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Topic Break Down

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QUESTION NO: 1

When continuing unique events, one uses a p-chart. The number plotted on a chart would be either a proportion or a percentage. When counting total events (e.g., the number of falls per patient day each month), one plots a ratio on a u-chart.

Examples of attributes data plotted as percentage on p-charts include figures such as (Choose two):

A. Percentage of patients who died

B. Percentage of visits by every patient

C. Percentage of scripts that had one or more medication errors

D. Percentage of patients discharged

ANSWER: A C

Explanation:

“Percentage of patients who died” is appropriate p-chart data because each patient in the defined population for a reporting period can be classified into one of two mutually exclusive outcomes: died or did not die. The plotted value is the number of patients who died divided by the total number of eligible patients, expressed as a proportion or percentage. The denominator may vary from month to month, which is a common situation for a p-chart.

“Percentage of scripts that had one or more medication errors” is also appropriate because each prescription or medication order is assessed as either having at least one error or having no error. Counting the number of affected scripts and dividing by the total number of reviewed scripts produces a binomial proportion. A p-chart is designed to monitor this type of attribute measure over time and uses the period-specific sample size when calculating control limits. This differs from measures of multiple events per unit, for which a u-chart is used. See the NIST description of p control charts and the Institute for Healthcare Improvement’s measurement guidance.

QUESTION NO: 2

Choosing a small number of items to represent characteristics of the whole is an example of

A. sampling methodology.

B. outlier identification.

C. statistical significance.

D. benchmarking.

ANSWER: A

Explanation:

Sampling methodology is correct because sampling is the systematic process of selecting a smaller group of observations, records, patients, cases, or other units from a defined population so that information from the sample can be used to describe or assess the larger whole. In healthcare quality work, reviewing every encounter or medical record may be impractical, costly, or unnecessary. A properly designed sample provides an efficient way to measure performance, estimate rates, monitor compliance, and identify opportunities for improvement while maintaining a reasonable basis for conclusions about the full population. The value of sampling depends on clearly defining the population, selecting an appropriate sampling approach, and obtaining a sample that is sufficiently representative for the intended measure and decision. Random or otherwise well-structured selection helps reduce selection bias and improves confidence that observed sample characteristics reflect population characteristics. This definition directly matches the act of choosing a small number of items to represent the whole. The U.S. Centers for Disease Control and Prevention describes sampling as selecting part of a population to draw conclusions about the population, and the Agency for Healthcare Research and Quality provides practical guidance on using samples for healthcare quality measurement. See the CDC Principles of Epidemiology: Sampling and AHRQ guidance on selecting quality measures.

QUESTION NO: 3

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? (Choose two.)

A. Structure

B. Process

C. Output

D. Cutbas

ANSWER: C D

Explanation:

The correct selections are **Output** and **Cutbas**. The classic framework for evaluating healthcare quality is Avedis Donabedian's structure-process-outcome model. It organizes quality measures according to the care setting and resources available (structure), what clinicians and organizations do in delivering care (process), and the effects of care on patients or populations (outcome). "Output" is not one of the three formal Donabedian categories. Although the term can be used informally in operational or productivity discussions, it is not the framework's measure category; the recognized term is *outcome*. "Cutbas" likewise is not a recognized category in the Donabedian model or a standard healthcare-quality measure classification. Correct use of this framework helps quality professionals select measures that assess organizational capacity, adherence to evidence-based care activities, and patient-level results in a coherent and balanced way. The model remains foundational in healthcare quality measurement and improvement. See the overview of Donabedian's framework in the National Library of Medicine's article on the quality-of-care model and the measure-classification guidance from AHRQ.

QUESTION NO: 4

For example, a bathroom scale that always reads 185 pounds is reliable. Although the scale may be reliable and consistent, it is not valid if the person does not weigh 185 pounds.

So in conventional use, the term validity refers to (Choose two):

A. The degree to which the measurement made by a interviews corresponds to some fair value

B. The degree to which the measurement made by a focus group corresponds to some true or real value

C. The extent to which an empirical measure accurately reflects the meaning of the concept under consideration

D. The degree to which the measurement made by a survey corresponds to some true or real value

ANSWER: C D

Explanation:

Validity concerns whether a measurement represents what it is intended to represent. "The degree to which the measurement made by a survey corresponds to some true or real value" captures criterion-related accuracy: if a survey measure is valid, its result is appropriately aligned with the actual characteristic, condition, or outcome being measured. In the scale example, validity depends on whether the displayed weight corresponds to the person's real weight, not merely whether the scale gives a repeatable reading.

"The extent to which an empirical measure accurately reflects the meaning of the concept under consideration" describes construct validity. Many healthcare-quality concepts—such as patient experience, safety culture, access, and quality of life—cannot be observed directly. A measure is valid when its items, scoring approach, and interpretation meaningfully represent the underlying concept defined for the measure. This is essential for using survey data and other performance measures in quality improvement because decisions should be based on measures that accurately capture the intended phenomenon. The CDC's evaluation guidance discusses selecting measures that appropriately reflect the indicators and outcomes being assessed, and AHRQ provides resources on developing and evaluating health-care quality measures. See CDC Evaluation Steps: Gather Credible Evidence and AHRQ: Criteria for Evaluating Quality Measures.

QUESTION NO: 5

Basically an operational definition is a description in quantifiable terms, of what to measure and the specific steps needed to measure it constantly.

A good operational definition (Choose two):

A. Gives communicable meaning to a concept or an idea

B. Is no doubt clear but somewhat ambiguous

C. Is a decision-making criteria

D. Enables consistently in data collection

ANSWER: A D

Explanation:

A good operational definition **Gives communicable meaning to a concept or an idea** because it converts an abstract quality concept—such as a fall, medication error, delayed care, or patient satisfaction—into language that all users interpret in the same way. In healthcare quality measurement, this shared meaning is essential for comparing results across units, time periods, reviewers, or facilities. The definition should state exactly what is included, the population or event to which it applies, and any relevant boundaries or exclusions.

A good operational definition also **Enables consistently in data collection**. It identifies the observable criteria, data source, timing, measurement method, and rules that data collectors use. These details support repeatable measurement, reduce variation caused by individual interpretation, and make the resulting data suitable for monitoring performance and improvement work. Consistency is particularly important when multiple abstractors collect data or when a measure is tracked longitudinally. Clear measure specifications and standardized collection procedures are core elements of reliable quality measurement. The Agency for Healthcare Research and Quality discusses the importance of clearly specified quality measures in its guide to understanding quality measures, and the CDC provides related guidance on consistent data standards through its data standards resources.

QUESTION NO: 6

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

Survey vendors also can minimize sampling bias through:

A. Judgment

B. Experience

C. Probability sampling

D. Cluster sampling

ANSWER: C

Explanation:

Probability sampling is the appropriate method because it uses a defined random-selection process in which each eligible patient has a known, nonzero chance of being selected. When the sampling frame is complete and the process is applied consistently, the resulting respondents are more likely to represent the broader eligible patient population rather than only patients who are easiest to contact, most engaged, or selected subjectively. This supports valid comparisons and more credible conclusions from patient-experience feedback.

In healthcare survey operations, probability-based approaches commonly include simple random, systematic, or stratified random selection from an eligible discharge or patient list. The vendor can document the sampling frame, selection method, and probability of selection, then use appropriate follow-up procedures to improve response across patient groups. These

practices reduce the risk that survey results systematically underrepresent particular populations. AHRQ's CAHPS resources describe standardized survey administration and sampling guidance for obtaining dependable patient-experience data: AHRQ CAHPS Surveys and Guidance. The National Academies also explains that probability samples provide a basis for making inferences to a target population: NCBI: Survey Sampling.

QUESTION NO: 7

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

A. Qualitative measures

B. Listing posts

C. Patient satisfaction surveys

D. Focus group research

ANSWER: A D

Explanation:

Qualitative measures and focus group research are appropriate ways to obtain richer information from patients and families for improvement work. Quantitative survey results identify patterns, trends, and opportunities, but qualitative methods help an organization understand the context behind those findings. They capture patients' perceptions, stories, priorities, and descriptions of barriers or facilitators encountered during care. This detail can help quality teams define a problem more accurately, identify contributing processes, and design changes that respond to what matters to patients and families.

Focus group research is a structured qualitative method in which a facilitator guides discussion among participants about a defined topic or care experience. The interaction among participants can surface common themes, differences in experience, and ideas that might not emerge through closed-ended survey items. Used with clear objectives, appropriate participant selection, and systematic thematic analysis, focus groups provide actionable patient- and family-centered insight. The Agency for Healthcare Research and Quality describes qualitative methods as valuable for understanding patient experiences and using those insights to improve care; see its CAHPS improvement resources. Additional guidance on incorporating patient and family perspectives is available from the Institute for Healthcare Improvement.

QUESTION NO: 8

An organization's preventable fall goal is not to exceed greater than 25% of its total falls. Which units below meet this goal?

A. Units 3 and 4

B. Units 1 and 2

C. Units 4 and 5

D. Units 2 and 4

E. Unit 4 only

ANSWER: E

Explanation:

Unit 4 only meets the stated goal. The appropriate measure for each unit is the proportion of falls classified as preventable: preventable falls divided by total falls, expressed as a percentage. A goal of no more than 25% is met when this result is 25% or lower. Unit 4 had zero preventable falls among one total fall, so its preventable-fall proportion is 0 ÷ 1 = 0%. Because 0% is below the 25% threshold, Unit 4 satisfies the performance target. This calculation uses the unit's total number of falls as the denominator and the number deemed preventable as the numerator, ensuring that the result measures the share of fall events that were preventable rather than merely the event count. Falls are a commonly monitored patient-safety

outcome, and organizations should use clearly defined measures and consistent classification criteria when evaluating fall-prevention performance. The Agency for Healthcare Research and Quality provides fall-prevention resources in its Preventing Falls in Hospitals toolkit. The Institute for Healthcare Improvement also describes use of outcome measures to assess fall-prevention improvement work in its How-to Guide: Reducing Patient Injuries from Falls.

QUESTION NO: 9

A local health center is launching a community health assessment. What data is recommended to identify the potential needs of the population?

A. zip codes for patients frequently using the emergency department

B. highest level of education of healthcare professionals

C. top five diagnoses for patient visits

D. number of fast food restaurants in the area

ANSWER: C

Explanation:

top five diagnoses for patient visits is the best data source because it provides direct, population-relevant evidence about the health conditions for which people in the community are seeking care. Reviewing the most common diagnoses helps the health center recognize disease burden, identify patterns in acute and chronic conditions, and prioritize services, prevention programs, education, staffing, and referral partnerships around documented needs. For example, a high volume of visits involving diabetes, hypertension, behavioral health conditions, asthma, or injuries can signal opportunities to strengthen screening, self-management support, care coordination, and community-based prevention efforts.

A community health assessment should combine multiple sources of quantitative and qualitative information, but clinical utilization data are an important foundation because they describe actual health problems observed within the population served. The Centers for Disease Control and Prevention describes community health assessment as a systematic process for collecting and analyzing health data to identify needs and priorities. Similarly, the Health Resources and Services Administration emphasizes using needs-assessment data to understand the health status and service needs of a target population. Aggregated diagnosis data should be reviewed alongside demographic, social, and community input data while protecting patient privacy. See the CDC public health assessment resources and HRSA health center needs-assessment guidance.

QUESTION NO: 10

A performance improvement project was initiated at the beginning of the flu season to increase the influenza vaccinations given in a pediatric clinic. The organization implemented a template to document patient influenza vaccine status and to offer the vaccine to any patients identified as not having been vaccinated. To evaluate and document the process improvement results over time, the quality professional should use which of the following?

A. Control chart

B. Matrix diagram

C. Process decision program chart

D. Force field analysis

ANSWER: A

Explanation:

Control chart is the appropriate tool because the project needs to evaluate and document whether the vaccination process performs differently over time after the documentation template and vaccine-offer workflow are implemented. A control chart plots a defined measure—such as the weekly or monthly percentage of eligible pediatric patients receiving influenza

vaccination—in chronological order. Its centerline and statistically derived control limits distinguish expected, routine variation from special-cause variation. This lets the quality professional identify a meaningful shift in vaccination performance, assess whether improvement is sustained throughout flu season, and recognize signals that warrant investigation or adjustment to the process.

For this project, the team should define the measure carefully, including a consistent numerator (patients vaccinated) and denominator (eligible pediatric patients seen), then collect results at regular intervals. Displaying those data on a control chart provides an auditable visual record of implementation and ongoing performance rather than merely a before-and-after comparison. The tool is therefore well suited to both evaluating the intervention's impact and supporting continued process control. The Institute for Healthcare Improvement describes control charts as a method for determining whether variation in a process over time is due to common or special causes: IHI Control Charts. Additional guidance on statistical process control is available from the American Society for Quality: ASQ Control Chart.

QUESTION NO: 11

One of the difficult things about quality is explaining how _____ is different from a process or system.

A. Tools

B. A method

C. Control

D. A and B are same

ANSWER: B

Explanation:

A method is correct because, in quality management, a method describes the particular way work is performed or the approach used to accomplish an activity. It may specify the technique, procedure, or practice that personnel follow to carry out work consistently. This differs conceptually from a process, which is an organized set of interrelated activities that transforms inputs into intended outputs, and from a system, which is a set of interacting elements managed together to achieve an objective. Understanding this distinction is important in healthcare quality because an improvement team may change a method used within a workflow without necessarily redesigning the entire process or the broader system in which it operates. For example, standardizing the method used to conduct medication reconciliation can improve reliability while remaining part of a larger medication-management process and organizational quality system. Quality professionals should use these terms precisely when documenting workflows, selecting improvement interventions, and communicating the scope of change. The American Society for Quality's Quality Glossary and ISO's overview of quality management systems provide useful context for distinguishing quality-management terminology and levels of work.

QUESTION NO: 12

In the Model for Improvement, teams use different types of measures to understand whether a change is producing an overall improvement.

Balancing measures are used to identify (Choose two):

A. Unintended consequences of a change

B. Adverse effects on another process or patient group

C. Whether staff completed the new process as designed

D. The final health outcome targeted by the project

ANSWER: A B

Explanation:

Balancing measures examine whether an improvement in one part of a system creates an unintended problem elsewhere. They may identify **unintended consequences** of a change and **adverse effects on another process, patient group, or area of performance**. For example, a project designed to reduce emergency department length of stay might monitor return visits or inpatient admission delays as balancing measures.

