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NEW QUESTION: 1
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. Deploy human capabilities fully and draw out finite potential
B. Both A and B
C. Respect human relations and build a workshop offering job satisfaction
D. Contribute to implement and development of the enterprise
Answer: (SHOW ANSWER)

NEW QUESTION: 2
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. Selection and use of a performance improvement methodology
B. Establishment of a performance improvement oversight entity
C. Establishment of partnership with key stakeholder
D. Staff understanding
Answer: A (LEAVE A REPLY)

NEW QUESTION: 3
Efficiency refers how well resources are used in achieving a given result. Efficiency whenever the resources used to produce a given output are _____________.

A. It is truly situation dependent
B. Increases, increased
C. Improves, reduced
D. Reduces, reduced
Answer: C (LEAVE A REPLY)

NEW QUESTION: 4
The increased focus on and mandate for healthcare data place healthcare providers in a different situation than they have known in the past. Providers document such things and, unfortunately, many providers struggle to address the measurement mandate proactively, which leads organizations to assume a defensive posture when external organizations release the data. Which of the following ways show/s the responses of provider in such cases? (Choose three.)
A. The data are old (typically one or two years) and do not reflect our current performance
B. The data are not stratified and do not represent appropriate comparisons.
C. We can move in a better way without doing competition with others
D. Our patients are siertan those at the other hospitals in our comparison group (i.e., no risk adjustments were made to the data).
Answer: (SHOW ANSWER)

NEW QUESTION: 5
After much planning and preparation, a healthcare quality professional believes the organization is ready to move forward with the process of achieving recognition through a program that highlights their achievements in nursing excellence. Which of the following distinctions is most appropriate for the organization to pursue?
A. Baldrige
B. Magnet
C. CMS Stars
D. Leapfrog Safety Grade
Answer: (SHOW ANSWER)
The Magnet Recognition Program, administered by the American Nurses Credentialing Center (ANCC), is the most appropriate distinction for organizations aiming to highlight nursing excellence. Magnet recognition is considered the gold standard for nursing excellence and is associated with improved patient outcomes, higher job satisfaction among nurses, and overall organizational excellence in nursing practices.
References:
ANCC Magnet Recognition Program

NEW QUESTION: 6
The American Society for Quality has formed six categories of quality tools.
Which of the following is NOT out of those categories?
A. Evaluation and decision making

B. Cause Analysis
C. Process analysis
D. Idea adoption
Answer: D (LEAVE A REPLY)

NEW QUESTION: 7
Organizational size affects the ability to disseminate best practices
A. Difficult to decide
B. True
C. It depends on situation
D. False
Answer: B (LEAVE A REPLY)

NEW QUESTION: 8
Payers are more likely to embrace the optimization definition of care which can put them at odds with:
A. Both A & B
B. Health administrators
C. Clinicians
D. Physicians
Answer: (SHOW ANSWER)

NEW QUESTION: 9
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.
References:
* NAHQ Guide to Sentinel Event Management and Never Event Prevention
* NAHQ Healthcare Quality Competency Framework: Patient Safety and Risk Management
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NEW QUESTION: 10
An organization recently lost its deemed status due to non-compliance with grievance process regulations.
Which of the following standards would the quality professional research to identify grievance process requirements to correct the cited opportunities for improvement?
A. Federal Register
B. Centers for Medicare and Medicaid Services
C. The Joint Commission (TJC)
D. DNV GL Healthcare
Answer: (SHOW ANSWER)
Detailed Explanation:
The Centers for Medicare and Medicaid Services (CMS) set regulatory requirements for grievance processes that healthcare organizations must follow to maintain compliance and deemed status.
Option B: Centers for Medicare and Medicaid Services
CMS establishes federal requirements that healthcare providers must meet, including those related to patient grievance processes.
References:
CPHQ resources indicate that CMS standards must be adhered to for organizations to maintain their deemed status, as they are the primary authority on grievance processes for Medicare/Medicaid compliance.

NEW QUESTION: 11
Experts on delivering superior customer service suggest that healthcare organizations adopt the following set principles EXCEPT:
A. Establish high standards of customer service
B. Evaluate processes of care to reduce patients and family anxiety and thus increase satisfaction
C. Help staff focus on service
D. Hire service-savvy people. Aptitude is everything; people can be taught technical skills

Answer: B (LEAVE A REPLY)

NEW QUESTION: 12

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: (SHOW ANSWER)

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.

References

* NAHQ Body of Knowledge: Patient-Centered Care and Engagement
* NAHQ CPHQ Exam Preparation Materials: Implementing Patient-Centered Approaches

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NEW QUESTION: 13

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

Measure	Current Performance	Threshold	Desired Direction
Timely Medical Record Documentation	95%	90%	Higher
Readmission Rate	13%	10%	Lower
Surgical Site Infection Rate	9%	5%	Lower
Use of Pre-procedure Timeouts	100%	100%	Higher
Patient Experience Score (Top Box)	94%	80%	Higher
Clinical Pathway Adherence	81%	70%	Higher

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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: 14

A healthcare quality professional Is doing a studyinthe emergency room. Every other patient admitted to the department Is Includedinthe 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 ofliterature 2: Systematic Sampling | A Step-by-Step Guide
* with Examples 4: What is systematic sampling? 3: Systematic Sampling: Advantages and Disadvantages

NEW QUESTION: 15

An organization Is tracking Infection rates to determine the benchmarks for the next fiscal year. The team Is analyzing the data for Infection rates. Which key variables are missing to interpret the graph?

A. the standardized infection ratio for the previous year and denominator for each measure

B. the timeframe for each data point andthe source (or the target line

C. the mode of the data points and expected rate for external hospitals

D. the quality of patients and hospital compliance with handwashing

Answer: B (LEAVE A REPLY)

The question pertains to key variables missing in a graph that tracks infection rates for benchmarking purposes. The options provided suggest various combinations of data that could potentially be missing, impacting the interpretation of the graph.
Option A suggests a need for historical data and specific denominators, but it doesn't address immediate contextual needs like timeframe or source/target lines.
Option C introduces external hospital expected rates and modes of data points, which might not be directly relevant to interpreting a specific organization's infection rate trends.
Option D focuses on qualitative aspects like patient quality and compliance with handwashing protocols, which are essential but not directly related to interpreting graphical data.
Option B is verified as correct because it highlights two critical elements: "the timeframe for each data point" and "the source (or target line)." These elements are fundamental to understanding any graph as they provide context regarding when the data was collected and what benchmarks or standards are being compared against.
The timeframe is essential to identify trends over time, seasonal variations, or impacts of specific interventions or changes in practice.
The source or target line provides a benchmark indicating expected performance levels or goals that the organization aims to achieve.
Without these two pieces of information, it would be challenging to derive meaningful insights from the graph about infection rate trends and their implications for future benchmarks.
References:
HQ Solutions: Resource for the Healthcare Quality Professional, Fifth Edition, Chapter 5: Quality Review and Accountability, p. 133-134 Learning Lab: Survey Readiness - A Team Approach to Success, Slide 8: Data Display Learning Lab: The Role of the Healthcare Quality Professional in Population Health Management, Slide 10:
Data Visualization

NEW QUESTION: 16
A patient safety manager provided training on hand hygiene guidelines. The clinical manager Is confident that staff are following the guidelines.
Which of the following Is the best method to evaluate the current compliance with the guidelines?
A. collection of bacterial hand cultures
B. direct observation of staff
C. calculation of Infection rates compared to a baseline
D. a test with a passing score of 98%
Answer: B (LEAVE A REPLY)
According to the WHO Guidelines on Hand Hygiene in Health Care, direct observation of hand hygiene practices is the gold standard for measuring compliance1. Direct observation allows for the assessment of the five moments of hand hygiene, the use of appropriate technique, and the identification of barriers and facilitators to adherence1.
Direct observation also provides an opportunity for immediate feedback and education to the health care workers, which can improve their knowledge and motivation to perform hand

hygiene2. Direct observation can be done covertly or overtly, depending on the purpose and context of the audit2.
Other methods of measuring hand hygiene compliance, such as collection of bacterial hand cultures, calculation of infection rates, or a test with a passing score, have limitations and disadvantages. For example, bacterial hand cultures may not reflect the actual transmission of pathogens, infection rates may be influenced by many factors other than hand hygiene, and a test score may not correlate with actual behavior2.
Reference: 1: WHO Guidelines on Hand Hygiene in Health Care, WHO, 2009 2: Hand Hygiene: Education, Monitoring and Feedback, CDC, 2019

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NEW QUESTION: 17
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. Structure
C. Processes
D. Efficacy
Answer: D (LEAVE A REPLY)

NEW QUESTION: 18
Which of the following monitors provides patient outcome information?
A. Equipment malfunction rate
B. Degree of compliance with nursing care documentation
C. Nosocomial infection rate
D. Degree of compliance with renewal of antibiotics therapy
Answer: C (LEAVE A REPLY)

NEW QUESTION: 19

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. Output
B. Cutbas
C. Process
D. Structure
Answer: A,B (LEAVE A REPLY)

NEW QUESTION: 20
Which of the following monitors provides patient outcome information?

A. Degree of compliance with nursing care documentation
B. Equipment malfunction rate
C. Degree of compliance with renewal of antibiotics therapy
D. Nosocomial infection rate
Answer: D (LEAVE A REPLY)

NEW QUESTION: 21
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. Walter Shewhart
B. Josph M. Juran
C. Armand Shewhart
D. W. Edwards Deming
Answer: (SHOW ANSWER)

NEW QUESTION: 22
A nursing unit has collected the following data:

Personnel	Timely Initial Assessment	Incomplete Documentation
Nurse A	45	0
Nurse B	40	12
Doctor A	10	26
Doctor B	25	20

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Which of the following is the best method to display this data?

A. Bar Chart
B. Gantt Chart
C. Pareto Chart

D. Run Chart
Answer: (SHOW ANSWER)
Detailed Explanation:
A bar chart is ideal for comparing categorical data across groups, which makes it suitable for displaying assessments and documentation completeness by personnel.
Option A: Bar Chart
Bar charts display data for different categories, making it easy to compare the performance of each individual.
Option C:
A Pareto chart shows the frequency of issues but does not allow for individual comparisons as effectively as a bar chart.
References:
Bar charts are recommended in healthcare data visualization for comparing categorical data across different groups, as noted in quality improvement tools in CPHQ resources.

