients with multiple visits to the emergency room within the last six months.

The population health management technique for this type of data review is called

**A.** public health surveillance.

**B.** hot-spotting.

**C.** syndromic surveillance.

**D.** cold-spotting.

**Answer: B (LEAVE A REPLY)**

Hot-spotting (Answer B) is a population health management technique used to identify patients or geographic areas that generate a disproportionately high number of emergency room visits or healthcare costs. By focusing on these "hot spots," healthcare providers can develop targeted interventions to address the underlying issues that lead to frequent ER visits, such as chronic disease management, social support needs, or access to primary care. The aim is to improve patient outcomes and reduce healthcare utilization in these high-need areas.

The other options refer to different public health or surveillance methods:

Public health surveillance (A) is the continuous, systematic collection and analysis of health data for the planning, implementation, and evaluation of public health practice.

Syndromic surveillance (C) involves the real-time collection of data on symptoms or syndromes to detect potential outbreaks of disease before diagnoses are confirmed.
Cold-spotting (D) typically refers to identifying areas or populations with low healthcare utilization or unmet needs, which is the opposite focus of hot-spotting.
Reference: National Association for Healthcare Quality (NAHQ) - Certified Professional in Healthcare Quality (CPHQ) Study Materials.
Population Health Management Techniques, NAHQ Documentation.

**NEW QUESTION: 87**
To identify outpatient data sources, the team should consider the following questions EXCEPT (Choose two):
**A.** Do the source outpatient data is the same as inpatient data
**B.** Is the physician in organized medical groups that have outpatient electronic medical records, which could be a source of data? Will their financial or billing systems be able to identify all patients with diabetes in their practices? If not, can the health plans in the area supply the data by practice site or individual physician?
**C.** Do the measures selected by team reflect the aspects of care that have the most influence on patient's outcome
**D.** Some of the most important diabetes measures are based on laboratory testing. Do the physicians have their own labs? If so, do they achieve the laboratory data for12-24-month snapshot? If they do not do their own lab testing, do they use a common reference lab that would be able to supply the data?
**Answer: A,C (LEAVE A REPLY)**

**NEW QUESTION: 88**
Each department in a hospital self-monitors and reports hand hygiene data each quarter. Results typically fall within the 58-72% range, with the exception of Respiratory Therapy, which consistently reports 100% compliance. Which of the following steps should a healthcare quality professional take next?
**A.** Require departments not achieving at least 95% compliance to develop corrective action plans.
**B.** Provide remedial hand hygiene training for the lowest scoring departments.
**C.** Validate that the Respiratory Therapy results are accurate.
**D.** Recognize the Respiratory Therapy department for its outstanding compliance.
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 89**
A performance improvement specialist at an ambulatory surgery center is facilitating a Plan-Do-Study-Act Cycle (PDSA) process to improve the rate of hand hygiene amongst surgical post-recovery staff to 90% or above. Data from the past 12 months are as follows:
Baseline: 60% compliance

Q1: 87% compliance
Q2: 79% compliance
Q3: 91% compliance
Q4: 72% compliance
The specialist is preparing to discuss aggregate results with the Quality Committee. To most accurately convey the results, the specialist highlights the
**A.** lack of overall change over the past 12 months indicates the process was unsuccessful.
**B.** contributing factors to the variation in results over the past 12 months.
**C.** sharp and consistent decline in results over the past 12 months.
**D.** overall improvement over the past 12 months.
**Answer: B (LEAVE A REPLY)**
When discussing the aggregate results of the PDSA cycle to improve hand hygiene compliance, it is crucial to highlight the contributing factors to the variation in results over the past 12 months. The data shows fluctuations in compliance rates, with a peak in Q3 and declines in Q2 and Q4. Analyzing and understanding the reasons behind these variations is essential for identifying what worked well and what challenges arose.
This approach allows the Quality Committee to develop strategies to address the inconsistencies and sustain improvements.
* Lack of overall change (A): This statement is inaccurate as there were periods of significant improvement, especially in Q1 and Q3.
* Sharp and consistent decline (C): This is misleading, as the data does not show a consistent decline; rather, it shows fluctuations.
* Overall improvement (D): While there was some improvement, the focus should be on understanding the causes of the variability rather than just the overall trend.
References
* NAHQ Body of Knowledge: Performance and Process Improvement
* NAHQ CPHQ Exam Preparation Materials: PDSA Cycle and Data Analysis
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**NEW QUESTION: 90**
An ambulatory pulmonary division is in the final phase of a DMAIC project. The division head asked the team to present the performance of the project.
Which chart demonstrates that change has occurred over time and the process has limited variation?
**A.** control chart
**B.** run chart
**C.** flowchart
**D.** Pareto chart
**Answer: A (LEAVE A REPLY)**
The DMAIC (Define, Measure, Analyze, Improve, Control) process is a data-driven quality strategy used to improve processes12. In the context of a DMAIC project, when you want to

demonstrate that change has occurred over time and the process has limited variation, a control chart is the most appropriate tool.
A control chart is a graph used to study how a process changes over time. It is particularly useful in the Control phase of the DMAIC process. The chart is used to monitor the process and ensure it remains stable. Data points are plotted in time order in a control chart and a centerline is calculated. The centerline is the average value of the metric you are charting. A control chart always has a central line for the average, an upper line for the upper control limit, and a lower line for the lower control limit. These lines are determined from historical data. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation).
Reference: https://asq.org/quality-resources/dmaic

**NEW QUESTION: 91**
A healthcare quality professional is conducting a study to determine how many patients contracted influenza despite receiving flu shots. This study is evaluating
**A.** appropriateness.
**B.** process.
**C.** prevalence.
**D.** efficacy.
**Answer: (SHOW ANSWER)**
The study described is evaluating the efficacy of flu shots, specifically how effective they are in preventing influenza among those who received the vaccination.
* Definition of Efficacy: Efficacy refers to the ability of an intervention, such as a vaccine, to produce the desired beneficial effect under ideal and controlled circumstances, typically measured in clinical trials.
* Measuring Efficacy: In this context, the healthcare quality professional is examining how well the flu shots work in preventing influenza, as indicated by the number of patients who still contracted the flu despite being vaccinated.
* Outcome Focus: The study's focus on the outcome (whether patients contracted the flu) is a direct measure of the vaccine's efficacy, distinguishing it from other metrics like prevalence or process evaluation.
References: (Based on Healthcare Quality NAHQ documents and resources)
* NAHQ Modules on Outcome Measurement and Evaluation.
* CPHQ Study Guide, Section on Effectiveness and Efficacy in Healthcare Interventions.
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**NEW QUESTION: 92**

Who is responsible for aligning resources and ensuring accountability in an improvement project?

**A.** team leader

**B.** sponsor

**C.** process owner

**D.** facilitator

**Answer: (SHOW ANSWER)**

The sponsor is responsible for aligning resources and ensuring accountability in an improvement project. The sponsor typically holds a leadership position and has the authority to secure necessary resources, remove obstacles, and ensure that the project stays on track. The sponsor also holds the team accountable for achieving the project's goals and maintaining alignment with organizational priorities.

* Team leader (A): The team leader manages day-to-day activities and drives the project forward but does not usually have the authority to align resources and enforce accountability at the organizational level.

* Process owner (C): The process owner is responsible for the process being improved but may not have the broader organizational influence required to align resources.

* Facilitator (D): The facilitator helps guide discussions and ensures effective team dynamics but does not typically handle resource alignment or accountability.

References

* NAHQ Body of Knowledge: Roles in Quality Improvement Projects

* NAHQ CPHQ Exam Preparation Materials: Responsibilities of Project Sponsors

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**NEW QUESTION: 93**

Patient satisfaction and patient experience-of-care surveys are the most common quantitative measures healthcare organizations use, but they can use other important ____________ to obtain important information from patients and their families to guide improvement work. (Choose two.)

**A.** Patient satisfaction surveys

**B.** Qualitative measures

**C.** Focus group research

**D.** Listing posts

**Answer: B,D (LEAVE A REPLY)**

**NEW QUESTION: 94**

Using the same operational definition becomes even more critical if you are trying to compare several hospitals or

clinics in a system. When national hospitals are made, the operational definition challenge becomes extremely
complex. All good measurements begin and end with_____________.
**A.** A vision
**B.** An objective and an outcome respectively
**C.** A milestone
**D.** An operational definition
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 95**
Which of the following is the most effective method to identify adverse events that cause harm to patients?
**A.** benchmarking
**B.** using patient satisfaction surveys
**C.** conducting a failure mode and effects analysis
**D.** employing trigger tools
**Answer: D (LEAVE A REPLY)**
The most effective method to identify adverse events that cause harm to patients is employing trigger tools.
Trigger tools are specific clues or indicators in the patient record that signal a potential adverse event, such as a sudden drop in hemoglobin levels, which could indicate a bleeding complication.
These tools are designed to systematically review patient records for signs of harm, making them highly effective in identifying adverse events, including those that might not be reported through other means.
* Benchmarking (A): This is useful for comparing performance across organizations but does not directly identify adverse events.
* Using patient satisfaction surveys (B): Surveys can provide insights into patient perceptions but are not reliable for identifying specific adverse events.
* Conducting a failure mode and effects analysis (C): FMEA is a proactive tool used to prevent potential failures, not for identifying existing adverse events.
References
* NAHQ Body of Knowledge: Patient Safety and Use of Trigger Tools
* NAHQ CPHQ Exam Preparation Materials: Identifying and Managing Adverse Events
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**NEW QUESTION: 96**
A healthcare quality professional can conclude that clinical performance measures in disease specific certification programs are best supported by the
**A.** practice guidelines.
**B.** regulatory requirements.
**C.** compliance committee.

**D.** licensing requirements.
**Answer: A (LEAVE A REPLY)**
Clinical performance measures in disease-specific certification programs are best supported by practice guidelines. These guidelines provide a framework for continuously reliable care. The Joint Commission's commitment to this certification ensures your program meets clinical performance standards for targeted metrics as well as other compliance standards1. Disease-specific certification helps reduce unwanted variations in care and improve the patient experience, improve efficiencies and outcomes at a potential lower cost1. Therefore, practice guidelines play a crucial role in supporting these measures.
Reference: 1

**NEW QUESTION: 97**
Which of the following actions best demonstrates that an organization has begun the work necessary to achieve the Malcolm Baldrige award?
**A.** creating a team to revise operations to conform to the Malcolm Baldrige requirements
**B.** develop a crosswalk between Malcolm Baldrige and Joint Commission requirements
**C.** determine effects on Centers for Medicare and Medicaid Services (CMS) Conditions of Participation.
**D.** reviewing the Malcolm Baldrige standards to determine organization alignment
**Answer: D (LEAVE A REPLY)**
The Malcolm Baldrige National Quality Award is the highest level of national recognition that a U.S.
organization can receive for performance excellence1. The award criteria focus on eight performance dimensions: Leadership and Governance, Strategy, Operations, Operational Continuity, Workforce, Customers and Markets, Community Engagement, and Finance1.
To achieve the Malcolm Baldrige award, an organization must demonstrate organizational resilience and long-term success through favorable performance levels and trends, comparisons to competitors and industry benchmarks (as appropriate), and relevant metrics1. Therefore, reviewing the Malcolm Baldrige standards to determine organization alignment is the best demonstration that an organization has begun the work necessary to achieve the Malcolm Baldrige award.
While creating a team to revise operations to conform to the Malcolm Baldrige requirements (Option A) is a step in the process, it does not necessarily demonstrate that the organization has begun the work necessary to achieve the award. The same applies to developing a crosswalk between Malcolm Baldrige and Joint Commission requirements (Option B) and determining effects on CMS Conditions of Participation (Option C). These actions could be part of the process, but they do not directly demonstrate that the organization has begun the work necessary to achieve the Malcolm Baldrige award.
Beginning work toward achieving the Malcolm Baldrige National Quality Award necessitates a comprehensive understanding of the criteria and how an organization currently aligns with them.

This would involve a thorough review of the Baldrige Excellence Framework, which includes the standards for performance excellence. By assessing current practices against the Baldrige criteria, an organization can identify areas of strength and opportunities for improvement. This review serves as a foundational step in the Baldrige journey, guiding the development of a detailed action plan to address gaps and enhance performance.
Reference: The Baldrige Performance Excellence Program provides a framework for organizations to improve performance and achieve excellence. The NAHQ references the Baldrige framework as a comprehensive standard for quality that healthcare organizations can aspire to and align with as part of their continuous quality improvement efforts.

**NEW QUESTION: 98**
Quality and technical performance refers to how well current scientific medical knowledge and technology are applied in a given situation.
It is usually assessed in terms of:
**A.** The quality of interpersonal relationships
**B.** Both A and B
**C.** Timeliness and accuracy of the diagnosis
**D.** Appropriateness of therapy and other medical interventions are performed
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 99**
A root cause analysis (RCA) was conducted for an event related to a delayed high-priority alarm response.
Alarm fatigue was determined to be a root cause. Which of the following is the most appropriate first intervention?
**A.** Add visual indicators to the existing audible alerts.
**B.** Review alarm signals for clinical appropriateness.
**C.** Establish a written policy for alarms escalation.
**D.** Implement a guideline with clear criteria for initiation of cardiac monitoring.
**Answer: B (LEAVE A REPLY)**
Detailed Explanation:
Addressing alarm fatigue involves reducing unnecessary or clinically irrelevant alarms, which contribute to desensitization.
Option B: Review alarm signals for clinical appropriateness
Ensuring only clinically necessary alarms are activated is essential to reduce the frequency and impact of alarm fatigue.
Option A: Add visual indicators
Adding more indicators may exacerbate fatigue without first reducing alarm frequency.
Options C and D:
Policies and guidelines can help structure alarm management but should follow initial steps to reduce unnecessary alarm signals.

References:
Best practices in alarm management highlight reducing non-essential alarms as an initial step, a recommendation supported by quality improvement literature and CPHQ resources on RCA interventions.

**NEW QUESTION: 100**
In healthcare, many terms call for more precise operational definitions that how do an organization define the terms such as:
**A.** Qui turnaround time
**B.** Surgical end time
**C.** A patient fall (a partial fall, a fall with injuries, or an assisted fall)
**D.** An accurate environmental compliance
**Answer: A,C (LEAVE A REPLY)**

**NEW QUESTION: 101**
Which of the following regulatory agencies oversee development of electronic clinical quality measures (eCQMs)?
**A.** DNV GL Healthcare
**B.** Centers for Medicare and Medicaid Services (CMS)
**C.** Occupational Safety and Health Association (OSHA)
**D.** The Joint Commission (TJC)
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 102**
A data analyst, using a clinical decision support system (administrative database), discovered a higher-than-expected incidence of renal failure (a serious complication) following coronary artery bypass surgery. The rat e was well above 10 percent for the most recent 12 months increased over the last six quarters. However, the clinical decision support system did not contain enough detail to explain whether this complication resulted from the coronary artery bypass graft procedures or was a chronic condition present on admission.
To find the answer, the data analyst use different steps.
This example illustrates:
**A.** That data should be thorough
**B.** Computer aided information systems are better to gather data
**C.** How data analyst use review chart to isolate cases
**D.** How an administrative system's cost effectiveness can be combined with the detailed information in a medical record review?
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 103**

In preparation for a provider organization accreditation survey, the most effective method for identifying training needs for staff is

**A.** conducting a gap analysis with an interdisciplinary team.

**B.** benchmarking with other organizations.

**C.** engaging a consultant to identify areas needing improvement.

**D.** comparing competency requirements with other facilities.

**Answer: A (LEAVE A REPLY)**

The most effective method for identifying training needs in preparation for an accreditation survey is conducting a gap analysis with an interdisciplinary team. A gap analysis compares the current state of staff competencies and organizational processes with the standards required for accreditation. Involving an interdisciplinary team ensures that all aspects of care and service are considered, leading to a comprehensive identification of training needs across different roles and departments.

* Benchmarking with other organizations (B): While benchmarking can provide useful comparisons, it may not directly identify the specific training needs of your staff.
* Engaging a consultant to identify areas needing improvement (C): A consultant can be helpful, but an internal gap analysis is more effective in creating ownership of the process and addressing specific accreditation requirements.
* Comparing competency requirements with other facilities (D): This can be part of benchmarking but does not provide the direct, internal insights that a gap analysis offers.

References

* NAHQ Body of Knowledge: Accreditation Preparation and Gap Analysis
* NAHQ CPHQ Exam Preparation Materials: Identifying Training Needs for Accreditation

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**NEW QUESTION: 104**

A quality improvement professional believes that their MRSA facility rates are high. What should the quality improvement professional do first?

**A.** Contact the infection control practitioner to obtain benchmark data.

**B.** Report the concerns to senior management and the Quality Council.

**C.** Form a quality improvement team.

**D.** Repeat the data collection process to Justify the new rate.

**Answer: (SHOW ANSWER)**

* The first step for a quality improvement professional who believes that their MRSA facility rates are high is to contact the infection control practitioner to obtain benchmark data. Benchmark data are comparative data that can help identify gaps in performance and set realistic and achievable goals for improvement 1. Benchmark data can beobtained from various sources, such as national or regional databases, professional organizations, peer-reviewed literature, or other similar facilities 2.
* By contacting the infection control practitioner, the quality improvement professional can access reliable and valid data on MRSA rates in their facility and compare them with other facilities or

standards. This can help them determine the magnitude and significance of the problem, and whether it warrants further investigation and action. The infection control practitioner can also provide guidance on the best practices and protocols for preventing and controlling MRSA infections, and the potential risk factors and causes of high MRSA rates 3.
* The other options are not the best first steps for the quality improvement professional. Reporting the concerns to senior management and the Quality Council (option B) may be premature and unnecessary without having sufficient evidence and analysis of the problem. Forming a quality improvement team (option C) may be helpful later in the process, but not before defining and measuring the problem.
Repeating the data collection process to justify the new rate (option D) may be wasteful and inaccurate, as it may not account for the variability and trends in the data, and it may not address the underlying causes of the problem . References:
* 1: NAHQ Healthcare Quality Competency Framework, Domain 5: Data Analytics, Skill 5.1.1
* 2: Benchmarking in Healthcare: A Practical Approach | NAHQ
* 3: Success and failures in MRSA infection control during the COVID-19 pandemic | Antimicrobial Resistance & Infection Control | Full Text 2
* : NAHQ Healthcare Quality Competency Framework, Domain 3: Performance and Process Improvement, Skill 3.1.1

**NEW QUESTION: 105**
- Health care provider accountability
- Decision making public reporting
- Organizational evaluation
- National performance improvement goals and activities
These are the performance measures identified by health organizations in order to meet:
**A.** Internal needs specifically
**B.** Organizational objective
**C.** External needs specifically
**D.** Organizational vision
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 106**
Advantages of prospective data collection are all of the following EXCEPT:
**A.** Detailed information not routinely available in administrative databases can be gathered
**B.** Data requiring a time stamp also can be captured
**C.** Physiologic parameters can be captured, such as the range of blood pressures for a patient on vasoactive infusions or 24-hour intake and output for patients with heart failure
**D.** Before time administration of certain therapies
**Answer: (SHOW ANSWER)**

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**NEW QUESTION: 107**
A healthcare quality professional identifies a need to improve compliance with colon cancer screening among primary care patients. Which of the following interventions should be used?
**A.** Develop a clinical pathway for managing high-risk patients.
**B.** Send reminders to patients six months before required screening.
**C.** Measure the number of patients who complete an annual screening.
**D.** Improve documentation of patient education on cancer risk factors.
**Answer: B (LEAVE A REPLY)**
Detailed Explanation:
Sending reminders to patients is an effective intervention to improve compliance with scheduled screenings.
Option B: Send reminders to patients six months before required screening Reminder systems are proven to increase adherence to screening schedules.
References:
Patient reminders are recommended in CPHQ resources as an evidence-based approach to improve preventive screening compliance.

**NEW QUESTION: 108**
Which of the following should the team do next?
**A.** Conduct an in-service for housekeeping staff.
**B.** Evaluate patient risk factors.
**C.** Refer this issue to the safety committee.
**D.** Collect frequency data on the causes of the falls.
**Answer: D (LEAVE A REPLY)**
=========

**NEW QUESTION: 109**
To assess compliance with quality standards, a healthcare organization needs
**A.** standardized data collection methods.
**B.** approval by the governing body.
**C.** a dedicated standards assessment team.
**D.** an electronic data analysis program.
**Answer: A (LEAVE A REPLY)**
=========

**NEW QUESTION: 110**

Healthcare purchasers and payers are demanding that providers demonstrate their ability to provide high quality
patient care at fair prices. Specifically, they are seeking:

**A.** Objective evidence that hospitals and other healthcare organizations manage their costs well

**B.** Objective evidence that hospitals and other healthcare organizations satisfy their customers and have desirable
outcomes

**C.** Baseline information

**D.** Current performance

**Answer: A,B (LEAVE A REPLY)**

**NEW QUESTION: 111**

The problem with using readily available, convenient data is that the data usually do a poor job of answering the questions necessary to access performance. Ten years ago this "good enough" approach to data collection might have been acceptable. Today, however, because of the increasing demand to demonstrate effectiveness of care and efficiency of healthcare processes, this mind set is not acceptable.

Performance quality and excellence do not occur because organizations do what they have always done or what is convenient.

Most healthcare observers agree that:

**A.** Specific measures should not be used in data collection

**B.** Quality improvement efforts definitely end up with a positive result

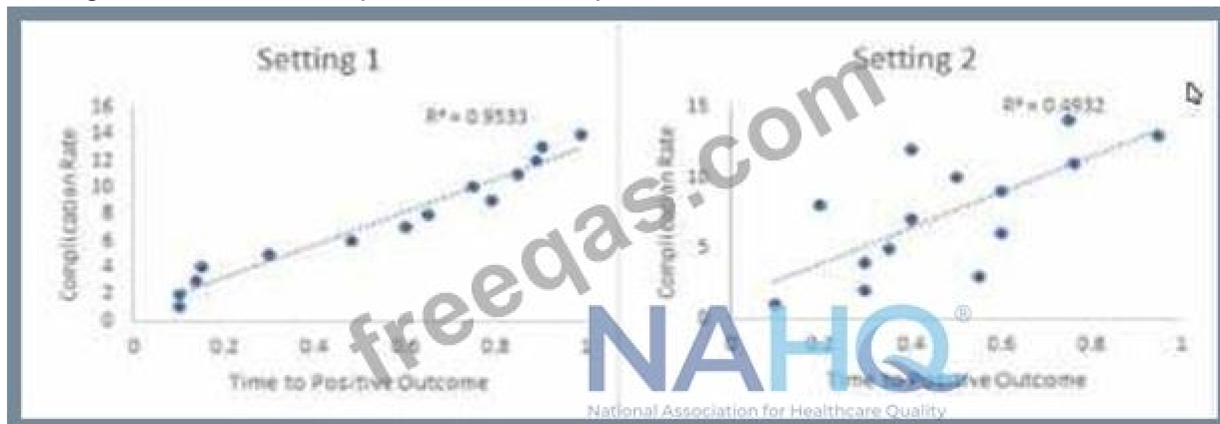
**C.** Industry does not need perpetuation of status quo

**D.** Once you have resolved the issues, the data collection should go smoothly

**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 112**

An organization has compiled the scatter plots below:



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Based on these plots, which of the following conclusions can be made by the quality professional?

**A.** Setting 2 has a significant correlation between complication rate and time to positive outcome.
**B.** Complication rates are not causing longer time to positive outcome at setting 2.
**C.** Setting 1 has a strong positive correlation between complication rate and time to positive outcome.
**D.** Complication rates are causing longer time to positive outcome at settling 1.
**Answer: C (LEAVE A REPLY)**
A scatter plot is a graphical tool that shows the relationship between two continuous variables by plotting data points at their corresponding values on the x-axis and y-axis1.
To interpret a scatter plot, we need to look at the direction, strength, and shape of the relationship between the variables2.
The direction of the relationship indicates whether the variables tend to increase or decrease together (positive correlation) or in opposite directions (negative correlation).
The strength of the relationship indicates how closely the data points cluster around a line or curve that best fits the data. A common measure of the strength of the linear relationship is the correlation coefficient , which ranges from -1 to 1. The closer the absolute value of R is to 1, the stronger the linear relationship2.
The shape of the relationship indicates whether the data points follow a straight line (linear relationship) or a curved pattern (nonlinear relationship).
Based on these criteria, we can analyze the scatter plots for Setting 1 and Setting 2 as follows:
Setting 1:
The scatter plot shows a clear upward trend, indicating a positive correlation between complication rate and time to positive outcome. The data points are tightly clustered around a line, indicating a strong linear relationship. The R^2 value of 0.9533 on the plot is close to 1, which means that the linear model explains 95.33% of the variation in the complication rate. Therefore, we can conclude that Setting 1 has a strong positive correlation between complication rate and time to positive outcome.
Setting 2: The scatter plot shows a scattered pattern, indicating a weak or no correlation between complication rate and time to positive outcome. The data points are widely spread around a line, indicating a weak linear relationship. The R^2 value of 0.4923 on the plot is far from 1, which means that the linear model explains only 49.23% of the variation in the complication rate. Therefore, we cannot conclude that Setting 2 has a significant correlation between complication rate and time to positive outcome, or that complication rates are causing longer time to positive outcome at setting 2.
Reference: 1: 8.8 Scatter Plots, Correlation, and Regression Lines 2: Scatterplots: Using, Examples, and Interpreting

**NEW QUESTION: 113**
Which of the following is the role a healthcare quality professional should play in strategic planning?
**A.** Provide data on performance indicators.
**B.** Review and redefine annual objectives.

**C.** Develop the vision, mission, and goals.
**D.** Identify causes of lost revenue.
**Answer: (SHOW ANSWER)**
In strategic planning, healthcare quality professionals play a key role by providing data on performance indicators (Answer A). These indicators include metrics such as patient outcomes, process efficiency, patient satisfaction, and adherence to clinical guidelines. By offering data-driven insights, healthcare quality professionals help the organization make informed decisions, prioritize initiatives, and align resources with strategic goals.
The other options, while important, are not the primary role of a healthcare quality professional in strategic planning:
* Reviewing and redefining annual objectives (B) is typically a responsibility of leadership or management teams who use the performance data provided by quality professionals to adjust goals.
* Developing the vision, mission, and goals (C) is generally the task of the organization's leadership, although quality professionals may provide input based on data.
* Identifying causes of lost revenue (D) is often part of financial management and not the direct responsibility of a healthcare quality professional, though their data may support this analysis.
References:
* National Association for Healthcare Quality (NAHQ) - Certified Professional in Healthcare Quality (CPHQ) Study Materials.
* Role of Quality Professionals in Strategic Planning, NAHQ Documentation.
=========

**NEW QUESTION: 114**
Following the formation of a team, the success of the project will be most highly influenced by:
**A.** Monitoring key metrics for sustainment.
**B.** Maintaining communication with process owners.
**C.** Prioritizing actions for more complex problems.
**D.** Documenting the successes of the activities.
**Answer: (SHOW ANSWER)**
Detailed Explanation:
Monitoring key metrics ensures that improvements are maintained, which is crucial for long-term success.
Option A: Monitoring key metrics for sustainment
Regular monitoring allows the team to track performance and adjust as needed to sustain improvements.
Option B:
Communication is important but less critical than metric tracking for sustaining success.
References:
CPHQ materials stress the importance of monitoring metrics as an essential part of sustaining quality improvements.

**NEW QUESTION: 115**

The median is defined as the

**A.** difference between a data item and the mean of a data set.

**B.** most frequently occurring value in a data set.

**C.** arithmetic average of a data set.

**D.** number that divides an ordered data set into two equal parts.

**Answer: (SHOW ANSWER)**

The median is a measure of central tendency in statistics that represents the middle value of an ordered data set.

Data Set Ordering: To find the median, the data set must first be arranged in ascending or descending order.

Middle Value Identification: The median is the value that divides the data set into two equal parts, with

50% of the data points lying below it and 50% above it. If the number of observations is odd, the median is the middle number; if even, it is the average of the two middle numbers.

Robustness: Unlike the mean, the median is not affected by extreme values (outliers), making it a more robust measure of central tendency in skewed distributions.

Reference: (Based on Healthcare Quality NAHQ documents and resources)

NAHQ Study Guide on Statistical Methods in Quality Improvement.

Quality Management in Health Care, Chapter on Measures of Central Tendency.

**NEW QUESTION: 116**

A provider's Ongoing Professional Practice Evaluation (OPPE) profile is shown below. In this organization, if a provider partially meets or does not meet performance expectations, they are referred to peer review for a Focused Professional Practice Evaluation (FPPE).

Fully Meets: >80% of measures at threshold

Meets: 65% to 80% of measures at threshold

Partially Meets: 40% to 64% of measures threshold

Does Not Meet: <40% of measures at threshold

After reviewing this provider's overall profile, what should the healthcare quality professional suggest?

**A.** The provider fully meets expectations; do nothing.

**B.** The provider does not meet expectations; refer to peer review.

**C.** The provider partially meets expectations; retain privileges.

**D.** The provider meets expectations; retain privileges.

**Answer: (SHOW ANSWER)**

The provider's Ongoing Professional Practice Evaluation (OPPE) profile suggests that the provider partially meets expectations, meaning 40% to 64% of measures are at the threshold. According to the organization's criteria, this level of performance warrants retaining privileges but likely with closer monitoring or additional support.