Outcome and process measures are also important, but they serve different purposes. Outcome measures assess the results of the system, while process measures assess whether key steps in the system are performed as intended. See the Institute for Healthcare Improvement: How to Improve.

QUESTION NO: 13

Honest criticism is hard to take, particularly from a relative, a friend, an acquaintance, or a stranger. Resistance to lower-than-expected results is common and reasonable. It is not necessarily a sign of complacency or lack of commitment to high-quality, patient entered care.

Most of the resistance comes in any two forms (Choose two):

A. People resistance

B. Arguments about patients

C. Data resistance

D. None of these

ANSWER: A C

Explanation:

“People resistance” and “Data resistance” describe the two broad, predictable reactions that commonly arise when performance data reveal results below expectations. People resistance reflects the human response to feedback: clinicians, leaders, or teams may feel threatened, unfairly judged, or concerned that results will be used punitively. Addressing this constructively requires psychological safety, respectful communication, and an emphasis on learning and improvement rather than blame.

Data resistance concerns confidence in the measurement itself. Before acting on reported results, healthcare quality professionals should transparently review data definitions, sources, completeness, risk adjustment where applicable, attribution, and analytic methods. This is a legitimate part of quality improvement because trustworthy measurement is necessary to identify real opportunities and monitor whether interventions lead to improvement. Quality leaders should acknowledge both forms of resistance, validate appropriate questions, and use a structured review to move the discussion toward reliable evidence and patient-centered improvement. The Agency for Healthcare Research and Quality’s guidance on communicating quality information and the Institute for Healthcare Improvement’s Psychology of Change Framework support engaging people while using data to guide improvement.

QUESTION NO: 14

A rapid cycle model for improvement derived from the Deming model encompassing the feedback loop of planning, implementing, and evaluating a rapid test of change would best be described by which of the following acronyms?

A. FMEA

B. FOCUS

C. DMAIC

D. PDSA

ANSWER: D

Explanation:

PDSA is the correct acronym because it stands for Plan-Do-Study-Act, the iterative learning cycle widely used for rapid-cycle quality improvement. In the planning phase, the team identifies a specific change, makes a prediction about its expected effect, and determines what data will be collected. The change is then tried on a small scale during the do phase. In the study phase, the team reviews the results, compares them with its prediction, and learns from both the data and implementation experience. Finally, the act phase uses that learning to adapt the change, adopt it more broadly, or test a revised approach through another cycle. This repeating feedback loop supports testing changes quickly and safely before full implementation. The Model for Improvement pairs a focused improvement aim, measures, and change ideas with PDSA cycles to build practical evidence in the local care setting. The cycle is rooted in the work of W. Edwards Deming and is a foundational method in healthcare quality improvement. See the Institute for Healthcare Improvement's Model for Improvement and the American Society for Quality's PDCA/PDSA cycle resource.

QUESTION NO: 15

A healthcare system has multiple medical clinics across a large geographic area. What is the best way to deliver education to assure continuous survey readiness?

A. train the trainer sessions with clinic managers

B. mandatory modules on accreditation standards

C. one-on-one sessions with noncompliant employees

D. just-in-time training to the highest risk clinics

ANSWER: A

Explanation:

"train the trainer sessions with clinic managers" is the best approach because it creates a scalable, sustained education structure for geographically dispersed clinics. Clinic managers can receive standardized instruction on applicable accreditation requirements, organizational policies, evidence of compliance, and how to recognize readiness gaps. They can then reinforce the same expectations with staff in their own locations through orientation, huddles, coaching, audits, and timely follow-up. This distributed model supports continuous readiness rather than treating survey preparation as a one-time event.

Managers are also positioned to adapt delivery to local workflows while preserving systemwide standards. Because they routinely oversee operations, they can observe whether education has translated into practice, identify recurring risks, and arrange reinforcement when processes or requirements change. A train-the-trainer structure therefore extends the quality team's reach, promotes consistent messaging across sites, and embeds survey readiness in daily management activities. The Joint Commission describes accreditation as an ongoing process of demonstrating compliance with standards, which aligns with building local capability for continual monitoring and education. CMS likewise emphasizes provider compliance with applicable health and safety requirements through its survey and certification framework. See The Joint Commission Accreditation and Certification and CMS Certification and Compliance.

QUESTION NO: 16

Amenities may cover areas as mentioned below EXCEPT:

A. Ample and convenient parking

B. Good directional signs

C. Comfortable waiting rooms

D. Vast and facilitated food providing area

ANSWER: D

Explanation:

"Vast and facilitated food providing area" is the exception because the term *amenities* in the healthcare experience context generally refers to practical environmental features that make access, wayfinding, and waiting more convenient and comfortable for patients and visitors. Commonly evaluated amenities therefore include accessible parking, effective directional signage, and comfortable waiting environments. Although food service may be available in a healthcare facility, describing a large or "vast" food-provision area is not a standard core amenity category and does not directly reflect the usual access, navigation, or waiting-area features addressed in patient-experience design. Healthcare organizations should design environments around patients' and families' needs, including clear navigation and welcoming, comfortable spaces. The Agency for Healthcare Research and Quality identifies the healthcare environment as an important component of patient- and family-centered care, while The Joint Commission's standards emphasize a safe, functional environment of care that supports those receiving services. See AHRQ's patient- and family-centered care resources and The Joint Commission's Environment of Care guidance.

QUESTION NO: 17

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

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

B. Establish high standards of customer service

C. Maintain a focus on facilities

D. Help staff cope better in a stressful atmosphere

ANSWER: A B D

Explanation:

Superior healthcare customer service depends on an organization's people, its explicit service expectations, and the conditions that enable staff to consistently meet those expectations. "Hire service-savvy people. Aptitude is everything, people can be taught technical skills" reflects the importance of recruiting for interpersonal qualities such as empathy, communication, respect, and a willingness to help. Technical competencies can be developed through orientation, training, coaching, and experience, but a genuine service orientation is foundational to patient- and family-centered interactions.

"Establish high standards of customer service" is also essential because leaders must define the behaviors, responsiveness, communication practices, and accountability mechanisms that constitute excellent service. Clear standards allow teams to align their daily work with a reliable patient experience. Finally, "Help staff cope better in a stressful atmosphere" recognizes that workforce well-being supports safe, compassionate, and sustainable care. Organizations that support staff resilience, psychological safety, teamwork, and manageable work demands are better positioned to deliver respectful service consistently. These principles align with the Institute for Healthcare Improvement's guidance on improving joy in work and AHRQ's patient- and family-engagement resources: IHI Framework for Improving Joy in Work and AHRQ Patient and Family Engagement resources.

QUESTION NO: 18

An organization may develop performance measure internally or adopt them from a multitude of external resources. However, regardless of the source of performance measure each measure should be evaluated against certain characteristics to ensure a credible and beneficial measurement effort.

Which of the following characteristics is/are critical to performance measures? (Choose three.)

A. Reliability

B. Validity

C. Cost-effectiveness

D. Interpretability

ANSWER: A B D

Explanation:

Reliability, validity, and interpretability are essential characteristics because they establish whether a performance measure produces dependable, meaningful, and usable information for improvement and accountability. Reliability means that the measure yields consistent results when applied under comparable conditions, including across abstractors, sites, or repeated measurement periods. A reliable measure reduces the likelihood that apparent performance differences are simply caused by inconsistent data collection or calculation.

Validity addresses whether the measure actually represents the clinical process, outcome, or quality concept it is intended to assess. Valid measures support sound conclusions and help leaders focus improvement resources on the intended aspect of care. Interpretability ensures that users can understand the measure's definition, direction, population, numerator, denominator, exclusions, and practical meaning. Without clear interpretation, even technically rigorous results cannot be applied consistently to decisions or improvement work.

These attributes align with established measure-evaluation frameworks. The National Quality Forum identifies reliability and validity as central components of scientific acceptability, while feasible, understandable measure specifications support practical use. See the National Quality Forum Measure Evaluation resources and the CMS Measures Management System Blueprint for measure-development guidance.

QUESTION NO: 19

A patient safety officer is developing a patient safety program. The following information has been reviewed:

Incident report data

Performance indicators

Customer complaintsWhich of the following additional information is needed prior to writing the patient safety plan?

A. Infection control data and accreditation results

B. Staff satisfaction and root cause analysis (RCA) data

C. The facility risk assessment and strategic goals

D. Physician satisfaction and financial goals

ANSWER: C

Explanation:

The facility risk assessment and strategic goals are needed because a patient safety plan must be based on a systematic view of the organization's most significant safety risks and must support its overall priorities. Incident reports, performance measures, and complaints provide valuable signals about events, trends, and patient experience, but a facility-wide risk assessment organizes those signals with other operational knowledge to identify and prioritize processes that present the greatest potential for patient harm. It helps the safety officer evaluate the likelihood and severity of risks, identify vulnerable populations or high-risk processes, and direct limited improvement resources toward the areas of greatest need.

Strategic goals provide the governance and organizational context for the plan. They ensure that patient-safety objectives, measures, ownership, timelines, and resource commitments are aligned with leadership's approved direction rather than existing as isolated quality activities. This linkage supports accountability and makes it possible to monitor whether planned interventions are producing meaningful safety improvement. The Joint Commission describes proactive risk assessment as a method for evaluating processes before harm occurs, while AHRQ's patient-safety resources emphasize organizational systems for identifying and improving safety risks. See The Joint Commission's guidance on proactive risk assessment and AHRQ Patient Safety.

QUESTION NO: 20

- Health care provider accountability

- Decision making public reporting

- Organizational evaluation

- National performance improvement goals and activities

These are the performance measures identified by health organizations in order to meet:

A. Internal needs specifically

B. External needs specifically

C. Organizational vision

D. Organizational objective

ANSWER: B

Explanation:

External needs specifically is correct because performance measures serve important accountability and transparency functions beyond the organization itself. Healthcare organizations use standardized measures to demonstrate provider accountability, support public reporting, enable informed decision-making by patients, purchasers, regulators, and policymakers, and contribute data to national quality-improvement priorities. These uses require measures that can be reported, compared, and interpreted by external stakeholders across organizations and settings.

External performance-measure requirements may arise from accrediting bodies, government programs, payers, public reporting initiatives, and national quality strategies. Selecting measures that address these expectations helps an organization communicate its quality and safety performance credibly, meet reporting obligations, and participate in broader efforts to improve population health and healthcare delivery. Organizational evaluation can also benefit from the resulting data, but the listed emphasis on accountability, public reporting, and national improvement activities most directly reflects externally driven measurement needs. The Agency for Healthcare Research and Quality describes quality measures as tools for assessing and reporting healthcare quality, including for public accountability and improvement: AHRQ—Quality Measures. CMS likewise uses quality measures in public reporting and quality programs: CMS—Quality Measures.

QUESTION NO: 21

Sampling is a key that healthcare professionals need to develop. If a process does not generate a lot of data, you probably will analyze all the occurrences of an event and not need to consider sampling.

Sampling usually is not required when the measure is (Choose two):

A. A percentage

B. A rate

C. A step by step process

D. A strata

ANSWER: A B

Explanation:

A percentage and a rate are commonly calculated using a numerator and denominator drawn from the full set of eligible events during a defined measurement period. When the event volume is manageable, quality professionals can collect information for every eligible case rather than estimate performance from a subset. This produces a complete measure and eliminates sampling error. For example, a percentage can represent the share of eligible patients who received a specified intervention, while a rate can express events relative to an appropriate population or opportunity. In each case, complete enumeration is practical when the process generates relatively few records and the data elements are available from routine documentation or reporting systems.

The decision is based primarily on the number of eligible observations and the feasibility of reviewing all of them, not simply on the label applied to the measure. The Institute for Healthcare Improvement notes that sampling is useful when reviewing every case is impractical, whereas small volumes can support collection of all available data. The Centers for Medicare & Medicaid Services likewise describes quality measures in terms of eligible populations, numerators, and denominators, which supports complete measurement when feasible. See the IHI sampling guidance and CMS measure specification resources.

QUESTION NO: 22

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: B

Explanation:

The **Ishikawa diagram**, also called a cause-and-effect or fishbone diagram, is the appropriate tool for systematically investigating the potential sources of process variation. It begins with a clearly defined effect, such as an observed quality problem, undesirable outcome, or variation in performance, and guides the improvement team in identifying and organizing all plausible contributing causes. Causes are commonly grouped into meaningful categories such as people, methods, equipment, materials, measurement, and environment; the categories can be adapted to the clinical or operational process under study.

This structured visual approach supports root-cause analysis by making the team's assumptions explicit, encouraging input from individuals who perform or are affected by the work, and revealing relationships among potential causal factors. The team can then use data collection, observation, or additional analytic methods to validate the most likely contributors and prioritize improvement actions. In healthcare quality improvement, this is especially useful when variation arises from interconnected workflow, communication, technology, and environmental factors. The American Society for Quality describes the fishbone diagram as a tool for identifying many possible causes of an effect and sorting ideas into useful categories: ASQ Fishbone Diagram. The Institute for Healthcare Improvement also includes cause-and-effect diagrams among practical quality-improvement tools: IHI Quality Improvement Essentials Toolkit.

QUESTION NO: 23

A nursing director for a unit in a cancer hospital Is reviewing and assessing outcomes data in the followingscatter 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

Explanation:

strong and positive. is correct because the plotted observations follow a clear upward pattern: larger values for the decrease in staffing targets are associated with larger infection-incidence values. In a scatter diagram, a positive relationship means that the two variables tend to move in the same direction on the graph. Here, moving from left to right represents an increasing amount of staffing reduction, while moving upward represents increasing infection incidence. The wording "decrease in staffing targets" describes what the horizontal-axis measure represents; it does not reverse the direction of the plotted variable. Because the points are closely grouped around an upward-sloping imaginary line rather than being widely dispersed, the association is strong as well as positive. Scatter diagrams are a standard healthcare-quality tool for examining whether two measured variables appear related and for judging the direction and relative strength of that relationship. This finding supports further investigation of staffing reductions as a potential contributor to infection outcomes, while recognizing that a scatter diagram demonstrates association rather than proving causation. See the American Society for Quality's scatter-diagram guidance and the AHRQ resource on using data to understand healthcare quality and safety.

QUESTION NO: 24

What action should be taken to align an organization's safety culture with improvement activities?