NEW QUESTION: 23
A CEO has directed a quality improvement council to develop objectives to meet an identified goal.
When developing objectives, the council must remember to
A. keep the objectives specific to the short term.
B. tie the objectives to the organization's financial performance.
C. use the Plan-Do-Study-Act cycle of continuous improvement.
D. state the end result or desired outcome.
Answer: D (LEAVE A REPLY)
When developing objectives, it is crucial for the quality improvement council to state the end result or desired outcome. Clearly defining what success looks like ensures that all stakeholders understand the goal and can work towards it effectively. Well-defined objectives help guide the direction of the project, allow for the measurement of progress, and ensure that the team's efforts are aligned with the overarching goal.
Keep the objectives specific to the short term (A): While short-term objectives can be important, objectives should be defined based on what is necessary to achieve the overall goal, whether short-term or long-term.
Tie the objectives to the organization's financial performance (B): While financial performance is important, not all quality improvement objectives need to be directly tied to financial outcomes. The primary focus should be on the desired outcomes related to quality and performance improvement. Use the Plan-Do-Study-Act cycle of continuous improvement (C): The PDSA cycle is a method for implementing change, but the initial step in developing objectives is to clearly define the desired end result.
Reference
NAHQ Body of Knowledge: Quality Improvement Objective Setting
NAHQ CPHQ Exam Preparation Materials: Developing SMART Objectives

NEW QUESTION: 24
The CAHPS (Consumer Assessment of Healthcare Providers and Systems) program is a multiyear public-private
initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Healthcare
organizations, public and private purchasers, consumers, and researchers use CAHPS results to:
A. All of the above
B. Compare and report on performance
C. Access the patients-centeredness of care
D. Improve quality of care
Answer: A (LEAVE A REPLY)

NEW QUESTION: 25
There is an art to constructing patient satisfaction surveys that produce valid, reliable, and relevant information.
Likewise, survey validation itself is a time-consuming and complex undertaking. A quality improvement team can:
A. Design with the help of outside experts to design the survey
B. Purchase an existing survey
C. Design the survey itself
D. Any one of these can be the case
Answer: D (LEAVE A REPLY)

NEW QUESTION: 26
A quality professional was asked to assist with strategic planning.
Which of the following should have the primary impact on the quality and performance improvement goals?
A. report of major competitors 'performance
B. findings from a staff needs assessment
C. financial statement of the organization
D. results of gap analysis
Answer: D (LEAVE A REPLY)

NEW QUESTION: 27
Quality improvement approaches are derivatives and models of the ideas and theories developed by thought leaders
and include all of the following EXCEPT:
A. PDCA/PDSA
B. Associate for process improvements
C. Baldrige criteria

D. ISO 2001
Answer: D (LEAVE A REPLY)

NEW QUESTION: 28
When developing objectives for an educational program, the quality professional should recommend
A. using the Plan-Do-Study-Act cycle of continuous improvement.
B. stating the end result or desired outcome.
C. keeping the objectives specific to the short term.
D. tying the objectives to the organization's financial performance.
Answer: B (LEAVE A REPLY)
According to NAHQ, one of the core competencies for healthcare quality professionals is education and training1, which involves designing, developing, delivering, and evaluating educational programs that support quality improvement and patient safety2.
When developing objectives for an educational program, the quality professional should follow the SMART criteria, which stands for specific, measurable, achievable, relevant, and time-bound3. These criteria help to ensure that the objectives are clear, realistic, and aligned with the desired outcomes of the program4.
Therefore, the quality professional should recommend stating the end result or desired outcome of the program, as this will help to define the purpose, scope, and direction of the program, as well as the criteria for measuring its success. For example, an objective for an educational program on infection prevention and control could be: "By the end of this program, participants will be able to identify and apply the best practices for preventing and managing healthcare-associated infections in their settings." The other options are not the best recommendations for developing objectives for an educational program, because:
A:using the Plan-Do-Study-Act cycle of continuous improvement is a method for implementing and evaluating quality improvement projects, not for developing objectives for an educational program.
C:keeping the objectives specific to the short term may limit the scope and impact of the program, as well as the opportunities for learning and improvement.
D:tying the objectives to the organization's financial performance may not reflect the true value and outcomes of the program, as quality improvement and patient safety may have other benefits that are not easily quantified in monetary terms.
Reference: 1: Competency Framework | NAHQ 2: NAHQ Healthcare Quality Competency Framework 3:
[HQ Principles | NAHQ] 4: How to Write SMART Learning Objectives - Convergence Training: Writing Measurable Learning Outcomes - Gavilan College: Infection Prevention and Control Education & Resources - APIC: Plan-Do-Study-Act (PDSA) Worksheet | IHI - Institute for Healthcare Improvement:
Setting Goals and Objectives for Projects | Smartsheet: [The Financial Case for Quality as a Business Strategy | NAHQ]

NEW QUESTION: 29

During the course of a root cause analysis, the team found the following Items contributed to the error:

* Fatigue and stress leading to Inattention
* Pressure to accomplish more tasks In the same amount of time
* The equipment was designed for right-handed staff

Which of the following best describe these types of causes?

A. production pressure
B. normalized deviance
C. errors of omission
D. human factors

Answer: D (LEAVE A REPLY)

Human factors in healthcare refer to the study of how humans interact with elements in a system, such as equipment, tasks, and environment, and how these interactions affect their behavior and performance12. The goal of human factors engineering is to optimize human performance, health, and safety2.

In the context of the question, the causes of the error identified during the root cause analysis are all related to human factors:

* Fatigue and stress leading to inattention: This is a psychological factor that can significantly affect a person's ability to perform tasks effectively and safely. Fatigue and stress can impair cognitive functions such as attention, decision-making, and reaction time1.
* Pressure to accomplish more tasks in the same amount of time: This is an organizational factor that can create a stressful work environment, leading to rushed work, shortcuts, and mistakes1.
* The equipment was designed for right-handed staff: This is a design factor that can affect the usability and safety of equipment. If equipment is not designed to accommodate the needs of all users, it can lead to errors and accidents1.

These factors are all part of the human factors framework, which emphasizes the importance of designing systems and processes that take into account human capabilities and limitations2.

References:

* 1: Human Factors in Healthcare - NHS England
* 2: Human Factors in Healthcare | SpringerLink
* 4: Certified Professional in Healthcare Quality Detailed Content ... - NAHQ

NEW QUESTION: 30

Leadership at an outpatient multi-specialty clinic Is working toward becoming a high-re I lability organization.

In the past week, there have been three medication errors with high-risk medications in the procedure area.

Which of the following responses by leadership Is consistent with high-reliability principles?

A. Ensure risk management staff coordinate disclosure to the patients.

B. Meet with staff Involved In the errors to gain additional Insight.
C. Require medications be double-checked before administration
D. Create an additional constraint on availability of high-risk medications.
Answer: B (LEAVE A REPLY)
High-reliability organizations (HROs) operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures1. They prioritize safety over other performance pressures1.
The principles of high reliability go beyond standardization; high reliability is better described as a condition of persistent mindfulness within an organization1. HROs work to create an environment in which potential problems are anticipated, detected early, and virtually always responded to early enough to prevent catastrophic consequences1.
One of the key characteristics of HROs is a preoccupation with failure1. Everyone is aware of and thinking about the potential for failure1. Near misses are viewed as opportunities to learn about systems issues and potential improvements, rather than as evidence of safety1.
Another important characteristic is deference to frontline expertise1. This means that those closest to the work, who have the most direct knowledge of the situation at hand, have the authority to make decisions1.
In the given scenario, meeting with the staff involved in the errors to gain additional insight (Option B) aligns with these principles. It shows a preoccupation with failure and deference to frontline expertise. By meeting with the staff, leadership can understand what led to the errors and how to prevent them in the future. This approach is consistent with the principles of high reliability and is likely to contribute to the clinic's goal of becoming a high-reliability organization.

NEW QUESTION: 31
When formulating medical standards, a critical decision that must be made is the _____ at which the standard should be set.
A. Clarity
B. utility of measurement
C. Depth
D. Level
Answer: (SHOW ANSWER)

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NEW QUESTION: 32

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: A (LEAVE A REPLY)
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 failuresmight 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: 33
It involves identification and selection of a patient's medical record or group of records after the patient has been

discharged from the hospital or clinic. Many proponents of medical record review believe it to be the most accurate
method of data collection. What is it?
A. Data collection forms
B. Prospective data collection
C. Scanners
D. Retrospective data collection
Answer: D (LEAVE A REPLY)

NEW QUESTION: 34
Overproduction
Inventory
Repairs/rejects
Motion
Processing
Waiting
Transport
These are the types of ____________ identified by Taiichiohno.
A. Continuous improvement
B. Areas to be focused during production
C. Waste (activities that do not add value to the process)
D. Quality controls
Answer: C (LEAVE A REPLY)

NEW QUESTION: 35
Which of the following is the best way to evaluate the success of a performance improvement team?
A. Incorporation of team recommendations into policies
B. Adherence to team deadlines
C. Periodic measurement of outcomes
D. Identification of improvement opportunities
Answer: C (LEAVE A REPLY)
Periodic measurement of outcomes is the most effective way to evaluate the success of a performance improvement team. By assessing the actual results of implemented changes, organizations can determine whether the improvements have led to desired outcomes, such as enhanced patient care, increased efficiency, or reduced errors.
While incorporating recommendations into policies (Option A) and adhering to deadlines (Option B) are important, they do not directly measure the impact of the team's efforts. Identifying improvement opportunities (Option D) is a preliminary step, not an evaluation of success.
References:
NAHQ Body of Knowledge: Performance and Process Improvement