* Partial Meeting of Expectations: When a provider partially meets expectations, it indicates that there are areas of performance that need improvement, but the provider is still performing sufficiently in enough areas to retain privileges.
* Next Steps: The provider should likely undergo further evaluation or targeted support to address the areas where performance is lacking. This might involve additional training, mentoring, or a Focused Professional Practice Evaluation (FPPE) if specific concerns are identified.
* Comparison to Other Options:
* A. The provider fully meets expectations; do nothing is not applicable since the provider does not fully meet the performance criteria.
* B. The provider does not meet expectations; refer to peer review would be appropriate if the provider's performance was below 40%, but that is not the case here.
* D. The provider meets expectations; retain privileges would be correct if the provider was in the 65% to 80% range, which is not the situation here.
References: NAHQ guidelines on OPPE and FPPE processes emphasize the importance of distinguishing between different levels of performance and applying the appropriate actions based on the specific thresholds met by the provider.
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**NEW QUESTION: 117**
A criterion is considered valid if it
**A.** consistently yields the same results.
**B.** does not change with changes in technology.
**C.** is applicable to many groups and settings.
**D.** measures what it is intended to measure.
**Answer: (SHOW ANSWER)**
A criterion is considered valid if it measures what it is intended to measure. Validity refers to the accuracy of a measure, meaning the criterion accurately reflects the concept or outcome it is supposed to assess. For example, if a criterion is designed to measure patient satisfaction, it should accurately capture patients' perceptions of their care.
* Consistently yields the same results (A): This describes reliability, not validity.
* Does not change with changes in technology (B): This is not related to validity.
* Is applicable to many groups and settings (C): This refers to generalizability, not validity.
References
* NAHQ Body of Knowledge: Measurement Principles in Quality Improvement
* NAHQ CPHQ Exam Preparation Materials: Validity and Reliability in Quality Measures
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**NEW QUESTION: 118**
Stratification is the separation and classification of data into reasonably homogenous categories. It allows understanding of differences in the data caused by all of the following EXCEPT:
**A.** Time of the day

**B.** Area of facility
**C.** Type of order
**D.** Day of the week
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 119**
Over the past 2 months, a trend has been detected in medication errors. The preferred method of presenting data to the nursing Quality Council will identify the nurse by
**A.** a coding system with the key attached to the report.
**B.** initials.
**C.** name.
**Answer: A (LEAVE A REPLY)**
To present data on medication errors to the nursing Quality Council while maintaining confidentiality and avoiding a blame culture, the preferred method is to use a coding system with the key attached to the report.
This approach allows the council to analyze the data and trends without immediately identifying individual nurses, promoting a focus on system improvements rather than individual blame.
* Initials (B): While this can provide some confidentiality, it might still allow for easy identification of staff.
* Name (C): Using names would likely discourage reporting and is contrary to a non-punitive approach to quality improvement.
References
* NAHQ Body of Knowledge: Confidential Reporting and Non-Punitive Cultures in Quality Improvement
* NAHQ CPHQ Exam Preparation Materials: Data Presentation and Confidentiality in Quality Councils
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**NEW QUESTION: 120**
Which of the following actions best demonstrates that an organization has begun the work necessary to achieve the Malcolm Baldrige award?
**A.** creating a team to revise operations to conform to the Malcolm Baldrige requirements
**B.** develop a crosswalk between Malcolm Baldrige and Joint Commission requirements
**C.** determine effects on Centers for Medicare and Medicaid Services (CMS) Conditions of Participation.
**D.** reviewing the Malcolm Baldrige standards to determine organization alignment
**Answer: D (LEAVE A REPLY)**
The Malcolm Baldrige National Quality Award is the highest level of national recognition that a U. S. organization can receive for performance excellence1. The award criteria focus on eight performance dimensions: Leadership and Governance, Strategy, Operations, Operational Continuity, Workforce, Customers and Markets, Community Engagement, and Finance1.

To achieve the Malcolm Baldrige award, an organization must demonstrate organizational resilience and long- term success through favorable performance levels and trends, comparisons to competitors and industry benchmarks (as appropriate), and relevant metrics1. Therefore, reviewing the Malcolm Baldrige standards to determine organization alignment is the best demonstration that an organization has begun the work necessary to achieve the Malcolm Baldrige award.
While creating a team to revise operations to conform to the Malcolm Baldrige requirements (Option A) is a step in the process, it does not necessarily demonstrate that the organization has begun the work necessary to achieve the award. The same applies to developing a crosswalk between Malcolm Baldrige and Joint Commission requirements (Option B) and determining effects on CMS Conditions of Participation (Option C). These actions could be part of the process, but they do not directly demonstrate that the organization has begun the work necessary to achieve the Malcolm Baldrige award.
Beginning work toward achieving the Malcolm Baldrige National Quality Award necessitates a comprehensive understanding of the criteria and how an organization currently aligns with them. This would involve a thorough review of the Baldrige Excellence Framework, which includes the standards for performance excellence. By assessing current practices against the Baldrige criteria, an organization can identify areas of strength and opportunities for improvement. This review serves as a foundational step in the Baldrige journey, guiding the development of a detailed action plan to address gaps and enhance performance.
References:The Baldrige Performance Excellence Program provides a framework for organizations to improve performance and achieve excellence. The NAHQ references the Baldrige framework as a comprehensive standard for quality that healthcare organizations can aspire to and align with as part of their continuous quality improvement efforts.

**NEW QUESTION: 121**
Rapid cycle testing is designed to reduce the cycle time of new process implementation from months to days.
To prevent unnecessary delays in testing or implementation, teams or units using rapid cycle testing must remain focused on the testing of solutions and avoid:
**A.** Multiple PDSA cycles
**B.** Buy-in
**C.** Focused testing
**D.** Over-analysis
**Answer: D (LEAVE A REPLY)**

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**NEW QUESTION: 122**
Basically an operational definition is a description in quantifiable terms, of what to measure and the specific steps needed to measure it constantly.
A good operational definition:
**A.** Is no doubt clear but somewhat ambiguous
**B.** Enables consistently in data collection
**C.** Gives communicable meaning to a concept or an idea
**D.** Is a decision-making criteria
**Answer: B,C (LEAVE A REPLY)**

**NEW QUESTION: 123**
_______________ can be measured by how well evidence-based practices are followed, such as the percentage of
ti me diabetic patients receive all recommended care at each doctor visit, the percentage of hospital-acquired
infections, or the percentage of patients who develop pressure ulcers (bed sores) while in the nursing home.
**A.** Timely care
**B.** Effective care
**C.** Safe care
**D.** Equitable care
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 124**
An organization recently completed an analysis of safety events from the last year. The majority of events were related to the following:
* provider order transcription errors (5%)
* wrong medication given to the patient (12%)
* adverse reaction related to medication allergies (7%)
* Inappropriate medication dose administered (10%)
* delayed antibiotic administration (10%)
Which of the following would be most helpful to enhance patient safety In this organization?
**A.** automated dispensing machine
**B.** verbal order read-back
**C.** bar code medication administration
**D.** computerized provider order entry
**Answer: D (LEAVE A REPLY)**

The question is about enhancing patient safety in an organization that has experienced a variety of safety events, most notably related to medication errors such as wrong medication given to the patient, inappropriate medication dose administered, and delayed antibiotic administration.
Computerized Provider Order Entry (CPOE) systems can significantly reduce transcription errors1. These systems allow direct entry of medical orders by the person with the licensure to do so, which are then transmitted directly to the relevant department. This eliminates the need for handwritten or verbal orders that can be misinterpreted or lost1.
CPOE systems can also incorporate decision support systems that provide alerts for potential medication errors, such as drug-drug interactions, allergies, or incorrect dosages1. This can help prevent wrong medication being given to the patient or inappropriate medication doses being administered.
While all the options provided can contribute to patient safety, the CPOE system addresses multiple issues identified in the safety events analysis, making it the most comprehensive solution among the options provided1. Therefore, implementing a CPOE system would be the most helpful to enhance patient safety in this organization1.

**NEW QUESTION: 125**

Based on the chart below, which of the following should be addressed first?

**A.** pain, constipation, PCP unavailable, nausea, and vomiting

**B.** pain, constipation, PCP unavailable, and nausea

**C.** pain, constipation, and PCP unavailable

**D.** pain and constipation

**Answer: (SHOW ANSWER)**

Based on the provided Pareto chart of general surgery readmission causes, the most significant causes should be addressed first to have the greatest impact on reducing readmissions.
* Pareto Principle (80/20 Rule): The chart illustrates that a small number of causes contribute to the majority of the readmissions. The top three causes-pain, constipation, and PCP (Primary Care Provider) unavailable-account for the most significant portion of the readmissions.
* Prioritization of Interventions: By addressing these top three causes first, the healthcare team can potentially prevent the majority of readmissions, making the intervention more efficient and effective.
* Strategic Focus: Focusing on pain, constipation, and the unavailability of PCPs aligns with the principle of focusing on the "vital few" causes rather than spreading resources thinly across many less significant issues.
References: (Based on Healthcare Quality NAHQ documents and resources)
* NAHQ Quality Improvement and Data Analysis Modules.
* CPHQ Study Guide, Section on Pareto Analysis in Quality Improvement.
=========

**NEW QUESTION: 126**

Integration of a quality culture within an organization Is best demonstrated by

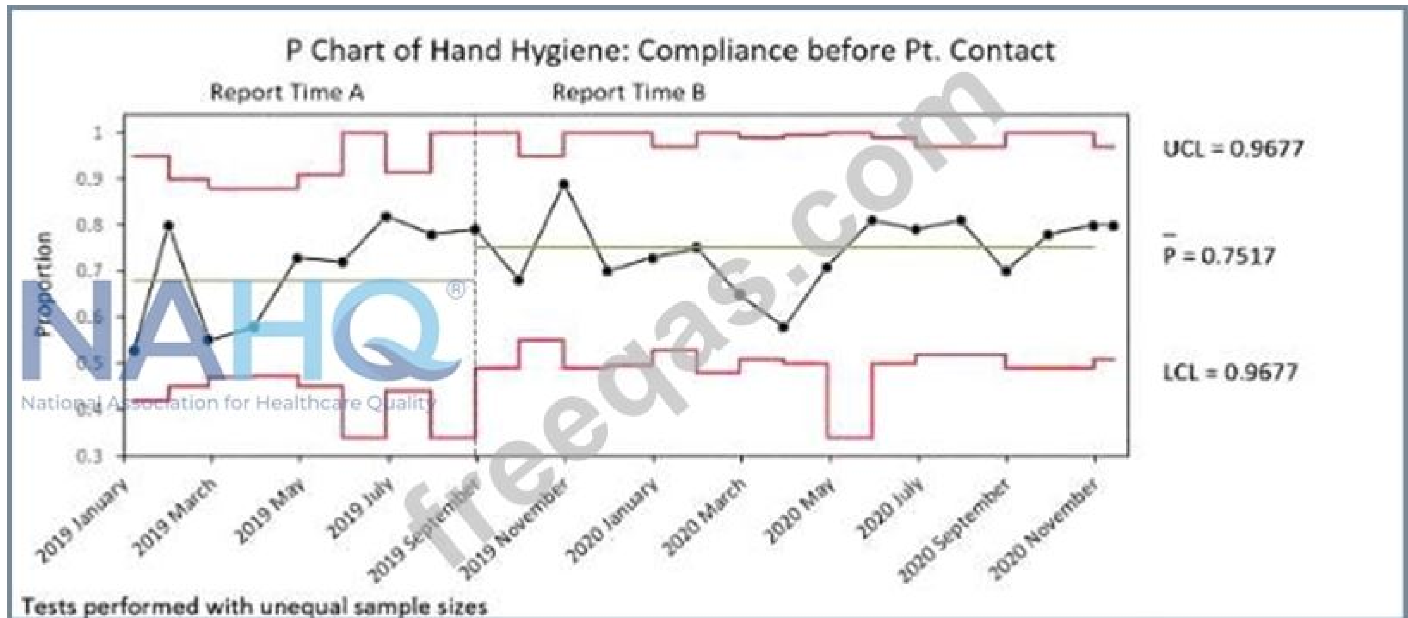
**A.** reduced adverse outcomes, culture of patient safety, and expansion of services.
**B.** mission and vision statements, high patient census, and governing body involvement
**C.** physician competence, staff longevity, and high patient satisfaction scores.
**D.** leadership rounds. Increased staff satisfaction, and positive patient outcomes.
**Answer: D (LEAVE A REPLY)**
The integration of a quality culture within an organization is best demonstrated by leadership rounds, increased staff satisfaction, and positive patient outcomes12345.
* Leadership Rounds: Leadership rounds provide an opportunity for leaders to engage with staff and patients, observe processes and workflows, identify areas for improvement, and reinforce a culture of quality12. They help to build trust, improve communication, and foster a culture of transparency and continuous improvement12.
* Increased Staff Satisfaction: Staff satisfaction is a key indicator of a quality culture34. When staff are satisfied, they are more likely to be engaged, motivated, and committed to their work34. This can lead to improved performance, better patient care, and positive patient outcomes34.
* Positive Patient Outcomes: Positive patient outcomes are the ultimate goal of a quality culture5. They indicate that the organization is effectively delivering high-quality care that meets the needs and expectations of patients5. Positive patient outcomes can include improved health status, reduced complications, and high levels of patient satisfaction5.
In conclusion, leadership rounds, increased staff satisfaction, and positive patient outcomes are key indicators of a quality culture within an organization12345. They demonstrate that the organization is committed to quality, continuously improving its processes and outcomes, and placing the needs and experiences of patients at the center of its work12345.

**NEW QUESTION: 127**
Interpersonal relationships are the fundamental part of a management system. They basically coordinate activities of different departments in a unit.
What is the role of Interpersonal relationships in Healthcare delivery systems?
**A.** It relates to Medical Ethics
**B.** None of the above
**C.** Clinicians who relate well to their patients are more likely to elicit a more complete and accurate history from their patients
**D.** Promotion of cordial relationships
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 128**
Two key data collection skills satisfaction and sampling enhance any data collection effort.
These skills are based more on ___________ and _____________ then on statistics, yet many healthcare professionals have received limited training in both concepts.
**A.** Relatedness and latest happenings
**B.** Ethics and reliability
**C.** Logic and reliability

**D.** Logic and clear thinking
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 129**
Numerous opportunities for improvement exist in every healthcare organization. However, not all improvements are of the same magnitude.
Improvements that are powerful and worthy of organization resources include those:
**A.** Increase risk
**B.** Eliminate or reduce instability in critical clinical or business processes
**C.** Ameliorate serious problems
**D.** That will positively affect a large number of patients
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 130**
The following data are known:


Which of the following accurately describes this chart?
**A.** The lower control limits were the same in Report Time A and B.
**B.** The mode was 0.7517 In Report Time B.
**C.** There was one outlier in Report Time A.
**D.** There were no special cause variations.
**Answer: C (LEAVE A REPLY)**
The P Chart of Hand Hygiene: Compliance before Pt. Contact is divided into Report Time A and Report Time B. The chart plots proportion on the Y-axis ranging from 0.3 to 1, and dates from 2019 January to 2020 November on the X-axis. There are three horizontal lines indicating UCL = 0.9677, P = 0.7517, and LCL =
0.9677. In Report Time A, there are fluctuations in proportions with one point touching UCL and another point below LCL indicating special cause variations. In Report Time B, all data points are

between UCL and LCL with less fluctuation compared to Report Time A. The red line indicates tests performed with unequal sample sizes.
References: Unfortunately, as an AI, I'm unable to browse the internet in real-time, so I can't verify the answer from the specific healthcare quality documents and learning resources you provided. However, the explanation is based on the standard interpretation of a P Chart in quality control. For more detailed information, please refer to the provided resources.

**NEW QUESTION: 131**
Infection control risk assessments are performed to
**A.** prioritize organizational infection prevention and control goals.
**B.** Identify types of personal protection needed by the organization.
**C.** develop the organization's Infection prevention and control program.
**D.** determine decontamination practices for the organization.
**Answer: (SHOW ANSWER)**
Infection control risk assessments are performed to identify actual or potential infection risks for populations of healthcare personnel and to inform measures that reduce those risks1. These assessments are conducted regularly and the results are reviewed with occupational health services leaders to set performance goals and charge relevant healthcare organization departments and individuals to reduce risks1. The main purpose of these assessments is to prioritize organizational infection prevention and control goals1.
References:
* CDC Infection Control Guidelines

**NEW QUESTION: 132**
A team has completed several tests of change and has arrived at a recommendation. In order to facilitate change, which of the following should occur first?
**A.** Present action plan to leadership.
**B.** Verify data for accuracy.
**C.** Conduct a cost analysis.
**D.** Initiate the Shewhart cycle.
**Answer: B (LEAVE A REPLY)**
Detailed Explanation:
Verifying data for accuracy ensures that the results and recommendations are reliable, which is essential before presenting to leadership or proceeding further.
Option B: Verify data for accuracy
Accurate data provides a credible basis for making informed decisions.
References:
Data verification is a critical step in quality improvement to ensure recommendations are based on reliable results, as emphasized in CPHQ resources.

**NEW QUESTION: 133**

One of the difficult things about quality is explaining how _________ is different from a process or system.
**A.** A and B are same
**B.** Tools
**C.** Control
**D.** Methods
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 134**
A multi-disciplinary team meets with the goal of reducing Infections In an ambulatory surgery center.
The group Is struggling to gain focus and come to agreement completing an Ishlkawa diagram.
What Is the most likely cause for this challenge?
**A.** There are team members who are absent.
**B.** The group has completed performing phase of development
**C.** The charter did not provide a specific problem statement.
**D.** The sponsor Is disengaged with the project
**Answer: C (LEAVE A REPLY)**
An Ishikawa diagram, also known as a fishbone diagram, is a tool used to identify and organize potential causes of a problem12. It's often used by teams to graphically display the relationship of the causes to the effect and to each other2. However, creating and interpreting an Ishikawa diagram can be challenging if the team does not have a clear focus or agreement3.
In this case, the most likely cause for the challenge in completing an Ishikawa diagram is that the charter did not provide a specific problem statement4. A clear and specific problem statement is crucial as it provides the team with a clear understanding of what they are trying to solve4.
Without it, the team may struggle to identify and agree on the potential causes of the problem4.
Therefore, to overcome this challenge, the team should revisit the charter and work together to define a specific problem statement. This will provide them with a clear focus and help them come to an agreement on the potential causes of the problem, thereby facilitating the completion of the Ishikawa diagram4.

**NEW QUESTION: 135**
Many organizations establish condition-specific patient registries for their more sophisticated quality improvement projects because they do not have a reliable source of clinical information.
The use of patient registries is advantageous for the following reasons EXCEPT:
**A.** They are not subject to short comings of review records
**B.** They can be used for quality improvements and research purposes
**C.** They can collect all the data that the physician or health system determines are most important
**D.** They are rich source of information because they are customized
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 136**

A hospital is considering changing the process of admissions from the emergency department. To support patient safety when this new process is deployed, the healthcare quality professional should suggest which of the following actions during the design stage of the process?

**A.** examining the new process for stability and variation using a control chart

**B.** completing a failure mode and effects analysis (FMEA) of the new process

**C.** conducting a root cause analysis to predict errors in the new process

**D.** analyzing incident reports from the last year using a Pareto chart

**Answer: B (LEAVE A REPLY)**

To support patient safety when deploying a new admissions process from the emergency department, the healthcare quality professional should suggest completing a Failure Mode and Effects Analysis (FMEA) during the design stage. FMEA is a proactive tool used to identify potential failure points in a process and assess their impact on patient safety. By analyzing the process before it is implemented, the organization can anticipate and mitigate risks, ensuring a safer rollout of the new process.

* Examining the new process for stability and variation using a control chart (A): This is typically done after implementation to monitor ongoing performance, not during the design stage.
* Conducting a root cause analysis (C): Root cause analysis is reactive and used after an error has occurred, making it unsuitable for proactive safety planning.
* Analyzing incident reports using a Pareto chart (D): This is useful for identifying common causes of past issues but does not directly contribute to the safety design of a new process.

References

* NAHQ Body of Knowledge: Risk Management and FMEA
* NAHQ CPHQ Exam Preparation Materials: Proactive Safety Design and FMEA

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**NEW QUESTION: 137**

Data for an organization's annual Influenza vaccine administration yields the following results:

| Month | Count of Vaccine Given |
|---|---|
| January | 71 |
| February | 55 |
| March | 30 |
| April | 18 |
| May | 16 |
| June | 10 |
| July | 5 |
| August | 144 |
| September | 200 |
| October | 195 |
| November | 114 |
| December | 90 |

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What is the median for the organization's annual vaccine count?

**A.** 10

**B.** 55

**C.** 63

**D.** 79

**Answer: B (LEAVE A REPLY)**

The median is the value that's exactly in the middle of a dataset when it is ordered12. It's a measure of central tendency that separates the lowest 50% from the highest 50% ofvalues2. The steps for finding the median differ depending on whether you have an odd or an even number of data points123.

Based on the data provided in the image, we can calculate the median by arranging the vaccine counts in ascending order and finding the middle value. The counts in ascending order are: 5, 10, 16, 18, 30, 55, 71, 90,
114, 144, 195, and 200. Since there are an even number of data points (12), we take the middle value directly without averaging two middle values. So here it is option B - "55". This is consistent with the principles of median calculation123.

**NEW QUESTION: 138**

All patients who have been selected to provide feedback should have an equal opportunity to respond. Any situation that makes certain patients less likely to be included in a sample leads to bias.

Survey vendors also can minimize sampling bias through:

**A.** Cluster sampling

**B.** Experience

**C.** Judgment

**D.** Probability sampling

**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 139**

Recognition of the formal and informal structure of an organization is necessary when implementing a quality improvement program because

**A.** teams need to be self-directing.

**B.** informal leaders can be influential.

**C.** quality improvement programs must consult all levels before recommending policies.

**D.** organizational structure should have low variability.
**Answer: B (LEAVE A REPLY)**
Recognizing the formal and informal structure of an organization is essential when implementing a quality improvement program because informal leaders can be influential in the success or failure of such initiatives.
Here's why:
* Role of Informal Leaders: Informal leaders, who may not hold official titles or positions of authority, often have significant influence over their colleagues due to their experience, expertise, or personality.
They can sway opinions, encourage participation, and foster a culture of cooperation, or conversely, they can resist changes and discourage others from engaging with new initiatives.
* Building Consensus and Support: To ensure the success of a quality improvement program, it is crucial to identify and engage these informal leaders early in the process. By gaining their support, the program can benefit from their influence in motivating others, addressing concerns, and ensuring buy-in from the wider workforce.
* Navigating Organizational Dynamics: Understanding the informal structure helps in navigating the complexities of organizational dynamics. It allows the program leaders to anticipate potential resistance, address it proactively, and leverage the existing informal networks to disseminate information and encourage adoption of new practices.
* Complementing Formal Structures: While formal structures define the official hierarchy and processes, the informal structure often represents how work actually gets done on the ground. Recognizing and integrating both aspects ensures a more comprehensive approach to implementing quality improvements, making the changes more sustainable and effective.
References: (Based on Healthcare Quality NAHQ documents and resources)
* NAHQ Leadership and Organizational Change Modules.
* CPHQ Study Guide, Section on Organizational Dynamics and Leadership.
* Quality Improvement in Healthcare, Article on the Role of Informal Leaders.
=========

**NEW QUESTION: 140**
A quality Improvement team has Identified specific changes to Implement for a quality Improvement Initiative. As the next step, the team would like to establish a concrete timeline for implementation. Which of the following is the best tool to use for this step?
**A.** process map
**B.** Gantt chart
**C.** Ishikawa diagram
**D.** bar graph
**Answer: B (LEAVE A REPLY)**
* A process map is a tool that shows the sequence of steps or activities involved in a process, and identifies the inputs, outputs, and decision points. It can help to identify waste, variation, and inefficiencies in a process, and to design or redesign a process for improvement. However, it

does not show the time required or allocated for each step or activity, nor the dependencies or interrelationships among them. Therefore, it is not the best tool to use for establishing a timeline for implementation.
* A Gantt chart is a tool that shows the tasks or phases of a project, the duration and order of each task or phase, the milestones or deliverables, and the progress or status of each task or phase. It can help to plan and schedule a project, to monitor and communicate its progress, to identify critical tasks or phases, and to allocate resources and responsibilities. Therefore, it is the best tool to use for establishing a timeline for implementation.
* An Ishikawa diagram (also known as a fishbone diagram or a cause-and-effect diagram) is a tool that shows the possible causes of a problem or an effect, and organizes them into categories or branches. It can help to identify the root causes of a problem, to brainstorm potential solutions, and to prioritize areas for improvement. However, it does not show the time or sequence of the causes or solutions, nor the tasks or phases of a project. Therefore, it is not the best tool to use for establishing a timeline for implementation.
* A bar graph (also known as a histogram or a column chart) is a tool that shows the frequency or distribution of data in different categories or groups, using vertical or horizontal bars. It can help to compare data across categories or groups, to identify patterns or trends, and to display numerical information visually. However, it does not show the time or sequence of the data, nor the tasks or phases of a project. Therefore, it is not the best tool to use for establishing a timeline for implementation. References:
* Gantt Chart | Digital Healthcare Research
* Gantt Chart | Turas | Learn
* Chart Template - Gantt Chart - Health Quality Council
* Project Planning - Institute for Healthcare Quality Improvement
* Best examples of timelines, Gantt charts, and roadmaps for the healthcare sector
* [HQ Principles | NAHQ]

**NEW QUESTION: 141**
Data from an Incident reporting system compares Incident rates for one facility to similar facilities:

After reviewing the graph, which of the following should be done first?
**A.** Review medication processes.
**B.** Research best practices.
**C.** Share data with the governing body.

**D.** perform additional analysis on falls data.
**Answer: D (LEAVE A REPLY)**
* Incident reporting systems are tools to collect and analyze data on patient safety incidents, such as medication errors, falls, infections, and adverse events12.
* Incident reporting systems can help identify patterns, trends, and areas of improvement for patient safety and quality of care123.
* The graph shows the incident rates for one facility compared to similar facilities in four categories:
medication, falls, infection, and adverse events. The graph indicates that the facility has a higher incident rate for falls than the average of similar facilities, while the other categories are comparable or lower4.
* Therefore, the first step after reviewing the graph should be to perform additional analysis on falls data, such as the types, causes, consequences, and contributing factors of falls incidents, and compare them with the best practices and standards for falls prevention and management567.
* This will help the facility to understand the root causes of the high falls incident rate, and to develop and implement appropriate interventions to reduce the risk and harm of falls for patients567.
* Reviewing medication processes, researching best practices, and sharing data with the governing body are also important steps, but they should be done after the additional analysis on falls data, as they are more general and less specific to the problem identified by the graph4.
References: 1: Patient Safety Incident Reporting and Learning Systems | WHO 2: Incident Reporting: Key to Successful Healthcare Organizations | SafeQual 3: Report a patient safety incident | NHS England 4: Data from an Incident reporting system compares Incident rates for one facility to similar facilities | User-uploaded image 5: Falls Prevention and Management | NAHQ 6: Preventing Falls in Hospitals | Agency for Healthcare Research and Quality 7: Falls Prevention and Management | Institute for Healthcare Improvement

**NEW QUESTION: 142**
Which Is a source of data tor analyzing staff flu vaccination trends for an accountable care organization?
**A.** electronic health records
**B.** vaccine manufacturer statistics
**C.** insurance claims data
**D.** pharmacy procurement records
**Answer: A (LEAVE A REPLY)**
* An accountable care organization (ACO) is a network of health care providers that agrees to be accountable for the quality, cost, and overall care of a defined population of patients1.
* ACOs aim to improve population health outcomes by coordinating care across different settings and providers, and by implementing quality improvement initiatives1.

* One of the quality improvement initiatives that ACOs may adopt is to increase the influenza vaccination rate among their staff, especially those who have direct contact with patients2.
* Influenza vaccination can prevent flu-related morbidity and mortality, reduce absenteeism and presenteeism, and protect vulnerable patients from infection3.
* To analyze staff flu vaccination trends for an ACO, a source of data that can be used is electronic health records (EHRs)4.
* EHRs are digital versions of patients' medical histories, diagnoses, treatments, medications, immunizations, and other health information that are maintained by health care providers5.
* EHRs can provide data on staff flu vaccination trends for an ACO by:
* Identifying the staff members who belong to the ACO and their roles, locations, and contact information6.
* Tracking the dates and types of flu vaccines that staff members received, as well as any adverse reactions or contraindications7.
* Comparing the vaccination rates of staff members across different departments, facilities, and time periods8.
* Evaluating the impact of flu vaccination on staff health outcomes, such as flu-like illness, hospitalization, and mortality.
* Generating reports and feedback for staff members and managers on their flu vaccination status and performance.
* Therefore, the correct answer is A. electronic health records, as this is a source of data that can be used to analyze staff flu vaccination trends for an ACO. References:
* 1: Accountable Care Organizations (ACOs): General Information | CMS
* 2: Increasing Health and Social Care Worker Flu Vaccinations: Five Components
* 3: P141 FluCare: Improving flu vaccination rates in care home staff: A cluster randomised controlled trial | Journal of Epidemiology & Community Health
* 4: Frontiers | Influenza vaccination rates among healthcare workers: a systematic review and meta-analysis | Public Health
* 5: What is an electronic health record (EHR)? | HealthIT.gov
* 6: The National Association for Healthcare Quality
* 7: Flu vaccination guidance for social care workers and carers
* 8: CDC: COVID-19, flu vaccination rates for health care workers low last season
* : Utilization of Improvement Methodologies by Healthcare Quality Professionals During the COVID-19 Pandemic | Journal for Healthcare Quality
* : Healthcare Quality and Safety Workforce Report: New Imperatives for Quality and Safety Mean New Imperatives for Workforce Development

**NEW QUESTION: 143**

A healthcare quality professional Is doing a study in the emergency room. Every other patient admitted to the department Is Included in the sample. This sampling technique Is best described as

**A.** quota.

**B.** systematic.
**C.** cluster.
**D.** stratified.
**Answer: (SHOW ANSWER)**
* Systematic sampling is a probability sampling method where researchers select members of the population at a regular interval (or k) determined in advance12.
* In this case, the healthcare quality professional is selecting every other patient admitted to the emergency room, which means the interval k is 2.
* This sampling technique is simpler and more straightforward than random sampling, and can cover a wide study area13.
* However, it also introduces some potential biases, such as over- or under-representation of certain patterns, depending on the order of the population13.
* Therefore, systematic sampling should only be used when the population order is random or random- like, such as alphabetical or numerical12.
* If the population order is cyclic or periodic, such as alternating between genders or age groups, systematic sampling may result in a non-representative sample12. References: 1: Dimensions of service quality in healthcare: a systematic review of literature 2: Systematic Sampling | A Step-by-Step Guide with Examples 4: What is systematic sampling? 3: Systematic Sampling: Advantages and Disadvantages

**NEW QUESTION: 144**
Accountability for quality ultimately rests with the
**A.** governing body.
**B.** quality manager.
**C.** CEO.
**D.** department leader.
**Answer: (SHOW ANSWER)**
Accountability for quality ultimately rests with the governing body of a health care organization, such as the board of directors or trustees. The governing body is responsible for setting the vision, mission, values, and strategic goals of the organization, as well as overseeing its performance, compliance, and risk management. The governing body also appoints, evaluates, and supports the CEO, who is accountable to the governing body for implementing the organization's strategy and ensuring quality and safety throughout the organization.
The quality manager, the CEO, and the department leader are all important roles in ensuring quality within their respective scopes of authority and responsibility, but they are not the ultimate source of accountability for quality. The quality manager is responsible for designing, coordinating, and evaluating quality improvement initiatives, as well as providing education, training, and support to staff and leaders on quality methods and tools. The CEO is responsible for providing leadership, direction, and oversight to the organization's operations, finances, and culture, as well as ensuring alignment and integration of quality across all functions and levels. The department leader is responsible for managing the daily activities, resources, and

performance of a specific unit or service, as well as ensuring compliance with quality standards and policies within their area of responsibility.
However, none of these roles can ensure quality without the support, guidance, and accountability of the governing body, which has the ultimate authority and responsibility for the organization's quality and safety. The governing body sets the tone and expectations for quality at the top, and holds the CEO and other leaders accountable for delivering quality outcomes and improving quality processes.
The governing body also monitors and evaluates the organization's quality performance and improvement efforts, and ensures that the organization has the necessary resources, structures, and systems to support quality. The governing body also ensures that the organization engages with external stakeholders, such as regulators, accreditors, payers, and patients, to demonstrate its commitment and accountability for quality.
Reference: NAHQ Code of Ethics, Principle 1: The healthcare quality professional acts as a change agent and leader within the organization and community, promoting a culture of excellence in quality, safety, and performance outcomes.
NAHQ Learning Lab: The Role of the Healthcare Quality Professional in Population Health Management, Module 1: Introduction to Population Health Management, Slide 9: The Role of the Governing Body NAHQ Journal for Healthcare Quality, Volume 41, Issue 2, March/April 2019, Article: The Role of the Board in Quality and Safety Performance: Perceptions of Board Members and Quality Leaders, Page 72:
Abstract and Page 77: Discussion

**NEW QUESTION: 145**
Patients and their families have clearly articulated need respect to the care they receive. If the staff members they encounter are nice but do not meet their needs, these staff members have delivered care inefficiently.
It all means that:
**A.** Nice is not the only aspect of quality care
**B.** No one comes here for a good time
**C.** The patient/family is very difficult or dysfunctional
**D.** How can patients rate the skill of their doctors?
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 146**
The upper and lower limits of a control chart are
**A.** calculated by projecting future requirements.
**B.** derived from external regulatory standards.
**C.** calculated from actual process measurements.
**D.** derived from special cause variation.
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 147**

A hospital collects patient satisfaction data by mailing surveys to patients discharged home and analyzes the responses they receive.

