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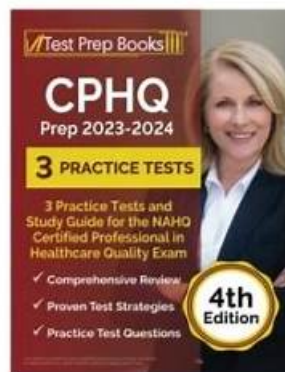
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The CPHQ Exam is designed for healthcare professionals who are involved in quality improvement initiatives, including healthcare quality directors, managers, coordinators, and analysts. It is also suitable for healthcare consultants, auditors, and researchers who specialize in healthcare quality. CPHQ Exam is open to individuals with a minimum of two years of experience in healthcare quality or a related field.

NAHQ Certified Professional in Healthcare Quality Examination Sample Questions (Q134-Q139):

NEW QUESTION # 134
Which of the following organizations is a deemed status provider for hospital CMS participation?

- A. National Committee for Quality Assurance
- B. Accreditation Commission for Health Care
- C. DNVGL
- D. Commission on Accreditation of Rehabilitation Facilities, International

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract:
Within the Organizational Leadership domain, DNVGL (Det Norske Veritas Germanischer Lloyd) is one of several deemed status accreditation organizations recognized by the Centers for Medicare & Medicaid Services (CMS).
Deemed status organizations are authorized to survey healthcare facilities and grant accreditation that satisfies CMS Conditions of Participation.
Other examples include The Joint Commission and HFAP, but among the listed options, DNVGL is the correct one for hospitals.
References:
NAHQ CPHQ Content Outline - Organizational Leadership: Accreditation and Regulatory Requirements NAHQ Healthcare Quality Competency Framework - Leadership: Accreditation Processes and Deemed Status Recognition

NEW QUESTION # 135
A healthcare organization had three medication incidents associated with narcotics. None of the events led to permanent loss of function or death, but could be considered near misses.
Which of the following would be the best tool to use to identify influencing factors?

- A. report from electronic health record (EHR)
- B. proactive risk assessment
- C. root cause analysis (RCA)
- D. nominal group technique

Answer: C

Explanation:
In the case of three medication incidents involving narcotics that were near misses, the best tool to identify influencing factors is a Root Cause Analysis (RCA). RCA is a systematic process used to investigate and understand the underlying causes of adverse events or near misses. The goal is to identify contributing factors and underlying system issues that need to be addressed to prevent future occurrences. RCA is particularly suited for situations where an incident has already occurred and the organization needs to understand how and why it happened.
Report from electronic health record (EHR) (A): While EHR data can provide useful information, it is not a tool for identifying root causes of incidents.
Proactive risk assessment (C): This would be more appropriate before incidents occur, not after near misses.
Nominal group technique (D): This is a group decision-making process and is less suited for detailed analysis of incidents compared to RCA.
Reference
NAHQ Body of Knowledge: Root Cause Analysis in Incident Investigation
NAHQ CPHQ Exam Preparation Materials: Incident Analysis Tools

NEW QUESTION # 136
The most important determinant of quality improvement success is

- A. The CQI model selected
- B. Organizational culture
- C. Monetary resource allocation
- D. The type of organization

Answer: B

Explanation:
Quality improvement (QI) success depends on multiple factors, but the organizational environment plays a pivotal role in enabling sustained change.
Option A (The CQI model selected): Continuous Quality Improvement (CQI) models like PDSA or DMAIC guide improvement, but their effectiveness depends on execution within a supportive environment.
Option B (Organizational culture): This is the correct answer. The NAHQ CPHQ study guide states,
"Organizational culture is the most important determinant of quality improvement success, as a culture of safety, collaboration, and accountability enables effective implementation of QI initiatives" (Domain 4). A supportive culture fosters staff engagement and sustains change.
Option C (Monetary resource allocation): Resources are important, but without a culture that prioritizes quality, funds may be misallocated.
Option D (The type of organization): The type (e.g., hospital, clinic) influences context but is secondary to culture in driving QI success.
CPHQ Objective Reference: Domain 4: Performance and Process Improvement, Objective 4.1, "Foster a culture for quality improvement," emphasizes culture's role. The NAHQ study guide notes, "A strong organizational culture is critical for sustaining QI efforts" (Domain 4).
Rationale: Organizational culture drives engagement and sustainability, making it the key determinant, as per CPHQ's improvement principles.
Reference: NAHQ CPHQ Study Guide, Domain 4: Performance and Process Improvement, Objective 4.1.