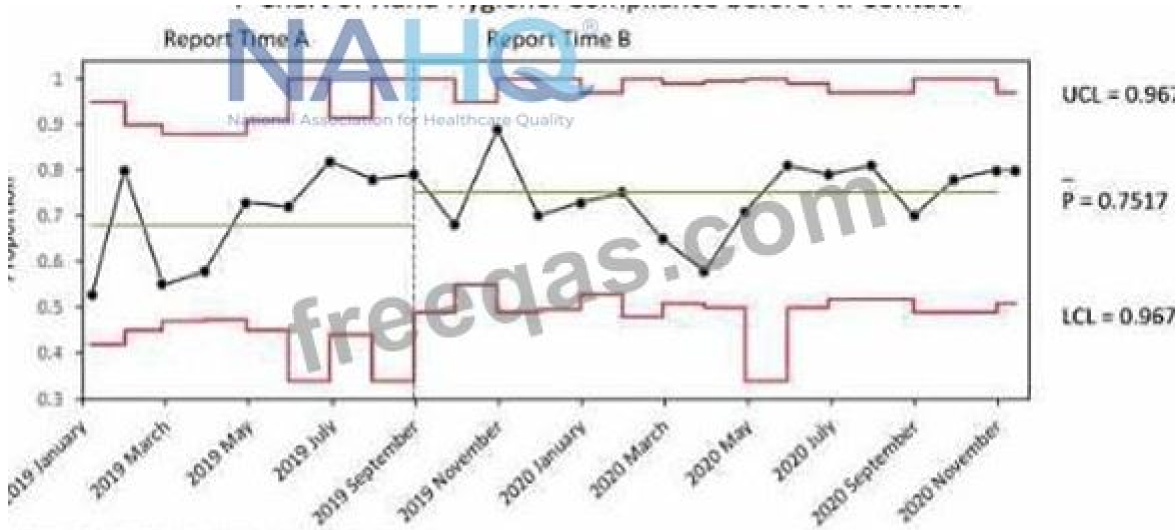
NEW QUESTION: 36
Which action should be taken to support continuous survey readiness?
A. Facilitate a failure mode and effects analysis (FMEA) on patient consent
B. Conduct time studies for patient registration processes
C. Map the value stream for elective surgery patients
D. Perform tracers on patients in restraints
Answer: D (LEAVE A REPLY)
Continuous survey readiness ensures that healthcare organizations are consistently prepared for accreditation surveys (e.g., Joint Commission, CMS) by maintaining compliance with standards. Tracers, which involve following a patient's care journey to assess compliance with standards, are a key tool for identifying gaps and ensuring ongoing readiness.
Option A (Facilitate a failure mode and effects analysis (FMEA) on patient consent): FMEA is a proactive risk assessment tool for specific processes, not a broad strategy for survey readiness. It may be used for targeted improvements but does not address overall compliance monitoring.
Option B (Conduct time studies for patient registration processes): Time studies are useful for process improvement (e.g., reducing wait times) but are not directly tied to survey readiness, which focuses on compliance with accreditation standards across multiple areas.
Option C (Map the value stream for elective surgery patients): Value stream mapping is a Lean tool for process optimization, not a method for ensuring survey readiness. It is too narrow in scope to address comprehensive compliance needs.
Option D (Perform tracers on patients in restraints): Tracers are a cornerstone of survey readiness, as they simulate the survey process by tracking patient care across departments to verify compliance with standards (e.
g., restraint use, documentation, safety protocols). NAHQ CPHQ study materials recommend tracers as a best practice for continuous readiness, particularly for high-risk areas like restraint use, which is heavily scrutinized by accrediting bodies.
Reference: NAHQ CPHQ Study Guide, Domain 4: Performance and Process Improvement, emphasizes tracers as a critical tool for maintaining continuous survey readiness by assessing compliance with accreditation standards.

NEW QUESTION: 37
Which of the following represents a medically underserved population?
A. high risk obstetric patients in the third trimester
B. families with a household size greater than 7.2
C. patients living within S miles of an urban area
D. patients living below the Income poverty line
Answer: (SHOW ANSWER)
A medically underserved population is a population of individuals with either a large elderly population, high infant mortality rate, high level of poverty or lack of providers1. This definition

aligns with option D, which refers to patients living below the income poverty line. These individuals often lack access to primary care health services2, which is a key characteristic of medically underserved populations. Therefore, the answer is D: patients living below the Income poverty line.

NEW QUESTION: 38

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: 39

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: 40
______________ is the collection of data used to analyze physician practice pattern, utilization of services, and outcomes of care. Its goal is to improve physician performance through accounts through accountability feedback and to decrease practice variations through adherence to evidence-based standards of care.
A. Value-based profiling

B. Physician profiling
C. Physicians portfolio management
D. Physician record review
Answer: B (LEAVE A REPLY)

NEW QUESTION: 41

The strategic plan for an organization calls for expansion of information technology. The following information is available:

Information Technology Initiative	Benefits	Implementation Changes	Cost
Option A	8	xxxx	ssss
Option B	6	xxx	$$$
Option C	5	x	ss
Option D	3	xx	$

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If equal weight is given to each consideration, which of the following options should be the primary choice?

A. Option A
B. Option B
C. Option C
D. Option D
Answer: C (LEAVE A REPLY)

If equal weight is given to each consideration (Benefits, Implementation Changes, and Cost), Option C should be the primary choice. The rationale is as follows:
* Benefits: While Option A has the highest benefit score (8), Option C's benefit score of 5 is still relatively strong.
* Implementation Changes: Option C has the fewest implementation changes ("x"), suggesting it will be easier to implement.
* Cost: Option C is the second most cost-effective option ("$$"), balancing cost against benefits and implementation changes.
Option C strikes a balance between benefits, ease of implementation, and cost, making it a solid choice when all factors are weighted equally.
* Option A (A): Although it offers the highest benefits, it also has the highest cost ("$$$$") and the most implementation changes ("xxxx").
* Option B (B): This option has slightly lower benefits, moderate implementation changes, and high cost ("$$$").
* Option D (D): Although it has the lowest cost, the benefits are also the lowest, making it less attractive overall.
References
* NAHQ Body of Knowledge: Strategic Decision-Making in IT Initiatives

* NAHQ CPHQ Exam Preparation Materials: Cost-Benefit Analysis in Healthcare Projects

NEW QUESTION: 42

An organization wants to promote Six Sigma across its enterprise with all staff members having general exposure to Six Sigma methods. Which of the following best differentiates the role of the various belts?

A. Black belts report to project sponsors.
B. White belts mentor staff.
C. Yellow belts allocate resources for projects.
D. Green belts provide executive coaching.

Answer: A (LEAVE A REPLY)

In Six Sigma methodology, different belt levels signify varying degrees of expertise and responsibility within process improvement projects. Understanding these roles is crucial for effective implementation across an organization.

* White Belt: Individuals at this level have a basic understanding of Six Sigma concepts and may participate in local problem-solving teams but do not lead projects or mentor others.
* Yellow Belt: Yellow Belts possess a foundational knowledge of Six Sigma and assist with project tasks and data collection. They do not typically allocate resources for projects.
* Green Belt: Green Belts work on Six Sigma projects part-time, often under the guidance of Black Belts.

They analyze and solve quality problems within their specific areas but do not provide executive coaching.

* Black Belt: Black Belts are full-time professionals who lead problem-solving projects and report to project sponsors or Champions. They are responsible for project execution and achieving measurable results.

Therefore, among the options provided, the statement "Black belts report to project sponsors" (Option A) best differentiates the role of the various belts.

References:

* American Society for Quality (ASQ) - "Six Sigma Belts, Levels & Roles"
* Six Sigma Institute - "Six Sigma Roles and Responsibilities"

NEW QUESTION: 43

Although Lean thinking focuses on removing waste and improving flow, it also has some secondary effects such as:

A. All of these
B. Quality is improved
C. Simplification of processes results in less time in process
D. Reduces the chances of damage

Answer: A (LEAVE A REPLY)

NEW QUESTION: 44

Which of the following is the appropriate group to review care delivered by an individual physician to a patient who suffered a serious adverse event?

A. peer review committee

B. quality council

C. governing body

D. bioethics committee

Answer: (SHOW ANSWER)

The appropriate group to review the care delivered by an individual physician to a patient who suffered a serious adverse event is the peer review committee. The peer review process is a critical component of healthcare quality and safety, designed to ensure that physicians provide care that meets established standards.

* Peer Review Committee's Role: This committee is composed of medical professionals who have the expertise and qualifications to assess the clinical performance of their peers. The review is confidential and focuses on evaluating the quality of care provided, adherence to established clinical guidelines, and the identification of any deviations from standard practices.

* Assessment of Serious Adverse Events: In the case of a serious adverse event, it is essential to determine whether the care delivered was appropriate or if there were errors or omissions that contributed to the event. The peer review committee is tasked with conducting this detailed analysis, identifying root causes, and recommending actions to prevent future occurrences.

* Ensuring Accountability and Improvement: The peer review process also ensures that physicians are held accountable for their actions while providing a pathway for continuous improvement. If deficiencies are found, the committee can suggest corrective actions, additional training, or other measures to enhance patient safety.

* Comparison with Other Options:

* Quality Council: Typically focuses on broader quality improvement initiatives across the organization, rather than the specific review of individual cases.

* Governing Body: Oversees the organization at a high level and would not typically be involved in the detailed clinical review of individual cases.

* Bioethics Committee: Focuses on ethical dilemmas in patient care but does not perform clinical performance reviews.

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

* National Association for Healthcare Quality (NAHQ), CPHQ Study Guide, Chapter on Peer Review Processes.

* NAHQ Code of Ethics and Standards of Practice, Section on Peer Review.

* Quality Management in Health Care, Article on Roles of Peer Review Committees.