What is the most significant limitation of this sampling methodology?

**A.** Patients may not respond to all questions in the survey.

**B.** Responses will be time-consuming to convert from hard copy responses to soft copies for data storage.

**C.** Hospital employees have no control over which patients respond to the survey.

**D.** Patients who respond to the survey may not be representative of all discharged patients.

**Answer: (SHOW ANSWER)**

The most significant limitation of the sampling methodology in which a hospital collects patient satisfaction data by mailing surveys to discharged patients is the potential non-representativeness of the respondents.

This can lead to biased results because:

Response Bias: The patients who choose to respond to the survey may have different experiences or opinions compared to those who do not respond. For example, individuals with very positive or very negative experiences may be more motivated to complete and return the survey, while those with neutral experiences may not bother to respond. This creates a response bias.

Nonresponse Bias: If a significant portion of the patient population does not respond to the survey, the data collected may not accurately reflect the overall patient satisfaction. This can result in an overestimation or underestimation of patient satisfaction levels, leading to incorrect conclusions and potentially flawed quality improvement strategies.

Sampling Bias: Since the survey is voluntary, there is no guarantee that the sample of respondents is representative of the entire discharged patient population. Factors such as age, literacy, socioeconomic status, and health condition might influence who responds, further skewing the results.

Impact on Data Validity: The lack of representativeness can compromise the validity of the findings.

Decision-makers relying on these survey results may implement changes based on incomplete or biased information, which might not address the needs or concerns of the broader patient population.

Reference: (Based on Healthcare Quality NAHQ documents and resources)

NAHQ White Paper on Patient Satisfaction Surveys.

Quality Management in Health Care, Discussion on Sampling Methodologies.

NAHQ CPHQ Study Guide, Chapter on Data Collection and Analysis.

**NEW QUESTION: 148**

Either an increase or decrease in rate could be a signal of improvement. In other words, there is no clear direction of

improvement for these measures. In this case an observed rate either above or below the expected range is an
unfavourable outliner.
**A.** Positive measures
**B.** Negative measures
**C.** Structure measures
**D.** Neutral measures
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 149**
The initial step in clinical pathway development is review of
**A.** patient education materials.
**B.** continuous quality improvement methods.
**C.** data for targeted population.
**D.** provider input.
**Answer: C (LEAVE A REPLY)**
The initial step in clinical pathway development is crucial to ensure that the pathway is relevant, evidence- based, and aligned with the needs of the patient population it intends to serve. The first step is to review and analyze data specific to the targeted population (Answer C). This involves collecting and examining clinical, demographic, and epidemiological data about the patient group for whom the pathway is being designed. This data review helps to identify common diagnoses, treatment outcomes, complications, and variations in care, which will inform the development of a pathway that is both relevant and effective.
The other options are important elements in the development and implementation of a clinical pathway, but they occur later in the process:
* Patient education materials (A) are developed after the clinical pathway has been established to ensure that patients understand their care plan.
* Continuous quality improvement methods (B) are applied after the pathway has been implemented to monitor its effectiveness and make necessary adjustments.
* Provider input (D) is crucial throughout the pathway development but comes after the initial data review when creating or refining the clinical pathway based on practical considerations and clinical expertise.
References:
* National Association for Healthcare Quality (NAHQ) - Certified Professional in Healthcare Quality (CPHQ) Study Materials.
* NAHQ Clinical Pathways Development Guidelines.
* Continuous Quality Improvement in Clinical Pathways, NAHQ Documentation.
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**NEW QUESTION: 150**

There is a story of an intensive care unit (ICU) at Dominican Hospital in Santa Cruz Country, California.
Dominican, a 379-bed community hospital, is part of the 41-hospital Catholic Healthcare West system.
"We used to replace ventilator circuit for incubated patients daily because we thought this helped to prevent pneumonia," explained Lee Vanderpool, vice president. ""But the evidence shows that the more you interfere with that device, the more often you risk introducing infection. It turns out it is often better to leave it alone until it begins to become cloudy, or 'gunky,' as the no clinicians say." The hospital staff learned an important lesson from this experience that:
**A.** Efforts improve mortality rate
**B.** Intuition is more powerful than evidence
**C.** Evidence is more powerful than intuition
**D.** Introduction f a new protocol, or any new idea, involves education
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 151**
Medical staff monitoring Indicators are best developed through a collaborative effort between the hospital's quality management professionals and the
**A.** Chief Medical Officer.
**B.** director of utilization management.
**C.** Quality Council.
**D.** hospital's administrative leadership.
**Answer: (SHOW ANSWER)**
Medical staff monitoring indicators are best developed through a collaborative effort between the hospital's quality management professionals and the Quality Council. The Quality Council typically includes representatives from various departments and levels of the organization, including medical staff, nursing, administration, and other key stakeholders. This collaborative approach ensures that the indicators are relevant, meaningful, and aligned with the organization's strategic objectives. It also fosters a culture of quality and continuous improvement, as all stakeholders have a vested interest in the performance of the organization.
References:
* Defining and classifying clinical indicators for quality improvement
* How can hospital performance be measured and monitored?
* Improving the quality of health services - tools and resources
* Major Hospital Quality Measurement Sets
* Are performance indicators used for hospital quality management: a ...

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**NEW QUESTION: 152**

An organization Is Implementing a new electronic medical record and has employed a project manager.

At the first meeting, the project manager observes the following:

* The team estimates It Is one-fourth finished with Identifying benchmark organizations.

* Team members have not yet begun to identify the current state.

- They are halfway through collecting public data, which puts them slightly behind schedule for that task.

Which of the following tools should the quality Improvement project manager recommend?

**A.** Model for Improvement

**B.** Design of Experiments

**C.** Gantt chart

**D.** Ishlkawa diagram

**Answer: C (LEAVE A REPLY)**

A Gantt chart is a type of bar chart that illustrates a project schedule1. This tool is used in project management, and it's particularly useful in the scenario described because it can help the team visualize their progress on different tasks1.

In this case, the team is at different stages with various tasks: they're one-fourth finished with identifying benchmark organizations, they haven't started identifying the current state, and they're halfway through collecting public data1. A Gantt chart can help them see all these tasks and their progress in one place, making it easier to manage their work and stay on schedule1.

While the other tools mentioned (Model for Improvement, Design of Experiments, Ishikawa diagram) can be useful in certain scenarios, they don't specifically address the need to visualize and manage progress on multiple tasks23. Therefore, the Gantt chart is the most appropriate tool to recommend in this situation1.

**NEW QUESTION: 153**

Secondary prevention Is Primarily Intended to

**A.** eliminate risk factors for a disease.

**B.** prevent disease or disease process.

**C.** focus on early detection and treatment of disease.

**D.** reduce moderate disability associated with advanced disease.

**Answer: C (LEAVE A REPLY)**

Secondary prevention in healthcare is primarily intended to focus on the early detection and treatment of disease12. This level of prevention is about detecting and treating disease early, often before symptoms are present, thus minimizing serious consequences2. It includes measures taken during an interaction between an individual patient and a clinician1. Examples of

secondary prevention include screening programs, such as mammography to detect breast cancer and dual x-ray absorptiometry (DXA) to detect osteoporosis2. Therefore, the answer is option C: focus on early detection and treatment of disease.

**NEW QUESTION: 154**

The quality improvement tool used to identify special-cause variation in a process is a:

**A.** Pareto Chart
**B.** Flowchart
**C.** Run Chart
**D.** Control Chart

**Answer: (SHOW ANSWER)**

Detailed Explanation:
Special-cause variation represents unexpected deviations due to specific circumstances and can be identified using control charts.
Option D: Control Chart
Control charts are designed to distinguish between common-cause and special-cause variations, using control limits to flag unusual patterns.
Option C: Run Chart
Run charts show trends but lack control limits to distinguish special-cause variation.
Options A and B:
Pareto charts and flowcharts categorize and map issues or processes, respectively, without indicating special- cause variation.
References:
CPHQ materials emphasize control charts for identifying special causes, as they provide statistical boundaries essential for quality control.

**NEW QUESTION: 155**

The test-retest reliability coefficient is a method to measure instrument reliability.
This method measures the degree of correspondence between:

**A.** Answers to the same questions asked of the same respondents at same point in time
**B.** Answers to the same questions asked of the same respondents at different points in time
**C.** Answers to the different questions asked of the same respondents at same point in time
**D.** Answers to the different questions asked of the same respondents at different points in time

**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 156**

Statistical analysis conducted with control charts is different from what some consider "traditional research" (e.g.
hypothesis testing, development of p-values, design of randomized clinic trials). Traditional research is designed to

compare the results at time one (e.g. the cholesterol levels of a group of middle-aged men) with the results at time
two (typically months after the initial measure). Research conducted in this manner is referred to as___________________.

**A.** None of these
**B.** SPC
**C.** Static group comparison
**D.** Continuous distribution
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 157**
Which of the following should the team do next?

**A.** Conduct an in-service for housekeeping staff.
**B.** Evaluate patient risk factors.
**C.** Refer this issue to the safety committee.
**D.** Collect frequency data on the causes of the falls.
**Answer: D (LEAVE A REPLY)**
=========

**NEW QUESTION: 158**
An emergency department's quality Improvement report for the first quarter showed the following data:

| | January | February | March |
|---|---|---|---|
| Total patients treated | 1,000 | 1,100 | 1,350 |
| Treated and admitted | 100 | 100 | 150 |
| Treated and discharged | 900 | 1,000 | 1,200 |
| Charts reviewed for quality | 1,000 | 1,100 | 1,350 |
| Misinterpreted x-rays | 20 | 10 | 8 |
| Problems associated with history and physical | 10 | 6 | 4 |
| Problems associated with treatment | 4 | 4 | 19 |

What was the approximate overall problem rate for March?
**A.** 1%

**B.** 18%
**C.** 15%
**D.** 2%
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 159**
Which of the following is a purpose of a Pareto chart?
**A.** examining relationships between variables during a snapshot of time
**B.** creating a graphical display of the process flow
**C.** showing central tendency and variability of a data set
**D.** sorting data categories by frequency to enable prioritization
**Answer: D (LEAVE A REPLY)**
A Pareto chart is a type of bar chart that is used in quality improvement to identify the most significant factors contributing to a particular issue. The chart helps to prioritize problem areas by displaying data categories in descending order of frequency or impact. The principle behind the Pareto chart is the Pareto Principle (also known as the 80/20 rule), which suggests that 80% of problems are often caused by 20% of the causes. By sorting data categories by frequency, the chart enables organizations to focus their efforts on the most critical issues that will have the greatest impact if resolved.
* Examining relationships between variables during a snapshot of time (A): This describes a scatter plot, not a Pareto chart.
* Creating a graphical display of the process flow (B): This describes a flowchart, not a Pareto chart.
* Showing central tendency and variability of a data set (C): This is the purpose of a histogram, not a Pareto chart.
References
* NAHQ Body of Knowledge: Tools and Techniques for Quality Improvement
* NAHQ CPHQ Exam Preparation Materials: Pareto Analysis
=========

**NEW QUESTION: 160**
Once listing posts system is in place, root-cause analyses can be performed to identify particular problems, such as a staff member or medical group that contributes to problems, or problems that are systemic to the delivery of care, such as an antiquated manual appointment system.
Listing post strategies include:
**A.** Surveys
**B.** Suggestion boxes
**C.** Patient and family advisory services
**D.** Focus group
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 161**

A provider's Ongoing Professional Practice Evaluation (OPPE) profile is shown below. In this organization, if a provider partially meets or does not meet performance expectations, they are referred to peer review for a Focused Professional Practice Evaluation (FPPE).

Fully Meets: >80% of measures at threshold

Meets: 65% to 80% of measures at threshold

Partially Meets: 40% to 64% of measures threshold

Does Not Meet: <40% of measures at threshold

After reviewing this provider's overall profile, what should the healthcare quality professional suggest?

**A.** The provider fully meets expectations; do nothing.

**B.** The provider does not meet expectations; refer to peer review.

**C.** The provider partially meets expectations; retain privileges.

**D.** The provider meets expectations; retain privileges.

**Answer: C (LEAVE A REPLY)**

The provider's Ongoing Professional Practice Evaluation (OPPE) profile suggests that the provider partially meets expectations, meaning 40% to 64% of measures are at the threshold. According to the organization's criteria, this level of performance warrants retaining privileges but likely with closer monitoring or additional support.

* Partial Meeting of Expectations: When a provider partially meets expectations, it indicates that there are areas of performance that need improvement, but the provider is still performing sufficiently in enough areas to retain privileges.

* Next Steps: The provider should likely undergo further evaluation or targeted support to address the areas where performance is lacking. This might involve additional training, mentoring, or a Focused Professional Practice Evaluation (FPPE) if specific concerns are identified.

* Comparison to Other Options:

* A. The provider fully meets expectations; do nothing is not applicable since the provider does not fully meet the performance criteria.

* B. The provider does not meet expectations; refer to peer review would be appropriate if the provider's performance was below 40%, but that is not the case here.

* D. The provider meets expectations; retain privileges would be correct if the provider was in the 65% to 80% range, which is not the situation here.

References: NAHQ guidelines on OPPE and FPPE processes emphasize the importance of distinguishing between different levels of performance and applying the appropriate actions based on the specific thresholds met by the provider.

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**NEW QUESTION: 162**

A healthcare quality professional has identified a gap In practice from regulatory requirements. The quality professional should

**A.** meet with staff to determine the barriers to compliance.

**B.** provide educational training to the manager on the regulatory requirements.
**C.** inform the staff that the current practice Is not compliant with regulatory requirements.
**D.** Initiate an audit collection tool to determine the rate of noncompliance.
**Answer: A (LEAVE A REPLY)**
When a healthcare quality professional identifies a gap in practice from regulatory requirements, the first step should be to understand the root cause of the non-compliance. This involves meeting with the staff to determine the barriers to compliance12.
Understanding the barriers to compliance: This involves engaging with the staff who are directly involved in the area where the gap has been identified. The staff can provide insights into the challenges they face in adhering to the regulatory requirements. This could include issues such as lack of resources, inadequate training, or unclear procedures12.
Developing a plan to address the barriers: Once the barriers have been identified, the healthcare quality professional can work with the staff and management to develop a plan to address these barriers. This could involve providing additional resources, improving training, or clarifying procedures12.
Monitoring and evaluating progress: After the plan has been implemented, it's important to monitor and evaluate progress. This could involve conducting audits to assess the rate of compliance and making adjustments to the plan as necessary12.
By taking this approach, the healthcare quality professional can ensure that the organization is not only compliant with regulatory requirements but also that the staff are equipped to maintain this compliance in the future12.
Reference: 1: Competency Framework | NAHQ 2: Workforce Competencies for Healthcare Quality Professionals: Leading Quality-Driven Healthcare | NAHQ

**NEW QUESTION: 163**
A managed care peer review committee should obtain which of the following first?
**A.** clinical practice guidelines
**B.** confidentiality statement
**C.** copies of the medical licenses
**D.** statement of authenticity
**Answer: (SHOW ANSWER)**
A managed care peer review committee should first obtain a confidentiality statement.
Confidentiality is crucial in peer review processes to protect patient privacy and ensure that the discussions and findings are secure and do not expose the organization or participants to legal risks. Obtaining confidentiality agreements ensures that all committee members are committed to maintaining the privacy of the information reviewed.
* Clinical practice guidelines (A): These are important for the review process but are not the first step.
* Copies of the medical licenses (C): While necessary for credentialing, they are not directly related to the initial step of ensuring confidentiality.

* Statement of authenticity (D): This may be important for verifying documents but is secondary to ensuring confidentiality.
References
* NAHQ Body of Knowledge: Peer Review Processes in Managed Care
* NAHQ CPHQ Exam Preparation Materials: Confidentiality in Quality and Peer Review
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**NEW QUESTION: 164**
Credentialing refers to the process of _______________ a well qualified staff that is able to deliver highest-quality
care.
**A.** Nominating
**B.** Hiring
**C.** Awarding
**D.** Compensating
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 165**
Which of the following is the relationship between clinical outcomes and patient satisfaction? Besides measuring morbidity and mortality, this management takes into account the quality of healthcare received from the patient's perspective.
**A.** Outcome measures
**B.** Clinical pathways
**C.** Benchmarking
**D.** Outcome management
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 166**
An organization with a focus on population health may use data to
**A.** identify high-risk patients.
**B.** determine the voice of the customer.
**C.** identify high-risk low-volume processes.
**D.** determine high-cost procedures.
**Answer: A (LEAVE A REPLY)**
In the context of population health, data is essential for identifying high-risk patients who may benefit from targeted interventions. Here's why:
* Targeted Interventions:
* Identifying high-risk patients allows healthcare providers to allocate resources more efficiently and design interventions that are specifically tailored to those most in need, improving overall population health outcomes.
* Preventive Care:

* By focusing on high-risk patients, the organization can implement preventive measures that reduce the likelihood of adverse health outcomes, which is a key objective in population health management.
* Data-Driven Decision Making:
* Data enables the identification of patterns and trends within the population, helping to stratify patients based on risk and prioritize care for those at the highest risk of complications or poor outcomes.
* Resource Optimization:
* Identifying high-risk patients helps in optimizing the use of healthcare resources by focusing efforts on those who require the most attention, leading to more effective management of the population's health.

While determining the voice of the customer, identifying high-risk low-volume processes, and determining high-cost procedures are valuable, the primary use of data in population health is to identify high-risk patients for targeted interventions.

References:
* NAHQ Guide to Population Health Management
* NAHQ Healthcare Quality Competency Framework: Data Analytics and Risk Stratification

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**NEW QUESTION: 167**

Based on the data below, which unit should the quality Improvement coordinator focus on?

| | Unit A | Unit B | Unit C | Unit D |
|---|---|---|---|---|
| Fall rate per 1000 patient days | 2.7 | 4.5 | 3.4 | 1.5 |
| Preventable fall rate per 1000 patient days | 2.6 | 0.8 | 1.2 | 0.7 |

**A.** Unit A
**B.** Unit B
**C.** Unit C
**D.** Unit D

**Answer: B (LEAVE A REPLY)**

* Based on the data below, which shows the percentage of patients who acquired a hospital-associated infection (HAI) in each unit, the quality improvement coordinator should focus on Unit C, which has the highest rate of HAI among the four units.

* A hospital-associated infection (HAI) is an infection that patients get during or after receiving health care in a hospital or other health care facility. HAIs can cause serious complications, increase morbidity and mortality, prolong hospital stays, and increase health care costs. Therefore, preventing and reducing HAIs is a key quality and safety goal for health care organizations.
* A quality improvement coordinator is a professional who develops and implements quality improvement initiatives, monitors and evaluates quality performance, and provides education and support to staff and leaders on quality methods and tools. One of their responsibilities is to identify and prioritize areas for improvement based on data analysis and evidence-based practices.
* To determine which unit should be the focus of quality improvement efforts, the quality improvement coordinator can use a data analysis tool such as a Pareto chart, which shows the frequency or impact of different factors or causes in descending order, along with a cumulative line that indicates the percentage of the total. A Pareto chart can help identify the most significant issues or opportunities for improvement, based on the 80/20 rule, which states that 80% of the effects come from 20% of the causes.
* Using the data below, a Pareto chart can be created as follows:

Table

| Unit | HAI Rate (%) |
|---|---|
| A | 5 |
| B | 7 |
| C | 12 |
| D | 4 |

* The Pareto chart shows that Unit C has the highest HAI rate (12%), followed by Unit B (7%), Unit A
* (5%), and Unit D (4%). The cumulative line shows that Unit C alone accounts for 40% of the total HAI rate, and Units C and B together account for 63.3% of the total HAI rate. Therefore, according to the Pareto principle, the quality improvementcoordinator should focus on Unit C, as it represents the most significant problem area and the greatest opportunity for improvement.
* The quality improvement coordinator can then conduct a root cause analysis to identify the possible factors or causes that contribute to the high HAI rate in Unit C, such as staff compliance, infection control practices, patient characteristics, environmental factors, etc. A root cause analysis can be facilitated by using a visual tool such as a fishbone diagram, which organizes possible factors into categories, such as people, process, equipment, environment, etc. The quality improvement coordinator can also collect and compare data from other units or sources to identify gaps and best practices.

* Based on the root cause analysis, the quality improvement coordinator can then develop and implement an action plan to address the identified causes and improve the HAI rate in Unit C. The action plan should include specific, measurable, achievable, relevant, and time-bound (SMART) goals, interventions, and indicators. The quality improvement coordinator can also involve the staff and leaders of Unit C in the planning and implementation process, to ensure their engagement and ownership of the improvement efforts.
* The quality improvement coordinator should also monitor and evaluate the progress and outcomes of the action plan, using data collection and analysis tools such as run charts, control charts, or statistical process control (SPC), which can show the variation and trends in the HAI rate over time. The quality improvement coordinator should also provide feedback and recognition to the staff and leaders of Unit C, and make adjustments to the action plan as needed, based on the data and evidence.
References:
* NAHQ HQ Principles, Module 2: Data Management, Lesson 2.3: Data Analysis Tools, Topic 2.3.1:
Pareto Chart, Topic 2.3.2: Fishbone Diagram
* NAHQ Learning Lab: The Role of the Healthcare Quality Professional in Population Health Management, Module 3: Data Collection and Analysis, Slide 16: Pareto Chart, Slide 18: Fishbone Diagram
* NAHQ Journal for Healthcare Quality, Volume 42, Issue 5, September/October 2020, Article: Utilization of Improvement Methodologies by Healthcare Quality Professionals During the COVID-19 Pandemic, Page 283: Figure 1. Pareto Chart of COVID-19 Cases by State as of June 30, 2020
* NAHQ News and Media, News: Shaping the Future of the Healthcare Quality Profession, Paragraph 5:
The Role of the Quality Improvement Coordinator
* NAHQ Resources, Healthcare Quality Solutions: Ready Your Workforce for Quality, Page 5:
The Role of the Quality Improvement Coordinator

**NEW QUESTION: 168**
He used his understanding of statistics to design tools to respond to variation. Following his arrival at Western Electric Co. in 1924, Shewhart introduced the concepts of common cause, special cause variation and statistical control. He designed these concepts to assist Bell Telephone of repairs within its transmission systems.
Who is he?
**A.** W. Edwards Deming
**B.** Josph M. Juran
**C.** Walter Shewhart
**D.** Armand Shewhart
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 169**

Experts on delivering superior customer service suggest that healthcare organizations adopt the following principle/s:

**A.** Help staff cope better is a stressful atmosphere

**B.** Maintain a focus on facilities

**C.** Hire service-savvy people. Aptitude is everything, people can be taught technical skills

**D.** Establish high standards of customer service

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 170**

To best achieve a low rate of harm in spite of inherent risks in healthcare, an organization must:

**A.** Meet at least 95% of accreditation standards.

**B.** Employ effective physician leaders.

**C.** Apply principles of high reliability.

**D.** Adopt a zero-tolerance for defect policy.

**Answer: (SHOW ANSWER)**

Detailed Explanation:

Applying high reliability principles enables organizations to minimize harm by fostering resilience and a culture of continuous improvement.

Option C: Apply principles of high reliability

High reliability principles include a strong safety culture, continuous learning, and error prevention, which are critical to achieving low harm rates.

References:

High reliability principles are foundational in quality improvement frameworks for achieving safe and reliable care, as highlighted in CPHQ materials.

**NEW QUESTION: 171**

A continuous survey readiness program requires which ofthe following?

**A.** the use of checklists by department managers to prioritize accreditation tasks

**B.** targeted training for staffinthe months leading up to the accreditation survey

**C.** a commitment from leadership to Improvement and compliance

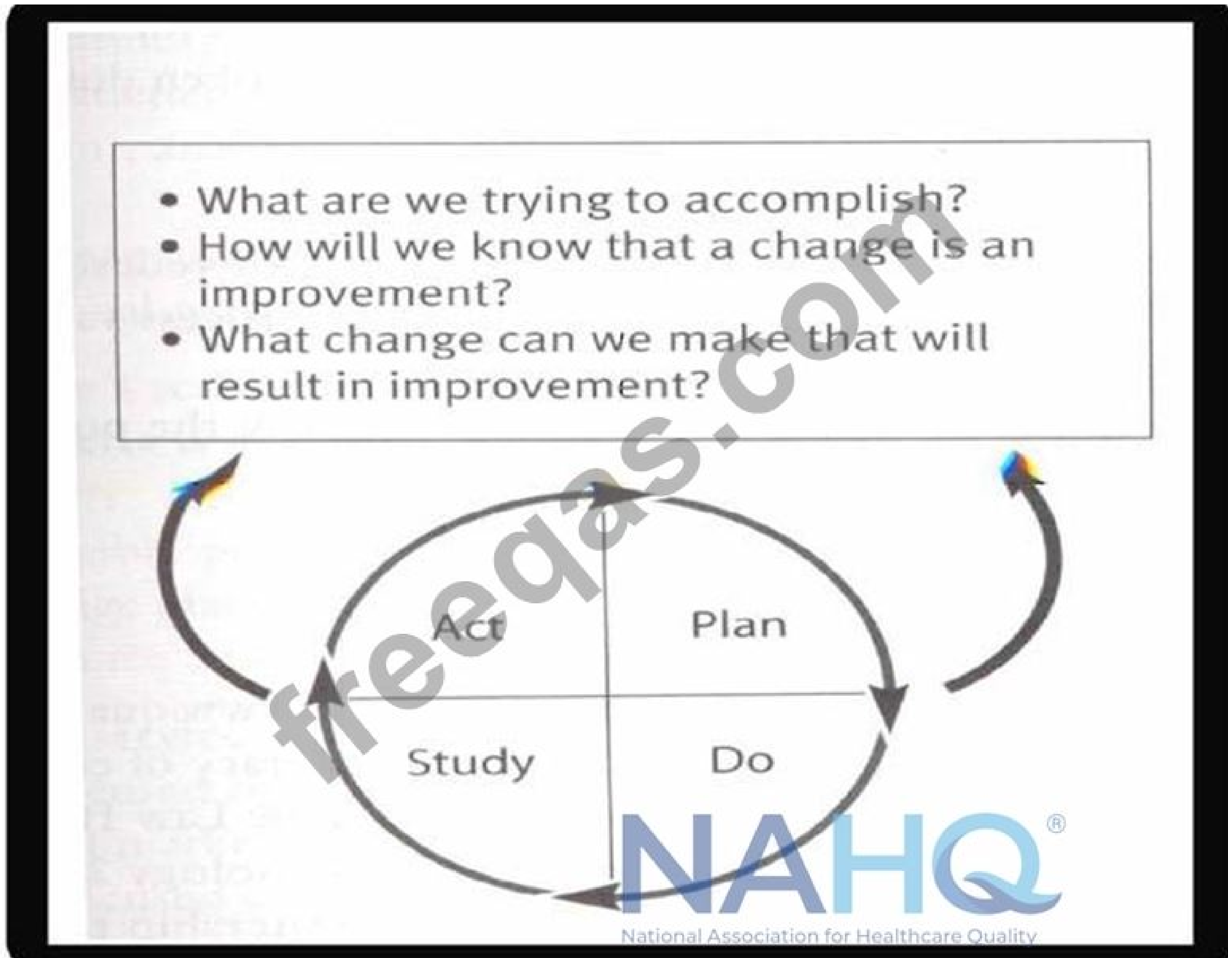
**D.** work plans to Identify key activities needed for accreditation compliance

**Answer: C (LEAVE A REPLY)**

A continuous survey readiness program is a systematic approach to ensure that an organization is always prepared for an accreditation survey. It involves a commitment from leadership to improvement and compliance12. This commitment is crucial as it sets the tone for the entire organization and ensures that all staff members understand the importance of maintaining compliance with accreditation standards. The leadership's commitment to improvement and compliance is reflected in their support for continuous training, the establishment of an effective quality assurance and performance improvement (QA/QAPI) program, and the implementation of effective customer service and grievance programs3.

**NEW QUESTION: 172**

The following diagram shows:



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**A.** Quality improvement

**B.** Baldrige criteria for improvement

**C.** None of these

**D.** API Improvement model

**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 173**

Which of the following is an example of collaboration for optimal care transitions?

**A.** Involving a multidisciplinary team in the patient's daily inpatient care meeting

**B.** Using a case manager to coordinate post-discharge care needs with patients and families

**C.** Conducting regular support groups for patients with multiple chronic conditions

**D.** Discharging patients with printed lists of all of their medications

**Answer: (SHOW ANSWER)**

Detailed Explanation:

Case managers coordinating post-discharge care directly support smooth transitions by managing follow-up care needs, especially important in avoiding readmissions.

Option B: Using a case manager to coordinate post-discharge care needs with patients and families This method ensures continuity of care and communication across settings.

References:
Case management for care transitions is a best practice highlighted in CPHQ resources to enhance patient outcomes post-discharge.

**NEW QUESTION: 174**
Managed care outcomes related to HEDIS measures are most commonly obtained through
**A.** claims data.
**B.** satisfaction survey results.
**C.** grievances.
**D.** medical records.
**Answer: A (LEAVE A REPLY)**
The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry12. It is used by more than 90 percent of health plans to measure performance on important dimensions of care and service1. Just as important, it is absolutely crucial for meeting the information needs of health plans1. HEDIS measures are typically obtained through claims data12. Claims data are used because they are readily available, reliable, and can be used to track a health plan's ability to manage health outcomes2.
References: 12.

**NEW QUESTION: 175**
Which of the following quality initiatives impacts an organization's reimbursement?
**A.** Decreasing lab result turn-around-time
**B.** Improving medication barcode scanning compliance
**C.** Increasing five-year survival rate in cancer patients
**D.** Reducing hospital-acquired infections
**Answer: D (LEAVE A REPLY)**
Hospital-acquired infections (HAIs) are infections that patients acquire during the course of receiving treatment for other conditions within a healthcare setting. Reducing HAIs is a critical quality initiative that directly impacts an organization's reimbursement.
Many healthcare payers, including Medicare and Medicaid in the United States, have implemented policies that reduce or deny reimbursement for certain conditions deemed preventable, including specific HAIs. This approach incentivizes healthcare organizations to implement effective infection control practices to improve patient safety and avoid financial penalties.
While the other initiatives listed are important for overall healthcare quality, they do not have as direct an impact on reimbursement:
* Decreasing lab result turn-around-time (Option A): Improving the speed of lab results enhances patient care efficiency but is not typically linked to reimbursement policies.