A. Focus root cause analysis on incidents involving staff competency

B. Debrief staff on safety culture survey results

C. Identify groups to survey on safety culture

D. Measure the number of reported safety incidents per staff member

ANSWER: B

Explanation:

Debrief staff on safety culture survey results is the appropriate action because survey findings identify workforce perceptions and provide a shared evidence base for selecting, prioritizing, and carrying out improvement work. A debrief closes the feedback loop: leaders communicate the results transparently, invite staff to interpret what the findings mean in their local work settings, and engage the people closest to care delivery in developing practical actions. This approach supports psychological safety, trust, and learning—core features of a positive safety culture—and helps ensure that improvement initiatives address the cultural conditions revealed by the assessment rather than being imposed without frontline context.

Survey use should extend beyond collecting scores. Teams should review strengths and opportunities, discuss patterns constructively, select focused improvement priorities, assign accountability, and later share progress. Engaging staff in this process increases understanding of the purpose of improvement activities and creates ownership of the resulting changes. The Agency for Healthcare Research and Quality describes communicating survey results and developing action plans as key steps in using the Surveys on Patient Safety Culture; see its Hospital Survey on Patient Safety Culture resources. AHRQ also provides practical guidance on turning safety-culture feedback into improvement through its TeamSTEPPS and patient-safety improvement resources.

QUESTION NO: 25

A healthcare organization has experienced a recent increase in the number of falls with injury. A response by leadership that best demonstrates a safety culture is in place within the organization is to

A. Acknowledge the injuries as systems errors

B. Hold the unit manager responsible for the increase

C. Require training of involved staff

D. Place involved staff on a corrective action plan

ANSWER: A

Explanation:

Acknowledge the injuries as systems errors is the response that best demonstrates a culture of safety. A mature safety culture treats adverse events, including falls with injury, as opportunities to learn about how work processes and conditions may have contributed to harm. Leadership should support a structured, systems-focused review that identifies contributing factors such as environmental hazards, communication gaps, patient-assessment processes, staffing workflows, equipment availability, or reliability of fall-prevention practices. This approach promotes psychological safety: staff can report incidents, near misses, and unsafe conditions without fear that reporting itself will result in blame. The resulting learning can be translated into sustainable improvements, monitored to determine whether they reduce harm. Accountability remains important in a safety culture, but it is applied fairly and in context; the initial leadership response is to understand the system in which the event occurred rather than presume individual fault. This systems orientation is central to patient-safety improvement and helps ensure that fall-prevention efforts address underlying causes across the organization. The Agency for Healthcare Research and Quality describes safety culture as the shared values, attitudes, and behaviors that support patient safety, including communication and organizational learning. See AHRQ Surveys on Patient Safety Culture and the AHRQ PSNet primer on safety culture.

QUESTION NO: 26

During which phase of DMAIC does the quality manager decide which priorities to focus on?

A. Define

B. Measure

C. Analyze

D. Improve

ANSWER: A

Explanation:

Define is the correct phase because it establishes the improvement project's purpose and direction before data collection or solution development begins. In DMAIC, the team identifies the problem or opportunity, clarifies the customers and their requirements, develops a problem statement and goal statement, establishes the project scope, and identifies the critical issues that merit attention. Deciding which priorities to focus on is therefore a central Define-phase activity: it ensures that improvement resources are directed to a meaningful, strategically relevant problem rather than dispersed across too many potential concerns. Quality managers commonly use the voice of the customer, organizational strategic objectives, high-level process information, and the expected impact on quality, safety, cost, or timeliness to select and frame the priority. A well-defined priority also gives the later DMAIC work clear boundaries and measurable objectives. The American Society for Quality's DMAIC overview describes Define as the stage for identifying the problem and project goals. Similarly, the Institute for Healthcare Improvement's improvement guidance emphasizes beginning improvement work by establishing a clear aim and focus.

QUESTION NO: 27

Benchmarking is used to compare an organization's performance with that of peer organizations, recognized best performers, or an established external reference.

Before acting on benchmark results, a quality professional should consider (Choose three):

A. Whether measure definitions are comparable

B. Whether populations and care settings are comparable or appropriately adjusted

C. Whether the data are timely and reliable

D. Whether the benchmarked organization has a larger marketing budget

ANSWER: A B C

Explanation:

Meaningful benchmarking requires confirmation that the organizations use **comparable measure definitions**, that the **patient populations and settings are sufficiently similar or appropriately adjusted**, and that the **data are timely and reliable**. Without these considerations, apparent performance differences may reflect inconsistent specifications, case-mix differences, or data-quality limitations rather than true differences in care.

Benchmarks can identify improvement opportunities and stimulate learning, but they should not be interpreted without understanding the measure methodology and context. See AHRQ: Comparing Quality Information.

QUESTION NO: 28

The healthcare quality professional is engaged with a leadership team. Which of the following will best help to establish performance improvement opportunities?

A. Reviewing the organization's balanced scorecard

B. Evaluating the organization's mission, vision, and values statement

C. Creating an organizational action plan

D. Performing a failure mode and effects analysis (FMEA)

ANSWER: A

Explanation:

Reviewing the organization's balanced scorecard is the best way to establish performance improvement opportunities because it gives the leadership team a structured, data-based view of performance relative to strategic aims. A balanced scorecard translates strategy into measurable objectives and indicators across complementary domains, commonly including patient or customer experience, clinical and operational processes, workforce learning and growth, and financial stewardship. Reviewing these measures enables the healthcare quality professional and leaders to recognize meaningful performance gaps, undesirable trends, variation, and measures that are not meeting established targets. Those findings provide an objective basis for selecting and prioritizing opportunities that are both important to organizational strategy and supported by evidence.

In healthcare quality management, improvement work should begin with understanding the current state through reliable performance measurement. The balanced scorecard supports this process by bringing multiple related measures together rather than relying on an isolated result. It also helps leaders connect improvement priorities to accountability, resources, and strategic goals, which is essential for sustained organizational improvement. The Institute for Healthcare Improvement describes the importance of using data to understand systems and guide improvement decisions in its How to Improve guidance. Background on the balanced-scorecard approach and its use in linking measures to strategy is available from Balanced Scorecard Institute.

QUESTION NO: 29

A quality professional is selecting members for a team to improve the specimen-collection process in the emergency department.

Which participants should be included to provide essential process knowledge? (Choose three.)

A. Emergency department nurses

B. Laboratory staff

C. An emergency department physician representative

D. A leader with no connection to the process

ANSWER: A B C

Explanation:

Improvement teams should include people who perform, receive, and are affected by the work. Emergency department nurses have direct knowledge of specimen collection and handoffs. Laboratory staff understand specimen receipt, labeling requirements, rejection criteria, and processing. A physician representative can provide clinical input on ordering practices, urgency, and the effect of delays on patient care.

An improvement team should be selected for relevant process expertise and stakeholder perspective rather than organizational title alone. Multidisciplinary involvement improves problem definition, intervention design, and implementation. See AHRQ TeamSTEPPS resources.

QUESTION NO: 30

A hospital is reviewing medication-administration errors after a serious event. The review team asks repeatedly why each contributing condition occurred, rather than stopping with the individual who made the final error.

This approach is most consistent with:

A. Root cause analysis

B. Benchmarking

C. Failure mode and effects analysis

D. Performance appraisal

ANSWER: A

Explanation:

Root cause analysis is correct because it seeks to identify the underlying system conditions and process failures that contributed to an event. Repeatedly asking why an event occurred can uncover issues such as unclear policies, interruptions, inadequate training, poor technology design, or ineffective communication processes.

Root cause analysis should focus on improving systems rather than assigning blame to an individual. The Joint Commission describes root cause analysis as a method for identifying the basic causal factors that underlie variation in performance. See The Joint Commission: Root Cause Analysis in Health Care.

QUESTION NO: 31

Failure mode and effects analysis is a proactive method used to identify and reduce risk before a process failure reaches a patient.

Common elements of an FMEA include (Choose three):

A. Severity of the potential effect

B. Likelihood that the failure will occur

C. Ability to detect the failure before harm occurs

D. Individual employee performance rating

ANSWER: A B C

Explanation:

FMEA begins by mapping a process and identifying possible ways each step can fail. The team then evaluates the **severity** of potential harm, the **likelihood of occurrence**, and the ability to **detect the failure before it reaches the patient**. These ratings help prioritize high-risk failure modes for redesign.

Unlike root cause analysis, which is commonly performed after an adverse event, FMEA is prospective. It supports prevention by identifying vulnerabilities before harm occurs. See Institute for Healthcare Improvement: FMEA Tool.

QUESTION NO: 32

A health system in an underserved area seeks to improve medication adherence in patients with hypertension. One of the barriers identified is patients with limited English proficiency. Which of the following solutions will best improve medication adherence?

A. Use clinicians with shared language as interpreters.

B. Use a telephonic interpreter service to communicate instructions.

C. Provide written medication instructions in patients' preferred language.

D. Implement an automatic refill program for hypertension medications.

ANSWER: C

Explanation:

Provide written medication instructions in patients' preferred language. Medication adherence depends on a patient being able to understand the medication’s purpose, dose, timing, refill process, and important precautions after leaving the clinical encounter. Instructions in a preferred language directly address the identified language barrier by making essential regimen information accessible for later reference at home, where daily medication-taking decisions occur. For hypertension, which is often asymptomatic, clear language-concordant instructions can reinforce why consistent treatment matters even when the patient feels well.

To be effective, the health system should use accurately translated, culturally appropriate materials written in plain language. The instructions should clearly state the medication name, what it treats, how much to take, when to take it, and what to do if a dose is missed. Staff can reinforce the written plan through teach-back, asking the patient to describe how they will take the medicine in their own words. Federal language-access guidance recognizes the need for meaningful access for individuals with limited English proficiency, and health-literacy guidance supports clear, understandable communication as a core safety and quality practice. See HHS Limited English Proficiency resources and AHRQ health literacy guidance.

QUESTION NO: 33

An effective meeting requires which of the following?

A. mission statement

B. planned agenda

C. recorder ' s name

D. written minutes

ANSWER: B

Explanation:

A planned agenda is essential because it gives a meeting a defined purpose, an ordered set of topics, and an expected flow of discussion. In healthcare quality work, meetings often bring together people with different roles to review performance data, make improvement decisions, address risks, or assign follow-up work. Distributing and following an agenda helps participants prepare relevant information in advance, keeps discussion focused on the intended objectives, and supports appropriate allocation of limited meeting time. It also clarifies the decisions or outputs expected from each topic and enables the facilitator to manage participation and transitions effectively. A well-designed agenda typically identifies the meeting objective, discussion items, the person responsible for each item, and the time allotted. This structure promotes reliable communication and helps the group leave with clear actions, owners, and deadlines—important features of accountable quality-improvement governance. The U.S. General Services Administration identifies agendas as a core planning element for productive meetings and conferences, while the Centers for Disease Control and Prevention emphasizes structured planning and clear processes for collaborative improvement activities. See the GSA Meetings and Conferences guidance and the CDC evaluation planning guidance.

QUESTION NO: 34

_____ 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. Physician profiling

B. Value-based profiling

C. Physicians portfolio management

D. Physician record review

ANSWER: A

Explanation:

Physician profiling is correct. In healthcare quality management, physician profiling is the systematic collection, analysis, and reporting of data about an individual physician's practice patterns, resource utilization, and patient-care outcomes. The resulting profile provides actionable performance feedback that can be used to support professional accountability, identify opportunities for improvement, and reduce unwarranted variation in clinical practice. Effective profiles typically compare performance with defined measures, peer groups, benchmarks, and evidence-based guidelines. They can include measures such as use of diagnostic tests, complication or readmission rates, adherence to preventive-care processes, length of stay, and patient outcomes. Quality leaders use these data in credentialing, peer review, performance-improvement activities, and medical-staff quality oversight. Importantly, the purpose is not merely to collect data; it is to translate valid, risk-aware performance information into feedback and improvement actions that advance safe, effective, equitable care. The National Academy of Medicine describes performance measurement as a means to assess and improve health-care quality, while the Centers for Medicare & Medicaid Services publishes clinician quality measures used to evaluate and provide feedback on care delivered. See the CMS Quality Measures and the National Academies' discussion of performance measurement.

QUESTION NO: 35

Over the past 2 months, a trend has been detected in medication errors. The preferred method of presenting data to the nursing Quality Council will identify the nurse by

A. a coding system with the key attached to the report.

B. initials.

C. name.

ANSWER: A

Explanation:

a coding system with the key attached to the report. is the preferred approach because it supports confidential, nonpunitive review while preserving the ability to identify an involved nurse when follow-up is necessary. A coded identifier allows the Quality Council to concentrate first on the pattern of medication errors, contributing workflow conditions, and opportunities for system improvement rather than on public attribution. The key permits authorized reviewers to connect the code with the appropriate individual if clarification, coaching, competency assessment, or other protected personnel follow-up is warranted. This approach is consistent with patient-safety reporting principles: reports should provide useful information for learning and improvement while protecting confidentiality to encourage candid reporting. Medication-error trend review should seek to understand process factors—such as interruptions, labeling, order communication, staffing, or technology design—and then implement and monitor improvements. A coded reporting process helps balance accountability with a just culture in which staff can report safety events without inappropriate fear. The Agency for Healthcare Research and Quality describes event reporting as a mechanism for identifying hazards and learning from patient-safety events, and its Common Formats support standardized collection of safety-event information. See AHRQ PSNet: Incident Reporting and AHRQ Common Formats for Event Reporting.

QUESTION NO: 36

A healthcare organization has recently launched a diabetes center of excellence to address the needs of its patients with advanced diabetes. The implementation of this program would fall into which of the following types of prevention?

A. Tertiary

B. Quaternary

C. Primary

D. Secondary

ANSWER: A

Explanation:

Tertiary is correct because the diabetes center of excellence is designed for patients who already have advanced, established diabetes. Tertiary prevention focuses on limiting the effects of an existing disease, preventing or slowing complications, reducing disability, and improving function and quality of life through coordinated, ongoing management. In this setting, the center may provide specialized glycemic management, multidisciplinary care, education and self-management support, monitoring for complications, and treatment of diabetes-related conditions such as kidney disease, neuropathy, retinopathy, or cardiovascular disease. These services are intended to optimize outcomes after the disease is present rather than prevent diabetes from developing in the first place. A center of excellence also supports consistent application of evidence-based care for complex patients, helping reduce avoidable complications, hospitalizations, and loss of function. This aligns with the prevention framework describing tertiary prevention as care that minimizes the impact of established illness and disability. The Merck Manual's overview of prevention describes tertiary prevention as limiting disability and restoring function in people with chronic disease. The CDC's diabetes information also emphasizes the importance of managing diabetes to prevent or delay serious complications.