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NEW QUESTION: 45

The chart above is used by a team to document process improvement results following an intervention that was implemented during the 20th week. Based on this chart, the team can conclude:

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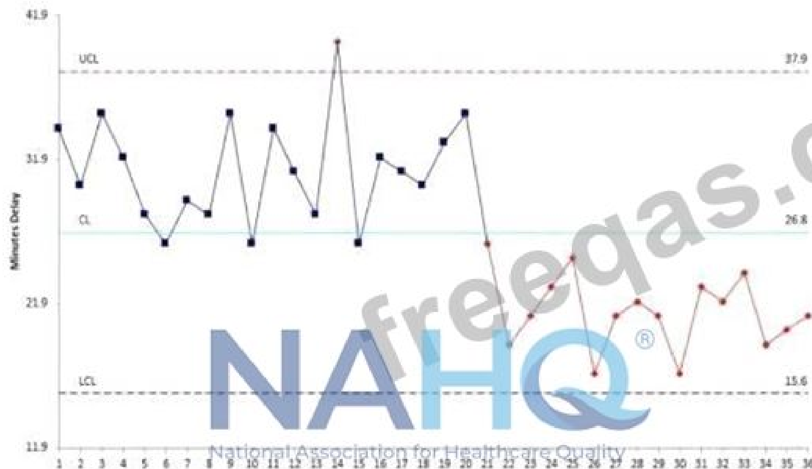

A. Variation in the process has decreased.
B. The intervention resulted in a shift in performance.
C. The process is in control.
D. There is a downward trend in performance.
Answer: B (LEAVE A REPLY)

* Understanding the Control Chart ComponentsThis control chart shows the median delay over time (by week), with control limits (UCL - Upper Control Limit, LCL - Lower Control Limit) and a center line (CL) indicating the process average before the intervention. Control charts like this one are used to determine whether an intervention has led to a significant change in process performance.
* Analyzing the Data Before and After the Intervention
* From weeks 1 to 19, before the intervention, the process appears to fluctuate around the control limits, with several points near the upper control limit, indicating higher variation and a generally stable process around a higher median delay.
* After week 20, following the intervention, the data points show a clear shift downward, consistently staying below the previous control line (CL). The process median delay has notably reduced, and all data points fall within a new, lower range.
* Conclusion Based on the Control Chart
* The consistent reduction in median delay and the clustering of data points below the previous center line indicate a shift in performance rather than mere random variation. This type of change, sustained over multiple weeks, strongly suggests that the intervention had a substantial impact on reducing the delay.
* While there may also be a decrease in variation, the primary visible effect is a shift in performance toward lower median delay values.
* Rationale for Selecting Answer BThe correct answer is B. The intervention resulted in a shift in performance, as the chart shows a distinct change in the process level post-intervention, indicating an improvement.

References:
* NAHQ "Quality Improvement in Healthcare: Statistical Process Control"

* "Interpreting Control Charts for Process Improvement" (NAHQ, 2020)

NEW QUESTION: 46

TQC is excellence driven rather than defect driven-a system that integrates:

A. Quality improvement and quality maintenance

B. Quality improvement and quality maintenance

C. Quality development, quality improvement and quality maintenance

D. Quality development, quality improvement and quality assessment

Answer: C (LEAVE A REPLY)

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NEW QUESTION: 47

TQC is excellence driven rather than defect driven-a system that integrates:

A. Quality development, quality improvement and quality assessment

B. Quality improvement and quality maintenance

C. Quality improvement and quality maintenance

D. Quality development, quality improvement and quality maintenance

Answer: D (LEAVE A REPLY)

NEW QUESTION: 48

Latent conditions can be described as

A. Specific unsafe acts that have adverse consequences

B. Defects that may go undetected for long periods of time

C. Unintentional mistakes made by an individual

D. Errors having a direct and immediate effect on safety

Answer: B (LEAVE A REPLY)

Latent conditions are underlying system vulnerabilities that increase the risk of errors but may not immediately cause harm, distinguishing them from active errors.

Option A (Specific unsafe acts that have adverse consequences): This describes active errors (e.g., wrong medication dose), not latent conditions.

Option B (Defects that may go undetected for long periods of time): This is the correct answer. The NAHQ CPHQ study guide states, "Latent conditions are systemic defects, such as poor equipment design or inadequate protocols, that remain undetected and increase error risk over time" (Domain 1). Examples include look-alike medications stored together.

Option C (Unintentional mistakes made by an individual): These are active errors, not latent system issues.
Option D (Errors having a direct and immediate effect on safety): These are active errors with immediate impact, not latent conditions.
CPHQ Objective Reference: Domain 1: Patient Safety, Objective 1.4, "Identify latent conditions contributing to errors," emphasizes recognizing systemic vulnerabilities. The NAHQ study guide notes, "Latent conditions are hidden system flaws that predispose to safety events" (Domain 1).
Rationale: Latent conditions are undetected system defects, aligning with CPHQ's focus on systemic safety risks.
Reference: NAHQ CPHQ Study Guide, Domain 1: Patient Safety, Objective 1.4.

NEW QUESTION: 49
A performance improvement council has been directed to set up a communication plan for spreading an innovative telehealth program throughout the healthcare system. Which of the following groups must the council include in the communication plan?
A. market competitors
B. adopter audiences
C. state legislators
D. local media
Answer: (SHOW ANSWER)
When a performanceimprovement council sets up a communication plan for spreading an innovative telehealth program throughout a healthcare system, the plan must include adopter audiences. Adopter audiences are the various groups within the healthcare system that will need to adopt the new program, including clinicians, administrators, and other staff members who will be directly involved in or affected by the implementation.
Importance of Adopter Audiences: Engaging adopter audiences is crucial because their buy-in, understanding, and participation are essential for the successful adoption and integration of the telehealth program.
Communication should be tailored to address their concerns, provide training, and outline the benefits of the innovation.
Comparison to Other Options:
A: market competitors: Involving market competitors in the communication plan is not appropriate, as they are external entities and could have conflicting interests.
C: state legislators: While state legislators may play a role in regulatory orpolicy support, they are not the primary focus of a communication plan aimed at internal adoption within the healthcare system.
D: local media: Local media can be useful for public relations and informing the broader community, but they are not directly involved in the adoption and implementation of the program within the healthcare system.

References: NAHQ resources highlight the importance of focusing on adopter audiences when communicating and implementing new healthcare initiatives, ensuring that the relevant stakeholders are informed, engaged, and prepared to support the change.
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NEW QUESTION: 50

Which of the following tools provides the best way to display quarterly comparisons of patient satisfaction surveys?

A. fishbone diagram

B. pie chart

C. flowchart

D. run chart

Answer: D (LEAVE A REPLY)

Comprehensive Step by Step Explanation

A run chart is the best tool to display quarterly comparisons of patient satisfaction surveys.

Here's why:

Purpose of the Tools: Each of the tools mentioned in the options serves a different purpose.

A fishbone diagram (also known as Ishikawa or cause and effect diagram) is used for root cause analysis. It helps identify, explore, and display the possible causes of a specific problem or quality characteristic1.

A pie chart is a type of graph in which a circle is divided into sectors that each represent a proportion of the whole1. It's useful for showing simple proportional part-to-whole information, but it's not ideal for comparisons over time1.

A flowchart is a type of diagram that represents a workflow or 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 problem.

A run chart, on the other hand, is a graph that displays observed data in a time sequence1. It is an effective tool to use for displaying and analyzing the trend of data over time1.

Why Run Chart: In the context of displaying quarterly comparisons of patient satisfaction surveys, a run chart is the most appropriate tool. It allows for the visualization of data trends over time, which is exactly what's needed when comparing patient satisfaction on a quarterly basis1. The x-axis represents time (in this case, quarters), and the y-axis represents the variable being measured (in this case, patient satisfaction). Each point on the chart represents a specific time period's data (a quarter's patient satisfaction survey results). The points are connected in the order of the time periods, creating a line that makes trends easy to spot1.

Limitations of Other Tools: The other tools (fishbone diagram, pie chart, and flowchart) are not designed to display trends over time, which is crucial when comparing quarterly data1.

Therefore, based on the purpose of each tool and the need to display trends over time, a run chart is the best tool to display quarterly comparisons of patient satisfaction surveys.

NEW QUESTION: 51

Depending upon the direction of a measure's improvement, outlier interpretations can be:
A. Negative measures
B. Positive measures
C. Structure measures
D. Outcome measures
Answer: A,B (LEAVE A REPLY)

NEW QUESTION: 52
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: (SHOW ANSWER)
* 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]

NEW QUESTION: 53
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. Pie chart
C. X-bar and S chart
D. Individual values and moving range chart
Answer: B (LEAVE A REPLY)

NEW QUESTION: 54
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
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. infection prevention
B. pain management
C. patient flow
D. environment of care
Answer: C (LEAVE A REPLY)

NEW QUESTION: 55
Which team role is responsible for maintaining improvements after the implementation of a quality initiative?

A. Champion
B. Process Owner
C. Sponsor
D. Facilitator
Answer: B (LEAVE A REPLY)
Detailed Explanation:
The process owner is accountable for the long-term maintenance and sustainment of improvements post- implementation.
Option B: Process Owner
This role ensures continuous oversight and improvement adherence, critical for sustaining changes.
Option A: Champion
Champions advocate and promote the initiative but may not manage ongoing maintenance.
Options C and D:
Sponsors provide support, and facilitators assist in the project's implementation but do not hold responsibility for sustainment.
References:
Process ownership is emphasized in quality management literature, where continuous oversight is necessary for successful and sustainable improvements.

NEW QUESTION: 56
An organization has Just experienced a wrong site surgery. A quality leader was asked to conduct a review to understand how the process failed. The best quality Improvement tool to use In developing a shared understanding of the current process.
Is which of the following?
A. Ishlkawa diagram
B. stratification chart
C. matrix diagram
D. flowchart
Answer: D (LEAVE A REPLY)
A flowchart is a type of diagram that represents a workflow or process, showing the steps as boxes of various kinds, and their order by connecting them with arrows. This diagrammatic representation illustrates a solution model to a given problem. Flowcharts are used in analyzing, designing, documenting, or managing a process or program in various fields12. In the context of a wrong site surgery, a flowchart can help visualize the entire process, identify potential points of failure, and understand how different steps in the process are interrelated. This makes it an effective tool for developing a shared understanding of the current process.

NEW QUESTION: 57
Which initiative should a quality professional promote in an organization seeking to optimize value-based reimbursement?