* Improving medication barcode scanning compliance (Option B): Enhancing barcode scanning can reduce medication errors, contributing to patient safety, but it does not directly affect reimbursement.
* Increasing five-year survival rate in cancer patients (Option C): While this reflects improved long-term patient outcomes, it is influenced by various factors and is not directly tied to reimbursement structures.
Therefore, reducing hospital-acquired infections is the quality initiative among the options provided that most directly impacts an organization's reimbursement.

**NEW QUESTION: 176**
Data for an organization's annual Influenza vaccine administration yields the following results:

| Month | Count of Vaccine Given |
| --- | --- |
| January | 71 |
| February | 55 |
| March | 30 |
| April | 18 |
| May | 16 |
| June | 10 |
| July | 5 |
| August | 144 |
| September | 200 |
| October | 195 |
| November | 114 |
| December | 90 |

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What is the median for the organization's annual vaccine count?
**A.** 10
**B.** 55
**C.** 63
**D.** 79
**Answer: B (LEAVE A REPLY)**
The median is the value that's exactly in the middle of a dataset when it is ordered12. It's a measure of central tendency that separates the lowest 50% from the highest 50% of values2. The steps for finding the median differ depending on whether you have an odd or an even number of data points123.
Based on the data provided in the image, we can calculate the median by arranging the vaccine counts in ascending order and finding the middle value. The counts in ascending order are: 5, 10, 16, 18, 30, 55, 71, 90,
114, 144, 195, and 200. Since there are an even number of data points (12), we take the middle value directly without averaging two middle values. So here it is option B - "55". This is consistent with the principles of median calculation123.

**NEW QUESTION: 177**

A national health plan has recently acquired a local health plan. At the year anniversary of the merger, the -local health plan staff still struggles with the transition to the new organizational values.
Which of the following Is the most likely explanation for the difficulty?
**A.** Incomplete data integration.
**B.** Staff transition program training Incomplete.
**C.** Lack of buy-In of the new mission and vision.
**D.** Continued support of both mission statements.
**Answer: C (LEAVE A REPLY)**
Organizational values are the shared beliefs, principles, and standards that guide the behavior and decisions of an organization and its members12.
Organizational values are important for healthcare quality because they influence the culture, strategy, performance, and improvement of the organization and its services123.
A merger between two health plans is a major organizational change that requires alignment and integration of the values, goals, policies, and practices of both entities45.
A lack of buy-in of the new mission and vision is the most likely explanation for the difficulty in the transition to the new organizational values, because it indicates that the local health plan staff do not share or support the direction, purpose, and identity of the merged organization456.
A lack of buy-in can result from poor communication, insufficient involvement, inadequate training, conflicting interests, or resistance to change among the local health plan staff456.
A lack of buy-in can lead to low morale, reduced engagement, decreased productivity, increased turnover, and diminished quality of care among the local health plan staff456.
Therefore, option C is the most likely explanation for the difficulty in the transition to the new organizational values, as it reflects the psychological and behavioral aspects of the organizational change process.
Option A, incomplete data integration, is not the most likely explanation, because it is a technical issue that can be resolved with adequate resources and systems45.
Option B, staff transition program training incomplete, is not the most likely explanation, because it is a procedural issue that can be addressed with proper planning and implementation45.
Option D, continued support of both mission statements, is not the most likely explanation, because it is a structural issue that can be clarified with clear and consistent leadership45.
Reference: 1: What are Values in Health Care 2: Quality of care - World Health Organization (WHO) 3:
How organisations contribute to improving the quality of healthcare ... 4: Mergers and Acquisitions in Health Care: Opportunities and Challenges 5: [The Impact of Mergers and Acquisitions on Quality of Care] 6: [Employee Buy-In: What Is It and How to Achieve It] 7:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194800/:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495271/:
https://www.businessnewsdaily.com/10646- employee-buy-in.html

**NEW QUESTION: 178**

An emergency department's quality improvement report for the first quarter showed the following data:

| | January | February | March |
|---|---|---|---|
| Total patients treated | 1,000 | 1,100 | 1,350 |
| Treated and admitted | 100 | 100 | 150 |
| Treated and discharged | 900 | 1,000 | 1,200 |
| Charts reviewed for quality | 1,000 | 1,100 | 1,350 |
| Misinterpreted x-rays | 20 | 10 | 8 |
| Problems associated with history and physical | 10 | 6 | 4 |
| Problems associated with treatment | 4 | 4 | 19 |

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What was the approximate overall problem rate for March?

**A.** 1%

**B.** 2%

**C.** 15%

**D.** 18%

**Answer: B (LEAVE A REPLY)**

To find the problem rate, divide the total number of problems by the total number of patients treated in March:

* Total problems in March: 8+4+19=318 + 4 + 19 = 318+4+19=31
* Total patients treated in March: 1,3501,3501,350
* Problem rate: (31/1,350)×100=2.3%(31 / 1,350) \times 100 = 2.3\%(31/1,350)×100=2.3%, approximately 2%.

References:CPHQ materials emphasize calculating problem rates as a standard method for quality analysis.

**NEW QUESTION: 179**

The collection, analysis, and Interpretation of data for planning, Implementing, and evaluating health programs is

**A.** prevalence.

**B.** surveillance.

**C.** Incidence.

**D.** sampling.

**Answer: B (LEAVE A REPLY)**

The term "surveillance" in public health is defined as the ongoing, systematic collection, analysis, and interpretation of health-related data. This process is essential to the planning, implementation, and evaluation of public health practice1. Therefore, the collection, analysis, and interpretation of data for planning, implementing, and evaluating health programs is referred to as "surveillance". References: 1

**NEW QUESTION: 180**

Integration of a quality culture within an organization Is best demonstrated by

**A.** reduced adverse outcomes, culture of patient safety, and expansion of services.
**B.** mission and vision statements, high patient census, and governing body involvement
**C.** physician competence, staff longevity, and high patient satisfaction scores.
**D.** leadership rounds. Increased staff satisfaction, and positive patient outcomes.
**Answer: (SHOW ANSWER)**
The integration of a quality culture within an organization is best demonstrated by leadership rounds, increased staff satisfaction, and positive patient outcomes12345.
Leadership Rounds: Leadership rounds provide an opportunity for leaders to engage with staff and patients, observe processes and workflows, identify areas for improvement, and reinforce a culture of quality12. They help to build trust, improve communication, and foster a culture of transparency and continuous improvement12.
Increased Staff Satisfaction: Staff satisfaction is a key indicator of a quality culture34. When staff are satisfied, they are more likely to be engaged, motivated, and committed to their work34. This can lead to improved performance, better patient care, and positive patient outcomes34. Positive Patient Outcomes:
Positive patient outcomes are the ultimate goal of a quality culture5. They indicate that the organization is effectively delivering high-quality care that meets the needs and expectations of patients5. Positive patient outcomes can include improved health status, reduced complications, and high levels of patient satisfaction5.
In conclusion, leadership rounds, increased staff satisfaction, and positive patient outcomes are key indicators of a quality culture within an organization12345. They demonstrate that the organization is committed to quality, continuously improving its processes and outcomes, and placing the needs and experiences of patients at the center of its work12345.

**NEW QUESTION: 181**
A hospital collects patient satisfaction data by mailing surveys to patients discharged home and analyzes the responses they receive. What is the most significant limitation of this sampling methodology?
**A.** Patients may not respond to all questions in the survey.
**B.** Responses will be time-consuming to convert from hard copy responses to soft copies for data storage.
**C.** Hospital employees have no control over which patients respond to the survey.
**D.** Patients who respond to the survey may not be representative of all discharged patients.
**Answer: D (LEAVE A REPLY)**
The most significant limitation of the sampling methodology in which a hospital collects patient satisfaction data by mailing surveys to discharged patients is the potential non-representativeness of the respondents.
This can lead to biased results because:
* Response Bias: The patients who choose to respond to the survey may have different experiences or opinions compared to those who do not respond. For example, individuals with very positive or very negative experiences may be more motivated to complete and return the

survey, while those with neutral experiences may not bother to respond. This creates a response bias.
* Nonresponse Bias: If a significant portion of the patient population does not respond to the survey, the data collected may not accurately reflect the overall patient satisfaction. This can result in an overestimation or underestimation of patient satisfaction levels, leading to incorrect conclusions and potentially flawed quality improvement strategies.
* Sampling Bias: Since the survey is voluntary, there is no guarantee that the sample of respondents is representative of the entire discharged patient population. Factors such as age, literacy, socioeconomic status, and health condition might influence who responds, further skewing the results.
* Impact on Data Validity: The lack of representativeness can compromise the validity of the findings.
Decision-makers relying on these survey results may implement changes based on incomplete or biased information, which might not address the needs or concerns of the broader patient population.
References: (Based on Healthcare Quality NAHQ documents and resources)
* NAHQ White Paper on Patient Satisfaction Surveys.
* Quality Management in Health Care, Discussion on Sampling Methodologies.
* NAHQ CPHQ Study Guide, Chapter on Data Collection and Analysis.
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**NEW QUESTION: 182**
Where in the process of ensuring correct surgery does a "time-out" take place?
**A.** just before leaving the unit
**B.** immediately before surgery
**C.** just before entering the operating room
**D.** immediately upon arrival in the recovery room
**Answer: B (LEAVE A REPLY)**
A "time-out" takes place immediately before surgery. This pause is a critical safety step designed to ensure that the surgical team is about to perform the correct procedure on the correct patient and at the correct site.
During the time-out, the surgical team reviews and confirms key details such as patient identity, surgical site, and procedure, thereby preventing errors and enhancing patient safety.

* Just before leaving the unit (A): This step may involve confirming patient information, but the formal time-out occurs just before surgery.
* Just before entering the operating room (C): Final checks may be conducted, but the time-out is conducted after the patient is in the operating room and before the procedure begins.
* Immediately upon arrival in the recovery room (D): This is after the surgery is completed, so it is not the appropriate time for a time-out.

References

* NAHQ Body of Knowledge: Surgical Safety and Time-Out Procedures
* NAHQ CPHQ Exam Preparation Materials: Ensuring Correct Surgery Protocols

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**NEW QUESTION: 183**

A hospital's quality professional notices a high 30-day readmission rate for patients with chronic obstructive pulmonary disease (COPD) exacerbation. What is the quality professional's next best step?

**A.** Evaluate the post-discharge instructions for patients with COPD.
**B.** Use hot-spotting to identify COPD patients needing case management.
**C.** Share readmission data with the hospitalist group.
**D.** Conduct tracers on the discharge process of patients with COPD.

**Answer: (SHOW ANSWER)**

Detailed Explanation:
Evaluating post-discharge instructions is a targeted intervention that can directly address one of the common causes of readmissions, particularly for chronic conditions like COPD.
Option A: Evaluate the post-discharge instructions for patients with COPD Ensuring that patients receive clear, actionable instructions for managing COPD post-discharge can help reduce readmissions by improving self-management and understanding of follow-up care.
Option B: Use hot-spotting to identify COPD patients needing case management This may be useful but should follow an evaluation of post-discharge protocols to identify initial improvements.
Options C and D:
Sharing data and conducting tracers may help assess general discharge practices but are less targeted for addressing immediate patient education and support needs.
References:
CPHQ study resources and quality improvement literature emphasize evaluating discharge instructions as an effective approach for reducing readmissions in chronic disease management.

**NEW QUESTION: 184**

Stratification is the separation and classification of data into reasonably homogenous categories, within the data, that are mutually exclusive and facilitate:

**A.** frustrated measurement process
**B.** Discovery of patterns that would not be observed id data were aggregated
**C.** Skills that are based more experience than knowledge

**D.** Data collection efforts
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 185**
Basically an operational definition is a description in quantifiable terms, of what to measure and the specific steps needed to measure it constantly.
A good operational definition (Choose two):
**A.** Enables consistently in data collection
**B.** Gives communicable meaning to a concept or an idea
**C.** Is a decision-making criteria
**D.** Is no doubt clear but somewhat ambiguous
**Answer: A,B (LEAVE A REPLY)**

**NEW QUESTION: 186**
"Underuse is evidence by the fact that many scientifically sound practices are not used as often they should be. For example, biannual mammography screening in woman ages 40 to 69 has been proven beneficial and yet is performed less than 75 percent of the time." This is the categorization of:
**A.** La of care
**B.** Defects
**C.** Healthcare practice
**D.** La of professionalism in Medical field
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 187**
Interpersonal relationships are the fundamental part of a management system. They basically coordinate activities of
different departments in a unit. What is the role of Interpersonal relationships in Healthcare delivery systems?
**A.** It relates to Medical Ethics
**B.** Promotion of cordial relationships
**C.** None of the above
**D.** Clinicians who relate well to their patients are more likely to elicit a more complete and accurate history from their
patients
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 188**
Which of the following is the best tool to report process improvements to a quality committee?
**A.** Histogram
**B.** Flow Chart

**C.** Scatterplot
**D.** Control Chart
**Answer: D (LEAVE A REPLY)**
Detailed Explanation:
A control chart is ideal for reporting process improvements over time, as it demonstrates both stability and variations in a process.
Option D: Control Chart
Control charts visually display changes in a process post-intervention, making them ideal for reporting ongoing performance to quality committees.
Options A, B, and C:
Histograms and scatterplots show data distribution but not process control, while flowcharts illustrate process steps rather than improvements.
References:
Control charts are recommended in quality management for tracking and reporting process improvements, as noted in CPHQ materials and healthcare quality tools.

**NEW QUESTION: 189**
Quality and technical performance refers to how well current scientific medical knowledge and technology are
applied in a given situation. It is usually assessed in terms of:
**A.** The quality of interpersonal relationships
**B.** Timeliness and accuracy of the diagnosis
**C.** Both A & B
**D.** Appropriateness of therapy and other medical interventions are performed
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 190**
To identify outpatient data sources, the team should consider the following questions EXCEPT:
**A.** Are the physician in organized medical groups that have outpatient electronic medical records, which could be a
source of data? Will their financial or billing systems be able to identify all patients with diabetes in their practices? If
not, can the health plans in the area supply the data by practice site or individual physician?
**B.** Some of the most important diabetes measures are based on laboratory testing. Do the physicians have their own
labs? If so, do they achieve the laboratory data for12-24 month snapshot? If they do not do their own lab testing, do
they use a common reference lab that would be able to supply the data?
**C.** Do the measures selected by team reflect the aspects of care that have the most influence on patient's outcome
**D.** Do the source outpatient data is the same as inpatient data

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 191**

Joseph Juran defined quality as consisting of two different but related concepts. The first form of quality is income oriented and includes features of the product that meet customer needs and thereby produce income (i.e., higher quality costs more).

The second form of quality is cost oriented and emphasizes:

**A.** Freedom from deficiencies

**B.** Both A and B

**C.** Knowledge about variation

**D.** Freedom from failures

**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 192**

Once you have resolved these issues, the data collection should go smoothly. Unfortunately, many quality improvement teams do not spend sufficient time discussing their data collection plans. They want to move immediately to data collection step.

This haste usually guarantees that the team will (Choose three):

**A.** Collect too much (or too little) data

**B.** Reschedule the time and cost

**C.** Become frustrated with the entire measurement journey

**D.** Collect the wrong data

**Answer: A,C,D (LEAVE A REPLY)**

**NEW QUESTION: 193**

The purpose of sentinel event review of never events is to

**A.** engage leadership in identifying barriers to effective communication.

**B.** identify individual performance gaps that resulted in the sentinel event.

**C.** monitor staff and leadership involvement in the systematic analysis.

**D.** specify sustainable systems-based improvements.

**Answer: D (LEAVE A REPLY)**

The primary purpose of a sentinel event review, particularly in the context of never events, is to identify and implement sustainable systems-based improvements.

Here's why:

Focus on Systemic Issues: Sentinel event reviews aim to uncover underlying system flaws that contributed to the event. By focusing on systems-based improvements, the organization can prevent recurrence and enhance overall safety.

Long-term Impact:

Sustainable improvements ensure that changes made as a result of the review have a lasting impact on patient safety, rather than just addressing the immediate issue.

Holistic Approach:

Addressing system-wide issues, rather than just individual performance gaps, promotes a culture of safety and continuous improvement across the organization. Compliance and Accreditation: Regulatory bodies and accreditation organizations emphasize the importance of systems-based improvements following sentinel event reviews, aligning with best practices in patient safety. While engaging leadership, identifying performance gaps, and monitoring involvement are important aspects of a sentinel event review, the ultimate goal is to implement changes that improve the safety of the system as a whole.
Reference: NAHQ Guide to Sentinel Event Management and Never Event Prevention NAHQ Healthcare Quality Competency Framework: Patient Safety and Risk Management

**NEW QUESTION: 194**
Benchmarking is goal directed and promotes performance improvement by all of the following ways EXCEPT:
**A.** Substantiating the need for improvement
**B.** Providing a customer internal focus
**C.** Providing an environment amenable to organizational change through continuous improvement and striving to match industry-leading practices and results
**D.** Creating objective measures of performance that are driven by industry leading targets instead of by past performance
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 195**
An internal customer of the admission process in a skilled nursing facility is the
**A.** patient's spouse and family.
**B.** insurance company.
**C.** patient being admitted.
**D.** nurse completing the Initial assessment.
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 196**
What Is the Initial step the quality professional should take when the organization's performance on a patient satisfaction strategic goal Is below the desired performance?
**A.** Research Industry benchmarks.
**B.** Review department-specific data.
**C.** Form a quality improvement team.
**D.** Initiate a needs assessment
**Answer: B (LEAVE A REPLY)**
When an organization's performance on a patient satisfaction strategic goal is below the desired level, the initial step should be to review department-specific data. This allows for a detailed understanding of the performance in different areas or units within the organization. It helps in identifying specific issues that may be contributing to the overall low performance. This targeted

approach facilitates the identification of tailored interventions that can be more effective than broad, non-specific actions.
References:The NAHQ emphasizes the use of data to drive quality improvement efforts. Department-specific data provides the detailed insights necessary to undertake focused quality improvement initiatives. This is a fundamental principle in the healthcare quality improvement process, aligning with the systematic approach outlined in the NAHQ's Healthcare Quality Competency Framework.

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**NEW QUESTION: 197**
Either an increase or decrease in rate could be a signal of improvement. In other words, there is no clear direction of improvement for these measures. In this case an observed rate either above or below the expected range is an unfavourable outliner.
**A.** Structure measures
**B.** Positive measures
**C.** Neutral measures
**D.** Negative measures
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 198**
The percentage of patients with congestive heart failure who are receiving an ACE inhibitor is an example of retrospective measure. The use of ACE inhibitors in the population is indicated for all patients with an ejection fraction of less than 40 percent. The ejection fraction is not part of the typical administrative database.
Sometimes the information is contained:
**A.** In an ERP system
**B.** In a worksheet
**C.** In a separate computer record
**D.** In a stand-alone database in cardiology department and is generated in accessible
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 199**
Prior to implementing a new patient service, the healthcare quality professional should recommend

**A.** developing a safety monitoring checklist.
**B.** conducting a root cause analysis (RCA).
**C.** initiating a failure modes and effects analysis (FMEA).
**D.** performing just-in-time staff safety training.
**Answer: C (LEAVE A REPLY)**
Before implementing a new patient service, the healthcare quality professional should recommend conducting a Failure Modes and Effects Analysis (FMEA). FMEA is a proactive tool used to identify potential failure points in a new process or service before they occur. This analysis helps to prioritize risks based on their severity, occurrence, and detectability, and to implement corrective actions to mitigate these risks. By using FMEA, the organization can enhance patient safety by addressing potential problems before they affect patients.
* Developing a safety monitoring checklist (A): While useful, this step comes after identifying potential risks and failure modes through FMEA.
* Conducting a root cause analysis (RCA) (B): RCA is a reactive tool used after an adverse event occurs, making it unsuitable for proactive risk assessment before implementing a new service.
* Performing just-in-time staff safety training (D): While important, this should follow the identification of risks and implementation of safety measures based on the FMEA findings.
References
* NAHQ Body of Knowledge: Risk Management and Patient Safety
* NAHQ CPHQ Exam Preparation Materials: FMEA Process and Application
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**NEW QUESTION: 200**
Which of the following is the best example of population health management?
**A.** ensuring timely access to eye examinations for people with diabetes
**B.** reducing medication errors in a pharmacy
**C.** reducing turn-around times in the emergency department
**D.** ensuring accurate medication reconciliation for people in hospice care
**Answer: (SHOW ANSWER)**
Population health management focuses on improving the health outcomes of a specific group by managing and coordinating care across the health continuum. Ensuring timely access to eye examinations for people with diabetes is a prime example of population health management because it targets a specific group (people with diabetes) and addresses a preventive measure (eye exams) to reduce the risk of complications, such as diabetic retinopathy.
* Reducing medication errors in a pharmacy (B): While important, this is more related to patient safety and quality improvement in a specific setting rather than population health management.
* Reducing turn-around times in the emergency department (C): This improves efficiency but is not directly related to managing the health of a specific population.
* Ensuring accurate medication reconciliation for people in hospice care (D): This is critical for patient care but focuses on a specific care process rather than broad population health management.

References
* NAHQ Body of Knowledge: Population Health Management and Preventive Care
* NAHQ CPHQ Exam Preparation Materials: Examples of Population Health Strategies
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**NEW QUESTION: 201**
The distinction between inpatient and outpatient data is an important consideration in planning the data collection
process because:
**A.** Mixing of data may or may not be reliable
**B.** Approaches to data collection may be different
**C.** Both A & B
**D.** The data sources may be different
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 202**
The clinic has a goal to reduce the Healthcare Effectiveness Data and Information Set (HEDIS) measure of ' the percent of diabetic patients with a HgA1c greater than 9.0% for accreditation.
Who should be Included on the quality Improvement team?
**A.** clinic manager, provider champion. HEDIS chart abstractor
**B.** clinic manager, quality Improvement specialist, provider champion
**C.** HEDIS chart abstractor, coder, primary care provider
**D.** primary care provider, quality improvement specialist, coder
**Answer: (SHOW ANSWER)**
* The HEDIS measure of the percent of diabetic patients with a HgA1c greater than 9.0% is an indicator of poor glycemic control and a risk factor for complications12. Reducing this measure is a quality improvement goal that requires a multidisciplinary approach and data-driven strategies34.
* A quality improvement team is a group of individuals with different roles and responsibilities who work together to achieve a common aim56. The team should include representatives from various areas of the clinic, such as management, clinical staff, and data analysts78.
* The clinic manager is responsible for providing effective and consistent leadership, communicating the vision and the steps for improvement, engaging the team in planning and monitoring, allocating resources and training, and fostering a culture of open communication and continuous learning78.
* The quality improvement specialist is responsible for analyzing and reviewing the clinical and business data, suggesting and selecting the key priority areas, implementing and evaluating the improvement interventions, and reporting the results and outcomes78.
* The provider champion is responsible for modeling enthusiasm and support for quality improvement, leading the clinical discussions and decisions, influencing and educating other providers and staff, and ensuring adherence to evidence-based guidelines and best practices78.

* The HEDIS chart abstractor, the coder, and the primary care provider are also important members of the quality improvement process, but they are not sufficient to form a comprehensive and effective team.
The HEDIS chart abstractor and the coder are mainly involved in collecting and coding the data, while the primary care provider is mainly involved in delivering the care. They need the guidance and coordination of the clinic manager, the quality improvement specialist, and the provider champion to
* align their efforts and achieve the desired outcomes78. References: 1: Hemoglobin A1c Control for Patients with Diabetes (HBD) 2: Glycemic Status Assessment for Patients with Diabetes 3: Quality Improvement Team Roles and Responsibilities - PracticeAssist 4: The Roles & Responsibilities of A Quality Management Team 5: QUALITY IMPROVEMENT TEAMS COMPOSITION 6: Comprehensive Diabetes Care - NCQA 7: HEDIS 2022 Manual - Johns Hopkins Medicine 8: HEDIS Hemoglobin A1c Control for Patients with Diabetes (HBD) 9: GSD - Glycemic Status Assessment for Patients With Diabetes

**NEW QUESTION: 203**

Analysis has shown that there Is a significant delayinreceiving laboratory results In the emergency room. A cross-functional team Is assigned the task of Improving laboratory reporting time. Which of the following Is the next step the team should take?

**A.** Identify the responsible Individual.
**B.** Complete a fishbone diagram.
**C.** Plot a scatter diagram.
**D.** Develop action plans.

**Answer: (SHOW ANSWER)**

When a cross-functional team is assigned the task of improving a process, such as laboratory reporting time in the emergency room, the first step after identifying the problem is usually to understand the root causes of the problem. A fishbone diagram, also known as a cause and effect diagram or Ishikawa diagram, is a visual tool used to systematically identify and present all possible causes of a certain outcome1234.
In this case, the significant delay in receiving laboratory results is the problem that needs to be addressed. The team would use a fishbone diagram to identify and categorize potential reasons for this delay, such as equipment issues, process inefficiencies, human errors, etc. This step is crucial before developing action plans (Option D) because it ensures that the team's efforts are directed towards addressing the root causes of the problem, rather than just the symptoms1234.
Options A (Identify the responsible individual) and C (Plot a scatter diagram) are not the immediate next steps in this scenario. Identifying a responsible individual is more about accountability after the root causes have been identified and action plans have been developed.
A scatter diagram is a graphical tool used to understand the relationship between two variables and is not typically the next step in process improvement after identifying the problem1234.
References:

https://fellow.app/blog/management/cross-functional-collaboration-common-challenges-and-tips-to-make-it-wor

**NEW QUESTION: 204**

A root cause analysts (RCA) was conducted tor an event related to a delayed high-priority alarm response. Alarm fatigue was determined to be a root cause.

Which of the following Is the most appropriate first Intervention?

**A.** Establish a written policy for alarms escalation.

**B.** Review alarm signals for clinical appropriateness.

**C.** Implement a guideline with clear criteria for Initiation of cardiac monitoring.

**Answer: B (LEAVE A REPLY)**

A root cause analysis (RCA) is a systematic process of identifying the factors that contributed to an adverse event or near miss in order to prevent recurrence and improve patient safety1.

Alarm fatigue is a condition in which clinicians become desensitized to the numerous alerts and warnings generated by medical devices, leading to longer response times or missed alarms2.

Alarm fatigue can compromise patient safety by increasing the risk of adverse events, such as delayed treatment, missed diagnosis, or cardiac arrest3.

To reduce alarm fatigue, the Joint Commission recommends a four-step approach: establish alarm system management as a priority; identify the most important alarms to manage; establish policies and procedures for alarm system management; and educate staff and patients about alarm system management4.

The most appropriate first intervention for an event related to a delayed high-priority alarm response is to review alarm signals for clinical appropriateness. This means to evaluate the alarm settings, limits, and delays for each device and patient population, and adjust them according to evidence-based guidelines and best practices5. This can help reduce the number of false or clinically insignificant alarms, and improve the specificity and sensitivity of the alarm system.

Establishing a written policy for alarm escalation is also an important intervention, but it is not the first step. A policy for alarm escalation should define the roles and responsibilities of staff, the criteria and process for escalating alarms, and the expected response time and actions for each alarm level.

However, before developing such a policy, it is necessary to review the alarm signals and ensure that they are clinically relevant and meaningful.

Implementing a guideline with clear criteria for initiation of cardiac monitoring is another intervention that can reduce alarm fatigue, but it is not the first step either. A guideline for cardiac monitoring should specify the indications, duration, and discontinuation of continuous electrocardiographic (ECG) monitoring for patients at risk of cardiac arrhythmias or ischemia.

However, before implementing such a guideline, it is necessary to review the alarm signals and ensure that they are appropriate for the patient population and clinical setting.

Reference: 1: NAHQ Code of Ethics 2: Reducing the Safety Hazards of Monitor Alert and Alarm Fatigue

3: Alarm fatigue: impacts on patient safety 4: The Joint Commission National Patient Safety Goal on clinical alarm safety 5: Alarm Management: Advancing From Failure Cause To Root Cause Analysis:
[Utilization of Improvement Methodologies by Healthcare Quality Professionals During the COVID-19 Pandemic]: [The Financial Case for Quality as a Business Strategy]: [Shaping the Future of the Healthcare Quality Profession]: [Practice Standards for Electrocardiographic Monitoring in Hospital Settings]: [Understanding the Evolving Landscape of Healthcare Quality]

**NEW QUESTION: 205**
The creation of an information technology infrastructure to analyze the performance of all physicians in a healthcare
system can be useful in:
**A.** Identifying the disease the hospital, physician, or physical group treats most
**B.** Organizations can develop clinical pathways
**C.** Physician report cards can be issued
**D.** Clinical issues can be sorted out
**Answer: A,B (LEAVE A REPLY)**

**NEW QUESTION: 206**
While the use of technology may result in fewer medical errors. In order for this strategy to be most effective.
It should be supported by
**A.** effectiveness of staff.
**B.** an organizational structure.
**C.** a culture of safety.
**D.** leadership training.
**Answer: C (LEAVE A REPLY)**
* The use of technology in health care can reduce medical errors by improving the reliability and accuracy of information, enhancing communication and coordination, and supporting decision making and care delivery. However, technology alone is not sufficient to ensure patient safety. It must be accompanied by a culture of safety that fosters a blame-free environment, encourages reporting and learning from errors, promotes teamwork and collaboration, and allocates resources and leadership support for safety improvement123
* A culture of safety is defined as "the extent to which an organization's culture supports and promotes patient safety. It refers to the values, beliefs, and norms that are shared by healthcare practitioners and other staff throughout the organization that influence their actions and behaviors." 4 A culture of safety can be measured by assessing the attitudes, perceptions, and behaviors of staff and leaders regarding patient safety issues5
* A culture of safety can enhance the effectiveness of technology by ensuring that it is designed, implemented, and used in ways that align with the needs and preferences of users, the goals and processes of care, and the context and environment of the organization6 A culture of safety can

also mitigate the potential risks and unintended consequences of technology, such as usability issues, workflow disruptions, alert fatigue, and new types of errors78

* Therefore, while the use of technology may result in fewer medical errors, in order for this strategy to be most effective, it should be supported by a culture of safety that creates the conditions and capacities for safe and quality care9 References: 1: How 4 hospitals are using technology to reduce medical errors - Advisory 2: Problems with health information technology and their effects on care delivery and patient outcomes: a systematic review | Journal of the American Medical Informatics Association | Oxford Academic 3: Use of Technology to Reduce Medication Errors and Improve Patient Safety 4: What Is Patient Safety Culture? | Agency for Healthcare Research and Quality 5: Safety Culture in Healthcare: A 7-Step Framework 6: Technology as a Tool for Improving Patient Safety | PSNet 7: Health IT's role in reducing medical errors - ONC 8: Safety Culture in Healthcare Settings | NIOSH | CDC 9: [Shaping the Future of the Healthcare Quality Profession]

**NEW QUESTION: 207**

The median is defined as the

**A.** difference between a data item and the mean of a data set.

**B.** most frequently occurring value in a data set.

**C.** arithmetic average of a data set.

**D.** number that divides an ordered data set into two equal parts.

**Answer: D (LEAVE A REPLY)**

The median is a measure of central tendency in statistics that represents the middle value of an ordered data set.