QUESTION NO: 37

Which of the following characteristics best describes a learning organization?

A. compliant, data rich, committed support of the organization's leader

B. adaptability, systems thinking, willingness to challenge assumptions

C. scholarship, valued autonomy, fiscal discipline

D. passion, quality control, intolerance of disruptive thought

ANSWER: B

Explanation:

adaptability, systems thinking, willingness to challenge assumptions best describes a learning organization because these qualities enable an organization to learn continuously and translate that learning into improved performance. Adaptability allows teams to respond constructively to changes in patient needs, evidence, technology, regulation, and operating conditions rather than relying solely on established routines. Systems thinking recognizes that healthcare outcomes arise from connected processes, people, policies, and environments; it therefore supports examining relationships and causes across the entire care-delivery system. Willingness to challenge assumptions creates the psychological and intellectual openness needed to test mental models, identify gaps between current practice and desired outcomes, and adopt more effective approaches.

These features align with Peter Senge's learning-organization framework, which identifies systems thinking as a core discipline and emphasizes reflection on mental models. In healthcare quality, this orientation supports continuous improvement: organizations use experience and data to understand how work is actually performed, learn across departments and disciplines, and make sustainable system-level changes. The Agency for Healthcare Research and Quality similarly describes learning health systems as organizations that continuously generate and apply evidence and learning to improve care. See Society for Organizational Learning: learning organization disciplines and AHRQ: Learning Health Systems.

QUESTION NO: 38

An organization is implementing a standardized clinical pathway across several inpatient units.

Which actions are most important for sustaining the change? (Choose three.)

A. Embed the pathway in routine workflow tools

B. Monitor performance over time

C. Provide feedback to frontline teams

D. Rely only on initial staff education

ANSWER: A B C

Explanation:

Sustaining improvement requires incorporating the new pathway into routine work. Standardizing the pathway in policies, order sets, and workflow tools reduces reliance on memory and individual preference. Monitoring performance over time allows leaders and staff to identify drift and evaluate whether the process remains reliable. Providing feedback to frontline teams supports accountability, learning, and continued engagement.

A one-time educational program alone is insufficient to sustain a change because staff turnover, competing priorities, and workflow variation can erode reliability. See the IHI Framework for Going to Full Scale.

QUESTION NO: 39

Once collected, performance measurement data require interpretation and analysis if they are to be used to improve the processes and outcomes of healthcare. Data can be used to compare:

A. An organizations performance against itself over time

B. The performance of one organization to the performance of a group of organizations collecting data on the same measures in the same way

C. An organization's performance against established benchmarks or guidelines

D. A, B and C

ANSWER: D

Explanation:

A, B and C is correct because healthcare performance data support several complementary forms of comparison, each of which can inform quality-improvement decisions. Comparing an organization's results with its own prior performance identifies trends, variation, and whether a change has produced sustained improvement. This longitudinal view is commonly displayed with run charts or statistical process control charts.

Comparing results with a group of organizations that collect the same measure using the same specifications provides benchmarking. Meaningful benchmarking depends on consistent definitions, data collection methods, time periods, and appropriate adjustment for differences in patient populations when applicable. It helps an organization understand its relative performance and identify opportunities to learn from high-performing peers.

Performance can also be assessed against externally established benchmarks, targets, clinical guidelines, or evidence-based standards. These comparisons help determine whether results meet an expected level of care and can prioritize improvement work where performance falls short of recognized goals. Using these perspectives together gives leaders a more complete interpretation of performance than any single comparison alone. CMS describes the role of standardized quality measures in evaluating and improving care at CMS Quality Measures, and the Institute for Healthcare Improvement provides practical guidance on analyzing performance over time through run charts.

QUESTION NO: 40

A stated purpose of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) public reporting is that accountable health care should:

A. Ensure data is collected and reported annually

B. Provide valid and reliable data

C. Require both measurement and transparency

D. Validate patient experience and satisfaction with care

ANSWER: C

Explanation:

"Require both measurement and transparency" is correct because HEDIS is a standardized performance-measurement framework designed to make health plan and health care performance visible, comparable, and usable for accountability. Accountable care depends on measuring defined aspects of quality, effectiveness, access, experience, and utilization in a consistent manner, then transparently reporting results so that consumers, purchasers, regulators, and health care organizations can assess performance and promote improvement. HEDIS supports this purpose by using standardized specifications that allow meaningful comparisons across reporting organizations and over time. Public reporting is therefore not simply the collection of data; it connects measurement to transparency so performance information can inform selection, oversight, and quality-improvement decisions. NCQA describes HEDIS as a widely used performance-measurement tool and explains that its measures enable comparison of health plan performance. Its broader public-reporting work similarly emphasizes making quality information available to support informed decisions and accountability. See NCQA's HEDIS overview and NCQA's Quality Compass/report-card resources.

QUESTION NO: 41

In healthcare, many terms call for more precise operational definitions that how do an organization define the terms such as (Choose two):

A. Qui turnaround time

B. An accurate environmental compliance

C. A patient fall (a partial fall, a fall with injuries, or an assisted fall)

D. Surgical end time

ANSWER: A C

Explanation:

Qui turnaround time and **A patient fall (a partial fall, a fall with injuries, or an assisted fall)** require operational definitions because each is a measurement concept that can otherwise be interpreted differently by staff, departments, or reporting systems. For turnaround time, the organization must specify the precise event that starts the clock, the event that stops it, the population or process included, and how exceptions are handled. This makes performance data consistent enough to trend over time and compare across teams.

A patient-fall definition must state what constitutes a fall and how related events, including assisted falls, partial falls, and falls causing injury, are counted and classified. A shared definition supports reliable incident reporting, accurate rate calculation, meaningful analysis of contributing factors, and evaluation of prevention efforts. Operational definitions convert broad quality concepts into observable, reproducible measures so that different people collect and interpret data in the same way. The American Society for Quality describes an operational definition as a clear, agreed-upon description of how a characteristic is measured, while AHRQ provides healthcare-specific fall-prevention resources that rely on consistent identification and reporting of falls. See ASQ: Operational Definition and AHRQ: Preventing Falls in Hospitals.

QUESTION NO: 42

A healthcare organization is establishing a dashboard for its governing board. The dashboard should support oversight of quality and patient safety performance.

Effective dashboard measures should be (Choose three):

A. Aligned with organizational strategic priorities

B. Clearly defined and consistently calculated

C. Displayed over time

D. Limited to favorable results

ANSWER: A B C

Explanation:

Dashboard measures should be **aligned with strategic priorities**, **clearly defined and consistently calculated**, and **displayed over time**. Alignment ensures that the board reviews matters that are important to organizational performance. Clear definitions improve the reliability and interpretability of results. Trends over time allow leaders to distinguish isolated results from meaningful patterns of improvement or deterioration.

A dashboard should be concise and actionable rather than a collection of all available data. Appropriate stratification, targets, and explanations of notable variation can further support informed governance decisions. See AHRQ: Health Care Quality Measures.

QUESTION NO: 43

A quality department is developing a data-validation process before reporting performance measures to senior leadership.

Data validation activities should include (Choose three):

A. Comparing results with source documentation

B. Reviewing numerator and denominator logic

C. Checking for missing, duplicate, or implausible values

D. Changing specifications to improve results

ANSWER: A B C

Explanation:

Comparing reported values with source documentation helps confirm that abstracted data accurately reflect the patient record or other original data source. Reviewing numerator and denominator logic ensures that eligible cases are counted correctly and that exclusions are applied consistently. Checking for missing, duplicate, or implausible values helps identify data-quality problems that could distort reported performance.

Changing a measure specification after reviewing results compromises consistency and interpretability unless the revision is formally approved, documented, and applied appropriately. Data validation supports credible performance reporting and reliable decisions. See CMS measure specification resources.

QUESTION NO: 44

A facility Is reviewing their quality program for compliance with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation. Which of the following Is the most Important factor in program compliance?

A. 12 months of data for each project

B. Integration into each department and service of the facility

C. poor improvement outcomes monitored for an additional 12 months

D. coordination by a full-time healthcare quality professional

ANSWER: B

Explanation:

Integration into each department and service of the facility is the most important factor because CMS quality-program requirements are designed to operate across the organization, rather than as an isolated quality-office activity or a series of individual projects. For hospitals, the Quality Assessment and Performance Improvement requirement calls for an ongoing, data-driven program that is hospital-wide; its scope must reflect the complexity of the organization's services and involve all hospital departments and services. This enterprise-wide approach enables the organization to identify quality and safety concerns wherever care is delivered, collect and use relevant data, implement improvement actions, and sustain leadership oversight and accountability. Meaningful integration also makes quality improvement part of daily clinical, operational, and support-service work, which is essential for demonstrating that the program is embedded in the facility's governance and care-delivery systems. CMS describes the regulatory requirement at 42 CFR § 482.21, including the expectation for a hospital-wide, data-driven QAPI program. CMS's Quality Assessment and Performance Improvement resources likewise emphasize systematic, organization-wide improvement of care and services.

QUESTION NO: 45

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

A. registry

B. network

C. research

D. certification

ANSWER: A

Explanation:

The correct choice is **registry**. A clinical registry is a structured system that collects standardized data about patients with a particular condition or who receive a defined type of care, such as cardiac services. Participating organizations submit comparable information on patient characteristics, treatments, processes of care, complications, and outcomes. The registry then produces reports that allow each participating organization to compare its results with aggregated results, peer organizations, or established benchmarks. This is directly aligned with the leaders' goal of assessing cardiac-care outcomes in relation to organizations providing similar services.

Registry participation also supports ongoing quality improvement. Risk-adjusted comparisons can help ensure that outcome differences are interpreted in light of variation in patient acuity and clinical complexity. Leaders and clinical teams can use the resulting performance data to identify improvement opportunities, monitor interventions over time, and evaluate whether changes in care processes improve outcomes. For example, the American College of Cardiology's registry programs provide hospitals with benchmarking and performance-measurement feedback for cardiovascular care. See the American College of Cardiology National Cardiovascular Data Registry and the AHIMA overview of health information and data use.

QUESTION NO: 46

Process improvement projects can be evaluated by using

A. A dashboard

B. A matrix diagram

C. A flow chart

D. An Ishikawa diagram

ANSWER: A

Explanation:

A dashboard is the best tool for evaluating a process improvement project because it brings the project's measures together in a readily interpreted format. Evaluation requires comparing performance over time with the project aim, baseline, target, and, where appropriate, established benchmarks. A well-designed dashboard can display outcome, process, balancing, and sometimes equity measures through trend charts, run charts, or control charts. This lets leaders and improvement teams see whether the implemented changes produced sustained improvement rather than a one-time fluctuation, identify variation requiring further investigation, and communicate results clearly to stakeholders.

In healthcare quality work, dashboards support ongoing performance measurement by making key indicators visible and actionable. For example, a project intended to reduce central-line infections can use a dashboard to follow infection rates, bundle-compliance measures, and balancing measures such as device utilization across successive reporting periods. The Institute for Healthcare Improvement describes the use of outcome, process, and balancing measures to determine whether changes result in improvement: IHI Model for Improvement, Part 2. The Agency for Healthcare Research and Quality also recognizes dashboards as a method for presenting performance data so users can monitor quality and support improvement decisions: AHRQ TalkingQuality.

QUESTION NO: 47

Patient and family advisory council is one of the most effective strategies for involving families and patients in the design of care.

Council responsibilities may include input on or involvement in (Choose three):

A. Program development, implementation, and evaluation

B. Planning for major renovation or the design of a new building or service

C. Staff evaluation

D. Marketing plan or practice services

ANSWER: A B D

Explanation:

Patient and family advisory councils create a formal mechanism for patients and family members to contribute their lived experience to organizational decisions. Their role extends beyond giving feedback on individual encounters: councils can partner with leaders and staff to shape how services are planned, delivered, assessed, and communicated. Therefore, *Program development, implementation, and evaluation* is an appropriate responsibility because advisors can identify patient-centered priorities, help test proposed workflows, and assess whether a program meets patient and family needs. *Planning for major renovation or the design of a new building or service* appropriately uses patient and family perspectives to improve accessibility, navigation, privacy, comfort, and practical usability of care environments and services. *Marketing plan or practice services* is also suitable because advisors can help ensure public-facing messages and descriptions of services are understandable, relevant, respectful, and responsive to the community served. These activities reflect meaningful partnership at the organizational level and support patient- and family-centered care. Guidance from the Agency for Healthcare Research and Quality describes patient and family engagement as active partnership in improving care processes and systems. The Institute for Patient- and Family-Centered Care also identifies advisory councils as vehicles for involvement in program and facility planning. See AHRQ's PFAC guidance and IPFCC resources on patient and family advisory councils.

QUESTION NO: 48

Patient and family engagement can strengthen healthcare quality-improvement activities.

Patients and family members can contribute to improvement work by (Choose three):

A. Identifying barriers in care processes

B. Participating in the design of improvement interventions

C. Helping interpret patient-experience findings

D. Replacing the organization's quality governance structure

ANSWER: A B C

Explanation:

Patients and families provide direct knowledge about how care is experienced across the continuum. They can **identify barriers in care processes**, **participate in the design of improvement interventions**, and **help interpret patient-experience findings**. Their participation can reveal communication gaps, burdensome workflows, access problems, and unintended effects that may not be apparent to staff.

Meaningful engagement requires that organizations prepare participants, clarify their roles, provide understandable information, and create an environment in which their input is respected and used. See AHRQ: Patient and Family Engagement.

QUESTION NO: 49

The data collection phase of the journey consists of two parts: (1) Planning for data collection and (2) The actual data gathering. A well designed data collection strategy should address different analytical questions.

Which of the following is/are the part of planning section for data collection? (Choose two.)

A. Will the data add value to your quality improvement efforts?

B. How often and for how long will you collect the data?

C. Will collecting these data have negative effects on patients or employees?

D. Do you have target and goals for the measures?

ANSWER: A B

Explanation:

“Will the data add value to your quality improvement efforts?” is a core planning question because a team should define the purpose of measurement before investing staff time and resources in collecting information. Data should support a specific improvement aim, reveal whether a process is changing, or help guide decisions. Selecting measures that are useful to the improvement effort helps ensure that collection is intentional and actionable rather than simply producing reports.

