Quality Improvement Glossary

- **Agency for Healthcare Research and Quality (AHRQ)**—The Agency for Healthcare Research and Quality (AHRQ) is the nation's lead federal agency for research on healthcare quality, costs, outcomes, and patient safety. AHRQ is the health services research arm of the U.S. Department of Health and Human Services (HHS), complementing the biomedical research mission of its sister agency, the National Institutes of Health. The agency is home to research centers that specialize in major areas of healthcare research, including: clinical practice and technology assessment, healthcare organization and delivery systems, and primary care. AHRQ is a major source of funding and technical assistance for health services research and research training at leading U.S. universities and other institutions. As a science partner, the agency works with the public and private sectors to build the knowledge base for what works—and does not work—in health and health care and to translate this knowledge into everyday practice and policy-making.

- **Benchmark (Benchmarking)**—Benchmarking is a way for hospitals and doctors to analyze quality data, both internally and against data from other hospitals and doctors, to identify best practices of care and improve quality.

- **Best Practices**—Best Practices are the most up-to-date patient care interventions, which result in the best patient outcomes and minimize patient risk of death or complications.

- **Center for Advancement of Palliative Care (CAPC).** The Center to Advance Palliative Care (CAPC) is the leading resource for palliative care program development and growth. This organization provides access to essential palliative care tools, education, resources and training for health care professionals.

- **Centers for Medicare & Medicaid Services (CMS) (formerly: Health Care Financing Administration: HCFA)**—The Centers for Medicare & Medicaid Services (CMS) seeks to ensure effective, up-to-date healthcare coverage and to promote quality care for beneficiaries. Ultimately, CMS is working to transform and modernize the healthcare system.
• **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**—The Consumer Assessment of Healthcare Providers and Systems (CAHPS) develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. CAHPS originally stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the name has evolved as well to capture the full range of survey products and tools.

• **Consumer Engagement**—Consumer Engagement is the situation in which consumers take an active role in their own health care, from understanding their own conditions and available treatments, to seeking out and making decisions based on information about the performance of healthcare providers.

• **Core Measures**—Core Measures are specific clinical measures that, when viewed together, permit a robust assessment of the quality of care provided in a given focus area, such as acute myocardial infarction (AMI).

• **Data Collection**—Data Collection is the acquisition of healthcare information or facts based upon patient and consumer race, ethnicity and language. Data Collection provides healthcare providers with the ability to perform benchmarking measures on healthcare systems to determine areas where improvement is needed in providing care.

• **Disease Registry**—A Disease Registry is a large collection or registry belonging to a healthcare system that contains information on different chronic health problems affecting patients within the system. A Disease Registry helps to manage and log data on chronic illnesses and diseases. All data contained within the Disease Registry are logged by healthcare providers and are available to providers to perform benchmarking measures on healthcare systems. CAPC has recently initiated a palliative care registry.

• **Effective Care**—Effective Care includes healthcare services that are of proven value and have no significant tradeoffs. The benefits of the services
so far outweigh the risks that all patients with specific medical needs should receive them. These services, such as beta-blockers for heart attack patients, are backed by well-articulated medical theory and strong evidence of efficacy, determined by clinical trials or valid cohort studies.

- **Evidence-Based Medicine**—Evidence-Based Medicine is the use of the current, best available scientific research and practices with proven effectiveness in daily medical decision-making, including individual clinical practice decisions, by well-trained, experienced clinicians. Evidence is central to developing performance measures for the most common and costly health conditions. The measures allow consumers to compare medical providers and learn which ones routinely offer the highest quality, safest, and most effective care.

- **Health Plan Employer Data and Information Set (HEDIS) Measures**—The Health Plan Employer Data and Information Set (HEDIS) Measures are a set of healthcare quality measures designed to help purchasers and consumers determine how well health plans follow accepted care standards for prevention and treatment. Formerly known as the Health Plan Employer Data Information Set, health plans can receive accreditation on HEDIS measures from certain organizations, such as the National Committee on Quality Assurance.

- **Hospital CAHPS (H-CAHPS or CAHPS Hospital Survey)**—Hospital CAHPS (H-CAHPS or CAHPS Hospital Survey) is a standardized survey instrument and data collection methodology for measuring patients’ perspectives of hospital care. While many hospitals collect information on patient satisfaction, there is no national standard for collecting or publicly reporting this information that would enable valid comparisons to be made across all hospitals. H-CAHPS is a core set of questions that can be combined with customized, hospital-specific items to produce information that complements the data hospitals currently collect to support improvements in internal customer service and quality-related activities.

- **Informed Decision-Making (IDM)**—Informed Decision-Making is a term to describe a process designed to help patients understand the nature of the disease or condition being addressed; understand the clinical service being
provided including benefits, risks, limitations, alternatives and uncertainties; consider their own preferences and values; participate in decision-making at the level they desire; and make decisions consistent with their own preferences and values, or choose to defer a decision until a later time.