* Data Set Ordering: To find the median, the data set must first be arranged in ascending or descending order.

* Middle Value Identification: The median is the value that divides the data set into two equal parts, with 50% of the data points lying below it and 50% above it. If the number of observations is odd, the median is the middle number; if even, it is the average of the two middle numbers.

* Robustness: Unlike the mean, the median is not affected by extreme values (outliers), making it a more robust measure of central tendency in skewed distributions.

References: (Based on Healthcare Quality NAHQ documents and resources)

* NAHQ Study Guide on Statistical Methods in Quality Improvement.

* Quality Management in Health Care, Chapter on Measures of Central Tendency.

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**NEW QUESTION: 208**

A quality manager needs to assign a staff member to assist a medical director in the development of a quality

program for a newly established service. Which of the following staff members is most appropriate for t his project ?

**A.** A motivated staff member who is actively seeking promotion

**B.** A competent staff member who has good interpersonal skills
**C.** A knowledgeable staff member who works best on defined tasks
**D.** A newly hired staff member who has demonstrated competence and has time to complete the task
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 209**
Once you have resolved these issues, the data collection should go smoothly. Unfortunately, many quality
improvement teams do not spend sufficient time discussing their data collection plans. They want to move
immediately to data collection step. This haste usually guarantees that the team will:
**A.** Reschedule the time and cost
**B.** Collect too much (or too little) data
**C.** Collect the wrong data
**D.** Become frustrated with the entire measurement journey
**Answer: B,C,D (LEAVE A REPLY)**

**NEW QUESTION: 210**
An orthopedic surgery practice has been working on improving patient safety for the last 3 years.
The following data table is available:
Which of the following is the most appropriate conclusion about patient safety outcomes?
**A.** The patient safety culture has remained consistent.
**B.** Patient safety outcomes have improved.
**C.** The increase in "time-outs" has reduced patient harm.
**D.** The safety event rate has remained stable.
**Answer: C (LEAVE A REPLY)**
The most appropriate conclusion from the data provided is that the increase in compliance with "time-outs" performed before procedures has likely contributed to reducing patient harm. "Time-outs" are a critical safety procedure designed to prevent errors such as wrong-site surgeries, and the significant increase in compliance from 30% to 80% correlates with stable Serious Safety Event Rates, suggesting that this practice has helped to maintain or even improve patient safety outcomes.
* Patient safety culture has remained consistent (A): The data shows variation in survey response rates, suggesting some changes in culture.
* Patient safety outcomes have improved (B): While some aspects have improved, the Serious Safety Event Rate has remained stable, not significantly improving.
* The safety event rate has remained stable (D): While true, it doesn't capture the potential impact of the increased "time-outs" on patient safety.
References
* NAHQ Body of Knowledge: Patient Safety Processes and Time-Outs

* NAHQ CPHQ Exam Preparation Materials: Analyzing Patient Safety Data
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**NEW QUESTION: 211**
A home health agency's Performance Improvement Committee has decided to base staff educational programs on aggregated occurrence report data. Due to budgetary and time constraints, not every area identified from the data can be addressed.
Which of the following would be most useful to the committee in determining their educational targets?
**A.** force field analysis
**B.** control chart
**C.** Pareto chart
**D.** scattergram
**Answer: C (LEAVE A REPLY)**
The Pareto chart is the most useful tool for the Performance Improvement Committee to determine educational targets based on aggregated occurrence report data. The Pareto chart helps to prioritize areas for improvement by showing the frequency or impact of different causes of problems, following the
80/20 rule (where 80% of problems often stem from 20% of causes). By identifying the most significant issues, the committee can focus its limited resources on the areas that will have the greatest impact on improving staff performance and patient outcomes.
Force field analysis (A): This tool is used for decision-making by analyzing forces for and against a change, but it is less suited for prioritizing based on frequency data.
Control chart (B): Used to monitor process stability over time, not for prioritization.
Scattergram (D): Used to identify correlations between variables, not for prioritizing educational targets.
Reference
NAHQ Body of Knowledge: Quality Improvement Tools and Techniques
NAHQ CPHQ Exam Preparation Materials: Using Pareto Charts in Performance Improvement

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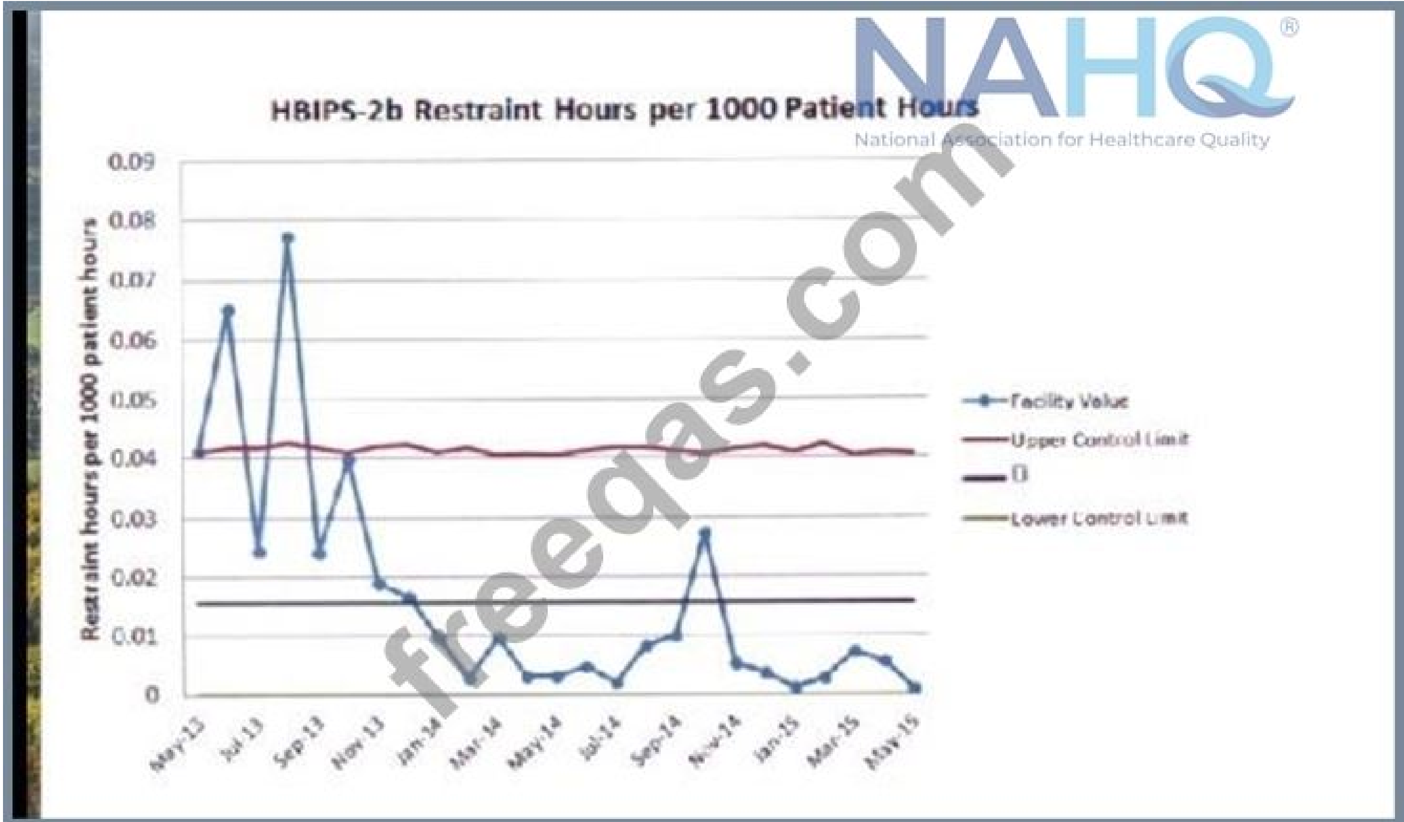
**NEW QUESTION: 212**
The primary benefit of adopting a countrywide or global uniform set of discharge data is to:
**A.** Assist medical records personnel in collecting internal data

**B.** Facilitate collection of comparable health information
**C.** Facilitate computerization of data
**D.** Validate data being collected from other sources
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 213**
The control chart above indicates which of the following?


**A.** Common cause variation
**B.** Special cause variation
**C.** Unique cause variation
**D.** No variation
**Answer: (SHOW ANSWER)**
* Understanding Control Charts and Variation TypesControl charts are used to monitor process stability over time by identifying different types of variation. Variations on a control chart can generally be categorized as:
* Common Cause Variation: Random variation that is inherent to the process, typically within control limits.
* Special Cause Variation: Variation that is unusual, not inherent to the process, and suggests an external factor or a change in the process.
* Unique Cause Variation: This term is not commonly used in statistical process control; it likely refers to a special or unusual cause.
* No Variation: Indicates a completely stable process with no changes over time, which is rarely the case in practice.

* Interpreting the Control ChartThe control chart shows the rate of restraint hours per 1000 patient hours over time. Key indicators of special cause variation include:
* Data points outside the control limits (Upper Control Limit and Lower Control Limit).
* Patterns, such as runs of data points above or below the mean, or sudden shifts and spikes in data.

In this chart, we see several spikes (particularly in July and September of 2013 and again in October 2014) that reach or exceed the upper control limit. This suggests that certain events or changes in these periods caused the restraint hours to increase significantly, which is not due to the inherent process variation.
* Conclusion for the Correct AnswerSince the chart displays data points that go outside the control limits and exhibit unusual patterns, it is indicative of Special Cause Variation. This suggests external factors or specific changes in the facility process during those periods that require further investigation to determine the cause of the spikes.

References:
* NAHQ Documentation on Control Charts and Process Variation
* "Using Statistical Process Control to Monitor Quality Improvement in Healthcare" (NAHQ, 2019)

**NEW QUESTION: 214**

Which of the following Is true of a clinical pathway?

**A.** depicted using a value stream map
**B.** limited to one patient care setting
**C.** used to reduce variations in care
**D.** required for accountable care organizations

**Answer: C (LEAVE A REPLY)**

A clinical pathway, also known as a care pathway, is a multidisciplinary management tool based on evidence- based practice for a specific group of patients with a predictable clinical course12. It details the steps in a course of treatment or care in a plan, pathway, algorithm, guideline, protocol, or other 'inventory of actions'

1. The main purpose of a clinical pathway is to reduce variation and improve the quality of care13245. It is not necessarily depicted using a value stream map (option A), not limited to one patient care setting (option B), and not required for accountable care organizations (option D).

References:
https://www.medbridge.com/blog/2022/02/clinical-pathways-leading-the-way-to-better-outcomes/

**NEW QUESTION: 215**

An alternative to a walk-through is a similar technique called ___________. A staff member asks permission to accompany a patient through the visit and take notes on patients' experience.

**A.** Patient shadowing
**B.** Patient graphing
**C.** Patient counselling
**D.** Patient profiling

**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 216**

An organization has Implemented a quality improvement project. The goal is a mean compliance rate of 90%.

The results of observations are found in the table below:

| Focus Area | Department A | Department B | Department C |
|---|---|---|---|
| | % Compliance | % Compliance | % Compliance |
| Infection Prevention | 100% | 82% | 95% |
| Environment of Care | 95% | 98% | 78% |
| Pain Management | 80% | 88% | 65% |
| Patient Flow | 96% | 87% | 60% |

Which focus area presents the greatest opportunity for the organization?

**A.** pain management

**B.** patient flow

**C.** infection prevention

**D.** environment of care

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 217**

Annual evaluation of a quality Improvement process must

**A.** be based on organizational objectives.

**B.** survey all departments and teams.

**C.** be accomplished by a healthcare quality professional.

**D.** document all problems identified In care/service.

**Answer: A (LEAVE A REPLY)**

The annual evaluation of a quality improvement process should be based on organizational objectives. This is because the quality improvement process is designed to enhance the effectiveness and efficiency of an organization's operations and align them with the organization's strategic goals12. The AAAHC (Accreditation Association for Ambulatory Health Care) requires that documentation demonstrates at least an annual governing body review of the Quality Improvement (QI) program to evaluate effectiveness and determine if the purposes and objectives continue to be met3. Therefore, the annual evaluation of a quality improvement process must be based on organizational objectives to ensure that the process is effectively contributing to the achievement of these objectives.

References: 123

**NEW QUESTION: 218**

Stratification is the separation and classification of data into reasonably homogenous categories. It allows understanding of differences in the data caused by all of the following EXCEPT:

**A.** Time of the day

**B.** Day of the week

**C.** Type of order

**D.** Area of facility
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 219**
Quality circles are groups of five to ten employees, with management support, who meet to solve problems and implement new procedures.
The aim/s of quality circle activities is/are:
**A.** Both A and B
**B.** Deploy human capabilities fully and draw out finite potential
**C.** Contribute to implement and development of the enterprise
**D.** Respect human relations and build a workshop offering job satisfaction
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 220**
Crossing the Quality Chasm provided a blueprint for the future that classified and unified the components of quality through six aims for improvement, chain of effects, and simple rules for redesign of healthcare.
The six aims for improvement, viewed also six dimensions of quality.
Which of the following is NOT out of those dimensions?
**A.** Efficient
**B.** Care centered
**C.** Safe
**D.** Effective
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 221**
A pulmonologist is gathering social determinants of health data from their patients. Which of the following best explains the purpose of collecting this data?
**A.** This information facilitates the patient's application for state resources.
**B.** This is a result of an update to the electronic medical record system.
**C.** This evaluates connections between the disease and the living conditions.
**D.** This information is needed to meet a new quality metric.
**Answer: C (LEAVE A REPLY)**
Collecting social determinants of health (SDOH) data is crucial for understanding the broader context in which patients live, which can significantly impact their health outcomes. The purpose of gathering this data is to evaluate connections between the disease and the living conditions (Answer C). SDOH includes factors like housing stability, education, income, and access to healthcare, which can all influence the prevalence and management of diseases, such as respiratory conditions managed by a pulmonologist. By understanding these factors, healthcare providers can tailor interventions to address not just the clinical aspects of care, but also the environmental and social conditions that affect patient health.

The other options are less directly aligned with the core purpose of SDOH data collection:
* Facilitating the patient's application for state resources (A) is a possible secondary outcome but not the primary reason for collecting SDOH data.
* An update to the electronic medical record system (B) may prompt the collection of such data, but it is not the underlying purpose.
* Meeting a new quality metric (D) might be a requirement, but the primary goal is to understand and address the impact of SDOH on health outcomes.
References:
* National Association for Healthcare Quality (NAHQ) - Certified Professional in Healthcare Quality (CPHQ) Study Materials.
* Social Determinants of Health and Their Impact, NAHQ Documentation.
=========

**NEW QUESTION: 222**
Which of the following should be used to show beginning and ending times for an activity along a timeline?
**A.** Control chart
**B.** Fishbone diagram
**C.** Pareto chart
**D.** Gantt chart
**Answer: (SHOW ANSWER)**
A Gantt chart is a type of bar chart that represents a project schedule, showing the start and end times of activities along a timeline. It is one of the most widely used tools in project management and healthcare quality improvement initiatives.
Key Features of a Gantt Chart:
* Displays tasks or activities on a horizontal timeline.
* Shows the duration of each task.
* Helps track progress and dependencies between activities.
* Facilitates coordination among different teams or stakeholders.
Why Other Options Are Incorrect:
* Control Chart (Option A): Used to track variations in a process over time and detect performance deviations, but it does not provide a structured timeline of activities.
* Fishbone Diagram (Option B): Also known as an Ishikawa diagram or cause-and-effect diagram, it identifies root causes of a problem but does not visualize timelines.
* Pareto Chart (Option C): Helps prioritize issues based on their frequency or impact (80/20 rule), but it does not track project timelines.
Thus, the correct answer is D. Gantt chart as it best represents activities along a timeline.
References:
* NAHQ's Healthcare Quality Competency Framework
* Project Management Institute (PMI) - "Fundamentals of Project Scheduling and Gantt Charts"

**NEW QUESTION: 223**

During development of a clinical pathway, a quality professional should

**A.** evaluate peer review committee findings.

**B.** implement best practice alerts.

**C.** consult peer-reviewed evidence.

**D.** gather patient outcome data.

**Answer: C (LEAVE A REPLY)**

Clinical pathways (CPWs) are a common component in the quest to improve the quality of health1. They are used to reduce variation, improve quality of care, and maximize the outcomes for specific groups of patients1. The development of a clinical pathway involves a structured multidisciplinary plan of care1.

This process includes translating guidelines or evidence into local structures1.

Therefore, during the development of a clinical pathway, a quality professional should consult peer- reviewed evidence. This is because the evidence forms the basis of the guidelines that are translated into the local structures during the development of the clinical pathway1. This ensures that the care provided is based on the most current and best practice, leading to improved patient outcomes2.

It's important to note that while evaluating peer review committee findings, implementing best practice alerts, and gathering patient outcome data can be part of the overall quality improvement process, they are not specifically part of the development of a clinical pathway34. These activities may occur before or after the development of the clinical pathway but are not integral to the development process itself34.

**NEW QUESTION: 224**

Four surgical centers formed a collaboration to reduce post-operative infection rates. The goal was to reduce infection rates by 20% from baseline.

| Center | Baseline | Outcome |
|---|---|---|
| A | 0.9% | 1.1% |
| B | 1.4% | 1.2% |
| C | 5.2% | 4.3% |
| D | 4.7% | 3.7% |

Which center met the goal?

**A.** Center A

**B.** Center B

**C.** Center C

**D.** Center D

**Answer: D (LEAVE A REPLY)**

Detailed Explanation:

To meet the goal, each center must reduce infection rates by at least 20% from their baseline:

Center D:
Baseline = 4.7%, Outcome = 3.7%
Reduction =
(
4.7
#
3.7
)
/
4.7
=
21.3
%
(4.7#3.7)/4.7=21.3%, meeting the 20% reduction target.
Other Centers:
Centers A and B did not show a 20% reduction; Center C reduced from 5.2% to 4.3%, which is only around
17.3%.
References:
CPHQ literature on collaborative quality goals emphasizes calculating percentage reduction to confirm if targets are met.

**NEW QUESTION: 225**
Ongoing practitioner practice evaluation (OPPE) Is used for which of the following?
**A.** monitoring a provider with an IdentifiedPracticeIssue
**B.** removal of privileges that a provider is no longer using
**C.** approval by the governing board for new provider privileges
**D.** identification of providers with potential competency issues
**Answer: A (LEAVE A REPLY)**
Ongoing Professional Practice Evaluation (OPPE) is part of the credentialing process for medical staff aimed at evaluating a provider's clinical competence and professional behavior on an ongoing basis, rather than at the time of reappointment only. OPPE is typically used to monitor providers with identified practice issues. It involves collecting data about a provider's performance over time, reviewing the information regularly, and using it to ensure that the provider meets professional standards. This proactive monitoring can lead to early identification and resolution of potential issues.
References:This aligns with best practices as outlined by the Joint Commission and is reflected in the guidelines and educational materials provided by NAHQ. OPPE is a standard element in healthcare quality and credentialing that focuses on continuous evaluation of a provider's ability to provide quality care.

**NEW QUESTION: 226**

Best- practice standards in healthcare continue to evolve in response to new medicines and treatment option. The
following list details a number of concerns in the creation of physician profiles EXCEPT:

**A.** Are these the most appropriate measures of quality improvement?

**B.** What do you want to measure, and why is this important?

**C.** How will findings influence change?

**D.** How and when standards will be marked?

**Answer: D (LEAVE A REPLY)**

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**NEW QUESTION: 227**

Which of the following are the three primary quality management activities?

**A.** define goals, assessment, and review results

**B.** measurement, assessment, and Improvement of outcomes

**C.** assessment, improvement, and strategic planning

**D.** review trends, assessment, and stakeholder accountability

**Answer: B (LEAVE A REPLY)**

Quality management is a critical aspect of healthcare, and it involves various activities to ensure that healthcare services meet the desired standards.
The three primary quality management activities are:
Measurement: This is the first step in quality management. It involves defining and collecting data on various aspects of healthcare service delivery. This could include patient outcomes, process efficiency, or other relevant metrics. The goal is to establish a baseline for understanding the current state of quality.
Assessment: Once data has been collected, it needs to be analyzed to assess the quality of healthcare services. This could involve comparing actual outcomes against desired outcomes, identifying gaps in service delivery, or looking for trends and patterns in the data.
Improvement of outcomes: Based on the assessment, targeted interventions are designed and implemented to improve outcomes. This could involve changes to processes, training for staff, or other interventions. The effectiveness of these interventions is then measured and assessed, creating a continuous cycle of quality improvement.
Reference: The information is based on standard quality management principles and practices, which are widely recognized and utilized in the healthcare industry123.

**NEW QUESTION: 228**

In the 1970s, Deming developed his 14 points for western Management in response to requests from U.S.
managers for the secret to the radical improvement that Japanese companies were achieving in a number of industries. As part of his "system of profound knowledge," Deming promoted that "around 15% of poor quality was because of workers, and the rest of 85% was due to bad management, improper systems and processes." The "system" is based on parts.
Which of the following is/are NOT out of those parts?

**A.** Theory of knowledge
**B.** Appreciation for a system
**C.** Knowledge about variation
**D.** Sociology

**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 229**

When continuing unique events, one uses a p-chart. The number plotted on a chart would be either a proportion or a percentage. When counting total events (e.g., the number of falls per patient day each month), one plots a ratio on a u-chart.
Examples of attributes data plotted as percentage on p-charts include figures such as (Choose two):

**A.** Percentage of scripts that had one or more medication errors
**B.** Percentage of visits by every patient
**C.** Percentage of patients discharged
**D.** Percentage of patients who died

**Answer: A,D (LEAVE A REPLY)**

**NEW QUESTION: 230**

A healthcare quality Improvement team is working on an action plan to address medication system defects.
Based on the data from the chart below, what would be the next step?

**A.** Begin working to address the "Administration" defects.
**B.** Conduct further analysis on "Administration" defects.
**C.** Conduct further analysis on "Other" defects.
**D.** Begin working to address the "Other" defects.
**Answer: (SHOW ANSWER)**
The chart provided in the question shows the number of defects in different categories of a medication system.
The category with the highest number of defects is "Other," followed by "Administration." However, the line graph overlaid on the bar graph shows the percentages of cumulative defects addressed, which increases from left to right. This suggests that while a significant portion of the defects in the "Other" category have been addressed, there are still many unaddressed defects in the "Administration" category.
Given this information, the next step for the healthcare quality improvement team would be to conduct further analysis on the "Administration" defects. This is because, although the "Administration" category does not have the highest number of defects, it has a significant number of defects that have not yet been addressed. Further analysis would help the team understand the root causes of these defects and develop effective strategies to address them123.
This approach aligns with the principles of healthcare quality improvement, which emphasize the importance of using data to guide decision-making and prioritizing areas where improvement is most needed123. It also aligns with the principles of Failure Mode and Effects Analysis (FMEA), a structured process used to identify system failures of high-risk processes before they occur1. In this context, the "Administration" defects could be considered a high-risk process that requires further analysis.
Please note that this answer is based on the general principles of healthcare quality improvement and the information provided in the chart. The specific action plan for addressing medication system defects may vary depending on the specific context and needs of the healthcare organization123.

**NEW QUESTION: 231**

The downside to asking nursing staff to perform data collection is that can district nurses from their direct patient care responsibilities.

A better approach would be:

**A.** To hire research assistants or fulltime data analysts who can perform data collection and be responsible for data entry and analysis

**B.** To assign this work to them during holidays

**C.** To hire research assistants or full-data analysts who can only perform data collection

**D.** To give this job work after their actual job timings

**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 232**

The approach to medical record review involves well-conceived steps, beginning with the development of a data

collection tool and ending with:

**A.** Implementation of the analysis of collected data set

**B.** Compilation of collected data element into a registry or electronic database software for review and analysis

**C.** Execution of the future activities on the finding of this record review

**D.** Compilation of collected data element into a register or physical record system

**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 233**

Which of the following actions will best promote organizational efficiency in managing quality improvement projects?

**A.** Create a team whenever there is an improvement project

**B.** Identify project managers for all improvement projects

**C.** Assign some projects to individuals and others to teams

**D.** Only approve projects that have a high return on investment

**Answer: (SHOW ANSWER)**

Detailed Explanation:

Identifying project managers ensures accountability and streamlined coordination, which is crucial for organizational efficiency in quality improvement.

Option B: Identify project managers for all improvement projects

Having dedicated project managers improves focus, accountability, and resource management.

References:

CPHQ resources emphasize project management as essential for efficient handling of quality improvement initiatives, ensuring clarity and focus throughout each project.

**NEW QUESTION: 234**

If you decided to interview ten patients in your emergency room on a given day and drew conclusions about your
emergency services from these people. You have taken limited data and made a huge jump in logic. This jump is
known as:

**A.** Stereotyping

**B.** Quota sampling

**C.** Ecological fallacy

**D.** Over-generalization

**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 235**

A Japanese tool called 5S (each step starts with letter "S") is a systematic program that helps workers take control of their workspace so that it actually works for them (and their customers) instead of being a neutral or, as is quite common, competing factor.
Which of the following is/are NOT out of these five 5S? (Choose two.)

**A.** Seiton

**B.** Seiso

**C.** Seiku

**D.** Shitsake

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 236**

A healthcare quality professional Is assisting an organization with evaluating patient safety actions that will prevent errors of omission. Which of the following systems will most likely be effective?

**A.** a reminder system that Isinclose proximity to the task and provides sufficient information about what needs to be done

**B.** a warning system that Is contiguous to the task and cues that the Individual Is about to Initiate the wrong intervention

**C.** a proactive risk assessment system that Integrates with the task and automatically notifies the risk manager

**D.** a detection system that notifies the team when an error has occurred and provides a checklist for mitigation measures

**Answer: (SHOW ANSWER)**

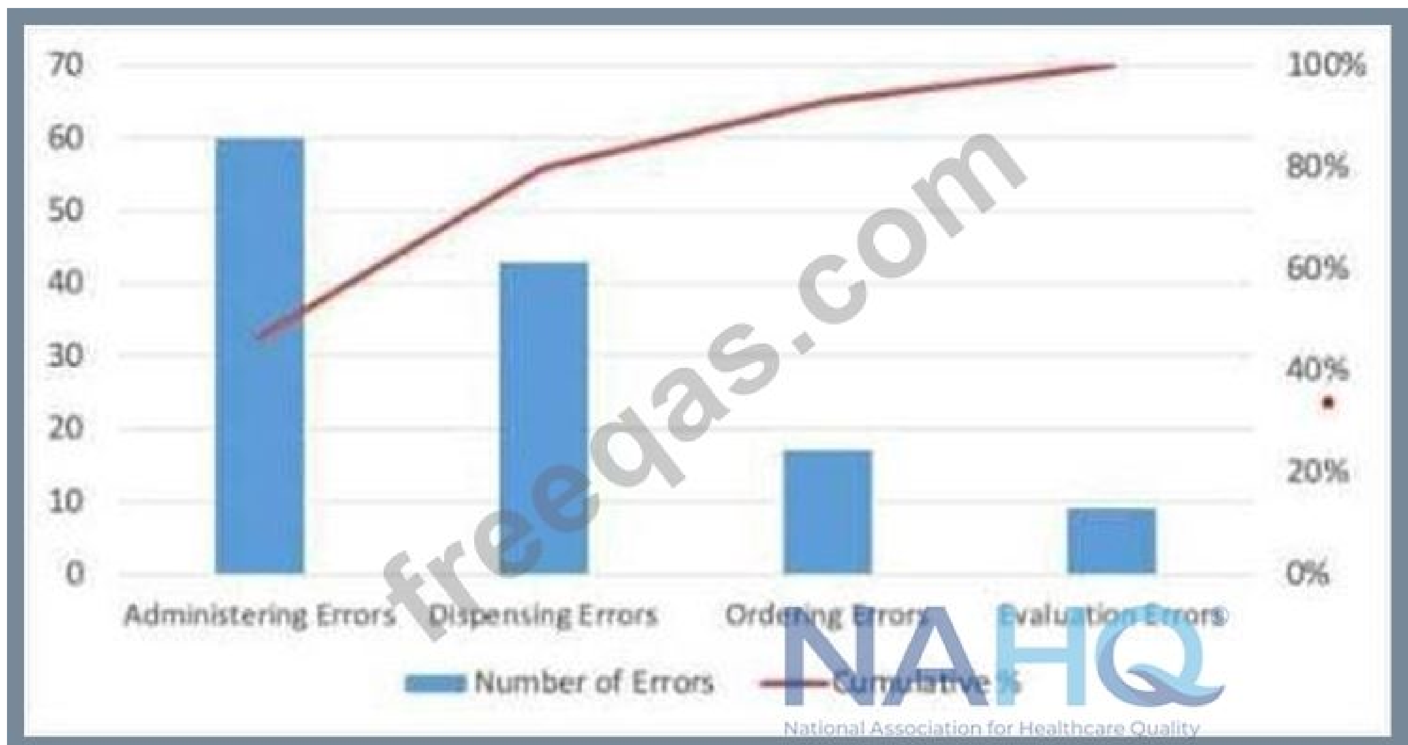
Errors of omission can lead to delayed or missed diagnosis1. In the context of healthcare quality, these errors are often preventable and can be mitigated through various systems and strategies23.

Option A, a reminder system that is in close proximity to the task and provides sufficient information about what needs to be done, aligns with the strategies to prevent errors of omission. This system serves as a proactive measure to ensure that necessary actions are taken and

important steps are not missed. It provides healthcare professionals with timely and relevant information, thereby reducing the likelihood of errors of omission1.
Option B, a warning system that is contiguous to the task and cues that the individual is about to initiate the wrong intervention, while useful, is more aligned with preventing errors of commission (doing something wrong) rather than errors of omission (failing to do something right).
Option C, a proactive risk assessment system that integrates with the task and automatically notifies the risk manager, is also a valuable tool in healthcare quality. However, it is more focused on identifying and managing risks rather than preventing errors of omission.
Option D, a detection system that notifies the team when an error has occurred and provides a checklist for mitigation measures, is a reactive measure. While it is crucial for mitigating the impact of errors, it does not directly prevent errors of omission.
Therefore, based on the information available, option A would most likely be the most effective system in assisting an organization with evaluating patient safety actions that will prevent errors of omission231.

**NEW QUESTION: 237**
A key concept in patient safety planning is to design procedures that
**A.** meet the needs of individual departments.
**B.** standardize patient care practices.
**C.** make errors non-transparent.
**D.** prevent all occurrences.
**Answer: (SHOW ANSWER)**
A key concept in patient safety planning is to design procedures that standardize patient care practices.
Standardization reduces variability in care, which helps prevent errors and ensures that all patients receive the same high standard of care. By establishing clear, consistent procedures, healthcare organizations can minimize the risk of mistakes and improve overall patient safety.
Meet the needs of individual departments (A): While departmental needs are important, the focus of patient safety is on standardizing practices across the organization.
Make errors non-transparent (C): Transparency is crucial in patient safety to learn from errors and improve practices.
Prevent all occurrences (D): While the goal is to minimize errors, it is unrealistic to prevent all occurrences; instead, the focus is on managing and mitigating risks.
Reference
NAHQ Body of Knowledge: Standardization in Patient Safety
NAHQ CPHQ Exam Preparation Materials: Principles of Patient Safety Planning

**NEW QUESTION: 238**
Based on the chart below, implementing which of the following technologies may have the greatest impact on reducing adverse events related to medication processes?