A. Standardize joint replacement care pathways.
B. Improve hand hygiene compliance.
C. Reduce use of inpatient restraints.
D. Implement computerized provider order entry (CPOE).
Answer: A (LEAVE A REPLY)
In an organization seeking to optimize value-based reimbursement, the most effective initiative for a quality professional to promote is the standardization of joint replacement care pathways.
Value-based reimbursement models reward healthcare providers for delivering high-quality care efficiently, often tying reimbursement to specific outcomes, particularly for high-cost procedures like joint replacements.
* Relevance to Value-Based Reimbursement: Joint replacement surgeries, such as hip and knee replacements, are common procedures with high costs and significant variability in outcomes. By standardizing care pathways, organizations can reduce this variability, ensuring more consistent and predictable outcomes, which are key metrics in value-based reimbursement.
* Impact on Quality and Cost: Standardized care pathways streamline the care process, reduce complications, minimize length of stay, and prevent readmissions-all of which directly improve the quality of care while controlling costs. These factors are critical in optimizing value-based reimbursement, where payment is increasingly linked to outcomes rather than volume.
* Comparison to Other Options:
* B. Improve hand hygiene compliance is important for patient safety and infection control but has a more indirect impact on value-based reimbursement.
* C. Reduce use of inpatient restraints focuses on patient safety and ethical care but does not have the same direct financial impact as standardizing high-cost procedures.
* D. Implement computerized provider order entry (CPOE) improves safety and efficiency but is more focused on reducing errors rather than directly influencing reimbursement tied to specific procedures.
References: National Association for Healthcare Quality (NAHQ) documents and resources discuss the importance of aligning clinical pathways with value-based care goals, particularly in high-impact areas like joint replacement surgeries, which are frequently targeted in reimbursement models.
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NEW QUESTION: 58
Which of the following is the best strategy for executive leaders to improve patient safety within an organization?
A. Model Just Culture practices.
B. Counsel staff involved in errors.
C. Implement leadershiprounds.
D. Support a blameless environment.
Answer: A (LEAVE A REPLY)

To improve patient safety, executive leaders need to foster an environment that promotes transparency, learning from errors, and accountability without blame. Here's why modeling JustCulture practices is the best strategy:
* Creating a Safe Environment:
* Just Culture encourages a balanced approach to accountability, where the focus is on understanding and correcting systems rather than blaming individuals. Leaders who model Just Culture practices demonstrate a commitment to safety and encourage the reporting of errors.
* Promoting a Learning Culture:
* By modeling Just Culture, leaders can promote a culture of continuous learning where staff feel safe to report errors and near misses. This is critical for identifying root causes and implementing system-wide improvements.
* Trust and Morale:
* When leaders consistently apply Just Culture principles, it builds trust among staff, leading to higher morale and a stronger commitment to patient safety initiatives.
* Systemic Change:
* Focusing on Just Culture allows organizations to address underlying system issues that contribute to errors, leading to more sustainable safety improvements.
While options B, C, and D are important elements of a patient safety strategy, modeling Just Culture practices directly addresses the cultural and systemic factors that are foundational to long-term improvements in patient safety.
References:
NAHQ Healthcare Quality Competency Framework: Patient Safety and Just Culture NAHQ Guide to Leadership and Patient Safety
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NEW QUESTION: 59
Which of the following is the primary benefit of the initial phase brainstorming?
A. Fosters discussion of ideas
B. Defines problem-solving roles and responsibilities
C. Allows input from all team members
D. Focuses on identifying the best solutions
Answer: C (LEAVE A REPLY)
Brainstorming in the initial phase of problem-solving encourages open idea generation to explore possibilities without judgment, setting the stage for collaborative solutions.
Option A (Fosters discussion of ideas): Discussion occurs during brainstorming, but it is a byproduct, not the primary benefit, which is inclusive input.
Option B (Defines problem-solving roles and responsibilities): Roles are defined in team formation, not brainstorming.
Option C (Allows input from all team members): This is the correct answer. The NAHQ CPHQ study guide states, "The primary benefit of initial brainstorming is to allow input from all team

members, ensuring diverse perspectives and inclusive idea generation" (Domain 4). This promotes creativity and engagement.
Option D (Focuses on identifying the best solutions): Initial brainstorming generates ideas, not evaluates or selects solutions, which occurs later.
CPHQ Objective Reference: Domain 4: Performance and Process Improvement, Objective 4.2, "Use collaborative techniques for problem-solving," includes brainstorming for inclusive input. The NAHQ study guide notes, "Brainstorming ensures all team members contribute ideas, enhancing solution development" (Domain 4).
Rationale: Allowing all team members to contribute fosters inclusivity and creativity, the primary benefit of initial brainstorming, as per CPHQ's improvement principles.
Reference: NAHQ CPHQ Study Guide, Domain 4: Performance and Process Improvement, Objective 4.2.

NEW QUESTION: 60
Survey preparation is initiated by a quality professional for an organization's annual three-year accreditation.
The executive committee and department managers are given an organizational schedule for training and accreditation activities. Which of the following is the best tool to use to manage this initiative?
A. Gantt chart
B. Multi-voting method
C. Affinity diagram
D. Ishikawa diagram
Answer: (SHOW ANSWER)
Managing an accreditation survey preparation initiative requires a tool to organize tasks, timelines, and dependencies across multiple stakeholders.
Option A (Gantt chart): This is the correct answer. The NAHQ CPHQ study guide states, "A Gantt chart is a project management tool that sequences tasks, shows timelines, and tracks dependencies, making it ideal for managing complex initiatives like accreditation preparation" (Domain 4). It visualizes the schedule for training and activities.
Option B (Multi-voting method): Multi-voting prioritizes options, not suitable for scheduling tasks.
Option C (Affinity diagram): Affinity diagrams organize ideas, not manage project timelines.
Option D (Ishikawa diagram): Ishikawa diagrams identify causes, not manage initiatives.
CPHQ Objective Reference: Domain 4: Performance and Process Improvement, Objective 4.3, "Use project management tools," includes Gantt charts for initiative planning. The NAHQ study guide notes, "Gantt charts are effective for managing accreditation preparation schedules" (Domain 4).
Rationale: A Gantt chart ensures clear task sequencing and tracking, aligning with CPHQ's project management principles for accreditation.
Reference: NAHQ CPHQ Study Guide, Domain 4: Performance and Process Improvement, Objective 4.3.

NEW QUESTION: 61

Which of the following Is an example of a population health strategy?

A. scheduling discharged Inpatients for follow up appointments

B. reviewing outpatient prescribing patterns for pain management patients

C. Implementing an employee wellness program

D. auditing Inpatient admission medications for duplicates

Answer: C (LEAVE A REPLY)

Population health strategies aim to improve the health outcomes of a group of individuals and reduce health disparities among populations1. They often involve collaboration across sectors, including healthcare, politics, charity, education, and business1. An employee wellness program is an example of a population health strategy because it targets a specific population (employees) and aims to improve their health outcomes. This can include initiatives to promote healthy behaviors, provide access to quality healthcare, and create a supportive work environment1.

Reference: https://www.healthcatalyst.com/insights/4-population-health-strategies-drive-improvement

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NEW QUESTION: 62

A more proactive posture would be to develop an organization-wide approach to quality measurement that meets
both internal and external demands. This approach is:

A. A task that should be completed at once

B. A task that should be done in chunks of improvement process

C. Not a task that can be completed once, rather a journey that has many potential pitfalls and detours

D. A task that should be completed through a series of related activities

Answer: C (LEAVE A REPLY)

NEW QUESTION: 63

Benchmarking is goal directed and promotes performance improvement by all of the following ways EXCEPT:

A. Creating objective measures of performance that are driven by industry leading targets instead of by past performance

B. Providing an environment amenable to organizational change through continuous improvement and striving to match industry-leading practices and results
C. Substantiating the need for improvement
D. Providing a customer internal focus
Answer: (SHOW ANSWER)

NEW QUESTION: 64
Quality measures must be relevant, scientifically sound, and
A. Confidential
B. Inexpensive
C. Feasible
D. Flexible
Answer: (SHOW ANSWER)
Quality measures are used to assess performance and drive improvement, requiring specific characteristics to ensure they are practical and effective.
Option A (Confidential): Confidentiality is important for data protection but is not a core characteristic of quality measures, which focus on measurement validity and utility.
Option B (Inexpensive): While cost is a consideration, it is not a defining attribute of quality measures, which prioritize accuracy and impact over expense.
Option C (Feasible): This is the correct answer. The NAHQ CPHQ study guide states, "Quality measures must be relevant (aligned with goals), scientifically sound (valid and reliable), and feasible (practical to collect and analyze)" (Domain 2). Feasibility ensures measures can be implemented with available resources and data systems.
Option D (Flexible): Flexibility is not a standard requirement for quality measures, which should be consistent and standardized to ensure comparability.
CPHQ Objective Reference: Domain 2: Health Data Analytics, Objective 2.1, "Evaluate the characteristics of quality measures," lists relevance, scientific soundness, and feasibility as essential attributes. The NAHQ study guide notes that feasibility ensures measures are practical for routine use in quality reporting.
Rationale: Feasible measures can be collected and analyzed without excessive burden, making them sustainable for ongoing quality improvement, as required by frameworks like CMS and The Joint Commission.
Reference: NAHQ CPHQ Study Guide, Domain 2: Health Data Analytics, Objective 2.1.

NEW QUESTION: 65
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: 66

Although Lean thinking focuses on removing waste and improving flow, it also has some secondary effects such as:

A. Reduces the chances of damage

B. Quality is improved

C. All of these

D. Simplification of processes results in less time in process

Answer: C (LEAVE A REPLY)

NEW QUESTION: 67

Six sigma (3.4 defects per million) is a system for improvement developed over time by Hewlett-Packard, Motorola, General Electric, and others in the 1980s and 1990s.