“How often and for how long will you collect the data?” is also part of the data-collection plan. Teams need an explicit sampling frequency and collection period so they can establish a baseline, observe variation over time, detect the effects of changes, and balance timely feedback with the burden placed on staff. These operational details should be decided before actual gathering begins and documented so collection is consistent across people and time periods. The Institute for Healthcare Improvement emphasizes selecting measures linked to an aim and collecting data over time to determine whether changes result in improvement. AHRQ likewise describes planning measurement activities, including defining the data needed and collection approach, before implementation. See IHI’s Model for Improvement and AHRQ measurement guidance.

QUESTION NO: 50

A quality professional's key role in a performance improvement team is to serve as a:

A. Process owner

B. Decision maker

C. Group facilitator

D. Clinical champion

ANSWER: C

Explanation:

Group facilitator is correct because quality professionals commonly enable the performance-improvement process rather than personally owning the clinical process or making all operational decisions. In this role, the quality professional helps the team define the improvement aim, select an appropriate method, establish measures, use data effectively, and maintain a structured, collaborative workflow. Facilitation includes guiding meetings, encouraging participation from varied disciplines, clarifying roles and next steps, and helping the team apply improvement cycles such as Plan-Do-Study-Act. This supports shared ownership by the people closest to the work while providing the team with quality-improvement expertise.

The National Association for Healthcare Quality identifies quality professionals’ work as involving performance and process improvement, data analysis, communication, and collaboration across healthcare settings. These competencies position the professional to help interdisciplinary teams systematically identify problems, test changes, interpret results, and sustain gains. The Institute for Healthcare Improvement likewise describes improvement work as team-based and dependent on practical testing and learning through the Model for Improvement. Serving as a group facilitator therefore reflects the quality professional’s central contribution: creating the conditions and structure for the improvement team to make informed, evidence-based progress. See NAHQ CPHQ Certification and the Institute for Healthcare Improvement: How to Improve.

QUESTION NO: 51

_____ is the degree to difference between survey results when the scales are applied in different settings. Survey scores should reflect differences institutions, where care is presumably different.

A. Discriminant validity

B. Criterion validity

C. Content validity

D. Construct validity

ANSWER: A

Explanation:

Discriminant validity is correct because it addresses whether a survey or measurement scale can distinguish between groups, settings, or institutions that are expected to differ on the attribute being measured. In healthcare quality measurement, this is especially important when survey results are used to compare hospitals, clinics, or other care settings. If meaningful differences in care quality or patient experience are presumed to exist across institutions, a valid survey should produce appropriately different scores rather than treating all settings as indistinguishable.

This form of validity evidence supports the interpretation that observed score differences represent real differences in the underlying construct, such as quality of care, safety culture, or patient experience. Demonstrating discrimination between known or expectedly different groups is often called known-groups validity and is commonly treated as evidence supporting construct validity. The survey's ability to detect these expected institutional differences helps establish that its results are useful for quality assessment, benchmarking, and improvement decisions. Guidance on evaluating measurement properties, including hypotheses about differences between known groups, is available from COSMIN. The Agency for Healthcare Research and Quality also describes the use of standardized patient-experience survey results for comparative quality reporting through its CAHPS program.

QUESTION NO: 52

A multidisciplinary team is focused on safe patient transfers to a long-term care facility and is conducting a failure mode and effects analysis (FMEA). Which of the following should be the first step?

A. Identify failure modes and causes

B. Analyze incident report data

C. Calculate the risk priority number

D. Determine the steps in the process

ANSWER: D

Explanation:

Determine the steps in the process is the correct first step because an FMEA is a prospective, structured analysis of how a defined process could fail. Before the team can identify potential failure modes, their causes, or their effects, it must establish a shared, accurate understanding of the transfer workflow as it is actually performed. For a transfer to long-term care, this process map might trace the work from deciding that transfer is appropriate through communication with the receiving facility, medication reconciliation, handoff documentation, transport, and confirmation of receipt. Mapping the workflow also identifies handoffs, decision points, people involved, information flows, and interfaces where risks may arise. The multidisciplinary team should validate the map with personnel who perform or receive each part of the work so that the analysis reflects real practice rather than an assumed policy process. Once the steps are defined, the team can systematically examine each step for credible failures and prioritize improvement actions. This sequence is consistent with the Institute for Healthcare Improvement's description of FMEA, which begins by selecting and diagramming the process, and with the VA National Center for Patient Safety's proactive risk assessment approach. See the IHI FMEA Tool and the VA Healthcare Failure Mode and Effect Analysis resource.

QUESTION NO: 53

Studies comparing self-reports with proxy reports do not consistently support the hypothesis that self-reports are more accurate than proxy reports.

However, conclusions drawn from studies in which responses were verified using hospital and physician records show that, on average (Choose two):

A. Self-reports tend to be more accurate than proxy reports

B. Health events are underreported in both populations

C. Proxy reports tend to be more accurate than self-reports

D. Health events are reported in both populations

ANSWER: A B

Explanation:

Self-reports tend to be more accurate than proxy reports, on average, when reported events are checked against hospital and physician records. The person receiving care has direct knowledge of symptoms, encounters, diagnoses, and services, whereas a proxy may not know about all events, particularly outpatient visits, sensitive conditions, or services received independently. Record verification is important because it supplies an external comparison standard rather than relying solely on agreement between two respondents.

Health events are underreported in both populations. Recall-based reporting is subject to omissions, telescoping, uncertainty about whether an event meets the survey definition, and incomplete knowledge of care received. Thus, even though self-report generally has better agreement with documented records than proxy report, neither reporting source captures every health event documented in administrative or clinical records. This distinction is central to healthcare-quality measurement: the source of information can affect estimates of utilization, outcomes, and population health, so survey design and interpretation should account for reporting error. The National Center for Health Statistics describes the importance of survey methods and data-quality considerations in the National Health Interview Survey at https://www.cdc.gov/nchs/nhis/index.htm. AHRQ also provides guidance on rigorous patient-experience survey measurement at https://www.ahrq.gov/cahps/surveys-guidance/index.html.

QUESTION NO: 54

Stratification is the separation and classification of data into reasonably homogenous categories.

It allows understanding of differences in the data caused by all of the following EXCEPT:

A. Day of the week

B. Time of the day

C. Type of order

D. Area of facility

ANSWER: C

Explanation:

Type of order is the best answer to the exception in this question. In quality-improvement stratification, teams divide aggregate results using operational factors that commonly reveal where and when variation occurs in a process. The fundamental purpose is to uncover a meaningful pattern that is obscured when all observations are combined, then focus investigation on the process conditions associated with that pattern. Standard stratification applications include time-based and location-based views of performance, because these views can identify differences associated with when work is performed or where it occurs. “Type of order” is not a standard operational source of variation identified by this item’s stratification framework; it describes the order itself rather than a usual time, place, or workflow condition used to expose variation. Quality teams should define stratification factors before collecting or analyzing data, based on a process map and a plausible theory for variation, so that the resulting subgroups support actionable improvement work. The American Society for Quality describes stratification as separating data to identify patterns and sources of variation: ASQ Stratification. AHRQ also emphasizes using data to understand variation in healthcare processes and performance: AHRQ Quality and Patient Safety.

QUESTION NO: 55

Because of their detail and straightforward design, patient registries are a powerful source of quality improvement data. Registries usually are specialty or procedure specific.

For instance (Choose two):

A. Acute myocardial infraction

B. Total joint replacement

C. Patient's bile test

D. Enrollment in disease management program

ANSWER: A B

Explanation:

Patient registries systematically collect standardized, clinically relevant data about people with a defined disease, condition, procedure, or exposure. This focused structure lets healthcare organizations compare outcomes, identify variation in care, monitor adherence to evidence-based practices, and target quality-improvement work. *Acute myocardial infraction*, evidently referring to acute myocardial infarction, is an appropriate registry focus because cardiovascular registries commonly follow patients with acute coronary conditions and capture measures such as timely reperfusion, medication use, complications, and mortality. These data support benchmarking and improvement in cardiac care.

Total joint replacement is also an appropriate registry focus because a registry can follow patients undergoing hip or knee arthroplasty across the care continuum. Such a registry may capture procedure details, implant information, complications, readmissions, revision procedures, functional outcomes, and patient-reported outcomes. Procedure-specific registries are especially useful for evaluating results over time and detecting opportunities to improve safety, reliability, and outcomes. The Agency for Healthcare Research and Quality describes registries as organized systems that use observational methods to collect uniform data for specified outcomes in a population defined by a particular disease, condition, or exposure. See AHRQ's Registries for Evaluating Patient Outcomes and the American College of Cardiology's National Cardiovascular Data Registry.

QUESTION NO: 56

Which of the following is the most proactive approach to quality improvement?

A. Plan-Do-Study-Act

B. fishbone diagram

C. failure mode and effects analysis (FMEA)

D. root cause analysis (RCA)

ANSWER: C

Explanation:

Failure mode and effects analysis (FMEA) is the most proactive approach because it is performed before a process failure, adverse event, or near miss occurs. An interdisciplinary team maps a planned or existing process, identifies where it could fail, estimates the potential effect and relative risk of each failure mode, and prioritizes safeguards or redesign actions. This forward-looking structure helps an organization prevent harm by building reliability into high-risk processes rather than waiting for an incident to reveal a weakness. In healthcare quality practice, FMEA is particularly useful when implementing new technologies, workflows, medication-use processes, handoffs, or other complex systems where potential vulnerabilities can be anticipated. The Institute for Healthcare Improvement describes FMEA as a systematic, proactive method for evaluating processes to identify where and how they might fail and assessing the relative impact of different failures. The Joint Commission likewise recognizes proactive risk assessment, including FMEA-based methods, as a way to identify and reduce risks before adverse outcomes occur. See the Institute for Healthcare Improvement FMEA tool and Joint Commission guidance on proactive risk assessment.

QUESTION NO: 57

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. ISO 2001

C. Baldrige criteria

D. Associate for process improvements

ANSWER: B

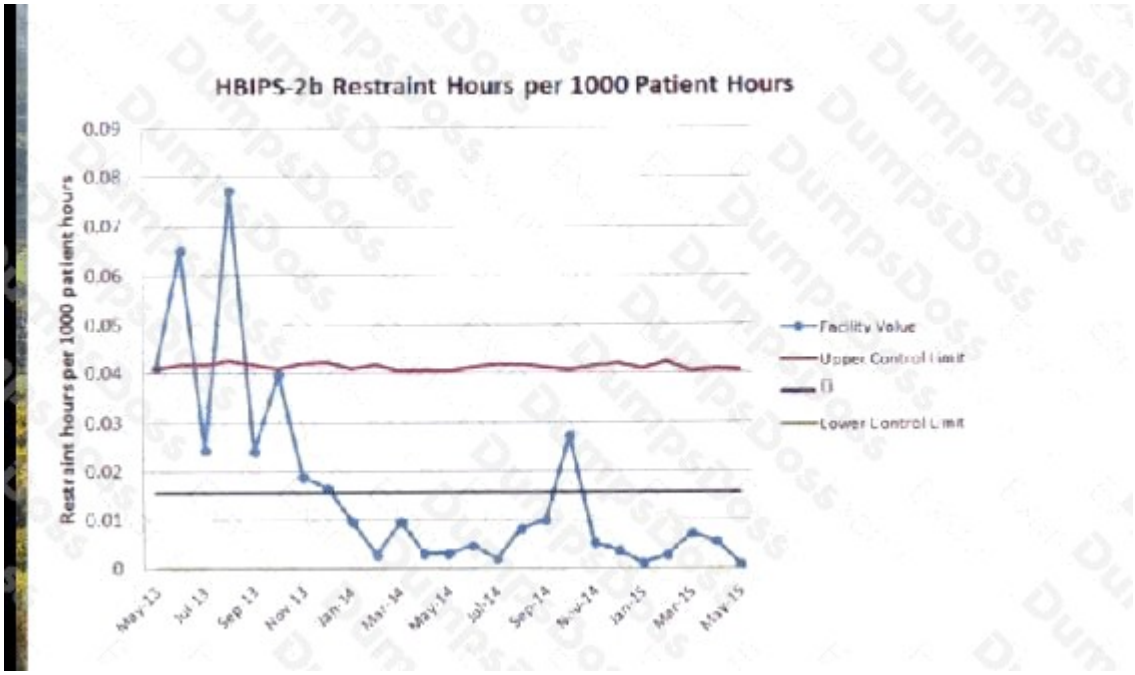
Explanation:

ISO 2001 is the exception because it is not the recognized ISO quality-management standard or a defined quality-improvement model. The internationally accepted standard associated with quality management systems is ISO 9001, not "ISO 2001." ISO 9001 provides requirements for an organization's quality management system, emphasizing a process approach, continual improvement, performance evaluation, and customer focus. Its current published edition is ISO 9001:2015, with an amendment issued in 2024. Therefore, "ISO 2001" does not accurately identify an established framework derived from quality-management theory or used as a quality-improvement approach in healthcare or other industries.

Using precise standard names is important in healthcare quality because accreditation, organizational policies, audits, and improvement plans must be based on identifiable, authoritative frameworks. A reference to ISO 9001 would describe a valid quality-management standard, but the number presented in this item does not correspond to that standard. ISO's overview of the ISO 9001 family and its quality-management principles is available at ISO: ISO 9001 and quality management. The official ISO catalogue entry for the current standard is available at ISO 9001:2015.

QUESTION NO: 58

The control chart above indicates which of the following?



A. Common cause variation

B. Special cause variation

C. Unique cause variation

D. No variation

ANSWER: B

Explanation:

Special cause variation is the correct interpretation because the displayed control chart contains a signal that is not consistent with the stable, predictable fluctuation expected from a process affected only by its routine sources of variation. In healthcare quality improvement, control charts distinguish normal, inherent process variation from statistically meaningful signals that suggest a particular, identifiable influence on performance. A special-cause signal warrants investigation of what changed in the system or its environment at the time of the signal—for example, a workflow change, staffing disruption, equipment issue, policy implementation, or data-collection problem. The appropriate next step is to examine the process context associated with the signal and determine whether the cause should be removed, controlled, or deliberately incorporated into the process. This interpretation supports evidence-based improvement rather than reacting to every routine rise or fall in a measure. The Institute for Healthcare Improvement describes the use of control-chart rules to distinguish common and special causes of variation in its control chart guidance. Additional practical guidance on understanding variation in quality improvement is available from NHS England's QI resources.

QUESTION NO: 59

A healthcare organization is evaluating whether a newly adopted patient-experience survey is appropriate for use across its outpatient practices.

Which characteristics support selection of the survey? (Choose three.)