**A.** computerized physician order entry
**B.** barcode medication system
**C.** automated medication cabinets
**D.** clinical decision support tools
**Answer: (SHOW ANSWER)**
Based on the chart, which shows that administering errors are the most frequent type of medication error, implementing a barcode medication system would likely have the greatest impact on reducing adverse events. Barcode systems help ensure that the right patient receives the right medication at the right dose and time by requiring a scan of both the patient's ID and the medication barcode before administration. This technology directly addresses the stage where most errors occur, thereby reducing the likelihood of administering errors.
Computerized physician order entry (A): This system would primarily reduce ordering errors, which are less frequent than administering errors in this data.
Automated medication cabinets (C): These help with dispensing errors, but these errors are less frequent than administering errors.
Clinical decision support tools (D): These tools help reduce evaluation and ordering errors but do not directly address the high rate of administering errors.
Reference
NAHQ Body of Knowledge: Medication Safety and Technology Interventions
NAHQ CPHQ Exam Preparation Materials: Reducing Medication Errors with Technology

**NEW QUESTION: 239**
The primary purpose of a management information system is to:
**A.** Computerize operations for greater effectiveness.
**B.** Provide information that facilitates management decisions.

**C.** Guarantee better coordination of organizational change.
**D.** Provide data for quality assessment.
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 240**
In healthcare, many terms call for more precise operational definitions that how do an organization define the terms
such as:
**A.** An accurate environmental compliance
**B.** A patient fall (a partial fall, a fall with injuries, or an assisted fall)
**C.** Qui turnaround time
**D.** Surgical end time
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 241**
The separate services of Pharmacy and Nursing are having difficulty developing an action plan for medication errors. Pharmacy Services states that Nursing Services causes the majority of the problems related to errors, while Nursing Services states the opposite.
The quality professional's role in resolving this problem is to:
**A.** Facilitate discussion between the groups to enable them to assume ownership of their portions of the problem
**B.** Assign the task to an uninvolved manager
**C.** Refer the problem to the facility wide quality council
**D.** Provide them with directives on how to solve the problem
**Answer: (SHOW ANSWER)**

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**NEW QUESTION: 242**
Which of the following is the most effective means of communicating commitment to patient safety?
**A.** CEO presenting most recent medication error rates to the governing body
**B.** articles by a CEO in the employee newsletter
**C.** posters and bulletin boards on units displaying up-to-date patient falls data
**D.** senior leaders having discussions on units with front-line staff

**Answer: D (LEAVE A REPLY)**
Effective communication in healthcare is paramount for patient safety. It is the accurate transfer of information between two or more providers1. Communication fails when it is incomplete, ineffective, or inappropriate, resulting in patient harm1. Good teamwork and effective communication rely on mutual respect, problem-solving, and sharing of ideas1.
Senior leaders having discussions on units with front-line staff is a direct and effective means of communication. It allows for immediate feedback, clarification of doubts, and a better understanding of the situation on the ground2. This direct interaction can foster a culture of safety, encourage the sharing of ideas, and promote problem-solving1.
In contrast, the other options (A, B, and C) are less direct and may not effectively communicate the commitment to patient safety. For example, presenting error rates or displaying data on bulletin boards (options A and C) are important but may not lead to immediate action or feedback. Similarly, articles in a newsletter (option B) may not reach all staff or may not be read thoroughly.
Reference: 1, 2
https://psnet.ahrq.gov/perspective/approach-improving-patient-safety-communication

**NEW QUESTION: 243**
Why is it important to convene a multidisciplinary team when conducting a failure mode and effects analysis (FMEA)?
**A.** so that all steps in the process are captured and evaluated
**B.** so the effective evaluation of the proposed changes may be accomplished
**C.** to gain buy-in from senior leadership
**D.** to help distribute the workload involved in a FMEA
**Answer: A (LEAVE A REPLY)**
A Failure Mode and Effects Analysis (FMEA) is a systematic method used to identify potential failures in a process and assess their impact.
Convening a multidisciplinary team is crucial for the following reasons:
Comprehensive Process Understanding:
A multidisciplinary team brings together diverse expertise, ensuring that all aspects of the process are considered. Different professionals can provide insights into various steps that may not be evident to others.
Capturing All Potential Failures:
Each discipline involved in the process can identify specific failure modes that others might overlook.
For instance, a nurse might identify different potential issues in patient care compared to a pharmacist or a physician.
Holistic Evaluation:
The presence of various disciplines ensures that both clinical and non-clinical aspects of the process are evaluated. This thorough evaluation is critical in identifying all potential risks and mitigating them effectively.
Avoiding Blind Spots:

By involving a multidisciplinary team, the FMEA is less likely to miss critical steps or potential failure points, leading to a more robust and effective analysis.
Other options like gaining buy-in, evaluating proposed changes, or distributing workload are important but secondary to the primary goal of ensuring a comprehensive evaluation of all process steps in the FMEA.
Reference: NAHQ Guide to Risk Management and Patient Safety
NAHQ Healthcare Quality Competency Framework: Process Improvement

**NEW QUESTION: 244**
In addition to being a good communicator, an essential characteristic of a quality champion is:
**A.** Serving as a department head or chief.
**B.** Being highly respected by peers.
**C.** Being a quality improvement expert.
**D.** Having excellent technological skills.
**Answer: B (LEAVE A REPLY)**
A quality champion plays a pivotal role in leading and advocating for quality improvement initiatives within healthcare organizations. Beyond effective communication skills, being highly respected by peers is an essential characteristic for a quality champion. Respect from colleagues enhances the champion's ability to influence and motivate others, facilitating the adoption of quality improvement practices.
Key reasons why peer respect is crucial include:
* Influence: Respected individuals are more likely to persuade others to embrace change and participate in quality initiatives.
* Credibility: Peers are more inclined to trust and follow leaders whom they hold in high esteem.
* Collaboration: Respect fosters a collaborative environment, encouraging open dialogue and teamwork essential for successful quality improvement.
While the other options may contribute to a quality champion's effectiveness, they are not as universally critical as peer respect:
* Serving as a department head or chief (Option A): Holding a leadership position can be beneficial but is not necessary for one to be an effective quality champion.
* Being a quality improvement expert (Option C): Expertise in quality improvement is valuable; however, the ability to lead and inspire change often hinges more on interpersonal skills and respect.
* Having excellent technological skills (Option D): Technological proficiency can aid in implementing certain aspects of quality improvement but is not a core requirement for a quality champion.
Therefore, in addition to being a good communicator, being highly respected by peers is fundamental to the success of a quality champion.
References:

* A study published in Implementation Science identified "influence" and "participative leadership style" as key attributes of effective champions, underscoring the importance of being respected and trusted by peers.
* The National Association for Healthcare Quality (NAHQ) highlights the role of healthcare quality professionals in engaging stakeholders and fostering teamwork, which are facilitated by mutual respect.

**NEW QUESTION: 245**

Prior to the implementation of a new electronic health record (EHR), a facility charters a failure mode and effects analysis (FMEA) team. After mapping out the process for creating a new patient chart, the next step should be to:

**A.** Examine each step for potential process failures.
**B.** Determine the reasons for identified process failures.
**C.** Calculate risk priority numbers for each process failure.
**D.** Consider the consequences of each process failure.

**Answer: (SHOW ANSWER)**

Failure Mode and Effects Analysis (FMEA) is a proactive risk assessment tool used to identify potential failure points in a process before they occur. It is widely used in healthcare to improve patient safety and reduce errors, particularly during major system changes like EHR implementation.

Steps in FMEA:

* Map the Process: The team outlines each step in the process (already completed in the scenario).
* Identify Potential Failure Modes (Correct Answer - Option A):
* The next step after mapping the process is to analyze each step for potential failures that could cause disruptions or errors.
* Consider the Consequences (Option D): Once failures are identified, their possible impacts on patient care and workflow are examined.
* Determine Root Causes (Option B): The team investigates why failures might occur and identifies contributing factors.
* Calculate Risk Priority Numbers (Option C): Risk is quantified using Severity × Occurrence × Detectability, helping to prioritize issues for improvement.
* Implement and Monitor Improvements: Solutions are developed, tested, and continuously evaluated.

Why Other Options Are Incorrect:

* Option B (Determine reasons for failures): This step comes after identifying potential failures.
* Option C (Calculate risk priority numbers): RPN calculations occur after failure modes are identified and analyzed.
* Option D (Consider consequences): Consequences are evaluated after potential failure modes are identified.

Thus, the correct next step is A. Examine each step for potential process failures.

References:
* NAHQ's "HQ Solutions: Resource for the Healthcare Quality Professional"
* Agency for Healthcare Research and Quality (AHRQ) - "Using FMEA to Improve Patient Safety"

**NEW QUESTION: 246**
Which of the following processes is most cost-effective in preventing unnecessary resource consumption in the hospital?
**A.** Accurate DRG assignment at admission
**B.** Preadmission insurance benefit denials
**C.** Second opinions for all surgeries
**D.** Effective preadmission screening
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 247**
A quality professional is creating a training session for clinical leaders about quality improvement. Which of the following should be incorporated into the training?
**A.** Limit discussion on case studies from external organizations.
**B.** Give training participants the opportunity to practice what was taught.
**C.** Introduce complex concepts first to allow time for understanding.
**D.** Explain quality improvement roles for leaders at all levels of the organization.
**Answer: B (LEAVE A REPLY)**
In a quality improvement training session, it is essential to give participants the opportunity to practice what was taught. This hands-on approach helps reinforce learning, allows participants to apply concepts in a real or simulated environment, and ensures that they are better prepared to implement quality improvement initiatives in their own work settings.
Limit discussion on case studies from external organizations (A): Case studies are valuable for illustrating concepts and should not be limited.
Introduce complex concepts first to allow time for understanding (C): It is generally better to start with basic concepts and gradually introduce more complex ideas.
Explain quality improvement roles for leaders at all levels (D): While important, this is a part of the training content but not the primary focus for effective learning compared to practice opportunities.
Reference
NAHQ Body of Knowledge: Education and Training in Quality Improvement
NAHQ CPHQ Exam Preparation Materials: Effective Training Methods

**NEW QUESTION: 248**
Each department in a hospital self-monitors and reports hand hygiene data each quarter. Results typically fall within the 58-72% range, with the exception of Respiratory Therapy, which consistently reports 100% compliance.
Which of the following steps should a healthcare quality professional take next?

**A.** Provide remedial hand hygiene training for the lowest scoring departments.
**B.** Recognize the Respiratory Therapy department for its outstanding compliance.
**C.** Require departments not achieving at least 95% compliance to develop corrective action plans.
**D.** Validate that the Respiratory Therapy results are accurate.
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 249**
The ability to report survey results at an actionable level is critical; in most cases, actionable level means:
**A.** Service level
**B.** The nursing unit
**C.** Average time frame of a service
**D.** Location of service
**Answer: B,D (LEAVE A REPLY)**

**NEW QUESTION: 250**
A local health center is launching a community health assessment. What data is recommended to identify the potential needs of the population?
**A.** zip codes for patients frequently using the emergency department
**B.** highest level of education of healthcare professionals
**C.** top five diagnoses for patient visits
**D.** number of fast food restaurants in the area
**Answer: C (LEAVE A REPLY)**
When launching a community health assessment, identifying the top five diagnoses for patient visits is recommended to understand the prevalent health issues within the population. This data helps pinpoint the most common health concerns and prioritize areas for intervention and resource allocation. It provides a clear picture of the community's health needs, which is essential for planning effective public health strategies.
* Zip codes for patients frequently using the emergency department (A): This can identify geographic areas of need but does not provide direct information on the types of health issues prevalent in the community.
* Highest level of education of healthcare professionals (B): This is related to workforce capabilities rather than community health needs.
* Number of fast food restaurants in the area (D): While relevant to understanding certain social determinants of health, it does not directly identify specific health needs.
References
* NAHQ Body of Knowledge: Community Health Assessment and Needs Identification
* NAHQ CPHQ Exam Preparation Materials: Data Collection for Community Health Improvement
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**NEW QUESTION: 251**

A skilled nursing facility has implemented a process to address delays in diagnostic test result availability to the ordering provider.

Which of the following measurements will best document improvement in this process?

**A.** lost specimen rate

**B.** turnaround time

**C.** average length of stay

**D.** provider satisfaction

**Answer: B (LEAVE A REPLY)**

The best measurement to document improvement in the process of addressing delays in diagnostic test result availability is turnaround time. Turnaround time measures the total time from when a diagnostic test is ordered to when the results are available to the ordering provider. This directly reflects the efficiency of the process and the impact of any improvements made to reduce delays. Lost specimen rate (A): This measures a different aspect of the process (specimen handling), not the speed of result availability.

Average length of stay (C): This is a broader measure that may be influenced by many factors beyond diagnostic test turnaround time.

Provider satisfaction (D): While important, it is a subjective measure and may not directly reflect process efficiency improvements.

Reference

NAHQ Body of Knowledge: Measuring and Improving Turnaround Time in Healthcare Processes

NAHQ CPHQ Exam Preparation Materials: Metrics for Process Improvement

**NEW QUESTION: 252**

Which of the following regulatory agencies oversee development of electronic clinical quality measures (eCQMs)?

**A.** DNV GL Healthcare

**B.** The Joint Commission (TJC)

**C.** Centers for Medicare and Medicaid Services (CMS)

**D.** Occupational Safety and Health Association (OSHA)

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 253**

Once you have resolved these issues, the data collection should go smoothly. Unfortunately, many quality improvement teams do not spend sufficient time discussing their data collection plans. They want to move immediately to data collection step.

This haste usually guarantees that the team will:

**A.** Reschedule the time and cost

**B.** Collect the wrong data

**C.** Become frustrated with the entire measurement journey

**D.** Collect too much (or too little) data

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 254**

Systematic sampling is achieved by numbering or ordering each element in the population (e.g., time order,
alphabetical order, and medical order) and then selecting every kth element. The key point that most people ignore
when doing a systematic sample is that:

**A.** The starting point for selecting every kth element should be guaranteed through a random process and should be
equal to or less than k but greater than zero.

**B.** The starting point for selecting every kth element should be guaranteed through a random process and should be
greater than zero.

**C.** The starting point for selecting every kth element should be guaranteed through a random process and should be
less than k but greater than zero.

**D.** The starting point for selecting every kth element should be guaranteed through a random process and should be
equal to or greater than zero.

**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 255**

A hospital Is anticipating an accreditation survey In the next four months, and the quality director forms a team to ensure compliance with current requirements.
This indicates the hospital Is

**A.** Implementing continuous survey readiness.

**B.** preparing for sustained compliance following the survey.

**C.** minimizing resources needed to demonstrate compliance.

**D.** practicing just-in-time readiness.

**Answer: D (LEAVE A REPLY)**

The scenario described involves a hospital that is forming a team specifically in anticipation of an accreditation survey within the next four months. This approach is indicative of an effort to ensure all standards and requirements are met by the time of the survey, which is a targeted and time-specific preparation strategy.
Option D, "practicing just-in-time readiness," best describes this action. This term refers to preparing for an event (such as an accreditation survey) shortly before it occurs, focusing on ensuring that all criteria are met right before the inspection or evaluation, rather than maintaining continuous compliance over time.

**NEW QUESTION: 256**

Which of the following measures would best evaluate the health of a metropolitan area?
**A.** Life expectancy
**B.** Average birth weight
**C.** Quality-adjusted life year
**D.** Maternal mortality rate
**Answer: (SHOW ANSWER)**
Evaluating the health of a metropolitan area requires comprehensive measures that reflect the overall well- being of its population. Among the options provided, life expectancy is the most encompassing indicator.
* Life Expectancy: This measure indicates the average number of years a person can expect to live, based on current mortality rates. It reflects the overall mortality level of a population and is influenced by a wide range of factors, including healthcare quality, socioeconomic conditions, and public health initiatives.
While the other measures provide valuable insights, they are more specific:
* Average Birth Weight: This metric focuses on newborn health and can indicate maternal health and prenatal care quality but does not encompass the broader population.
* Quality-Adjusted Life Year (QALY): QALY measures the value of health outcomes by combining quantity and quality of life. It's often used in health economics to assess the value of medical interventions but is less commonly applied to assess the overall health of a metropolitan area.
* Maternal Mortality Rate: This rate measures the number of maternal deaths per 100,000 live births.
While it is a critical indicator of women's health and healthcare quality, it does not provide a comprehensive view of the entire population's health.
Therefore, life expectancy serves as the most comprehensive measure among the options listed for evaluating the health of a metropolitan area.
References:
* City Health Dashboard - "Metrics Background"
* National Center for Biotechnology Information (NCBI) - "Measuring, Monitoring, and Evaluating the Health of a Population"

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**NEW QUESTION: 257**
Patients hospitalized for congestive heart failure should be able to walk farther, have more energy, and experience

less shortness of breath following hospital treatment. Patients who undergo total knee replacements should have less
knee pain when they talk; have a good range of joint motion; and be able to perform activities of daily living such as
walking, doing yard work, and performing normal household chores. This example shows that:

**A.** Treatment is a very sensitive process

**B.** The purpose of medical treatment and hospital procedures is to improve patients' functional status or quality of life

**C.** There should be full engagement at the management and staff level

**D.** Patient treatment results are regularly reviewed

**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 258**

Patients and their families have clearly articulated need respect to the care they receive. If the staff members they
encounter are nice but do not meet their needs, these staff members have delivered care inefficiently. It all means
that:

**A.** How can patients rate the skill of their doctors?

**B.** No one comes here for a good time

**C.** The patient/family is very difficult or dysfunctional

**D.** Nice is not the only aspect of quality care

**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 259**

A focused professional practice evaluation (FPPE) Is Initiated

**A.** annually for all providers on staff.

**B.** during the survey corrective action period.

**C.** at the discretion of the chief medical officer (CMO).

**D.** when new privileges are granted.

**Answer: D (LEAVE A REPLY)**

A Focused Professional Practice Evaluation (FPPE) is a process used to assess a practitioner's competence in performing specific privileges, including new ones1234. This process is initiated when a practitioner is granted new privileges1234. The FPPE process is designed to ensure that practitioners can competently perform the privileges requested at the organization1. It is also used when there is a question about a currently privileged practitioner's ability to provide safe, high-quality patient care1. The FPPE process must be predefined and consistently implemented for all newly requested privileges1. The period of FPPE begins at the time privileges are granted1.

Reference: 1234

**NEW QUESTION: 260**
Measures of central tendency describe the:
**A.** Typical or middle data point
**B.** Average distance of any point in the data set from the mean
**C.** Type and number of classes for dividing the data
**D.** Extent to which the data points are scattered
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 261**
__________ are similar to proportion measures in that both are based on count (or attributes) data but differ in that
the numerator and the denominator address different attributes.
**A.** Predicted rate
**B.** Ratio measures
**C.** Continuous variable measures
**D.** Outcome measures
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 262**
Healthcare organizations' ability to deliver high-quality, patient-centered care to their members and patients depends
in part on their understanding of basic customer service principles and their ability to integrate these principles into
clinical settings. Healthcare organizations should pay attention to customer service for several reasons. Which of the
following is NOT out of t hose reasons?
**A.** Existing patients and members are a valuable source of information healthcare organizations can use to learn how
to improve what they do and reduce waste by eliminating services that are unnecessary or not valued
**B.** As in any other service industry, a satisfied (and loyal) member or patient creates value over the course of a life
ti me.
**C.** Poor customer service raises the risk of a negative "grapevine effect"
**D.** Better service translates into higher satisfaction for the patient and, subsequently, for the employer who pays most
of the bills
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 263**

A team has been working together for six months to improve a patient outcome, and the desired result has not been achieved. An assessment of team effectiveness was conducted and revealed the following:

| Goal | Score |
|---|---|
| Team Productivity | 90% |
| Team Member Satisfaction | 96% |
| Team Member Growth | 95% |

The healthcare quality professional should recommend

**A.** evaluating barriers impacting team productivity.

**B.** developing interventions to maintain team member satisfaction.

**C.** continuing to monitor as the team is performing within acceptable limits.

**D.** creating a reward system based on team member growth.

**Answer: A (LEAVE A REPLY)**

The assessment reveals that while team member satisfaction and growth scores are high (96% and 95% respectively), team productivity is slightly lower at 90%. Since the desired patient outcome has not been achieved, it is important to identify and address any barriers that may be hindering the team's productivity. By evaluating these barriers, the team can better understand the factors impacting their ability to meet their goals, such as workflow inefficiencies, resource limitations, or external factors affecting performance.

The other options are less relevant in this context:

* Developing interventions to maintain team member satisfaction (B) is unnecessary at this point, as satisfaction is already high.
* Continuing to monitor as the team is performing within acceptable limits (C) does not address the fact that the desired outcomes have not been achieved.
* Creating a reward system based on team member growth (D) is unrelated to the immediate issue of productivity and patient outcomes.

References:

* National Association for Healthcare Quality (NAHQ) - Certified Professional in Healthcare Quality (CPHQ) Study Materials.
* Team Effectiveness and Productivity Barriers, NAHQ Documentation.

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**NEW QUESTION: 264**

A social service department regularly monitors the number of inappropriate referrals, the timeliness of discharge planning, and the number of days of discharge delays.

What additional monitor should be added to evaluate the appropriateness of social service interventions?

**A.** Attainment of social service goals

**B.** Timeliness of referrals to social services

**C.** Number of social service referrals from nursing
**D.** Inadequacy of documentation in progress notes
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 265**
Why is it important to convene a multidisciplinary team when conducting a failure mode and effects analysis (FMEA)?
**A.** so that all steps in the process are captured and evaluated
**B.** so the effective evaluation of the proposed changes may be accomplished
**C.** to gain buy-in from senior leadership
**D.** to help distribute the workload involved in a FMEA
**Answer: A (LEAVE A REPLY)**
A Failure Mode and Effects Analysis (FMEA) is a systematic method used to identify potential failures in a process and assess their impact. Convening a multidisciplinary team is crucial for the following reasons:
* Comprehensive Process Understanding:
* A multidisciplinary team brings together diverse expertise, ensuring that all aspects of the process are considered. Different professionals can provide insights into various steps that may not be evident to others.
* Capturing All Potential Failures:
* Each discipline involved in the process can identify specific failure modes that others might overlook. For instance, a nurse might identify different potential issues in patient care compared to a pharmacist or a physician.
* Holistic Evaluation:
* The presence of various disciplines ensures that both clinical and non-clinical aspects of the process are evaluated. This thorough evaluation is critical in identifying all potential risks and mitigating them effectively.
* Avoiding Blind Spots:
* By involving a multidisciplinary team, the FMEA is less likely to miss critical steps or potential failure points, leading to a more robust and effective analysis.
Other options like gaining buy-in, evaluating proposed changes, or distributing workload are important but secondary to the primary goal of ensuring a comprehensive evaluation of all process steps in the FMEA.
References:
* NAHQ Guide to Risk Management and Patient Safety
* NAHQ Healthcare Quality Competency Framework: Process Improvement
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**NEW QUESTION: 266**
In order to make effective long-term changes, performance Improvement emphasizes the need to study and understand

**A.** outcomes.
**B.** statistics.
**C.** standards.
**D.** processes.
**Answer: D (LEAVE A REPLY)**
Performance improvement (PI) is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement1.
PI is based on the assumption that most problems are related to the processes rather than the people who perform them2. Therefore, studying and understanding the processes that deliver the services or outcomes is essential to identify the root causes of problems, the gaps between current and desired performance, and the potential solutions to improve them34.
PI uses various methods and tools to analyze and measure processes, such as flowcharts, process maps, cause-and-effect diagrams, Pareto charts, histograms, control charts, run charts, and scatter diagrams5. These tools help to visualize the steps, inputs, outputs, and variations of a process, and to monitor and evaluate its performance over time6.
PI also uses various models and frameworks to guide and accelerate improvement work, such as the Model for Improvement, Plan-Do-Study-Act (PDSA) cycles, Lean, Six Sigma, and Total Quality Management (TQM)7. These models and frameworks help to define the aim, the measures, and the changes for improvement, and to test and implement them in a systematic and iterative way8. Therefore, in order to make effective long-term changes, PI emphasizes the need to study and understand the processes that produce the services or outcomes, as this will help to identify and address the sources of variation, waste, and inefficiency, and to achieve better quality, safety, equity, value, and system sustainability9 .
Reference: 1: QAPI Description and Background | CMS 2: Basics of Quality Improvement | AAFP 3: How to Improve: Model for Improvement | Institute for Healthcare Improvement 4: Performance Management and Quality Improvement - CDC 5: [Tools for Quality Improvement | NAHQ] 6: [Quality Improvement Tools and Methods | Agency for Healthcare Research and Quality] 7: [Quality Improvement Models and Frameworks | NAHQ] 8: [Quality Improvement Essentials Toolkit | Institute for Healthcare Improvement]
9: [Healthcare Quality and Safety Workforce Report: New Imperatives for Quality and Safety Mean New Imperatives for Workforce Development | NAHQ]: [The Financial Case for Quality as a Business Strategy
| NAHQ] :
[Tools for Quality Improvement | NAHQ]: [Quality Improvement Tools and Methods | Agency for Healthcare Research and Quality]: [Quality Improvement Models and Frameworks | NAHQ] : [Quality Improvement Essentials Toolkit | Institute for Healthcare Improvement]: [Healthcare Quality and Safety Workforce Report: New Imperatives for Quality and Safety Mean New Imperatives for Workforce Development | NAHQ]: [The Financial Case for Quality as a Business Strategy | NAHQ]

10: Tools for Quality Improvement | NAHQ: Quality Improvement Tools and Methods | Agency for Healthcare Research and Quality

**NEW QUESTION: 267**
A healthcare organization wishes to develop an education plan for quality and patient safety. Based on adult learning principles, the planned education Is most likely to be effective when
**A.** training is provided by a subject matter expert, attendees have opportunities to ask questions, and written materials are provided.
**B.** the content Is designed to meet accreditation standards, the training Is highly encouraged, and learners are allowed to obtain on-demand training.
**C.** the program Is designed for delivery at the department level, staff are recognized for attendance, and written competency tests are administered.
**D.** there is opportunity for active participation, staff members recognize a need to learn, and the material is presented in a logical progression.
**Answer: D (LEAVE A REPLY)**
Adult learning principles, also known as andragogy, emphasize the value of the process of learning. It includes techniques such as active participation, practical experiences, problem-solving, and the relevance of learning to real-life situations12345.
* Active Participation: Adult learners are internally motivated and self-directed4. They prefer to be actively involved in their learning process12345. This can be achieved through discussions, practical exercises, and problem-solving activities1.
* Recognize a Need to Learn: Adults are goal-oriented and relevancy-oriented4. They are more likely to engage in learning if they recognize the need for it and see the relevance of the learning to their work or personal life12345.
* Logical Progression: Adults bring life experiences and knowledge to learning experiences4. They prefer learning that is structured and presented in a logical progression12345. This helps them connect new learning with their existing knowledge and experiences, making the learning more meaningful and easier to retain.
In the context of developing an education plan for quality and patient safety in a healthcare organization, these principles translate into a program where staff members actively participate, recognize a need to learn, and the material is presented in a logical progression. This approach aligns with option D and is most likely to result in effective learning outcomes.
Adult learning principles emphasize that adults learn best when they are actively engaged in the learning process, see the relevance of the information to their own experience, and are able to apply the knowledge to solve problems. Therefore, educational programs that offer active participation, cater to recognized learning needs, and present material in a logical sequence that builds upon previous knowledge, are more likely to be effective. Such programs engage learners and foster a better understanding and retention of the material, which is vital for implementing quality and patient safety initiatives in healthcare settings.

References:The application of adult learning principles to education plans in healthcare is a recommendation supported by NAHQ. These principles are fundamental to designing effective education programs for healthcare professionals to improve quality and patient safety.

**NEW QUESTION: 268**

The desired outcome of peer review Is to

**A.** evaluate process Improvement Initiatives.

**B.** compare provider performance.

**C.** Improve the quality of care.

**D.** limit privileges of at-risk providers.

**Answer: C (LEAVE A REPLY)**

According to the National Association for Healthcare Quality (NAHQ), peer review is a quality control measure for medical research and practice, in which professionals review each other's work to ensure that it is accurate, relevant, and significant12.

The overall purpose of peer review is to improve the quality of care by enhancing the scientific validity, transparency, and integrity of published research, as well as the clinical performance, safety, and outcomes of healthcare providers1234.

Among the four options given, the best answer is C. Improve the quality of care, because this is the ultimate goal and benefit of peer review, regardless of the specific methods, metrics, or settings involved1234.

The other options are less accurate because:

A: Evaluate process improvement initiatives is a possible outcome of peer review, but not the desired one. Peer review can help assess the effectiveness, efficiency, and sustainability of process improvement initiatives, but the aim is not to evaluate them for their own sake, but to improve the quality of care for patients125.

B: Compare provider performance is a possible outcome of peer review, but not the desired one. Peer review can help compare provider performance against established standards, benchmarks, or best practices, but the aim is not to rank or judge them, but to identify areas of strength and weakness, and to provide feedback and support for improvement126.

D: Limit privileges of at-risk providers is a possible outcome of peer review, but not the desired one. Peer review can help identify and address at-risk providers who may pose a threat to patient safety or quality of care, but the aim is not to punish or exclude them, but to protect patients and to help providers remediate their performance or behavior127.

Reference: 1: [Peer review: What is it and why do we do it?] 2: [Peer Review Matters: Research Quality and the Public Trust] 3: [Peer review of quality of care: methods and metrics] 4: [What is the purpose of peer review in health care?] 5:
[Utilization of Improvement Methodologies by Healthcare Quality Professionals During the COVID-19 Pandemic] 6: [Shaping the Future of the Healthcare Quality Profession] 7:
[Understanding the Evolving Landscape of Healthcare Quality]:
https://www.medicalnewstoday.com/articles/281528:

https://pubs.asahq.org/anesthesiology/article/134/1/1/114542/Peer-Review-Matters-Research-Quality- and-the: https://qualitysafety.bmj.com/content/32/1/1: https://www.mlsgroupllc.com/mls-blog/what-is-the- purpose-of-peer-review-in-health-care: https://nahq.org/resources/journal

**NEW QUESTION: 269**

Which of the following is the quality professional's first step prior to implementing a new infection prevention protocol in the clinic?

**A.** Create an education program around the protocol.

**B.** Implement an audit process.

**C.** Solicit support from key stakeholders.

**D.** Develop a communication plan.

**Answer: (SHOW ANSWER)**

Before implementing a new infection prevention protocol in a clinic, the first step for a quality professional should be to solicit support from key stakeholders. This step is crucial for several reasons:

* Building Consensus and Buy-In: Gaining the support of key stakeholders, such as clinic leadership, department heads, and influential staff members, is critical for the successful implementation of the new protocol. Without their buy-in, the protocol may face resistance, which can hinder its effectiveness.