The aim of six sigma is:

A. To counter the wastage of activities

B. To reduce variations (eliminate defects) in processes

C. To remove bloages in process

D. To control and analyze the related and unrelated activities

Answer: (SHOW ANSWER)

NEW QUESTION: 68

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. Over-analysis

B. Multiple PDSA cycles

C. Buy-in

D. Focused testing

Answer: A (LEAVE A REPLY)

NEW QUESTION: 69
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 management
B. Benchmarking
C. Clinical pathways
D. Outcome measures
Answer: B (LEAVE A REPLY)

NEW QUESTION: 70
A nursing unit has collected the following data:
Which of the following is the best method to display this data?
A. Bar Chart
B. Gantt Chart
C. Pareto Chart
D. Run Chart
Answer: (SHOW ANSWER)
Detailed Explanation:
A bar chart is ideal for comparing categorical data across groups, which makes it suitable for displaying assessments and documentation completeness by personnel.
Option A: Bar Chart
Bar charts display data for different categories, making it easy to compare the performance of each individual.
Option C:
A Pareto chart shows the frequency of issues but does not allow for individual comparisons as effectively as a bar chart.
References:
Barcharts are recommended in healthcare data visualization for comparing categorical data across different groups, as noted in quality improvement tools in CPHQ resources.

NEW QUESTION: 71
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: (SHOW ANSWER)

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: 72
An outpatient medical clinic wants to test whether a relationship exists between two factors: lack of available transportation and the number of times patients do not keep appointments.
Which of the following tools should be used?
A. Pareto chart
B. scatter diagram
C. control chart
D. histogram
Answer: (SHOW ANSWER)
A scatter diagram is a graphic representation of the relationship between two variables12. It is used to test a theory that the two variables are related and to assess the strength, trend, and shape of that relationship2.
A Pareto chart is a type of bar chart that shows the frequency or impact of different causes or problems in descending order, along with a line graph that shows the cumulative percentage of the total3. It is used to identify the most significant factors among a large number of potential causes or problems3.
A control chart is a type of line chart that shows how a process changes over time, with upper and lower limits that indicate the range of acceptable variation4. It is used to monitor and control a process and to detect special causes of variation that may indicate problems or improvement opportunities4.
A histogram is a type of bar chart that shows the frequency distribution of a single variable in a data set5.

It is used to summarize and display the shape and spread of the data and to identify outliers or gaps5.
Based on these definitions, the best tool to use for the outpatient medical clinic's purpose is a scatter diagram, as it can show whether there is a relationship between lack of available transportation and the number of times patients do not keep appointments, and how strong or weak that relationship is. The other tools are not suitable for this purpose, as they do not show the relationship between two variables.
Reference: 1: Scatter Diagram | Digital Healthcare Research 2: Scatter Plot - Clinical Excellence Commission 3: Pareto Chart | Institute for Healthcare Improvement 4: Plotting basic control charts:
tutorial notes for healthcare practitioners 5: Histogram | Institute for Healthcare Improvement

NEW QUESTION: 73
Which of the following regulatory agencies oversee development of electronic clinical quality measures (eCQMs)?
A. Centers for Medicare and Medicaid Services (CMS)
B. DNV GL Healthcare
C. The Joint Commission (TJC)
D. Occupational Safety and Health Association (OSHA)
Answer: (SHOW ANSWER)

NEW QUESTION: 74
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: (SHOW ANSWER)
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: 75
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: A (LEAVE A REPLY)
The scatter diagram shows that as the "Decrease in Staffing Targets" increases, the "Infection Incidence" also increases. This suggests a positive relationship between the two variables, where a higher reduction in staffing targets correlates with a higher incidence of infection.
This relationship appears to be strong as the points are relatively closely clustered along a trend that moves upward from left to right across the plot.

NEW QUESTION: 76
Which of the following is most important for healthcare organizations to improve population health by reducing readmission rates?
A. Creation of disease registries
B. Local resource directory
C. Transition of care programs
D. Health information exchange
Answer: C (LEAVE A REPLY)
Reducing readmission rates is a critical goal in population health management, as it reflects effective care coordination and patient outcomes post-discharge. Transition of care programs are specifically designed to ensure continuity of care as patients move between different healthcare settings (e.g., from hospital to home or skilled nursing facilities). These programs typically include interventions such as medication reconciliation, patient education, follow-up appointments, and communication between providers, all of which directly address factors contributing to readmissions.
Option A (Creation of disease registries): While disease registries are valuable for tracking patients with specific conditions and identifying trends, they are primarily a data management tool and do not directly address the processes needed to prevent readmissions. They are more supportive of long-term population health strategies rather than immediate care transitions.
Option B (Local resource directory): A local resource directory can help connect patients to community services, but it is not a structured intervention to manage care transitions or reduce readmissions. It is a supplementary tool rather than a primary solution.
Option C (Transition of care programs): According to NAHQ CPHQ study materials, transition of care programs are evidence-based interventions that reduce readmissions by ensuring effective handoffs, patient follow-up, and care coordination. Programs like the Transitional Care Model (TCM) or Project BOOST (Better Outcomes by Optimizing Safe Transitions) emphasizestructured discharge planning, which aligns with CMS and Joint Commission standards for reducing readmissions. This makes it the most important and direct intervention for this goal.
Option D (Health information exchange): Health information exchanges (HIEs) facilitate data sharing between providers, which can support care transitions. However, HIEs are a tool to enable communication rather than a comprehensive program addressing the multifaceted causes of readmissions, such as patient education or follow-up care.

Reference: NAHQ CPHQ Study Guide, Domain 5: Population Health and Care Transitions, emphasizes the role of transition of care programs in reducing readmissions through structured interventions. Additionally, CMS's Hospital Readmissions Reduction Program (HRRP) highlights care coordination as a key strategy.

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NEW QUESTION: 77

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: 78

To identify outpatient data sources, the team should consider the following questions EXCEPT (Choose two):

A. Do the measures selected by team reflect the aspects of care that have the most influence on patient's outcome

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 source outpatient data is the same as inpatient data

D. 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?
Answer: A,C (LEAVE A REPLY)

NEW QUESTION: 79
Which of the following tools should be used to determine the root cause of variations in a process?
A. histogram
B. Ishikawa diagram
C. Shewhart chart
D. scatter plot
Answer: (SHOW ANSWER)
The Ishikawa diagram, also known as a fishbone diagram or cause-and-effect diagram, is the best tool to determine the root cause of variations in a process. This diagram helps teams visually map out all potential causes of a problem, categorizing them into major factors such as methods,machinery, materials, and people.
By exploring these potential causes systematically, teams can identify the root causes of variations and focus their improvement efforts accordingly.
Histogram (A): A histogram is used to display the distribution of data points but does not help in identifying root causes.
Shewhart chart (C): Also known as a control chart, it monitors process stability over time but is not specifically for root cause analysis.
Scatter plot (D): A scatter plot shows relationships between two variables but does not identify root causes of variations.
References
NAHQ Body of Knowledge: Root Cause Analysis Tools in Quality Improvement NAHQ CPHQ Exam Preparation Materials: Using Ishikawa Diagrams for Root Cause Analysis
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NEW QUESTION: 80
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: A (LEAVE A REPLY)
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"

NEW QUESTION: 81
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. When all the sample elements are so weighted, the overall data should provide a reasonable representation of the majority of the samples
B. 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
C. 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
D. All persons in a given cell are then assigned a weight appropriate to their proportion of the total
Answer: A (LEAVE A REPLY)

NEW QUESTION: 82
Joseph juran defined quality as consisting of two different but related concepts. The first form of quality is income oriented and includes features of t he product t hat meet customer needs and thereby produce income (i.e., higher quality costs more).
The second form of quality is cost oriented and emphasizes:
A. Both A and B
B. Freedom from deficiencies
C. Knowledge abut variation

D. Freedom from failures
Answer: A (LEAVE A REPLY)

NEW QUESTION: 83
A multidisciplinary team has been convened to review delays in laboratory turnaround time between the medicine clinic and the laboratory. The team's first step in evaluating the issue is to
A. create a flow chart to study the process.
B. conduct a failure mode and effects analysis (FMEA).
C. see if the surgery clinic is also experiencing delays.
D. observe how the medical assistants prepare the specimens.
Answer: (SHOW ANSWER)
The first step for a multidisciplinary team tasked with evaluating delays inlaboratory turnaround time is to create a flow chart to study the process. A flow chart visually maps out the steps involved in the current process, allowing the team to understand each stage, identify bottlenecks, and pinpoint where delays might be occurring. This provides a clear, shared understanding of the process among all team members, which is essential before diving into more detailed analysis or improvements.
Conduct a failure mode and effects analysis (FMEA) (B): FMEA is a valuable tool for identifying potential failures, but it is typically used after understanding the process in detail.
See if the surgery clinic is also experiencing delays (C): While this could be useful information, the primary focus should be on the specific process under review.
Observe how the medical assistants prepare the specimens (D): Observation is important, but understanding the entire process flow is the first step.
References
NAHQ Body of Knowledge: Process Mapping and Flowcharting in Quality Improvement NAHQ CPHQ Exam Preparation Materials: Initial Steps in Process Improvement
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NEW QUESTION: 84
An outbreak of measles in a school district resulted in 58 cases over a period of 5 months. Which of the following data displays best illustrates the occurrence of student measles by month?
A. Gantt chart
B. Pie chart
C. Cause-and-effect diagram
D. Run chart
Answer: D (LEAVE A REPLY)
Illustrating the occurrence of measles cases by month requires a data display that shows trends over time.
Option A (Gantt chart): Gantt charts manage project timelines, not display epidemiological trends.
Option B (Pie chart): Pie charts show proportions, not time-based trends.
Option C (Cause-and-effect diagram): This identifies causes, not displays temporal data.

Option D (Run chart): This is the correct answer. The NAHQ CPHQ study guide states, "Run charts display data over time, making them ideal for showing trends, such as disease cases by month" (Domain 2). A run chart would plot measles cases per month, highlighting patterns.
CPHQ Objective Reference: Domain 2: Health Data Analytics, Objective 2.3, "Select appropriate data display tools," emphasizes run charts for temporal data. The NAHQ study guide notes, "Run charts are effective for tracking disease outbreaks over time" (Domain 2).
Rationale: Run charts show measles cases by month, aligning with CPHQ's data visualization principles.
Reference: NAHQ CPHQ Study Guide, Domain 2: Health Data Analytics, Objective 2.3.