NEW QUESTION # 137
Based on the data below, which unit should the quality Improvement coordinator focus on?

- A. Unit B
- B. Unit C
- C. Unit A
- D. Unit D

Answer: A

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

5
B
7
C
12
D
4

* The Pareto chart shows that Unit C has the highest HAI rate (12%), followed by Unit B (7%), Unit A (5%), and Unit D (4%). The cumulative line shows that Unit C alone accounts for 40% of the total HAI rate, and Units C and B together account for 63.3% of the total HAI rate. Therefore, according to the Pareto principle, the quality improvement coordinator should focus on Unit C, as it represents the most significant problem area and the greatest opportunity for improvement.
* The quality improvement coordinator can then conduct a root cause analysis to identify the possible factors or causes that contribute to the high HAI rate in Unit C, such as staff compliance, infection control practices, patient characteristics, environmental factors, etc. A root cause analysis can be facilitated by using a visual tool such as a fishbone diagram, which organizes possible factors into categories, such as people, process, equipment, environment, etc. The quality improvement coordinator can also collect and compare data from other units or sources to identify gaps and best practices.
* Based on the root cause analysis, the quality improvement coordinator can then develop and implement an action plan to address the identified causes and improve the HAI rate in Unit C. The action plan should include specific, measurable, achievable, relevant, and time-bound (SMART) goals, interventions, and indicators. The quality improvement coordinator can also involve the staff and leaders of Unit C in the planning and implementation process, to ensure their engagement and ownership of the improvement efforts.
* The quality improvement coordinator should also monitor and evaluate the progress and outcomes of the action plan, using data collection and analysis tools such as run charts, control charts, or statistical process control (SPC), which can show the variation and trends in the HAI rate over time. The quality improvement coordinator should also provide feedback and recognition to the staff and leaders of Unit C, and make adjustments to the action plan as needed, based on the data and evidence.
References:
* NAHQ HQ Principles, Module 2: Data Management, Lesson 2.3: Data Analysis Tools, Topic 2.3.1:
Pareto Chart, Topic 2.3.2: Fishbone Diagram
* NAHQ Learning Lab: The Role of the Healthcare Quality Professional in Population Health Management, Module 3: Data Collection and Analysis, Slide 16: Pareto Chart, Slide 18: Fishbone Diagram
* NAHQ Journal for Healthcare Quality, Volume 42, Issue 5, September/October 2020, Article:
Utilization of Improvement Methodologies by Healthcare Quality Professionals During the COVID-19 Pandemic, Page 283: Figure 1. Pareto Chart of COVID-19 Cases by State as of June 30, 2020
* NAHQ News and Media, News: Shaping the Future of the Healthcare Quality Profession, Paragraph 5:
The Role of the Quality Improvement Coordinator
* NAHQ Resources, Healthcare Quality Solutions: Ready Your Workforce for Quality, Page 5: The Role of the Quality Improvement Coordinator

NEW QUESTION # 138

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 the clinic 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 800 patients using a snowball sampling method
- B. Selection of patients who had a visit during the last month of the year
- C. Selection of the entire population as a sample to make sure the results are accurate
- D. Selection of 400 charts using a simple random sampling method

Answer: D

Explanation:
Detailed Explanation:
For a large population, a simple random sample of 400 charts would be sufficient to obtain representative data for statistical analysis:
Option B:Selection of 400 charts using a simple random sampling method
Simple random sampling ensures each patient has an equal chance of selection, providing unbiased and representative results while being more manageable than reviewing all 8,000 records.
Option A: Selection of patients who had a visit during the last month of the year This could lead to biased results, as it would not be representative of visits throughout the year.
Option C: Selection of 800 patients using a snowball sampling method
Snowball sampling is typically used for hard-to-reach populations and is not appropriate for this scenario.

Option D: Selection of the entire population
Auditing all records would be time-consuming and unnecessary when a statistically valid sample can provide reliable results.
References:
CPHQ guidelines and quality improvement literature support the use of simple random sampling for representative data collection in large populations.

NEW QUESTION # 139
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