* Resource Allocation: Key stakeholders often control the resources-both financial and human-that are necessary for the implementation of new protocols. Their support ensures that the necessary resources are allocated and that the protocol is prioritized within the organization.

* Ensuring Alignment with Organizational Goals: Engaging stakeholders ensures that the new protocol aligns with the clinic's broader goals and priorities. This alignment increases the likelihood that the protocol will be integrated smoothly into existing practices and will be supported by ongoing quality improvement efforts.

* Facilitating Communication and Education: Once stakeholder support is secured, they can help champion the protocol, assist with communication efforts, and advocate for necessary staff education and training, all of which are critical for successful implementation.

References: (Based on Healthcare Quality NAHQ documents and resources)

* NAHQ Modules on Stakeholder Engagement.

* CPHQ Study Guide, Section on Leadership and Communication.

* Quality Improvement in Healthcare, Article on Implementing New Protocols.

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**NEW QUESTION: 270**

Accountability for quality ultimately rests with the

**A.** governing body.

**B.** quality manager.

**C.** CEO.

**D.** department leader.

**Answer: A (LEAVE A REPLY)**
* Accountability for quality ultimately rests with the governing body of a health care organization, such as the board of directors or trustees. The governing body is responsible for setting the vision, mission, values, and strategic goals of the organization, as well as overseeing its performance, compliance, and risk management. The governing body also appoints, evaluates, and supports the CEO, who is accountable to the governing body for implementing the organization's strategy and ensuring quality and safety throughout the organization.
* The quality manager, the CEO, and the department leader are all important roles in ensuring quality within their respective scopes of authority and responsibility, but they are not the ultimate source of accountability for quality. The quality manager is responsible for designing, coordinating, and evaluating quality improvement initiatives, as well as providing education, training, and support to staff and leaders on quality methods and tools. The CEO is responsible for providing leadership, direction, and oversight to the organization's operations, finances, and culture, as well as ensuring alignment and integration of quality across all functions and levels. The department leader is responsible for managing the daily activities, resources, and performance of a specific unit or service, as well as ensuring compliance with quality standards and policies within their area of responsibility.
* However, none of these roles can ensure quality without the support, guidance, and accountability of the governing body, which has the ultimate authority and responsibility for the organization's quality and safety. The governing body sets the tone and expectations for quality at the top, and holds the CEO and other leaders accountable for delivering quality outcomes and improving quality processes. The governing body also monitors and evaluates the organization's quality performance and improvement efforts, and ensures that the organization has the necessary resources, structures, and systems to support quality. The governing body also ensures that the organization engages with external stakeholders, such as regulators, accreditors, payers, and patients, to demonstrate its commitment and accountability for quality.
References:
* NAHQ Code of Ethics, Principle 1: The healthcare quality professional acts as a change agent and leader within the organization and community, promoting a culture of excellence in quality, safety, and performance outcomes.
* NAHQ Learning Lab: The Role of the Healthcare Quality Professional in Population Health Management, Module 1: Introduction to Population Health Management, Slide 9: The Role of the Governing Body
* NAHQ Journal for Healthcare Quality, Volume 41, Issue 2, March/April 2019, Article: The Role of the Board in Quality and Safety Performance: Perceptions of Board Members and Quality Leaders, Page
72: Abstract and Page 77: Discussion

**NEW QUESTION: 271**
An organization Is shirting paradigms from top-down leadership to participatory management. The process of moving forward Includes the four Identified phases below:

1. gathering baseline data
2. evaluating effectiveness and Improvement
3. making the commitment
4. Implementing the program

Which of the following Is the most logical sequence for these phases?

**A.** 1.2,4,3
**B.** B. 1.3.2.4
**C.** 3.1,4.2
**D.** 3.4.1.2

**Answer: C (LEAVE A REPLY)**

* The most logical sequence for the phases of shifting from top-down leadership to participatory management is to start with making the commitment, then gathering baseline data, implementing the program, and evaluating effectiveness and improvement.
* Making the commitment is the first step because it involves creating a shared vision, setting goals and objectives, and securing support and resources for the change process12. Without a clear and strong commitment, the other steps may not be feasible or successful.
* Gathering baseline data is the second step because it helps to assess the current situation, identify the gaps and needs, and establish a baseline for comparison and measurement13. Data can be collected from various sources, such as surveys, interviews, observations, and records, and can cover aspects such as organizational culture, performance, quality, satisfaction, and costs13.
* Implementing the program is the third step because it involves putting the plan into action, engaging and empowering the staff and stakeholders, and monitoring andadjusting the process as needed14. Implementation can be done in phases, pilots, or trials, depending on the scope and complexity of the program14.
* Evaluating effectiveness and improvement is the fourth step because it helps to measure the outcomes, impacts, and benefits of the program, compare them with the baseline data and the goals and objectives, and identify the strengths, weaknesses, and areas for improvement15. Evaluation can be done using quantitative and qualitative methods, such as indicators, metrics, feedback, and stories, and can be conducted at different levels, such as individual, team, and organizational15.

References: 1: Participatory Leadership for Health 2: Quality improvement and person-centredness: a participatory mixed methods study to develop the 'always event' concept for primary care 3: Why healthcare leadership should embrace quality improvement 4: PARTICIPATIVE MANAGEMENT IN HEALTH CARE SERVICES 5: [Utilization of Improvement Methodologies by Healthcare Quality Professionals During the COVID-19 Pandemic]

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**been updated** and **answers have been corrected** get the **newest** PrepPdf.com CPHQ dumps with Test Engine here: https://www.preppdf.com/NAHQ/CPHQ-prepaway-exam-dumps.html (**808** Q&As Dumps, **40%OFF Special Discount: Exam-Tests**)

**NEW QUESTION: 272**
Following evaluation of the compounding process used by a pharmacy, the batch compounding consistently yields 12% more drug than Is needed. The excess Is stored until used or expired. Which of the following types of waste should be recorded when reporting this finding?
**A.** inventory
**B.** overproduction
**C.** extra processing
**D.** overuse
**Answer: (SHOW ANSWER)**
The question is about the type of waste that should be recorded when a pharmacy's compounding process consistently yields more drug than is needed. This excess is stored until it is used or expired. In the context of waste in healthcare, this scenario is a clear example of overproduction.
Overproduction refers to situations where more product is produced than is required at that time. This is a form of waste because it leads to unnecessary storage and potential disposal if the product expires or becomes obsolete1.
Reference: https://www.leanblog.org/eight-types-of-waste-in-healthcare/

**NEW QUESTION: 273**
Credentialing refers to the process of _______________ a well-qualified staff that is able to deliver highest-quality care.
**A.** Compensating
**B.** Nominating
**C.** Hiring
**D.** Awarding
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 274**
The collection, analysis, and Interpretation of data for planning, Implementing, and evaluating health programs is
**A.** prevalence.
**B.** surveillance.
**C.** Incidence.
**D.** sampling.
**Answer: B (LEAVE A REPLY)**
The term "surveillance" in public health is defined as the ongoing, systematic collection, analysis, and interpretation of health-related data. This process is essential to the planning,

implementation, and evaluation of public health practice1. Therefore, the collection, analysis, and interpretation of data for planning, implementing, and evaluating health programs is referred to as "surveillance".
Reference: 1

**NEW QUESTION: 275**
The median is defined as the
**A.** difference between a data item and the mean of a data set.
**B.** most frequently occurring value in a data set.
**C.** arithmetic average of a data set.
**D.** number that divides an ordered data set into two equal parts.
**Answer: (SHOW ANSWER)**
The median is a measure of central tendency in statistics that represents the middle value of an ordered data set.
* Data Set Ordering: To find the median, the data set must first be arranged in ascending or descending order.
* Middle Value Identification: The median is the value that divides the data set into two equal parts, with
50% of the data points lying below it and 50% above it. If the number of observations is odd, the median is the middle number; if even, it is the average of the two middle numbers.
* Robustness: Unlike the mean, the median is not affected by extreme values (outliers), making it a more robust measure of central tendency in skewed distributions.
References: (Based on Healthcare Quality NAHQ documents and resources)
* NAHQ Study Guide on Statistical Methods in Quality Improvement.
* Quality Management in Health Care, Chapter on Measures of Central Tendency.
=========

**NEW QUESTION: 276**
Which of the following is the best strategy to increase a community's annual influenza vaccination rate?
**A.** Empower the community to take on its own problem-solving
**B.** Form a community coalition tasked with developing local interventions
**C.** Contract with pharmaceutical company to distribute vaccines
**D.** Review vaccine distribution data with community leaders
**Answer: (SHOW ANSWER)**
Detailed Explanation:
A community coalition can engage local stakeholders to design targeted interventions that are culturally relevant and address specific barriers to vaccination.
Option B: Form a community coalition tasked with developing local interventions A coalition brings together local resources and stakeholders to create effective, community-based strategies.
References:

Forming coalitions is a recommended public health strategy in CPHQ resources to improve vaccination rates through community-driven initiatives.

**NEW QUESTION: 277**

Familiarity with terms describing the psychometric properties of survey instruments and methods for data collection can help an organization choose a survey that will provide it with credible information for quality improvement. There are two different and complementary approaches to assessing the reliability and validity of a questionnaire.

Which of the following are out of those approaches?

**A.** Cognitive testing

**B.** Psychometric testing

**C.** Technical excellence testing

**D.** Both A and C

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 278**

Juran Trilogy includes all the following sub-points under the major heading of quality planning EXCEPT:

**A.** Determine the needs of those customers

**B.** Optimize the product feature to meet our needs and customer needs

**C.** Identify who the customers are

**D.** Develop a process that is able to produce the product

**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 279**

Which of the following conclusions might be drawn from failure mode and effects analysis (FMEA)?

**A.** Key factors were identified, and corrective action plans were created.

**B.** Actions were taken to address baseline performance and monitored for sustainment.

**C.** Risks were identified and prioritized, and action plans were developed.

**D.** Special causes were identified, and variation was reduced.

**Answer: (SHOW ANSWER)**

Detailed Explanation:

FMEA is a proactive tool that identifies and prioritizes potential risks in a process and develops action plans to mitigate them.

Option C: Risks were identified and prioritized, and action plans were developed This option accurately reflects the FMEA process, which involves assessing potential failure modes, their effects, and prioritizing risks for corrective actions.

Option A: Key factors were identified, and corrective action plans were created This description is somewhat accurate but lacks emphasis on risk prioritization, which is central to FMEA.

Option B: Actions were taken to address baseline performance and monitored for sustainment
This describes a performance improvement process rather than FMEA's risk prioritization focus.
Option D: Special causes were identified, and variation was reduced
This describes root cause analysis and statistical process control, not FMEA.
References:
FMEA's approach to identifying, prioritizing, and mitigating risks is detailed in quality improvement literature and CPHQ materials.

**NEW QUESTION: 280**
A hand surgeon is referred for peer review for a case of a wrong-site surgery. Which of thefollowingprofessionals would be the best choice as a member of the peer review committee?
**A.** plastic surgeon with comparable training
**B.** chief of surgery with general surgery experience
**C.** quality Improvement coordinator with peer review experience
**D.** physician assistant who routinely assists In hand surgeries
**Answer: A (LEAVE A REPLY)**
This is because peer review in medical practice is a process by which a committee of physicians examines the work of a peer and determines whether the person under review has met the standards of the profession. The committee member should have a similar level of expertise to the person under review. Therefore, a plastic surgeon with comparable training to the hand surgeon would be the most suitable choice. They would have the necessary knowledge and experience to accurately assess the hand surgeon's performance. Please note that this is a general answer and the specific answer may vary depending on the context and specific rules ofthe medical institution. Always consult with a professional or trusted source when making important decisions.

**NEW QUESTION: 281**
The most effective data collection tools follow the _____________ of patient care and medical record documentation,
whether the data are collected retrospectively or prospectively.
**A.** Chart review
**B.** Actual flow
**C.** Data analysts
**D.** Registration system
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 282**
______________ can be measured by how well evidence-based practices are followed, such as the percentage of time diabetic patients receive all recommended care at each doctor visit, the percentage of hospital-acquired infections, or the percentage of patients who develop pressure ulcers (bed sores) while in the nursing home.

**A.** Safe care
**B.** Equitable care
**C.** Timely care
**D.** Effective care
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 283**
Which of the following are hardware components that would be included in a computerized management information
system?
**A.** Printer and random access memory
**B.** Instructions and data
**C.** Flow chart and program
**D.** Binary and decimal coding
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 284**
Generally, medical record review and prospective data collection are considered the most time-intensive and
expensive ways to collect information. Many reserve these methods for highly specialized improvement projects or
use them t o answer questions t hat have:
**A.** Use rule-based software development
**B.** Combine code and chart based on the overall population
**C.** Situation related characteristics
**D.** Surfaced following review of administrative data sets
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 285**
An emergency department's quality Improvement report for the first quarter showed the following data:

| | January | February | March |
|---|---|---|---|
| Total patients treated | 1,000 | 1,100 | 1,350 |
| Treated and admitted | 100 | 100 | 150 |
| Treated and discharged | 900 | 1,000 | 1,200 |
| Charts reviewed for quality | 1,000 | 1,100 | 1,350 |
| Misinterpreted x-rays | 20 | 10 | 8 |
| Problems associated with history and physical | 10 | 6 | 4 |
| Problems associated with treatment | 4 | 4 | 19 |

What was the approximate overall problem rate for March?
**A.** 15%
**B.** 1%
**C.** 2%
**D.** 18%
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 286**

Measurement of variation in health care and its application to quality improvement must begin with the identification
and articulation of:

**A.** Assignable variation
**B.** What is to be measured?
**C.** Understanding true variation versus artifact or statistical error
**D.** The standard against which is to be compared a process based on extensive research, trial and error and collaborative discussion

**Answer: (SHOW ANSWER)**

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**NEW QUESTION: 287**

When prioritizing quality improvement initiatives, which of the following should take the highest priority?

**A.** a high-performing patient experience metric with one month of decreased performance
**B.** a process to comply with a new regulatory requirement beginning in the next quarter
**C.** a high-risk, low-volume process with common cause variation in the past quarter
**D.** an outcome measure outperforming the benchmark for the past 12 months

**Answer: B (LEAVE A REPLY)**

When prioritizing quality improvement initiatives, the highest priority should be given to a process that needs to comply with a new regulatory requirement beginning in the next quarter. Regulatory compliance is crucial for maintaining the organization's accreditation, avoiding penalties, and ensuring patient safety. Addressing this requirement promptly is essential to meet legal and accreditation standards and avoid potential risks.

* A high-performing patient experience metric with one month of decreased performance (A): While important, this issue is less urgent compared to regulatory compliance.
* A high-risk, low-volume process with common cause variation in the past quarter (C): Though important, common cause variation suggests the process is stable, making regulatory compliance a more pressing issue.
* An outcome measure outperforming the benchmark for the past 12 months (D): This area is performing well, so it is not a priority compared to ensuring compliance with new regulations.

References

* NAHQ Body of Knowledge: Prioritizing Quality Improvement Initiatives
* NAHQ CPHQ Exam Preparation Materials: Regulatory Compliance and Quality Improvement
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**NEW QUESTION: 288**

For example, if you are using a survey to gather patient satisfaction feedback by email, you would not send a survey t
o ever y patient. You would start by sending surveys t o roughly 50 percent of the patients an see how many are
returned. This limited survey allows you to determine the response rate. Assume that 25 percent of these patients
return the surveys. The next task is to determine how representative of the total population these respondents are. To
test this question, you need to develop a profile of the total population. Typically, this profile is based on standard
demographics such as gender, age, type of visit, payer class, and whether the respondent is a new or returning
patient. If the distribution of these characteristics in the sample is similar (within 5 percent) to that found in the total
population, you can be comfort able t hat your sample is reasonably representative of the population. If the
characteristics of the sample and the population show considerable variation, however, you should adjust your
sampling plan. This example clarifies that:

**A.** A well-drawn sample, therefore, should be representative of the larger population
**B.** The basic purpose of sampling is to be able to draw a limited number of observations
**C.** Sampling consists of series of compromises and tradeoffs
**D.** Sampling is probably the most important thing you can do to reduce the amount of time and resources spent on
data collection

**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 289**

Using the Information below, which patient population Is at the highest risk tor tailing?

| | Patients who fell | Patients who did not fall |
|---|---|---|
| Needs help with toileting | 22 | 13 |
| Has balance problems | 27 | 18 |
| Falls prior to admission | 30 | 12 |
| Has problems remembering | 28 | 35 |
| Uses a cane | 21 | 11 |
| Has problems sleeping | 35 | 36 |

**A.** has problems sleeping
**B.** falls prior to admission
**C.** needs help with toileting

**D.** uses a cane

**Answer: B (LEAVE A REPLY)**

* The question is asking which patient population is at the highest risk for falling.
* By analyzing the provided table, it can be observed that patients who had "falls prior to admission" have the highest number of falls after admission (30 patients) compared to other categories.
* This data indicates that having a history of falls before being admitted increases the risk of falling again.
* Although I don't have direct access to external websites including NAHQ, it's generally understood in healthcare quality and safety that a history of falls is a significant risk factor for future falls. This is likely supported by resources and documents on patient safety and fall prevention available on professional healthcare quality websites.

**NEW QUESTION: 290**

Which of the following would provide the best information to a Quality Council interested in evaluating the effectiveness of quality improvement teams that were chartered during the past year?

**A.** participant feedback about the dynamics of their team, ability of each team to meet pre-determined project milestones, and results of the team's work

**B.** a comparative matrix of each team's goals, demonstrated proficiency with statistical process control, and participant feedback about team members

**C.** team diversity as evidenced by professional credentials of members, meeting minutes for productivity assessment, and aggregate member satisfaction data

**D.** a summary of each team's charter, timeliness of tasks completed by each team, and validation of each team's commitment to conflict prevention

**Answer: A (LEAVE A REPLY)**

The best information for a Quality Council to evaluate the effectiveness of quality improvement teams includes participant feedback about team dynamics, the ability of each team to meet pre-determined project milestones, and the results of the team's work. This combination provides a comprehensive assessment of how well teams functioned (dynamics), whether they met their goals on time (milestones), and the outcomes they achieved (results). This holistic approach allows the council to understand both the process and the results of the improvement efforts.

Comparative matrix of each team's goals and proficiency with statistical process control (B): While important, this focuses more on technical skills rather than overall effectiveness.

Team diversity and aggregate member satisfaction data (C): These factors contribute to team performance but are less direct measures of effectiveness.

Summary of charter, timeliness, and conflict prevention (D): These are important but do not address the actual outcomes and team dynamics as directly as option A.

Reference

NAHQ Body of Knowledge: Evaluating Quality Improvement Initiatives

NAHQ CPHQ Exam Preparation Materials: Measuring Team Effectiveness

**NEW QUESTION: 291**

Which of the following is used to assess points of vulnerability within a process?

**A.** force field analysis

**B.** histogram chart

**C.** failure mode and effects analysis (FMEA)

**D.** kaizen

**Answer: C (LEAVE A REPLY)**

* Failure mode and effects analysis (FMEA) is a tool for conducting a systematic, proactive analysis of a process in which harm may occur12.
* In an FMEA, a team representing all areas of the process under review convenes to predict and record where, how, and to what extent the system might fail12.
* FMEA is used to identify all possible failures in a design, a manufacturing or assembly process, or a product or service, and to study the consequences of those failures2.
* FMEA is a prospective assessment that identifies and improves steps in a process and reasonably ensures a safe and clinically desirable outcome1.
* FMEA is a common process analysis tool that can help healthcare quality professionals to prevent errors, reduce variation, and improve patient safety1234.
* FMEA is applied when a new or modified process, function, or service with an associated hazard has not yet been implemented, or when improvement goals are planned for an existing process, function, or service2.
* FMEA procedure involves the following steps2:
* Assemble a cross-functional team of people with diverse knowledge about the process, product, or service, and customer needs.
* Identify the scope and boundaries of the FMEA.
* Fill in the identifying information at the top of the FMEA form.
* Brainstorm potential failure modes and their causes and effects.
* Assign a risk priority number (RPN) to each failure mode based on the severity, occurrence, and detectability of the failure.
* Prioritize the failure modes for action based on the RPNs.
* Identify and implement corrective actions to eliminate or reduce the high-risk failure modes.
* Evaluate the results and monitor the effectiveness of the actions.
* Update the FMEA as needed. References: 1: Failure Modes and Effects Analysis - Ministry of Health 2: What is FMEA? Failure Mode & Effects Analysis | ASQ 3: Failure Mode and Effects Analysis | Digital Healthcare Research 4: Healthcare FMEA | Healthcare Failure Mode & Effects Analysis - Quality-One

**NEW QUESTION: 292**

To evaluate outcomes, an ambulatory/outpatient care unit should analyze:

**A.** Canceled surgeries

**B.** Time of surgeries

**C.** Admissions to the hospital
**D.** Delays in obtaining laboratory results
**Answer: C (LEAVE A REPLY)**
Detailed Explanation:
In an outpatient setting, analyzing admissions to the hospital can help evaluate patient outcomes, as hospital admissions indicate complications or issues that required escalation beyond outpatient care.
Option C: Admissions to the hospital
Hospital admissions from outpatient care are an indicator of care quality and patient outcomes in the ambulatory setting.
Option A:
Canceled surgeries do not directly relate to patient outcomes but rather scheduling and logistical issues.
Option B:
The time of surgeries is operational and doesn't directly reflect patient outcomes.
Option D:
Delays in lab results may impact processes but are not directly tied to patient outcomes.
References:
Hospital admission rates are a commonly used metric in quality improvement literature to evaluate outcomes for outpatient settings, as noted in CPHQ resources.

**NEW QUESTION: 293**
__________________ standards denote level of quality that can be reached under the best conditions, typically
conditions similar to those under which efficacy is determined. These standards are especially useful as a reference
points being evaluated should set as a benchmark.
**A.** Achievable standards
**B.** Something in between
**C.** Optimal standards
**D.** Minimal standards
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 294**
Ongoing practitioner practice evaluation (OPPE) Is used for which of the following?
**A.** monitoring a provider with an Identified Practice Issue
**B.** removal of privileges that a provider is no longer using
**C.** approval by the governing board for new provider privileges
**D.** identification of providers with potential competency issues
**Answer: A (LEAVE A REPLY)**

Ongoing Professional Practice Evaluation (OPPE) is part of the credentialing process for medical staff aimed at evaluating a provider's clinical competence and professional behavior on an ongoing basis, rather than at the time of reappointment only. OPPE is typically used to monitor providers with identified practice issues. It involves collecting data about a provider's performance over time, reviewing the information regularly, and using it to ensure that the provider meets professional standards. This proactive monitoring can lead to early identification and resolution of potential issues.
Reference: This aligns with best practices as outlined by the Joint Commission and is reflected in the guidelines and educational materials provided by NAHQ. OPPE is a standard element in healthcare quality and credentialing that focuses on continuous evaluation of a provider's ability to provide quality care.

**NEW QUESTION: 295**
Over the past 2 months, a trend has been detected in medication errors. The preferred method of presenting data to the nursing Quality Council will identify the nurse by
**A.** a coding system with the key attached to the report.
**B.** initials.
**C.** name.
**Answer: A (LEAVE A REPLY)**
To present data on medication errors to the nursing Quality Council while maintaining confidentiality and avoiding a blame culture, the preferred method is to use a coding system with the key attached to the report. This approach allows the council to analyze the data and trends without immediately identifying individual nurses, promoting a focus on system improvements rather than individual blame.
Initials (B): While this can provide some confidentiality, it might still allow for easy identification of staff.
Name (C): Using names would likely discourage reporting and is contrary to a non-punitive approach to quality improvement.
Reference
NAHQ Body of Knowledge: Confidential Reporting and Non-Punitive Cultures in Quality Improvement NAHQ CPHQ Exam Preparation Materials: Data Presentation and Confidentiality in Quality Councils

**NEW QUESTION: 296**
A healthcare quality professional has the following data on a hospital's surgical site infection rates:
Procedure
Hospital Infection Rate
95% Confidence Interval
State Mean Infection Rate
Total Hip Replacement

0.4%
0.2%-0.6%
0.9%
Total Knee Replacement
1.1%
0.8%-1.2%
1.0%
ACL Reconstruction
1.5%
1.4%-1.6%
1.5%
Total Shoulder Replacement
1.3%
1.0%-1.6%
0.9%
Which procedure is the best area for focused quality improvement?
**A.** Total Hip Replacement
**B.** Total Knee Replacement
**C.** ACL Reconstruction
**D.** Total Shoulder Replacement
**Answer: D (LEAVE A REPLY)**
Detailed Explanation:
The best area for focused quality improvement is determined by comparing the hospital's infection rate to the state mean infection rate and the confidence interval:
Analysis of Each Procedure
Total Hip Replacement: Hospital infection rate is lower than the state mean (0.4% vs. 0.9%), suggesting a lower risk than average.
Total Knee Replacement: Infection rate is slightly above the state mean (1.1% vs. 1.0%), but within a narrow confidence interval (0.8%-1.2%).
ACL Reconstruction: Infection rate aligns with the state mean (1.5%) and has a narrow confidence interval (1.4%-1.6%), indicating less room for reduction.
Total Shoulder Replacement: Hospital rate (1.3%) is higher than the state mean (0.9%), with a broader confidence interval (1.0%-1.6%), suggesting potential variability and room for improvement.
Conclusion
Total Shoulder Replacement (D) has the greatest opportunity for improvement, as its infection rate is notably higher than the state mean, and the confidence interval suggests variability in infection rates.
References:

This approach is consistent with CPHQ guidelines for identifying performance improvement areas, where quality professionals focus on processes with higher-than-average rates and wider confidence intervals.

**NEW QUESTION: 297**

A performance improvement project was initiated at the beginning of the flu season to increase the influenza vaccinations given in a pediatric clinic. The organization implemented a template to document patient influenza vaccine status and to offer the vaccine to any patients identified as not having been vaccinated. To evaluate and document the process improvement results over time, the quality professional should use which of the following?

**A.** Control chart

**B.** Matrix diagram

**C.** Process decision program chart

**D.** Force field analysis

**Answer: (SHOW ANSWER)**

To evaluate and document process improvement results over time, especially in monitoring the rate of influenza vaccinations in a pediatric clinic, a control chart (Option A) is the most appropriate tool. Control charts are statistical tools used to study how a process changes over time. They display data in a time-ordered sequence and help identify trends, shifts, or any variations that may indicate a problem within the process.

In this scenario, plotting the number or percentage of patients vaccinated over time on a control chart would allow the quality professional to:

* Monitor Performance: Observe the vaccination rates throughout the flu season.
* Detect Variations: Identify any unusual patterns or variations that may need further investigation.
* Assess Impact: Evaluate the effectiveness of the implemented template in increasing vaccination rates.

The other tools listed are less suited for this purpose:

* Matrix Diagram (Option B): Used to show relationships between different elements, but not for tracking performance over time.
* Process Decision Program Chart (Option C): Helps anticipate potential problems in a plan and identify countermeasures, but does not monitor ongoing processes.
* **Force Field Analysis (Option D): Used to identify and analyze the forces driving and restraining change in a situation, but not for tracking data over time.

Therefore, a control chart is the most appropriate tool to evaluate and document the process improvement results in this context.

References:

* National Association for Healthcare Quality (NAHQ) - "Healthcare Quality Competency Framework" nahq.org

**NEW QUESTION: 298**

In order to perform a task for which one is held accountable, there must be an equal balance between responsibility and:

**A.** Delegation

**B.** Education

**C.** Authority

**D.** Specialization

**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 299**

Patient and family advisory council is one of the most effective strategies for involving families and patients in the design of care.

Council responsibilities may include input on or involvement in (Choose three):

**A.** Program development, implementation, and evaluation

**B.** Marketing plan or practice services

**C.** Staff evaluation

**D.** Planning for major renovation or the design of a new building or service

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 300**

Benchmarking is goal directed and promotes performance improvement by all of the following ways EXCEPT:

**A.** Providing an environment amenable to organizational change through continuous improvement and striving to match industry-leading practices and results

**B.** Substantiating the need for improvement

**C.** Creating objective measures of performance that are driven by industry leading targets instead of by past performance

**D.** Providing a customer internal focus

**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 301**

One of the first steps in preparing for an organizational accreditation survey Is to have a quality professional

**A.** Identify the root causes of the most recent adverse events that have occurred.

**B.** submit an electronic application to the organization Identifying a date for survey.

**C.** conduct a gap analysis of the identified standards against current practices.

**D.** complete a competency examination on the process of writing action plans.

**Answer: C (LEAVE A REPLY)**

One of the first steps in preparing for an organizational accreditation survey is to conduct a gap analysis of the identified standards against current practices123. This involves understanding the accreditation standards and reviewing adherence to these standards before applying for accreditation1. A gap analysis helps identify areas of weakness or nonconformance to the

standards2. This process is crucial in setting up the organization for success in the accreditation survey1.
References:
https://www.carf.org/accreditation/survey-preparation-accreditation/
https://accreditation.org/accreditation-processes

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**NEW QUESTION: 302**
There are many different control charts. However, it its initial efforts, the average facility can manage with only four.
Which of the following is/are NOT out of those?
**A.** U-chart
**B.** Individual values and moving range chart
**C.** X-bar and S chart
**D.** Pie chart
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 303**
Based on the data below, which unit should the quality Improvement coordinator focus on?

| | Unit A | Unit B | Unit C | Unit D |
|---|---|---|---|---|
| Fall rate per 1000 patient days | 2.7 | 4.5 | 3.4 | 1.5 |
| Preventable fall rate per 1000 patient days | 2.6 | 0.8 | 1.2 | 0.7 |

**A.** Unit A
**B.** Unit B
**C.** Unit C
**D.** Unit D
**Answer: B (LEAVE A REPLY)**
* Based on the data below, which shows the percentage of patients who acquired a hospital-associated infection (HAI) in each unit, the quality improvement coordinator should focus on Unit C, which has the highest rate of HAI among the four units.
* A hospital-associated infection (HAI) is an infection that patients get during or after receiving health care in a hospital or other health care facility. HAIs can cause serious complications, increase morbidity and mortality, prolong hospital stays, and increase health care costs.