NEW QUESTION: 85

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: 86
Which of the following is the best method to achieve a reduction in medical errors?
A. Establish disciplinary measures for clinical practitioners who commit errors
B. Encourage patients, families, and staff to report actual and potential errors
C. Counsel employees to be more careful when providing care
D. Change the process for reporting medical errors within the organization
Answer: B (LEAVE A REPLY)
Reducing medical errors requires a systems-based approach that promotes a culture of safety and proactive error identification.
Option A (Establish disciplinary measures for clinical practitioners who commit errors): Punitive measures discourage reporting and undermine a non-punitive safety culture, increasing errors.
Option B (Encourage patients, families, and staff to report actual and potential errors): This is the correct answer. The NAHQ CPHQ study guide states, "Encouraging reporting of errors and near misses by all stakeholders fosters a culture of safety, enabling systems improvements to reduce errors" (Domain 1). This aligns with AHRQ's safety culture principles.
Option C (Counsel employees to be more careful when providing care): Counseling assumes individual failure, ignoring system issues, and is ineffective for systemic error reduction.
Option D (Change the process for reporting medical errors within the organization): While improving reporting processes is helpful, encouraging reporting by all stakeholders is the most direct way to identify and address errors.
CPHQ Objective Reference: Domain 1: Patient Safety, Objective 1.2, "Promote a culture of safety," emphasizes encouraging error reporting. The NAHQ study guide notes, "A non-punitive reporting culture is essential for identifying and mitigating errors" (Domain 1).
Rationale: Encouraging reporting builds a safety culture, enabling error identification and systems improvements, as per CPHQ's patient safety principles.
Reference: NAHQ CPHQ Study Guide, Domain 1: Patient Safety, Objective 1.2.

NEW QUESTION: 87
Performance Improvement plans are most successful when linked first with
A. strategic goals.
B. organizational structure.
C. core values.
D. bylaws.
Answer: A (LEAVE A REPLY)

Performance Improvement Plans (PIPs) are most successful when they are first linked with strategic goals12. This is because strategic goals provide a clear direction for the organization and its employees1. When a PIP is linked to these goals, it ensures that the performance improvements being targeted are aligned with the overall objectives of the organization12. This alignment helps to ensure that the efforts put into performance improvement are contributing to the success of the organization as a whole12.
References:
* Forbes Article on Performance Improvement Plan
* Venngage Article on Performance Improvement Plan Examples

NEW QUESTION: 88
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: 89
A customer complains to the health care quality professional about a service in the organization. Which of the following actions should be taken first?
A. Create a quality improvement team to address the concern
B. Refer the issue to the appropriate department

C. Direct the customer to put the complaint in writing
D. Review patient experience data for the department
Answer: B (LEAVE A REPLY)
Handling customer complaints requires a prompt, appropriate response to address the issue and maintain trust, with escalation as needed.
Option A (Create a quality improvement team to address the concern): A QI team is appropriate for systemic issues, not an individual complaint, which requires immediate resolution.
Option B (Refer the issue to the appropriate department): This is the correct answer. The NAHQ CPHQ study guide states, "The first step in addressing a customer complaint is to refer it to the department best equipped to resolve it, ensuring timely action" (Domain 1). For example, a billing complaint goes to finance, or a care issue to clinical staff.
Option C (Direct the customer to put the complaint in writing): Requiring written complaints may delay resolution and frustrate the customer, not aligning with patient-centered care.
Option D (Review patient experience data for the department): Reviewing data is useful for trends but not the first step for an individual complaint, which needs direct action.
CPHQ Objective Reference: Domain 1: Patient Safety, Objective 1.6, "Address patient and family concerns," emphasizes prompt referral for complaints. The NAHQ study guide notes, "Referring complaints to the appropriate department ensures efficient resolution" (Domain 1).
Rationale: Referring the complaint to the relevant department ensures timely resolution, aligning with CPHQ' s patient safety and service principles.
Reference: NAHQ CPHQ Study Guide, Domain 1: Patient Safety, Objective 1.6.

NEW QUESTION: 90
A hospital has been experiencing a significant Increase in the number of medication errors. The hospital's governing board has adopted barcoding technology with electronic documentation at the point of care.
Which of the following medication errors will most likely be reduced by the Implementation of this technology?
A. prescribing errors
B. transcription errors
C. administration errors
D. dispensing errors
Answer: (SHOW ANSWER)
Barcoding technology with electronic documentation at the point of care is primarily designed to reduce medication errors that occur during the administration stage123. This technology, known as Bar-coded Medication Administration (BCMA), provides point-of-care verification of the correct patient and medication3.
When a medication is administered, the healthcare professional scans the barcode on the patient's identification band and the barcode on the medication. The system then checks the scanned information against the medication order in the patient's electronic health record. This

process helps ensure that the right patient is receiving the right medication at the right dose and at the right time, thereby significantly reducing administration errors1234.

While barcoding technology can also help reduce other types of errors such as dispensing errors3, its impact is most significant on administration errors. Therefore, in the context of the question, the implementation of barcoding technology with electronic documentation at the point of care will most likely reduce administration errors.

NEW QUESTION: 91

In aligning an organization's performance Improvement plan with strategic goals, a healthcare quality professional should consider

A. staff satisfaction data, risk management data, and utilization review data.

B. customer expectations, occurrence reports, and utilization review data.

C. staff satisfaction data, benchmarking data, and occurrence reports.

D. customer expectations, benchmarking data, and patient outcome data.

Answer: D (LEAVE A REPLY)

A performance improvement plan (PIP) is a set of focused activities designed to monitor, analyze, and improve the quality of processes and outcomes in a healthcare organization12.

A PIP should be aligned with the strategic goals of the organization, which are the long-term objectives that reflect the vision, mission, and values of the organization3.

To align a PIP with strategic goals, a healthcare quality professional should consider the following factors45:

Customer expectations: These are the needs, preferences, and perceptions of the patients, families, and other stakeholders who receive or are affected by the healthcare services. Customer expectations are a key driver of quality improvement, as they reflect the degree of satisfaction and loyalty of the customers.

Customer expectations can be measured by surveys, feedback, complaints, and compliments6 .

Benchmarking data: These are the comparative data that show how the organization performs relative to other similar or best-in-class organizations in terms of quality, efficiency, and effectiveness.

Benchmarking data can help identify gaps, opportunities, and best practices for improvement.

Benchmarking data can be obtained from external sources, such as national databases, accreditation agencies, or professional associations, or from internal sources, such as historical data, peer groups, or departments.

Patient outcome data: These are the data that show the results or impacts of the healthcare services on the health status, quality of life, and satisfaction of the patients. Patient outcome data are the ultimate indicators of quality improvement, as they reflect the effectiveness and value of the healthcare services.

Patient outcome data can be measured by clinical indicators, such as mortality, morbidity, complications, or readmissions, or by patient-reported indicators, such as functional status, symptom relief, or experience of care.

By considering these factors, a healthcare quality professional can align a PIP with strategic goals in the following ways45:
Identify the strategic goals and priorities of the organization and ensure that they are clear, specific, measurable, achievable, relevant, and time-bound (SMART).
Assess the current performance of the organization in relation to the strategic goals and priorities, using customer expectations, benchmarking data, and patient outcome data as sources of information and evidence.
Identify the gaps and opportunities for improvement based on the assessment of the current performance and the comparison with the strategic goals and priorities.
Develop and implement improvement actions that address the gaps and opportunities for improvement, using evidence-based methods and tools, such as the Plan-Do-Study-Act (PDSA) cycle, root cause analysis, or process mapping.
Monitor and evaluate the improvement actions and their effects on the performance of the organization, using customer expectations, benchmarking data, and patient outcome data as measures of success and feedback.
Communicate and disseminate the improvement results and the lessons learned to the relevant stakeholders, such as the leadership, staff, customers, and partners, and celebrate the achievements and recognize the contributions.
Review and revise the improvement actions and the PIP as needed, based on the monitoring and evaluation results and the changing needs and expectations of the customers and the organization.
Reference: 1: Health Care Quality Improvement (QI) Action Plan Template 2: Quality Improvement (QI) Toolkit with Templates, Instructions, and ... 3: The Top 4 Examples of Quality Improvement in Healthcare 4:
Model Quality & Performance Improvement Plan 5: 8 Examples Of Quality Improvement Initiatives In Healthcare 6: [Shaping the Future of the Healthcare Quality Profession] :
[The Role of the Healthcare Quality Professional in Population Health Management]: [Healthcare Quality Solutions: Ready Your Workforce for Quality]: [HQ Principles]: [The Financial Case for Quality as a Business Strategy]: [Utilization of Improvement Methodologies by Healthcare Quality Professionals During the COVID-19 Pandemic]

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NEW QUESTION: 92
An example of a clinical care process measure is:

A. Patient experience
B. Administration of beta blocker
C. Case mix mortality
D. 30-day readmission rate
Answer: (SHOW ANSWER)
Clinical care process measures evaluate specific actions taken during patient care to ensure adherence to best practices and guidelines. These measures focus on whether healthcare providers perform particular interventions that are known to improve patient outcomes.
Option B, "Administration of beta blocker," is a direct example of a clinical care process measure. For instance, administering a beta blocker to patients after a myocardial infarction is a recommended practice to reduce mortality and prevent further cardiac events. Monitoring the rate at which eligible patients receive beta blockers assesses compliance with this evidence-based guideline.
The other options represent different types of measures:
* Patient experience (Option A): This is an outcome measure that captures patients' perceptions of their care, such as satisfaction and communication effectiveness.
* Case mix mortality (Option C): This is an outcome measure that reflects the mortality rate within a specific patient population, adjusted for the diversity and severity of cases treated.
* 30-day readmission rate (Option D): This is an outcome measure indicating the percentage of patients who are readmitted to a hospital within 30 days of discharge, often used to assess the quality of care transitions and discharge planning.
Therefore, among the options provided, "Administration of beta blocker" is the example of a clinical care process measure.
References:
* National Association for Healthcare Quality (NAHQ) - "Healthcare Quality Competency Framework" nahq.org

NEW QUESTION: 93
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: 94

A health system is designing a new wellness program and wants to incorporate social determinants of health.
Which of the following should be considered?