- **Institute for Healthcare Improvement (IHI)**—The Institute for Healthcare Improvement (IHI) is an independent nonprofit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Mass., IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping healthcare systems put those ideas into action.

- **Measuring What Matters**-----The AAHPM Quality and Practice Standards Task Force and the HPNA Research Advisory Group are jointly undertaking a consensus project that will involve selecting/adapting a recommended panel of measures for all hospice and palliative care programs. “Measuring What Matters” hopes to recommend 5-10 cross-cutting measures for palliative care programs to use for program improvement. They hope to answer the question, how do you measure health care quality within and across palliative care programs?

- **Metric**-----A numeric expression used in describing the quality of care. For example, the percentages of patients who receive a palliative care consult prior to death.

- **Patient Registry**—A Patient Registry is a patient database maintained by a hospital, doctors’ practice or health plan that allows providers to identify their patients according to disease, demographic characteristics and other factors. Patient registries can help providers better coordinate care for their patients, monitor treatment and progress and improve overall quality of care.

- **Patient Satisfaction**—Patient Satisfaction is a measurement designed to obtain reports or ratings from patients about services received from an organization, hospital, physician or healthcare provider.
• **Patient-Centered Care**—Patient-Centered Care considers patients' cultural traditions, personal preferences and values, family situations and lifestyles. Responsibility for important aspects of self-care and monitoring is put in patients' hands—along with the tools and support they need. Patient-centered care also ensures that transitions between different healthcare providers and care settings are coordinated and efficient. When care is patient-centered, unneeded and unwanted services can be reduced.

• **Pay-for-Performance (P4P)**—Pay-for-Performance (P4P) is a method for paying hospitals and physicians based on their demonstrated achievements in meeting specific healthcare quality objectives. The idea is to reward providers for the quality—not the quantity—of care they deliver.

• **Performance Measures**—Performance Measures are sets of established standards against which healthcare performance is measured. Performance Measures are now widely accepted as a method for guiding informed decision-making as a strong impetus for improvement.

• **Physician Quality Reporting Initiative (PQRI)**—The Physician Quality Reporting Initiative (PQRI) is authorized through the Medicare, Medicaid, and SCHIP Extension Act of 2007. It is a financial incentive for healthcare professionals to improve the quality of care that they provide.

• **Processes of Care Measures**—Indicators of how care is provided, e.g., measures of timely and effective care.

• **Process Improvement**—Process Improvement comprises techniques and strategies used to make the processes implemented to solve healthcare problems better. Process improvement can occur in emergency room or hospital settings, as well as in other health-system environments.

• **Quality (of Care)**—Quality (of Care) is a measure of the ability of a doctor, hospital or health plan to provide services for individuals and populations that increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results. According to the mantra for the
quality improvement movement, care should be "safe, effective, patient-
centered, timely, efficient and equitable."

- **Quality Improvement (QI)**—Quality Improvement (QI) is a term first coined in the private sector, when corporations began looking at ways to streamline and improve processes and systems. The most well-known example of quality improvement methodology is the "Six Sigma" method of change, developed by engineers at Motorola. In the healthcare context, the goal of quality improvement strategies is for patients to receive the appropriate care at the appropriate time and place with the appropriate mix of information and supporting resources. In many cases, healthcare systems are designed in such a way as to be overly cumbersome, fragmented, and indifferent to patients' needs. Quality improvement tools range from those that simply make recommendations but leave decision-making largely in the hands of individual physicians (e.g., practice guidelines) to those that prescribe patterns of care (e.g., critical pathways). Typically, quality improvement efforts are strongly rooted in evidence-based procedures and rely extensively on data collected about processes and outcomes.

- **Quality Indicator**—A Quality Indicator is an agreed-upon process or outcome measure that is used to determine the level of quality achieved. It is a measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or achievement of quality goals.

- **Quality Measures**—Quality Measures are mechanisms used to assign a quantity to quality of care by comparison to a criterion.

- **Rapid Cycle Change**—Rapid Cycle Change is a quality-improvement method that identifies, implements and measures changes made to improve a process or a system. At the onset, the team sets an outcome measure based on the system’s goals. Improvement occurs through small, rapid PDSA (Plan, Do, Study, Act) cycles to advance practice change. This model requires targeting a specific area to change; planning changes on the basis of sound science, theory and evidence; piloting several changes with small patient groups; measuring the effects of changes; and acting according to the data. The fundamental concept of rapid-cycle improvement is that healthcare processes—once defined, in place and in effect—should be
continually improved by instituting a constant cycle of innovations or improvements.

- **Standard of Care**—The Standard of Care is the expected level and type of care provided by the average caregiver under a certain given set of circumstances. These circumstances are supported through findings from expert consensus and based on specific research and/or documentation in scientific literature.