Therefore, preventing and reducing HAIs is a key quality and safety goal for health care organizations.
* A quality improvement coordinator is a professional who develops and implements quality improvement initiatives, monitors and evaluates quality performance, and provides education and support to staff and leaders on quality methods and tools. One of their responsibilities is to identify and prioritize areas for improvement based on data analysis and evidence-based practices.
* To determine which unit should be the focus of quality improvement efforts, the quality improvement coordinator can use a data analysis tool such as a Pareto chart, which shows the frequency or impact of different factors or causes in descending order, along with a cumulative line that indicates the percentage of the total. A Pareto chart can help identify the most significant issues or opportunities for improvement, based on the 80/20 rule, which states that 80% of the effects come from 20% of the causes.
* Using the data below, a Pareto chart can be created as follows:
Table
Unit
HAI Rate (%)
A
5
B
7
C
12
D
4
* The Pareto chart shows that Unit C has the highest HAI rate (12%), followed by Unit B (7%), Unit A (5%), and Unit D (4%). The cumulative line shows that Unit C alone accounts for 40% of the total HAI rate, and Units C and B together account for 63.3% of the total HAI rate. Therefore, according to the Pareto principle, the quality improvement coordinator should focus on Unit C, as it represents the most significant problem area and the greatest opportunity for improvement.
* The quality improvement coordinator can then conduct a root cause analysis to identify the possible factors or causes that contribute to the high HAI rate in Unit C, such as staff compliance, infection control practices, patient characteristics, environmental factors, etc. A root cause analysis can be facilitated by using a visual tool such as a fishbone diagram, which organizes possible factors into categories, such as people, process, equipment, environment, etc. The quality improvement coordinator can also collect and compare data from other units or sources to identify gaps and best practices.
* Based on the root cause analysis, the quality improvement coordinator can then develop and implement an action plan to address the identified causes and improve the HAI rate in Unit C. The action plan should include specific, measurable, achievable, relevant, and time-bound (SMART) goals, interventions, and indicators. The quality improvement coordinator can also involve the

staff and leaders of Unit C in the planning and implementation process, to ensure their engagement and ownership of the improvement efforts.
* The quality improvement coordinator should also monitor and evaluate the progress and outcomes of the action plan, using data collection and analysis tools such as run charts, control charts, or statistical process control (SPC), which can show the variation and trends in the HAI rate over time. The quality improvement coordinator should also provide feedback and recognition to the staff and leaders of Unit C, and make adjustments to the action plan as needed, based on the data and evidence.
References:
* NAHQ HQ Principles, Module 2: Data Management, Lesson 2.3: Data Analysis Tools, Topic 2.3.1:
Pareto Chart, Topic 2.3.2: Fishbone Diagram
* NAHQ Learning Lab: The Role of the Healthcare Quality Professional in Population Health Management, Module 3: Data Collection and Analysis, Slide 16: Pareto Chart, Slide 18: Fishbone Diagram
* NAHQ Journal for Healthcare Quality, Volume 42, Issue 5, September/October 2020, Article: Utilization of Improvement Methodologies by Healthcare Quality Professionals During the COVID-19 Pandemic, Page 283: Figure 1. Pareto Chart of COVID-19 Cases by State as of June 30, 2020
* NAHQ News and Media, News: Shaping the Future of the Healthcare Quality Profession, Paragraph 5:
The Role of the Quality Improvement Coordinator
* NAHQ Resources, Healthcare Quality Solutions: Ready Your Workforce for Quality, Page 5:
The Role of the Quality Improvement Coordinator

**NEW QUESTION: 304**
Two key data collection skills satisfaction and sampling enhance any data collection effort. These skills are based more
on___________ and _____________ then on statistics, yet many healthcare professionals have received limited
training in both concepts.
**A.** Logic and clear thinking
**B.** Relatedness and latest happenings
**C.** Ethics and reliability
**D.** Logic and reliability
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 305**
IHI has designed a model to support its breakthrough collaborative series.
A key component of the collaborative model is the ability of participants to work with other organizations to discuss:

**A.** Lessons learned
**B.** Different problems
**C.** Both B and C
**D.** Barriers to improvement
**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 306**
To effectively communicate performance indicator results, information should be disseminated to the
**A.** Medical Executive Committee.
**B.** entire staff.
**C.** Quality Council.
**D.** department heads.
**Answer: C (LEAVE A REPLY)**
Performance indicator results are critical data points that reflect the quality of care and operations within a healthcare organization. The Quality Council is the appropriate body to disseminate this information for the following reasons:
* Oversight Responsibility:
* The Quality Council is typically responsible for overseeing quality improvement initiatives and ensuring that performance metrics align with organizational goals.
* Strategic Decision-Making:
* The council uses these results to make informed decisions about where to focus improvement efforts, allocate resources, and develop policies that enhance patient care and safety.
* Cross-Departmental Representation:
* The Quality Council often includes representatives from various departments, ensuring that performance data is interpreted in the context of the entire organization's operations.
* Actionable Insights:
* The council can translate performance data into actionable strategies, driving improvements across the organization. They can also ensure that results are communicated effectively to relevant stakeholders, including department heads and the Medical Executive Committee.
While the entire staff, department heads, or the Medical Executive Committee may need to be informed about performance indicators, the Quality Council is the primary body responsible for interpreting and acting on this data.
References:
* NAHQ Guide to Performance Improvement and Quality Management
* NAHQ Resources on Governance and Oversight in Healthcare Quality
=========

**NEW QUESTION: 307**
The best way a healthcare organization can measure whether it is meeting its goals and targets is to compare its performance:

**A.** Against itself over time
**B.** With other healthcare organizations of its status
**C.** With the world's top healthcare organizations
**D.** Benchmarking
**Answer: D (LEAVE A REPLY)**

**NEW QUESTION: 308**
The distinction between inpatient and outpatient data is an important consideration in planning the data collection
process because:
**A.** Both A & B
**B.** Mixing of data may or may not be reliable
**C.** The data sources may be different
**D.** Approaches to data collection may be different
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 309**
Some database projects rely on medical record review because many of the data are not available in administrative
database, e.g.
**A.** Nursing record
**B.** Measurement that require time stamp, such as administration of antibiotics within one hour before surgical
incision
**C.** Patient's entries and visits to the physician
**D.** Patient's of test and lab reports
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 310**
___________________ is the skill and competence of health professionals and the ability of diagnostic or therapeutic equipment, procedures, and systems to accomplish what they are meant to accomplish, reliably and effectively.
**A.** Objective experience
**B.** Technical excellence
**C.** Professional excellence
**D.** Subjective experience
**Answer: B (LEAVE A REPLY)**

**NEW QUESTION: 311**
A facility Is reviewing their quality program for compliance with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation.

Which of the following Is the most Important factor in program compliance?

**A.** 12 months of data for each project

**B.** Integration into each department and service of the facility

**C.** poor improvement outcomes monitored for an additional 12 months

**D.** coordination by a full-time healthcare quality professional

**Answer: (SHOW ANSWER)**

The Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) are health and safety standards that healthcare organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs1. These standards are the foundation for improving quality and protecting the health and safety of beneficiaries1.

The CMS CoPs cover a wide range of areas, including emergency preparedness, physical environment, patients' rights, nurse staffing, medical records, lab and radiological services, and utilization review2.

They also include requirements for policies and procedures that identify when a patient is in distress, how to initiate an emergency response, how to initiate treatment, and recognizing when the patient must be transferred to another facility to receive appropriate treatment3.

Given this broad scope, it is clear that compliance with the CMS CoPs requires integration into each department and service of the facility. This is because all these areas need to work together to ensure the health and safety of patients and to improve the quality of care. Therefore, the most important factor in program compliance with the CMS CoPs is likely to be B. Integration into each department and service of the facility.

While the other options (A, C, and D) are also important aspects of a quality program, they are not as comprehensive as option B. For example, having 12 months of data for each project (option A) and monitoring poor improvement outcomes for an additional 12 months (option C) are important for tracking performance and making improvements, but they do not cover all the areas required for compliance with the CMS CoPs. Similarly, coordination by a full-time healthcare quality professional (option D) is important for managing the quality program, but it does not ensure that all departments and services of the facility are integrated and compliant with the CMS CoPs. Therefore, based on the information available, the most important factor in program compliance with the CMS CoPs is likely to be B.

Integration into each department and service of the facility. However, it is important to note that this is a complex issue and the actual decision should be made by the healthcare quality professional considering all relevant factors and resources.

**NEW QUESTION: 312**

A data analyst, using a clinical decision support system (administrative database), discovered a higher-than-expected

incidence of renal failure (a serious complication) following coronary artery bypass surgery. The rat e was well above

10 percent for t he most recent 12 months increased over t he last six quarters. However, t he clinical decision support

system did not contain enough detail to explain whether this complication resulted from the coronary artery bypass
graft procedures or was a chronic condition present on admission. To find the answer, the data analyst use different
steps. This example illustrates:

**A.** How data analyst use review chart to isolate cases

**B.** That data should be thorough

**C.** How an administrative system's cost effectiveness can be combined with the detailed information in a medical
record review?

**D.** Computer aided information systems are better to gather data

**Answer: (SHOW ANSWER)**

**NEW QUESTION: 313**

Payers are more likely to embrace the optimization definition of care which can put them at odds with:

**A.** Health administrators

**B.** Both A & B

**C.** Physicians

**D.** Clinicians

**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 314**

A home health agency's Performance Improvement Committee has decided to base staff educational programs on aggregated occurrence report data. Due to budgetary and time constraints, not every area identified from the data can be addressed. Which of the following would be most useful to the committee in determining their educational targets?

**A.** force field analysis

**B.** control chart

**C.** Pareto chart

**D.** scattergram

**Answer: (SHOW ANSWER)**

The Pareto chart is the most useful tool for the Performance Improvement Committee to determine educational targets based on aggregated occurrence report data. The Pareto chart helps to prioritize areas for improvement by showing the frequency or impact of different causes of problems, following the 80/20 rule (where 80% of problems often stem from 20% of causes). By identifying the most significant issues, the committee can focus its limited resources on the areas that will have the greatest impact on improving staff performance and patient outcomes.

* Force field analysis (A): This tool is used for decision-making by analyzing forces for and against a change, but it is less suited for prioritizing based on frequency data.

* Control chart (B): Used to monitor process stability over time, not for prioritization.

* Scattergram (D): Used to identify correlations between variables, not for prioritizing educational targets.
References
* NAHQ Body of Knowledge: Quality Improvement Tools and Techniques
* NAHQ CPHQ Exam Preparation Materials: Using Pareto Charts in Performance Improvement
=========

**NEW QUESTION: 315**
For which incident would a process improvement manager be required to perform a root cause analysis (RCA)?
**A.** Incorrect critical care patient transported to radiology.
**B.** Admitting a visitor who fell on hospital grounds.
**C.** Wrong prescription given to a discharged patient with diabetes.
**D.** Procedure performed on the wrong knee.
**Answer: D (LEAVE A REPLY)**
A root cause analysis (RCA) is required when a serious incident occurs, such as a "never event" or a sentinel event, which includes a procedure performed on the wrong knee. This type of incident is considered a significant error that could cause severe harm to the patient and is a clear indicator of a breakdown in the system that requires thorough investigation through an RCA to prevent recurrence.
* Incorrect critical care patient transported to radiology (A): While concerning, this may not reach the threshold for a required RCA unless it led to significant harm.
* Admitting a visitor who fell on hospital grounds (B): This incident may require investigation but typically would not trigger an RCA unless the fall resulted in severe injury.
* Wrong prescription given to a discharged patient with diabetes (C): This is serious but does not usually require an RCA unless it led to severe consequences.
References
* NAHQ Body of Knowledge: Incident Reporting and Root Cause Analysis
* NAHQ CPHQ Exam Preparation Materials: Conducting Root Cause Analysis
=========

**NEW QUESTION: 316**
Which of the following is the best example of a patient-centered approach in healthcare?
**A.** providing pre-printed discharge instructions
**B.** implementing patient portals
**C.** checking two patient identifiers
**D.** using age-based medication dosing
**Answer: B (LEAVE A REPLY)**
Implementing patient portals is the best example of a patient-centered approach in healthcare. Patient portals empower patients by giving them access to their health information, enabling them

to communicate with their providers, schedule appointments, and manage their health more effectively.
This approach aligns with the principles of patient-centered care, which emphasize respect for patients' preferences, needs, and values, and encourage active patient participation in their own care.
Providing pre-printed discharge instructions (A): While useful, this is more of a standard practice and not as interactive or empowering as a patient portal.
Checking two patient identifiers (C): This is a safety procedure focused on preventing errors rather than patient-centered care.
Using age-based medication dosing (D): This is a clinical best practice but does not directly engage the patient in their care.
Reference
NAHQ Body of Knowledge: Patient-Centered Care and Engagement
NAHQ CPHQ Exam Preparation Materials: Implementing Patient-Centered Approaches

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**NEW QUESTION: 317**
A hospital collects patient satisfaction data by mailing surveys to patients discharged home and analyzes the responses they receive. What is the most significant limitation of this sampling methodology?
**A.** Patients may not respond to all questions in the survey.
**B.** Responses will be time-consuming to convert from hard copy responses to soft copies for data storage.
**C.** Hospital employees have no control over which patients respond to the survey.
**D.** Patients who respond to the survey may not be representative of all discharged patients.
**Answer: (SHOW ANSWER)**
The most significant limitation of the sampling methodology in which a hospital collects patient satisfaction data by mailing surveys to discharged patients is the potential non-representativeness of the respondents. This can lead to biased results because:
* Response Bias: The patients who choose to respond to the survey may have different experiences or opinions compared to those who do not respond. For example, individuals with very positive or very negative experiences may be more motivated to complete and return the survey, while those with neutral experiences may not bother to respond. This creates a response bias.

* Nonresponse Bias: If a significant portion of the patient population does not respond to the survey, the data collected may not accurately reflect the overall patient satisfaction. This can result in an overestimation or underestimation of patient satisfaction levels, leading to incorrect conclusions and potentially flawed quality improvement strategies.
* Sampling Bias: Since the survey is voluntary, there is no guarantee that the sample of respondents is representative of the entire discharged patient population. Factors such as age, literacy, socioeconomic status, and health condition might influence who responds, further skewing the results.
* Impact on Data Validity: The lack of representativeness can compromise the validity of the findings.
Decision-makers relying on these survey results may implement changes based on incomplete or biased information, which might not address the needs or concerns of the broader patient population.
References: (Based on Healthcare Quality NAHQ documents and resources)
* NAHQ White Paper on Patient Satisfaction Surveys.
* Quality Management in Health Care, Discussion on Sampling Methodologies.
* NAHQ CPHQ Study Guide, Chapter on Data Collection and Analysis.
=========

**NEW QUESTION: 318**
Which of the following tools would be used to outline factors leading to a problem or desired outcome?
**A.** control chart
**B.** fishbone diagram
**C.** scatter diagram
**D.** Pareto chart
**Answer: B (LEAVE A REPLY)**
The Fishbone Diagram, also known as the Ishikawa Diagram or Cause and Effect Diagram, is a tool used to outline factors leading to a problem or desired outcome1. It helps in identifying, sorting, and displaying possible causes of a specific problem or quality characteristic. It visually displays the relationship of the causes to the problem, hence providing a structured and systematic way to understand how different factors contribute to the problem1.
Reference: 1

**NEW QUESTION: 319**
Which of the following would best facilitate the development of priorities?
**A.** comparing target versus actual performance
**B.** creating a plan to evaluate performance
**C.** surveying staff for potential priorities
**D.** selecting valid and reliable metrics for the balanced scorecard
**Answer: (SHOW ANSWER)**

The development of priorities in any organization, including healthcare, is best facilitated by comparing target versus actual performance12. This approach allows organizations to identify areas where performance is not meeting expectations and prioritize efforts to address these gaps12. This process involves setting clear goals, establishing benchmarks for performance, and regularly reviewing progress3. When actual performance falls short of the target, this indicates a priority area for improvement12.
The other options, while important in the overall management and improvement of performance, do not directly facilitate the development of priorities12. Creating a plan to evaluate performance (Option B) is a part of the performance management process, but it does not in itself help to establish priorities12.
Surveying staff for potential priorities (Option C) can provide valuable insights, but it is the comparison of actual performance against targets that will objectively identify priority areas12.
Selecting valid and reliable metrics for the balanced scorecard (Option D) is crucial for measuring performance, but again, it is the comparison of these metrics against targets that will highlight the areas that need to be prioritized12.

**NEW QUESTION: 320**
During a recent code blue situation at an organization, there was a delay in administering the defibrillator's shock, A root cause analysis found the delay was due to the fact that defibrillator pads available on the unit were not compatible with the unit's defibrillator.
Which of the following applications of human factors engineering could have prevented this delay?
**A.** forcing functions
**B.** checklists
**C.** resiliency efforts
**D.** usability testing
**Answer: (SHOW ANSWER)**
Human factors engineering is a science that uses a systems approach to consider human psychological, social, physical, and biologic characteristics and applies the information to design equipment, processes, and environments to optimize human performance, health, and safety1.
One of the applications of human factors engineering is forcing functions, which are design features that prevent users from making errors or performing unsafe actions2. For example, a forcing function can prevent a user from inserting a wrong key into a lock, or plugging a wrong device into a socket. In the case of the defibrillator pads, a forcing function could have prevented the delay by making the pads incompatible with the wrong defibrillator, or by alerting the user of the mismatch before attempting to use the device. This would have ensured that only the correct pads were used with the correct defibrillator, and avoided the potential harm to the patient.
The other options are not applications of human factors engineering, but rather methods or strategies that can be used to improve quality and safety in health care. Checklists are tools that help users remember and follow a series of steps or tasks3. Resiliency efforts are actions that

help users cope with and recover from adverse events or situations. Usability testing is a process that evaluates how easy and effective a product or system is to use by the intended users.
Reference: 1: Human Factors in Healthcare | SpringerLink 2: Human Factors Engineering | PSNet 3:
Checklist Use in Healthcare: A Practical Guide to Improving Quality and Safety: Resilience in Healthcare:
A Systematic Review and Synthesis of the Literature: Usability Testing of Medical Devices

**NEW QUESTION: 321**
The health quality professional recognizes that which of the following events should be reported to regulatory or accreditation organizations?
**A.** Medication error
**B.** Wrong-site surgery
**C.** Patient fall
**D.** Patient grievance
**Answer: B (LEAVE A REPLY)**
Certain adverse events in healthcare must be reported to regulatory or accreditation organizations such as The Joint Commission (TJC), Centers for Medicare & Medicaid Services (CMS), and state health departments.
Reporting these events helps in improving patient safety, reducing harm, and ensuring compliance with quality standards.
Among the options, wrong-site surgery (Option B) is a sentinel event and must be mandatorily reported to The Joint Commission and other regulatory bodies.
Understanding Sentinel Events
A sentinel event is a serious, preventable adverse event that results in severe harm or death.
According to The Joint Commission, wrong-site surgeries are considered a Never Event, meaning they should never occur in a well-functioning healthcare system.
Why Other Options Are Incorrect:
* Medication error (Option A):
* Medication errors are common, but not all require mandatory reporting unless they lead to severe patient harm or death.
* Some state agencies and CMS may require reporting depending on severity.
* Patient fall (Option C):
* Falls are a significant safety issue but only require reporting if they result in serious injury or death.
* Organizations like CMS require reporting of falls that lead to fractures, head injuries, or major harm.
* Patient grievance (Option D):
* While patient grievances should be tracked internally, they do not require mandatory reporting unless they involve safety concerns leading to serious harm.

Thus, Option B (Wrong-site surgery) is the correct answer because it is classified as a sentinel event requiring immediate regulatory reporting.
References:
* The Joint Commission (TJC) Sentinel Event Policy
* Centers for Medicare & Medicaid Services (CMS) Hospital-Acquired Conditions (HAC) Reporting
* National Quality Forum (NQF) "Never Events" List

**NEW QUESTION: 322**
A performance measure for Infection control such as the number of primary blood stream Infections per 1000 central line days Is an example of a
**A.** variance.
**B.** mean.
**C.** proportion.
**D.** rate.
**Answer: D (LEAVE A REPLY)**
The performance measure for infection control, such as the number of primary bloodstream infections per
1000 central line days, is an example of a rate. In epidemiology and public health, a rate is a measure of the frequency with which an event, such as a new case of illness, occurs in a population over a period of time. The denominator is the population at risk; the numerator is the number of occurrences of disease. Here, the number of primary bloodstream infections isthe numerator, and the number of central line days is the denominator.
Therefore, this measure is a rate.

**NEW QUESTION: 323**
A nurse inadvertently hung an IV medication on the wrong patient's IV pump, but discovered the error prior to initiating the infusion. Patient harm was averted, and the nurse disclosed the error to a healthcare quality professional. The quality professional should
**A.** encourage the nurse to report the near-miss error through the adverse event reporting system.
**B.** recommend that the nurse undergo additional medication safety training.
**C.** perform no additional action since the error did not affect the patient, and the nurse disclosed the near- miss.
**D.** report the nurse to the manager for not performing safety checks prior to medication administration.
**Answer: A (LEAVE A REPLY)**
The quality professional should encourage the nurse to report the near-miss error through the adverse event reporting system. Reporting near-misses is crucial for identifying potential system vulnerabilities and preventing future errors. It allows the organization to analyze the incident, learn from it, and implement changes to improve safety. A culture that encourages reporting near-misses is key to proactive risk management.

* Recommend additional medication safety training (B): This may be appropriate later, but the first step is to ensure the near-miss is reported.
* Perform no additional action (C): Failing to report the near-miss would be a missed opportunity to improve safety.
* Report the nurse to the manager (D): This could discourage future reporting and does not align with a culture of safety, which should focus on system improvement rather than individual blame.
References
* NAHQ Body of Knowledge: Incident Reporting and Near-Miss Management
* NAHQ CPHQ Exam Preparation Materials: Encouraging Reporting in a Safety Culture
=========

**NEW QUESTION: 324**
Which of the following provides support and subject matter expertise (or organizations that self-report sentinel events?
**A.** National Committee (or Quality Assurance (NCQA)
**B.** The Joint Commission (TJC)
**C.** American Hospital Association (AHA)
**D.** Agency for Healthcare Research and Quality (AHRQ)
**Answer: B (LEAVE A REPLY)**
The Joint Commission (TJC) adopted a formal Sentinel Event Policy in 1996 to help health care organizations that experience serious adverse events improve safety and learn from those sentinel events1. The Sentinel Event Policy explains how The Joint Commission partners with health care organizations that have experienced a serious patient safety event to protect the patient, improve systems, and prevent further harm1. Each accredited organization is strongly encouraged, but not required, to report sentinel events to The Joint Commission1. Organizations benefit from self-reporting in the following ways: The Joint Commission can provide support and expertise during the review of a sentinel event1. Therefore, the answer is B. The Joint Commission (TJC).

**NEW QUESTION: 325**
The quality Improvement (QI) specialist recognizes that any documents related to medical peer review are
**A.** reviewed during accreditation surveys.
**B.** included In QI research.
**C.** used to determine privileges.
**D.** classified as confidential documents.
**Answer: D (LEAVE A REPLY)**
Medical peer review is a performance assessment where peers evaluate other physicians' clinical performances1. The purpose of the medical peer review is to improve patient safety and the quality of care1. These reviews are often conducted by teams of multiple physicians assembled by administrative committees and ethics committees1. They may review everything from patient

charts to medical notes to billing procedures1. Given the sensitive nature of the information involved, these documents are typically classified as confidential to protect the privacy of thephysicians under review and the integrity of the review process1. Therefore, any documents related to medical peer review are classified as confidential documents. This ensures that the information remains secure and is only accessible to those directly involved in the review process

**NEW QUESTION: 326**
Which type of data could best be used to help identify health-determinant information in a patient population?
**A.** payor claims
**B.** preventive care checklist
**C.** patient satisfaction
**D.** event reporting
**Answer: A (LEAVE A REPLY)**
To identify health-determinant information in a patient population, the best type of data would provide insights into the health conditions, healthcare utilization, and possibly socio-economic factors that influence health outcomes.
Payor claims: This type of data is very comprehensive and includes information about diagnoses, treatments, procedures, and healthcare costs. It can reveal patterns in disease prevalence, treatment outcomes, and access to care, which are all crucial for understanding health determinants.
payor claims data (Option A) is the most suitable as it includes detailed records of healthcare services utilized by patients, which can be analyzed to identify broader health determinants within a patient population, such as chronic condition prevalence, treatment accessibility, and potential socioeconomic barriers to health.

**NEW QUESTION: 327**
Physicians' actions have been noted be a major contributor to unexplained clinical variation in healthcare.
Unexplained clinical variation leads to increased healthcare costs, medical errors, patient frustration, and poor clinical
outcomes. The increase in information being collected on physician practice patterns has begun to expose widespread
variations in practice. In healthcare, variation exists among providers by:
**A.** Specialty and practice setting
**B.** Geographical region
**C.** Facilities
**D.** Staff performance
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 328**

A strategy to address social determinants of health would be to
**A.** launch a community campaign to promote influenza vaccines.
**B.** identify high-risk patients with high-cost medications.
**C.** create patient education materials that are culturally competent.
**D.** implement a standard questionnaire for pediatric lead screening.
**Answer: (SHOW ANSWER)**
A strategy to address social determinants of health involves creating patient education materials that are culturally competent. Culturally competent materials consider the cultural, linguistic, and literacy needs of the patient population, making the information accessible and relevant. This approach helps to bridge gaps in understanding and engagement, which are often influenced by social determinants such as education, income, and cultural background.
* Launch a community campaign to promote influenza vaccines (A): While important for public health, this is not directly focused on social determinants of health.
* Identify high-risk patients with high-cost medications (B): This is more related to cost management and clinical care than addressing social determinants.
* Implement a standard questionnaire for pediatric lead screening (D): This addresses a specific health issue but does not broadly address social determinants of health.
References
* NAHQ Body of Knowledge: Addressing Social Determinants of Health in Healthcare
* NAHQ CPHQ Exam Preparation Materials: Culturally Competent Care and Education
=========

**NEW QUESTION: 329**
Which of the following is one purpose of clinical pathways?
**A.** to increase efficiency by generation of automated care plans
**B.** to minimize errors by guiding staff through the steps of a process
**C.** to reduce variability by establishing a standardized process
**D.** to improve diagnostic accuracy by making diagnostic recommendations
**Answer: C (LEAVE A REPLY)**
The primary purpose of clinical pathways is to reduce variability in patient care by establishing a standardized process. Clinical pathways outline the optimal sequence and timing of interventions for specific diagnoses or procedures, ensuring that all patients receive consistent and evidence-based care.
This standardization helps to improve outcomes, reduce errors, and enhance the efficiency of care delivery.
Increase efficiency by generation of automated care plans (A): While clinical pathways can improve efficiency, their primary goal is to standardize care, not necessarily to generate automated care plans.
Minimize errors by guiding staff through the steps of a process (B): Error minimization is a benefit, but the main purpose is reducing variability.

Improve diagnostic accuracy by making diagnostic recommendations (D): Clinical pathways focus more on treatment and care processes than on making diagnostic recommendations.
Reference
NAHQ Body of Knowledge: Clinical Pathways and Standardization in Care
NAHQ CPHQ Exam Preparation Materials: Benefits and Purposes of Clinical Pathways

**NEW QUESTION: 330**
Annual evaluation of a quality Improvement process must
**A.** be based on organizational objectives.
**B.** survey all departments and teams.
**C.** be accomplished by a healthcare quality professional.
**D.** document all problems identified In care/service.
**Answer: A (LEAVE A REPLY)**
The annual evaluation of a quality improvement process should be based on organizational objectives.
This is because the quality improvement process is designed to enhance the effectiveness and efficiency of an organization's operations and align them with the organization's strategic goals12.
The AAAHC (Accreditation Association for Ambulatory Health Care) requires that documentation demonstrates at least an annual governing body review of the Quality Improvement (QI) program to evaluate effectiveness and determine if the purposes and objectives continue to be met3.
Therefore, the annual evaluation of a quality improvement process must be based on organizational objectives to ensure that the process is effectively contributing to the achievement of these objectives.
Reference: 123

**NEW QUESTION: 331**
Studies comparing self-reports with proxy reports do not consistently support the hypothesis that self- reports are more accurate than proxy reports.
However, conclusions drawn from studies in which responses were verified using hospital and physician records show that, on average (Choose two):
**A.** Proxy reports tend to be more accurate than self-reports
**B.** Health events are underreported in both populations
**C.** Health events are reported in both populations
**D.** Self-reports tend to be more accurate than proxy reports
**Answer: B,D (LEAVE A REPLY)**

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**NEW QUESTION: 332**
Payers are more likely to embrace the optimization definition of care which can put them at odds with:
**A.** Physicians
**B.** Clinicians
**C.** Health administrators
**D.** Both A and B
**Answer: A (LEAVE A REPLY)**

**NEW QUESTION: 333**
For example, if you are using a survey to gather patient satisfaction feedback by email, you would not send a survey to ever y patient. You would start by sending surveys to roughly 50 percent of the patients and see how many are returned. This limited survey allows you to determine the response rate. Assume that
25 percent of these patients return the surveys.
The next task is to determine how representative of the total population these respondents are.
To test this question, you need to develop a profile of the total population. Typically, this profile is based on standard demographics such as gender, age, type of visit, payer class, and whether the respondent is a new or returning patient. If the distribution of these characteristics in the sample is similar (within 5 percent) to that found in the total population, you can be comfort able that your sample is reasonably representative of the population. If the characteristics of the sample and the population show considerable variation, however, you should adjust your sampling plan.
This example clarifies that:
**A.** Sampling consists of series of compromises and tradeoffs
**B.** The basic purpose of sampling is to be able to draw a limited number of observations
**C.** Sampling is probably the most important thing you can do to reduce the amount of time and resources spent on data collection
**D.** A well-drawn sample, therefore, should be representative of the larger population
**Answer: (SHOW ANSWER)**

**NEW QUESTION: 334**
All the evaluations of quality of care can be classified in terms of one three aspects of care giving they measure.
Which of the following is/are NOT out of these measures?
**A.** Cutbas
**B.** Process
**C.** Output
**D.** Structure

**Answer: A,C (LEAVE A REPLY)**

**NEW QUESTION: 335**

A healthcare quality professional has been asked to assess a facility's patient safety culture. Which of the following should be surveyed?

**A.** A stratified sample of physicians and nurses

**B.** All patients and their families

**C.** All staff and physicians

**D.** A random sample of leaders and staff

**Answer: (SHOW ANSWER)**

Assessing a facility's patient safety culture involves evaluating the shared values, beliefs, and norms about patient safety within the organization. To gain a comprehensive understanding, it is essential to gather input from all individuals involved in patient care and organizational operations.

**NEW QUESTION: 336**

A surgeon's wound infection rate is 32%. Further examination of which of the following data will provide the most useful information in determining the cause of this surgeon's infection rate?

**A.** Type of anesthesia used

**B.** Facility infection rate

**C.** Use of prophylactic antibiotics

**D.** Mortality rate

**Answer: C (LEAVE A REPLY)**

**NEW QUESTION: 337**

A healthcare quality professional's initial step in the creation of a patient safety program is to

**A.** define key processes that contribute to patient complaints.

**B.** assess the organization's current culture of safety.

**C.** recommend software purchases to enhance the program.

**D.** identify the applicable patient safety standards.

**Answer: B (LEAVE A REPLY)**

The initial step in creating a patient safety program is to assess the organization's current culture of safety. Understanding the existing culture provides a baseline for identifying areas that need improvement and informs the design of the program. It helps the healthcare quality professional understand staff attitudes, behaviors, and perceptions related to patient safety, which are critical to developing a successful and sustainable patient safety program.

Define key processes that contribute to patient complaints (A): This may be part of a broader quality improvement initiative but not the first step in a patient safety program.

Recommend software purchases to enhance the program (C): This is a later step, after the program's goals and needs have been established.

Identify the applicable patient safety standards (D): While important, this is typically done after assessing the current safety culture.

Reference

NAHQ Body of Knowledge: Patient Safety and Safety Culture Assessment

NAHQ CPHQ Exam Preparation Materials: Developing a Patient Safety Program

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