A. Reliability

B. Validity

C. Feasibility

D. Ambiguity of scoring

ANSWER: A B C

Explanation:

A survey should be reliable so that it produces consistent results under comparable conditions. It should be valid so that it measures the patient-experience concepts it is intended to measure. It should also be feasible, meaning that the organization can administer it, obtain sufficient responses, analyze results, and use findings without an unreasonable burden.

A survey that is difficult to interpret or inconsistent in administration will not support meaningful comparison or improvement. Measure selection should balance scientific soundness with practical usefulness. See AHRQ: Criteria for Evaluating Quality Measures.

QUESTION NO: 60

In fact, because patients' satisfaction is so influenced by _____ rather than to the more indiscernible technical ones-health maintenance organizations, hospitals and other health care delivery organizations have come to view the quality of nontechnical aspects of care as crucial to attractions and retaining patients.

A. Their reactions to interpersonal and amenity aspects of care

B. Patients recognize that they do not possess the wherewithal to evaluate all technical elements of care

C. Every patient has definite preference in every clinical situation

D. Their likelihood of desires outcomes

ANSWER: A

Explanation:

Their reactions to interpersonal and amenity aspects of care correctly completes the statement. Patient satisfaction is principally shaped by features that patients can directly experience and evaluate during an episode of care: respectful communication, listening, responsiveness, courtesy, privacy, comfort, cleanliness, and the convenience of services. These are interpersonal and amenity dimensions of care, rather than clinical processes or technical competence that may be important but are generally difficult for patients to observe and assess accurately.

For healthcare organizations, these experiences matter both as quality measures and as practical drivers of patient loyalty and reputation. Patient-experience surveys therefore focus extensively on communication with clinicians, staff responsiveness, care coordination, and the care environment. Improving these visible, nontechnical dimensions can strengthen patients' trust in the organization, influence whether they return for care, and affect whether they recommend it to others. This reflects the quality-management principle that patient-centered care includes not only the clinical service delivered but also how patients experience receiving it. The Agency for Healthcare Research and Quality describes CAHPS surveys as standardized tools for measuring patients' experiences with healthcare, including communication and service interactions: AHRQ: About CAHPS. CMS likewise identifies communication, responsiveness, and care transitions as core hospital patient-experience measures: CMS: HCAHPS.

QUESTION NO: 61

The ability to report survey results at an actionable level is critical; in most cases, actionable level means (Choose two):

A. The nursing unit

B. Location of service

C. Average time frame of a service

D. Service level

ANSWER: A B

Explanation:

"The nursing unit" and "Location of service" are actionable reporting levels because they identify a discrete setting and the leaders or teams that can examine results, identify contributing workflow issues, and implement targeted improvements. Patient-experience and satisfaction survey findings have the greatest practical value when they are stratified to the operational area where care was delivered, rather than being available only as an organization-wide aggregate. For example, a nursing-unit report can support unit leadership in addressing communication, responsiveness, or care-transition concerns with its own staff and processes. Reporting by location of service similarly allows ambulatory, emergency, inpatient, and other care locations to recognize their distinct performance patterns and develop locally appropriate actions.

This level of reporting also supports accountability: managers can review data relevant to their area, involve frontline personnel in interpreting findings, prioritize improvement work, and monitor whether interventions change subsequent results. AHRQ describes using patient-experience survey data to identify opportunities for quality improvement and to provide feedback at meaningful organizational levels. CMS likewise makes patient-experience measures available for comparison and improvement in specific care settings. See the AHRQ CAHPS Improvement Guide and CMS Hospital Quality Initiative.

QUESTION NO: 62

Which of the following is most important to include in a project to reduce post-operative infections?

A. evidence-based literature

B. a multidisciplinary team

C. staff education

D. data collection tools

ANSWER: B

Explanation:

a multidisciplinary team is the most important inclusion because preventing post-operative infections requires coordinated changes across the entire perioperative pathway, rather than an isolated action in one department. Surgical clinicians, perioperative and inpatient nurses, infection-prevention professionals, anesthesia personnel, pharmacists, quality leaders, and data specialists each influence essential practices such as appropriate antimicrobial prophylaxis, skin preparation, sterile technique, glycemic control, normothermia, wound care, surveillance, and feedback of outcomes. Bringing these perspectives together enables the organization to map the process accurately, identify local barriers, select evidence-based interventions, establish clear ownership, and sustain reliable practice changes. It also promotes shared accountability for infection measures and ensures that improvement work extends from preoperative preparation through postoperative follow-up. This collaborative structure is a core quality-improvement principle for complex clinical outcomes with multiple contributing processes. The World Health Organization's surgical-site-infection guidance emphasizes a bundle of preventive measures spanning the perioperative period, which inherently requires coordination among multiple disciplines. The Agency for Healthcare Research and Quality likewise identifies interdisciplinary teamwork as foundational to safety improvement efforts. See the WHO Global Guidelines for the Prevention of Surgical Site Infection and AHRQ's CUSP toolkit resources.

QUESTION NO: 63

A hospital is preparing a quality-improvement project charter to reduce delays in obtaining critical laboratory results.

Which of the following should be included in the project charter? (Choose three.)

A. A clear problem statement

B. A measurable project aim

C. Defined project scope

D. A predetermined root cause

ANSWER: A B C

Explanation:

A project charter establishes the shared direction and boundaries of an improvement effort. A clear problem statement describes the current performance gap and its effect on patients, staff, or the organization. A measurable aim states the desired improvement, population, target, and timeframe. Defining the project scope identifies the processes, departments, locations, and activities included or excluded from the work.

Root causes should not be assumed before investigation. The team should use data and analysis to identify contributing factors after the project is chartered. See the Institute for Healthcare Improvement Model for Improvement.

QUESTION NO: 64

In earlier formulations, responsiveness to patients' preferences was just one of the factors seen as determining the quality of patient clinician interpersonal relationship. But, now it is translated into many factors.

Which of the following is out of such factors? (Choose three.)

A. Respect for patients' values

B. Respect for patients' preferences

C. Respect for patients' expressed needs

D. Respect for Respect for patient's convenience

ANSWER: A B C

Explanation:

Respect for patients' values, respect for patients' preferences, and respect for patients' expressed needs are central components of patient-centered care and of a high-quality patient–clinician relationship. Together, these concepts require care teams to elicit what matters to each individual, incorporate the person's goals and cultural beliefs into planning, and respond to needs the patient identifies during care. This approach recognizes that quality is not limited to technical correctness or clinical outcomes; it also depends on whether care is aligned with the individual receiving it.

The Institute of Medicine's quality framework defines patient-centered care as providing care that is respectful of and responsive to individual patient preferences, needs, and values, while ensuring that patient values guide clinical decisions. This wording directly supports all three selected concepts. Respectful engagement also promotes shared decision-making, informed choices, trust, and care plans that are practical for the patient's circumstances. Quality professionals can operationalize these principles through patient-reported experience measures, shared care planning, clear communication, and processes for documenting and acting on patient goals. See the Institute of Medicine quality framework and AHRQ's patient-centered care resources.

QUESTION NO: 65

Within any unit, organization, or system, there will be barriers to spread and adoption (e.g., organizational culture, communication, leadership support).

However, failure to transfer knowledge effectively may result in (Choose two):

A. Unnecessary waste

B. Inconsistency

C. organizational persistence

D. Benchmarks

ANSWER: A B

Explanation:

Unnecessary waste and inconsistency are appropriate consequences of ineffective knowledge transfer. Knowledge transfer makes evidence, effective practices, lessons learned, and operational know-how available to the people and settings that need them. When this does not occur, teams may unknowingly repeat work that has already been completed, duplicate improvement efforts, or continue using inefficient processes. This consumes staff time, materials, funding, and leadership attention without adding value, creating unnecessary waste.

Effective transfer also supports reliable implementation of a practice across units and over time. Without clear dissemination, shared understanding, training, and feedback, individual teams can interpret or apply a practice differently. The resulting variation can produce inconsistent workflows, uneven adherence to standards, and differing outcomes for patients or customers. In healthcare quality improvement, spreading validated practices and organizational learning is essential to reducing unwarranted variation and sustaining gains. The World Health Organization describes knowledge translation as a process that supports the use of evidence in policy and practice, while the Institute for Healthcare Improvement emphasizes spread as a deliberate method for moving successful changes across an organization. See WHO knowledge translation resources and IHI's framework for spread.

QUESTION NO: 66

The creation of an information technology infrastructure to analyze the performance of all physicians in a healthcare system can be useful in:

A. Identifying the disease the hospital, physician, or physical group treats most

B. Organizations can develop clinical pathways

C. Clinical issues can be sorted out

D. Physician report cards can be issued

ANSWER: A B C D

Explanation:

An enterprise-level information technology infrastructure that integrates physician-level clinical, utilization, and outcomes data supports several core healthcare-quality activities. Identifying the disease the hospital, physician, or physical group treats most establishes the case mix and volume profile needed to interpret performance meaningfully and identify priority populations for improvement. Organizations can develop clinical pathways by using aggregated evidence on variation in care processes and outcomes to standardize appropriate care for common conditions. Clinical issues can be sorted out through drill-down analysis of performance data, allowing quality teams and physicians to distinguish system-wide concerns, specialty-specific patterns, and opportunities requiring further review. Physician report cards can be issued when validated measures are attributed appropriately and presented in a consistent format; these reports can support confidential feedback, peer comparison, quality improvement, credentialing, and accountability activities. Effective use requires reliable data definitions, appropriate risk adjustment where applicable, transparent methodology, and safeguards for data quality and confidentiality. These capabilities align with health information technology's role in measurement, reporting, and quality improvement. The Agency for Healthcare Research and Quality describes health IT as an important tool for improving healthcare quality and safety: AHRQ Health IT. CMS also provides quality-measure resources that support standardized performance reporting: CMS Quality Measures.

QUESTION NO: 67

Once listing posts system is in place, root-cause analyses can be performed to identify particular problems, such as a staff member or medical group that contributes to problems, or problems that are systemic to the delivery of care, such as an antiquated manual appointment system.

Listing post strategies include (Choose two):

A. Surveys

B. Focus group

C. Patient and family advisory services

D. Suggestion boxes

ANSWER: A B

Explanation:

Surveys and focus groups are established listening-post strategies because they deliberately gather the patient, family, and customer experience data that an organization needs to identify, prioritize, and investigate care-delivery problems. Surveys provide standardized, quantifiable feedback across a broad population. Their structured results allow quality professionals to detect patterns, compare performance over time, and identify processes that warrant deeper review. The Agency for Healthcare Research and Quality's CAHPS program is a prominent example of using standardized patient-experience surveys for quality improvement and accountability.

Focus groups complement survey findings by obtaining detailed qualitative information from a small, facilitated group. Participants can describe experiences in their own words, clarify what occurred during a care process, and help the organization understand the context behind recurring concerns. This richer information can be used to formulate root-cause-analysis questions and develop improvement actions that address patient needs. AHRQ identifies focus groups as a method for collecting in-depth stakeholder perspectives, particularly when organizations need to explore the reasons behind measured experience results. Together, surveys and focus groups create a practical combination of broad measurement and detailed insight. See AHRQ: About CAHPS and AHRQ: Conducting Focus Groups.

QUESTION NO: 68

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

A. 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?

B. Some of the most important diabetes measures are based on laboratory testing. Do the physicians have their own labs? If so, do they achieve the laboratory data for12-24-month snapshot? If they do not do their own lab testing, do they use a common reference lab that would be able to supply the data?

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

D. Do the source outpatient data is the same as inpatient data

ANSWER: C D

Explanation:

"Do the measures selected by team reflect the aspects of care that have the most influence on patient's outcome" is appropriately excluded because it addresses measure selection and the clinical relevance of performance measures, rather than locating, accessing, or assessing an outpatient data source. A quality team should certainly ensure that measures are meaningful and linked to outcomes, but that work occurs when defining the measurement strategy, not when determining where outpatient data can be obtained.

"Do the source outpatient data is the same as inpatient data" is also appropriately excluded. Outpatient and inpatient care occur in distinct settings and commonly use different workflows, documentation practices, data systems, reporting structures, and encounter definitions. Source identification should therefore establish what outpatient records, claims, laboratory feeds, registries, or electronic health record extracts are available and whether they contain the required population, clinical, and time-period data. It should not presume that outpatient data are identical to inpatient data.

These distinctions support valid quality measurement: a measure must have a clearly specified setting and feasible data capture process. CMS describes the importance of defined data elements and data sources for electronic clinical quality measures in its eCQI Resource Center. AHRQ also provides practical resources on using health-care data for quality improvement through its Data and Analytics resources.

QUESTION NO: 69

Depending upon the direction of a measure's improvement, outlier interpretations can be (Choose two):

A. Positive measures

B. Negative measures

C. Structure measures

D. Outcome measures

ANSWER: A B

Explanation:

Outlier interpretation must account for whether a higher numerical result represents better or worse performance. **Positive measures** are measures for which higher values indicate more desirable performance. For example, a higher rate of providing an evidence-based preventive service can represent better care. In this direction, a high outlier may identify notably strong performance, while a low outlier may signal an improvement opportunity.

Negative measures are measures for which lower values indicate more desirable performance, such as rates of adverse events, infections, complications, or potentially avoidable utilization. For these measures, a high outlier can identify performance that warrants investigation, whereas a low outlier may represent especially favorable performance. Quality professionals therefore need to establish the measure's intended direction before labeling an observed result as favorable or unfavorable. This avoids treating every statistically unusual value as either good or bad without considering what the metric actually measures. CMS guidance describes quality measures as tools for assessing healthcare processes, outcomes, patient perceptions, and systems, while measure specifications define how rates and their direction are interpreted. See CMS Quality Measures and AHRQ Quality and Patient Safety.