A. How often patients have moved in the last year
B. Average age of individuals in the community
C. Types of patients' health insurance
D. Percent of families with multigenerational households

Answer: D (LEAVE A REPLY)

Social determinants of health (SDOH) are non-medical factors like housing, education, and social support that influence health outcomes. A wellness program should consider SDOH that impact health behaviors and access.
Option A (How often patients have moved in the last year): Mobility may affect continuity but is less directly tied to wellness program design compared to social support structures.
Option B (Average age of individuals in the community): Age is a demographic factor, not a primary SDOH, though it may inform program focus.
Option C (Types of patients' health insurance): Insurance affects access to care but is a secondary SDOH compared to social or environmental factors.
Option D (Percent of families with multigenerational households): This is the correct answer. The NAHQ CPHQ study guide states, "Social determinants like family structure, including multigenerational households, impact health by influencing support systems and resource access" (Domain 5). Multigenerational households may affect caregiving and wellness participation.
CPHQ Objective Reference: Domain 5: Population Health and Care Transitions, Objective 5.4, "Incorporate SDOH into health programs," emphasizes social factors like family structure. The NAHQ study guide notes,
"SDOH such as household composition are critical for tailoring wellness programs" (Domain 5).
Rationale: Multigenerational households directly influence health behaviors, making them a key SDOH for wellness program design, as per CPHQ's population health principles.
Reference: NAHQ CPHQ Study Guide, Domain 5: Population Health and Care Transitions, Objective 5.4.

NEW QUESTION: 95

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: (SHOW ANSWER)

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: 96

To promote staff engagement In a new Initiative, educators should focus on staff

A. perceptions of the benefits of change.

B. attitudes of business as usual.

C. who appear resistant to change.

D. who want to advance In the organization.

Answer: (SHOW ANSWER)

To promote staff engagement in a new initiative, it's crucial to focus on staff perceptions of the benefits of change123. This involves communicating the value and benefits of the new initiative to the staff, and how it will improve their work or the outcomes for patients12. Staff are more likely to engage with a new initiative if they perceive it as beneficial and worthwhile23. This can be achieved through clear communication, education, and providing proof that new practices will be worthwhile3. It's also important to create a culture that empowers staff to achieve positive change2.

Reference: https://www.bmj.com/content/368/bmj.m872 https://hbr.org/2022/02/3-ways-hospitals-can- boost-worker-engagement

NEW QUESTION: 97

Which of the following actions best illustrates an organization has begun the work necessary to achieve the Malcolm Baldrige Award?

A. evaluating current operations against the ISO standards
B. creating a team to revise operations to conform to the Malcolm Baldrige criteria
C. reviewing the Malcolm Baldrige criteria to determine organization alignment
D. demonstrating wide-spread integration of Lean principles
Answer: C (LEAVE A REPLY)
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NEW QUESTION: 98
Which of the following best describes the purpose of the nominal group technique?
A. eliminates redundant Ideas generated by team members
B. diffuses potential conflict between team members
C. ensures effective communication among team members
D. encourages equal participation from all team members
Answer: D (LEAVE A REPLY)
The Nominal Group Technique (NGT) is a structured method for group brainstorming that encourages contributions from everyone12. It is designed to facilitate quick agreement on the relative importance of issues, problems, or solutions2. The process involves participants identifying and contributing ideas toward a topic or question specified by the facilitator1. Participants then discuss and individually prioritize the ideas1. This method ensures that the opinions of all group members are taken into account and prevents the discussion and process from being dominated by an individual participant1. Therefore, it encourages equal participation from all team members.
References:
https://asq.org/quality-resources/nominal-group-technique

NEW QUESTION: 99
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: 100

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. Mortality rate

B. Facility infection rate

C. Use of prophylactic antibiotics

D. Type of anesthesia used

Answer: C (LEAVE A REPLY)

NEW QUESTION: 101

An initial step to address health disparities within a population is to:

A. Expand the collection and standardization of health equity data.

B. Create dashboards to visualize gaps in health equity.

C. Increase accessibility to healthcare services for all equally.

D. Engage with community leaders and identify available resources.

Answer: A (LEAVE A REPLY)

Addressing health disparities is a critical component of improving population health. An initial and foundational step in this process is to expand the collection and standardization of health equity data.

Comprehensive data collection allows healthcare organizations to identify and understand disparities in health outcomes among different population groups. Standardizing this data ensures consistency, making it easier to compare and analyze information across various demographics, such as race, ethnicity, socioeconomic status, and geographic location.

By systematically collecting and standardizing health equity data, organizations can:

* Identify Disparities: Detect variations in health outcomes and access to care among different population groups.

* Inform Policy and Practice: Develop targeted interventions and policies to address identified disparities.

* Monitor Progress: Track the effectiveness of interventions over time and make data-driven adjustments as needed.

While the other options listed are important components of a comprehensive strategy to address health disparities, they are more effective when informed by robust data:

* Creating dashboards to visualize gaps in health equity (Option B): This is a valuable tool for communicating disparities and monitoring progress but relies on accurate and standardized data.

* Increasing accessibility to healthcare services for all equally (Option C): Enhancing access is crucial but should be guided by data identifying where disparities in access exist.

* Engaging with community leaders and identifying available resources (Option D): Community engagement is essential for implementing effective interventions, but understanding the specific needs and disparities within the community requires comprehensive data.
Therefore, the initial step is to expand the collection and standardization of health equity data, which serves as the foundation for subsequent actions to effectively address health disparities.
References:
* National Association for Healthcare Quality (NAHQ) emphasizes the importance of analyzing and using clinical, cost, equity, and social determinants of health data to drive and monitor improvement efforts.
nahq.org
* The Agency for Healthcare Research and Quality (AHRQ) identifies "Equitable" as one of the six domains of healthcare quality, highlighting the need to provide care that does not vary in quality due to personal characteristics.
ahrq.gov

NEW QUESTION: 102
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.
Reference
NAHQ Body of Knowledge: Risk Management and Patient Safety
NAHQ CPHQ Exam Preparation Materials: FMEA Process and Application

NEW QUESTION: 103

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: 104

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. Over-analysis

B. Focused testing

C. Multiple PDSA cycles

D. Buy-in

Answer: A (LEAVE A REPLY)

NEW QUESTION: 105

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.

References

* NAHQ Body of Knowledge: Efficiency and Cost Management in Healthcare
* NAHQ CPHQ Exam Preparation Materials: Analyzing Quality in Bundled Payment Models

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NEW QUESTION: 106

Organizational size affects the ability to disseminate best practices

A. Difficult to decide

B. True

C. It depends on situation

D. False

Answer: (SHOW ANSWER)

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NEW QUESTION: 107

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. Barriers to improvement

B. Different problems

C. Lessons learned
D. Both B and C
Answer: (SHOW ANSWER)

NEW QUESTION: 108
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.
Reference: 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: 109

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: 110

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. Colon cancer screening

B. A, B and C

C. Mammograms

D. Immunization

Answer: B (LEAVE A REPLY)

NEW QUESTION: 111

The safety reporting system being used by an organization cannot produce reports or information in a usable format.

After evaluating the existing system and other products on the market, which of the following should the quality professional do before making recommendations to leadership?

A. Prepare a comparative analysis based on the information gathered.

B. Conduct a focus group with participants from other sites within the organization.

C. Interview current users of the other identified products.

D. Create a potential implementation plan for the preferred product.

Answer: (SHOW ANSWER)

Before making recommendations to leadership, the quality professional should prepare a comparative analysis based on the information gathered. This analysis should compare the capabilities, limitations, costs, and benefits of the existing system and the alternative products identified. A thorough comparative analysis will provide leadership with a clear understanding of the options available, enabling them to make an informed decision on whether to upgrade the current system or switch to a new one.

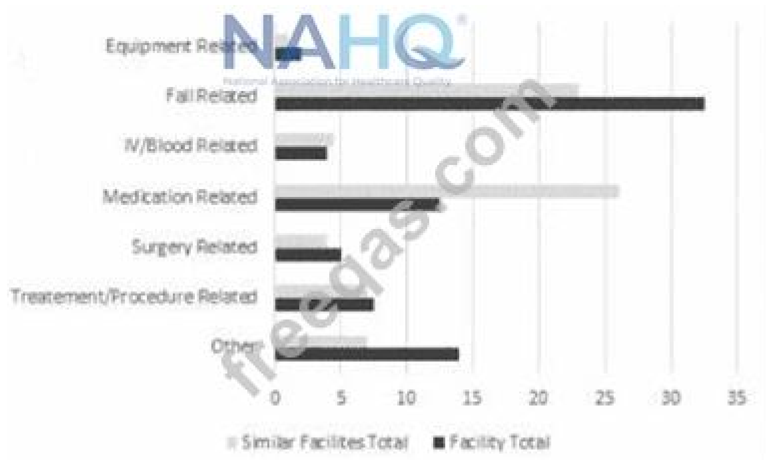
Conduct a focus group with participants from other sites within the organization (B): This might provide additional insights but should be part of the comparative analysis process rather than a standalone action.
Interview current users of the other identified products (C): This can inform the comparative analysis but is not a replacement for a comprehensive comparison.
Create a potential implementation plan for the preferred product (D): This should follow the decision- making process, not precede it.
Reference
NAHQ Body of Knowledge: Evaluation and Selection of Quality Improvement Tools NAHQ CPHQ Exam Preparation Materials: Decision-Making in Quality Management

NEW QUESTION: 112
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: B (LEAVE A REPLY)
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: 113
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: B (LEAVE A REPLY)
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: 114
Which of the following processes is most cost-effective in preventing unnecessary resource consumption in the hospital?
A. Preadmission insurance benefit denials
B. Second opinions for all surgeries
C. Effective preadmission screening
D. Accurate DRG assignment at admission
Answer: C (LEAVE A REPLY)

NEW QUESTION: 115
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 onpatient 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: 116
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: A (LEAVE A REPLY)
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.

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