QUESTION NO: 70

In an aging population, one of the challenges associated with the use of practice guidelines is

A. the cost of instructions to implement new guidelines increases yearly.

B. the constant evolution of healthcare makes it difficult to keep practice guidelines relevant.

C. changing the behavior to improve care is a complex process.

D. most practice guidelines only address a single issue, not multiple co-morbidities.

ANSWER: D

Explanation:

Most practice guidelines only address a single issue, not multiple co-morbidities is correct because older adults commonly live with several chronic conditions at the same time and may receive care from multiple clinicians. Many clinical practice guidelines are developed from evidence focused on one disease, one treatment goal, or a relatively narrowly defined patient group. Applying several single-condition guidelines simultaneously can create a burdensome or potentially conflicting plan of care, including polypharmacy, duplicate monitoring, competing lifestyle recommendations, and treatment goals that do not adequately reflect the individual's functional status, prognosis, or personal priorities. Healthcare quality professionals should therefore support individualized, patient-centered use of guidelines rather than treating them as rigid instructions. This includes medication review, coordination across services, shared decision-making, and consideration of the cumulative effects of recommended interventions. The challenge is especially important in an aging population because multimorbidity increases with age and directly affects whether disease-specific guideline recommendations are feasible, safe, and beneficial for a particular patient. The National Institute on Aging discusses the frequent coexistence of multiple chronic conditions in older adults at https://www.nia.nih.gov/health/health-care-professionals-information/multiple-chronic-conditions. Guidance on multimorbidity and individualized care planning is also available from NICE at https://www.nice.org.uk/guidance/ng56.

QUESTION NO: 71

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

A. prevalence.

B. surveillance.

C. Incidence.

D. sampling.

ANSWER: B

Explanation:

surveillance. is correct because public health surveillance is the ongoing, systematic collection, analysis, interpretation, and dissemination of health-related data to guide action. Its purpose is practical: decision-makers use the resulting information to identify health needs and trends, prioritize resources, plan interventions, monitor implementation, and evaluate whether programs are achieving intended outcomes. In healthcare quality and population health work, surveillance creates the evidence base for timely, data-informed improvement rather than relying on isolated observations or one-time reports. The wording in the question closely reflects the established Centers for Disease Control and Prevention definition of public health surveillance, which specifically links these data activities to planning, implementing, and evaluating public health practice. Surveillance may track infectious diseases, injuries, chronic conditions, healthcare-associated infections, patient safety events, or other indicators relevant to a defined population. Reliable surveillance depends on consistent data definitions, appropriate collection processes, meaningful analysis, and communication of findings to people who can act on them. See the CDC overview of public health surveillance and the World Health Organization's public health surveillance resources.

QUESTION NO: 72

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

A. balanced scorecard

B. histogram

C. matrix diagram

D. Gantt chart

ANSWER: A

Explanation:

The balanced scorecard presents high-level performance measures through four connected perspectives: financial, customer, internal business processes, and learning and growth. Developed by Robert Kaplan and David Norton, this framework translates an organization's mission and strategy into a balanced set of measures rather than relying solely on financial results. In a healthcare quality setting, the framework can connect strategic objectives such as patient experience, safety and process reliability, workforce capability, and stewardship of financial resources. The learning-and-growth perspective focuses on the people, skills, culture, and information systems that enable improvement. Internal-business measures address the processes that produce care and operational results. Customer measures reflect how patients and other stakeholders experience the organization, while financial measures assess responsible use of resources and financial performance. Linking measures across these perspectives helps leaders monitor both current results and the organizational capabilities that drive sustainable future performance. This is why the balanced scorecard is a strategic performance-management tool, not simply a reporting format: it supports alignment of departmental work, improvement priorities, and accountability with organizational strategy. The original balanced-scorecard framework is described by the Harvard Business Review, and the four-perspective model is also summarized by the Balanced Scorecard Institute.

QUESTION NO: 73

Physicians' actions have been noted be a major contributor to unexplained clinical variation in healthcare. Unexplained clinical variation leads to increased healthcare costs, medical errors, patient frustration, and poor clinical outcomes. The increase in information being collected on physician practice patterns has begun to expose widespread variations in practice.

In healthcare, variation exists among providers by (Choose two):

A. Specialty and practice setting

B. Geographical region

C. Facilities

D. Staff performance

ANSWER: A B

Explanation:

Variation among providers is appropriately described by **Specialty and practice setting** and **Geographical region**. A clinician's specialty shapes the patient populations treated, diagnostic approaches, procedural capabilities, professional guidelines, and usual patterns of care. Practice setting also affects available resources, care-team composition, referral relationships, technology, and operational processes; consequently, otherwise similar patients may receive different patterns of testing, treatment, or follow-up.

Geographic variation is a well-established healthcare-quality and utilization concept. Rates of services, intensity of care, and spending can differ substantially across regions even after accounting for differences in illness burden. Studying these patterns helps quality professionals distinguish warranted variation—care tailored to clinical need and patient preferences—from unexplained variation that may signal opportunities for standardization, evidence-based pathways, peer comparison, and improvement. The Dartmouth Atlas documents geographic differences in healthcare use and outcomes, while the Agency for Healthcare Research and Quality provides resources for measuring and reducing unwarranted variation. See The Dartmouth Atlas of Health Care and AHRQ: Health Care Quality.

QUESTION NO: 74

A healthcare quality professional identifies a statistically significant difference in uncontrolled hypertension between its African American and Caucasian populations. What is the next best step?

A. Evaluate data for an additional quarter to determine if the disparity persists.

B. Host a community health fair that provides free blood pressure monitors.

C. Partner with local community leaders to develop a community garden to improve nutrition.

D. Invite patients with uncontrolled blood pressure to attend a focus group to discuss barriers.

ANSWER: D

Explanation:

Invite patients with uncontrolled blood pressure to attend a focus group to discuss barriers. A statistically significant disparity establishes that the observed difference is unlikely to be due to random variation, but it does not identify the practical, social, clinical, or system-level causes that contribute to poorer blood-pressure control. The appropriate next quality-management action is therefore to gather patient-centered qualitative information that can guide a targeted improvement effort. A carefully facilitated focus group can identify barriers such as difficulties obtaining appointments or medications, transportation constraints, health-literacy needs, communication preferences, trust, food access, competing demands, and experiences with the care process. These findings help the organization define the problem more completely, distinguish likely drivers from assumptions, and develop interventions with the affected population rather than for the population alone. This approach supports health equity because patients' lived experience is essential context for interpreting stratified outcome data and designing equitable care processes. The Centers for Disease Control and Prevention describes hypertension control as requiring coordinated, patient-centered strategies, while the Agency for Healthcare Research and Quality provides methods for obtaining patient feedback to improve care delivery. See the CDC high blood pressure data and research resources and AHRQ guidance on using focus groups.

QUESTION NO: 75

Many organizations establish condition-specific patient registries for their more sophisticated quality improvement projects because they do not have a reliable source of clinical information.

The use of patient registries is advantageous for the following reasons EXCEPT:

A. They are rich source of information because they are customized

B. They can collect all the data that the physician or health system determines are most important

C. They are not subject to short comings of review records

D. They can be used for quality improvements and research purposes

ANSWER: C

Explanation:

"They are not subject to short comings of review records" is the exception because a patient registry does not inherently eliminate the limitations of the underlying clinical record. Registries commonly obtain data through manual chart abstraction, electronic health record extraction, or a combination of both. Therefore, the completeness, accuracy, consistency, and timeliness of registry data depend on the quality of clinical documentation, the registry's data definitions, abstraction procedures, and validation processes. Missing documentation, inconsistent terminology, delayed entry, and differences in how clinicians record information can still affect the data available in a registry.

A well-designed registry can make condition-specific information more structured and usable by defining a population, standardizing required data elements, and applying routine data-quality checks. These practices help an organization measure outcomes, identify care gaps, monitor improvement work, and support approved research. However, those benefits arise from intentional registry design and governance, not from immunity to record-review limitations. Health care quality teams should establish clear specifications, train abstractors where applicable, assess completeness and accuracy, and

periodically validate registry data against source records. The Agency for Healthcare Research and Quality describes registries as organized systems that collect uniform data for defined purposes and emphasizes planning for data quality: AHRQ Registries for Evaluating Patient Outcomes. Additional guidance on data quality in health information systems is available from CDC.

QUESTION NO: 76

Measurement of variation in health care and its application to quality improvement must begin with the identification and articulation of (Choose two):

A. What is to be measured?

B. Assignable variation

C. The standard against which is to be compared a process based on extensive research, trial and error and collaborative discussion

D. Understanding true variation versus artifact or statistical error

ANSWER: A C

Explanation:

“What is to be measured?” is correct because meaningful evaluation of variation starts with an explicit operational definition of the quality attribute, outcome, process, population, data source, and measurement method. A clearly specified measure ensures that observations are consistent and that subsequent analysis reflects the intended aspect of care. The measure should be clinically relevant, feasible to collect, and stated precisely enough that different users would obtain comparable results.

“The standard against which is to be compared a process based on extensive research, trial and error and collaborative discussion” is also correct because interpreting measured performance requires a defined reference point. This may be an evidence-based guideline, validated performance target, benchmark, or locally agreed specification. A standard provides the basis for determining whether observed process performance is acceptable and for setting an improvement aim. Together, an unambiguous measure and an appropriate comparison standard establish the foundation for credible quality measurement before teams analyze patterns of variation or act on improvement opportunities. CMS describes quality measures as tools used to quantify healthcare processes, outcomes, patient perceptions, and related structures; AHRQ provides practical guidance on using measurement to support quality improvement. See CMS: What Is a Quality Measure? and AHRQ: Improve Quality Through Measurement.

QUESTION NO: 77

Reducing the risk of preventable harm in healthcare is known as:

A. Just culture

B. Patient safety

C. Risk-free environment

D. Quality control

ANSWER: B

Explanation:

Patient safety is the correct term for the organized effort to reduce the risk of unnecessary or preventable harm associated with healthcare delivery. It encompasses the systems, processes, culture, and clinical practices used to identify hazards, prevent errors where possible, mitigate their consequences, and learn from safety events. This includes practices such as reliable patient identification, medication-safety safeguards, infection prevention, effective communication during transitions of care, event reporting, and improvement of care processes. The focus is not solely on whether a service meets a technical

specification; it is on protecting patients from avoidable injury throughout the continuum of care. The World Health Organization defines patient safety as the absence of preventable harm to a patient and reduction of risk of unnecessary harm to an acceptable minimum. This definition directly aligns with reducing preventable harm in healthcare. The CPHQ body of knowledge treats patient safety as a central healthcare quality competency because quality leaders help establish the structures, measurement systems, and improvement methods that make care safer. See the World Health Organization patient safety fact sheet and the NAHQ CPHQ certification overview.

QUESTION NO: 78

During improvement in healthcare system, because of a combination of technical complexity, system fragmentation, a tradition of autonomy, and hierarchical authority structures, overcoming the “daunting barrier to creating the habits and beliefs of common purpose, teamwork and individual accountability” necessary for spread and sustainability will require (Choose two):

A. Continual focus

B. Commitment

C. Focus to maintain benchmark levels

D. Right time

ANSWER: A B

Explanation:

“Continual focus” and “Commitment” are required because sustained healthcare improvement depends on deliberately building and reinforcing a culture in which people share responsibility for quality, work across professional and organizational boundaries, and consistently use improvement practices. Healthcare’s complexity, fragmented delivery, professional autonomy, and hierarchy do not change through a single project or short-term intervention. Leaders and teams must maintain continual attention to the desired behaviors, measures, learning, and feedback needed to make improvement part of daily work. This ongoing focus supports reliable implementation and helps successful changes spread beyond an initial pilot area.

Commitment is equally essential because lasting cultural and operational change requires active, persistent support from leadership and frontline staff. Commitment supplies the resources, alignment, accountability, and willingness to continue learning that allow teams to sustain gains when priorities compete or conditions change. Together, continual focus and commitment create the conditions for common purpose, teamwork, and individual accountability to become established habits rather than temporary campaign activities. This approach aligns with the Institute for Healthcare Improvement’s guidance on achieving and sustaining system-wide improvement and the Agency for Healthcare Research and Quality’s patient-safety culture resources. See IHI’s Whole System Quality resource and AHRQ’s Surveys on Patient Safety Culture.

QUESTION NO: 79

Priorities must be established for selecting processes for quality improvement because

A. Some improvements are not meaningful

B. Few processes require improvement

C. Many organizations lack the resources to improve all processes

D. There are difficulties in accurately measuring improvement

ANSWER: C

Explanation:

Many organizations lack the resources to improve all processes because quality improvement requires finite organizational capacity, including staff time, leadership attention, data and analytic support, funding, and operational resources. A

healthcare organization will typically identify more improvement opportunities than it can responsibly undertake at one time. Establishing priorities enables the organization to direct those limited resources toward work that is most likely to advance strategic goals and produce meaningful gains in patient safety, clinical outcomes, patient experience, equity, regulatory performance, or cost stewardship.

Structured prioritization also supports disciplined improvement management. Teams can assess opportunities using criteria such as the size and seriousness of the problem, patient risk, variation in performance, expected benefit, feasibility, available evidence, and alignment with organizational priorities. Selecting a manageable set of high-value processes makes it more feasible to define measures, test changes, monitor results, sustain gains, and avoid overextending improvement teams. This approach reflects the Institute for Healthcare Improvement's guidance to focus improvement efforts through clear aims and measurement, as well as CMS's expectation that quality assessment and performance improvement activities be data-driven and targeted. See the Institute for Healthcare Improvement's improvement guidance and CMS Quality Assurance and Performance Improvement resources.

QUESTION NO: 80

Today's patients' perception of the quality of our healthcare system is not favorable.

In healthcare, quality is household word that evokes great emotion, including (Choose two):

A. Frustration and despair, exhibited by patients who experience healthcare services firsthand or family members who observe the care of their loved ones

B. Anxiety over the ever-increasing costs and complexities of care

C. Patient centered measures

D. Timely care that may be experienced in terms of performance of services

ANSWER: A B

Explanation:

"Frustration and despair, exhibited by patients who experience healthcare services firsthand or family members who observe the care of their loved ones" correctly identifies the powerful emotional impact that perceived poor-quality care can have on patients and families. Quality is not merely an organizational score; it is experienced directly through access, communication, safety, coordination, and outcomes. When care falls short of expectations or causes harm, patients and families may understandably feel distressed and lose trust in the healthcare system.

"Anxiety over the ever-increasing costs and complexities of care" is also correct because affordability and the difficulty of navigating healthcare are central to how people perceive quality. Patients commonly encounter complex coverage decisions, bills, referrals, medications, and transitions among settings. These burdens can create anxiety even when clinical services are technically appropriate. The Institute of Medicine's quality framework recognizes patient-centeredness as a core aim of quality, and AHRQ emphasizes that patient experience and access are important aspects of healthcare quality. See the Institute of Medicine's quality aims and AHRQ's six domains of healthcare quality.

QUESTION NO: 81

The components which support successful implementation of performance improvement programs and attainment of project goals and objective include/s (Choose three):

A. Leadership commitment

B. Establishment of performance improvement oversight entity

C. Establishment of partnership

D. Expected time frames

ANSWER: A B C

Explanation:

Leadership commitment, establishment of a performance improvement oversight entity, and establishment of partnership are foundational supports for successful performance improvement work. Leadership commitment supplies the strategic direction, resources, accountability, and visible endorsement needed to make improvement a sustained organizational priority. Leaders also help remove barriers that project teams cannot resolve independently.

An oversight entity, such as a quality council, steering committee, or governance structure, provides formal accountability for selecting priorities, reviewing measures, monitoring progress, coordinating projects, and ensuring that improvement work aligns with organizational goals. This structure enables consistent escalation and decision-making throughout the project lifecycle.

Partnership is equally essential because healthcare improvement depends on collaboration among clinical teams, operational staff, leaders, patients and families, and other relevant stakeholders. Meaningful partnership brings practical expertise to the work, promotes shared ownership of interventions, and supports implementation in the settings where care is delivered. These components align with AHRQ's guidance on building organizational support and multidisciplinary teams for quality improvement and CMS expectations for governing-body responsibility and quality-assurance/performance-improvement governance. See AHRQ's Quality Improvement guidance and CMS Quality Assurance and Performance Improvement resources.

QUESTION NO: 82

The quality professional has been asked to perform chart audits on a population to assess how often hypertension is being addressed by clinicians when hypertensive patients presented to theclinic in the last year. The clinic has over 8,000 patients diagnosed with hypertension. Which of the following would be most appropriate for the quality professional to consider when selecting a sampling methodology?

A. Selection of patients who had a visit during the last month of the year

B. Selection of 400 charts using a simple random sampling method

C. Selection of 800 patients using a snowball sampling method

D. Selection of the entire population as a sample to make sure the results are accurate

ANSWER: B

Explanation:

Selection of 400 charts using a simple random sampling method is appropriate because the purpose is to estimate performance across a large, defined population of patients with hypertension without the burden of reviewing every chart. In a simple random sample, each eligible chart has the same known probability of selection. This supports an unbiased estimate of how consistently clinicians addressed hypertension among qualifying visits during the measurement year, provided that the sampling frame includes all eligible patients or encounters and selection is performed randomly.

A sample near 400 records is commonly used as a practical benchmark for a population of this size when estimating a proportion with conventional statistical precision, such as a 95% confidence level and an approximately 5% margin of error. The exact required sample should be confirmed based on the organization's desired confidence level, margin of error, anticipated rate of documented hypertension management, and any planned subgroup analysis. The audit specification should also clearly define eligibility, the review period, and what constitutes "addressed" so reviewers apply the measure consistently. Guidance on developing representative healthcare samples and using random selection is available from the Agency for Healthcare Research and Quality and the CDC evaluation sampling guidance.

QUESTION NO: 83

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

Specifically, they are seeking (Choose two):

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

B. Current performance

C. Baseline information

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

ANSWER: A D

Explanation:

Healthcare purchasers and payers increasingly evaluate providers through a value-based lens: whether an organization delivers meaningful patient outcomes and experience while responsibly managing the total cost of care. Therefore, they seek objective evidence that hospitals and other healthcare organizations manage their costs well. Reliable cost and utilization measures allow purchasers to assess affordability, efficiency, and whether resources are being used to support appropriate care rather than avoidable waste.

They also seek objective evidence that hospitals and other healthcare organizations satisfy their customers and have desirable outcomes. Quality assessment extends beyond clinical results to include patient experience, safety, outcomes, and other performance measures that demonstrate the care delivered is effective and responsive to patients. Objective, comparable measures support informed contracting, benefit design, provider selection, and accountability for value. This reflects the Centers for Medicare & Medicaid Services' value-based care approach, which links quality of care and patient outcomes with payment and cost stewardship. See the CMS overview of value-based care and AHRQ guidance on healthcare quality measures.

QUESTION NO: 84

A multidisciplinary team is focused on safe patient transfers to a long-term care facility and is performing a failure mode and effects analysis (FMEA). Which of the following should be the first step in the process?

A. Determine the steps in the process.

B. Identify failure modes and causes.

C. Analyze incident report data.

D. Calculate the risk priority number.

ANSWER: A

Explanation:

Determine the steps in the process. FMEA is a prospective, systematic method for identifying where a process can fail and prioritizing improvements before harm occurs. Its foundation is a clear, shared understanding of the process under review. For a transfer to a long-term care facility, the multidisciplinary team should first create a process map or flow diagram that defines the transfer's boundaries and sequences the actual work steps—for example, confirming readiness for discharge, reconciling medications, communicating clinical information, arranging transportation, and completing handoff at the receiving facility. Mapping the current-state process allows team members from different disciplines and settings to identify variations, interfaces, and handoffs that may create risk. Once the process steps are defined, the team can systematically identify potential failure modes and their causes at each step, assess their effects, and prioritize risks for action. This order ensures subsequent analysis is tied to a specific workflow rather than assumptions about how transfers occur. The Institute for Healthcare Improvement describes process mapping as an essential tool for understanding care processes and identifying improvement opportunities, while the VA National Center for Patient Safety outlines FMEA as beginning with selecting and diagramming the process. See the Institute for Healthcare Improvement flowchart guidance and the VA Healthcare Failure Mode and Effect Analysis resource.

QUESTION NO: 85

A risk manager comes to thequality improvement (QI) professional and requests help to improve compliance with a corrective action plan. How can the QI professional help?

A. Provide disciplinary action to non-compliant departments.

B. Provide an analysis for the Patient Safety Committee.

C. Determine if the action plan is in compliance with the national standards.

D. Determine areas of non-compliance through a root cause analysis.

ANSWER: D

Explanation:

Determine areas of non-compliance through a root cause analysis is the best way for the QI professional to help improve adherence to a corrective action plan. A corrective action plan is effective only when the organization understands the system conditions that prevent its intended actions from being performed consistently. Root cause analysis provides a structured process for examining the gap between the required action and actual practice. The QI professional can use this process to gather relevant data, map the workflow, identify contributing factors, and distinguish proximate issues from underlying system causes. Findings may reveal barriers such as unclear ownership, inadequate training, impractical workflows, unavailable resources, communication failures, or insufficient monitoring measures. The organization can then revise the plan so that corrective actions are specific, feasible, assigned to accountable owners, and measured over time. This approach supports sustainable improvement because it focuses on strengthening processes rather than merely documenting whether requirements were met. The Agency for Healthcare Research and Quality describes root cause analysis as a method to identify underlying causes and develop prevention strategies; see AHRQ PSNet: Root Cause Analysis. The Joint Commission also emphasizes analyzing contributing factors and implementing effective actions to reduce recurrence; see The Joint Commission: Sentinel Event Resources.

QUESTION NO: 86

Case-mix adjustment accounts for the different types of patients in institutions. Adjustment should be considered when hospital survey results are being released to the public.

The characteristics commonly associated with the patient reports on quality of care are all of the following EXCEPT (Choose two):

A. Patient age (i.e., older patients tend to report fewer problems with care)

B. Discharge service (e.g., childbirth patients evaluate their experiences more favorably than do medical or surgical patients; medical patients report the most problems with care)

C. Patient satisfaction

D. Number of visits to the hospitals

ANSWER: C D

Explanation:

“Patient satisfaction” and “Number of visits to the hospitals” are the exceptions because they are not the standard patient-level characteristics commonly used to describe or case-mix-adjust public reports of patients’ experiences of quality of care. Patient satisfaction is a reported perception or outcome measure; it is not a demographic, clinical, or service-related characteristic that defines the type of patient receiving care. Quality reporting programs distinguish patients’ reports of specific care experiences from global satisfaction ratings, because these constructs serve different measurement purposes.

Likewise, the number of hospital visits is a utilization history measure rather than a routinely applied core case-mix characteristic for comparing hospital patient-experience results. Standard patient-mix adjustment approaches focus on attributes that are consistently associated with how patients report their experiences and that may differ across organizations, such as age, education, self-rated health, and service line. These adjustments support more equitable comparisons by reducing differences attributable to the composition of surveyed patient populations rather than to the care delivered. The CMS HCAHPS program describes its patient-mix adjustment approach and the variables used for publicly reported survey results at CMS HCAHPS. Additional methodological context is available from AHRQ CAHPS.

QUESTION NO: 87

A performance improvement team is looking at data from similar medical centers to improve patterns of care. This method of assessment is known as:

A. Outcome measurement

B. Benchmarking

C. Peer review

D. Statistical analysis

ANSWER: B

Explanation:

Benchmarking is correct because it is the structured process of comparing an organization's performance, processes, or outcomes with those of similar organizations or recognized high performers. In this situation, the performance improvement team is examining data from comparable medical centers specifically to identify opportunities to improve patterns of care. Those external comparisons provide context for interpreting the organization's own results, setting achievable improvement targets, and identifying practices that may be adapted locally.

In healthcare quality management, benchmarking may compare clinical outcomes, patient safety measures, patient experience results, resource utilization, or adherence to evidence-based care processes. Comparisons are most useful when participating organizations have sufficiently similar populations, services, and measurement definitions, and when results are adjusted as appropriate for relevant differences in case mix or risk. The goal is not merely to collect comparative data; it is to use the findings to prioritize improvement work and learn from better-performing peers. The Agency for Healthcare Research and Quality describes benchmarking as comparing performance against peers or best performers to support quality improvement: AHRQ: Benchmarking. The Joint Commission also recognizes the use of comparative data to evaluate and improve performance: The Joint Commission: Comparative Data.

QUESTION NO: 88

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

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

A. Reschedule the time and cost

B. Collect too much (or too little) data

C. Collect the wrong data

D. Become frustrated with the entire measurement journey

ANSWER: B C D

Explanation:

Careful planning is essential because measurement in quality improvement must be directly tied to the improvement aim, the operational definitions of measures, and a practical method for obtaining data consistently. When a team begins collecting information before agreeing on exactly what it needs to know, it can easily **collect too much (or too little) data**. Excessive collection creates unnecessary workload and delays learning, while insufficient sampling or missing key fields prevents the team from seeing meaningful patterns or determining whether a change produced improvement.

Haste also leads teams to **collect the wrong data** when measures are not explicitly linked to the process, outcome, or balancing question being studied. Clear definitions of the population, numerator, denominator, source, collection frequency, and responsible person help ensure that the resulting data answer the intended question. Finally, poorly designed collection processes create burdensome, inconsistent, or unusable data work, causing participants to **become frustrated with the**

entire measurement journey. A focused plan supports efficient testing and timely feedback through run charts and iterative improvement cycles. The Institute for Healthcare Improvement describes selecting measures and using data to learn during improvement work in its Model for Improvement and provides practical guidance on displaying results with a Run Chart Toolkit.

QUESTION NO: 89

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. Our patients are sicker than those at the other hospitals in our comparison group (i.e., no risk adjustments were made to the data).

D. We can move in a better way without doing competition with others

ANSWER: A B C

Explanation:

“The data are old (typically one or two years) and do not reflect our current performance,” “The data are not stratified and do not represent appropriate comparisons,” and “Our patients are sicker than those at the other hospitals in our comparison group (i.e., no risk adjustments were made to the data)” describe common defensive responses when externally reported performance data are released. These responses focus on methodological limitations that may affect how fairly results portray an organization: reporting periods can lag behind current improvement work; unstratified results may conceal meaningful differences among patient populations or care settings; and differences in patient severity, comorbidities, and other clinical risk factors can influence outcomes independently of care quality.

These concerns reflect important measurement concepts. Timely data, meaningful comparison groups, stratification for equity and population differences, and appropriate risk adjustment all support valid interpretation of quality measures. Healthcare quality leaders should understand these issues and address them prospectively through sound measurement governance, data validation, transparent performance review, and improvement activities rather than waiting to respond after public reporting. CMS describes how measure specifications and reporting support comparable quality information, while AHRQ outlines the role of risk adjustment in making fair comparisons across providers. See CMS Measures and Data and AHRQ: Understanding Risk Adjustment.

QUESTION NO: 90

A Japanese tool called 5S (each step starts with letter “S”) is a systematic program that helps workers take control of their workspace so that it actually works for them (and their customers) instead of being a neutral or, as is quite common, competing factor.

Which of the following is/are NOT out of these five 5S? (Choose two.)

A. Seiton

B. Seiso

C. Shitsake

D. Seiku

ANSWER: C D

Explanation:

The terms that are not among the formal five Japanese 5S labels are **Shitsake** and **Seiku**. The established 5S framework is conventionally expressed as Seiri, Seiton, Seiso, Seiketsu, and Shitsuke. These terms represent a repeatable workplace-organization method used in Lean management to make work areas orderly, visual, safe, and easier to sustain. In particular, the final element is spelled *Shitsuke*, not “Shitsake”; it concerns discipline or sustaining the agreed workplace practices. “Seiku” is likewise not one of the recognized names in the standard 5S sequence. Correct use of the formal terminology matters in healthcare quality improvement because 5S activities are often incorporated into visual management, standard work, supply organization, and safety efforts. Using consistent labels helps teams connect daily workspace practices to the intended Lean method and to shared improvement training. The Lean Enterprise Institute’s 5S glossary provides the standard sequence and definitions: Lean Enterprise Institute: 5S. The American Society for Quality also describes 5S as a Lean workplace-organization practice: ASQ: Five S Tutorial.

QUESTION NO: 91

A healthcare quality professional wants to measure quality of care for knee replacement surgeries. Which of the following is the best example of an outcome measure?

A. Patient experience survey

B. Procedural complication rate

C. Knee replacement pathway compliance rate

D. Number of times a “time-out” is completed before the procedure

ANSWER: B

Explanation:

Procedural complication rate is an outcome measure because it captures a result experienced by patients following knee replacement surgery. Examples may include surgical-site infection, venous thromboembolism, joint dislocation, unplanned reoperation, or other adverse events occurring during or after the procedure. Calculating the rate—for example, the number of patients with a defined complication divided by the number of knee replacement procedures—allows the organization to evaluate whether care is achieving safe clinical results over time and to compare performance across relevant populations or facilities. Meaningful use requires a precise complication definition, a specified surveillance period, reliable clinical data collection, and appropriate risk adjustment when comparisons involve patients with differing baseline risks. This aligns with the Donabedian quality framework, in which outcomes are the effects of healthcare on patient health and well-being. The Agency for Healthcare Research and Quality also identifies complications as patient-safety outcomes used to assess the quality of hospital care. See the Donabedian model overview and AHRQ’s Patient Safety Indicators resources.