

## QUALITY/PERFORMANCE ASSESSMENT AND IMPROVEMENT TERMS AND DEFINITIONS

**Accreditation Body:** An organization with authority to accredit other organizations to perform services such as quality system certification.

**Action plan:** Specific method or process to achieve results called for by one or more objectives.

**Adverse Event:** Healthcare term for any event that is not consistent with the desired, normal or usual operation of the organization; also known as a sentinel event.

**Alignment:** Actions taken to ensure a process or activity supports the organization's strategy, goals, and objectives. Alignment refers to a consistency of plans, processes, information, resource allocation, results, analysis, and any associated learning.

**American Society for Quality:** Professional not-for-profit association that develops, promotes, and applies quality-related information and technology for the private sector, government, and academia. The society serves more than 108,000 individuals and 1,100 corporate members in the United States and 108 other countries.

**Analysis:** Examination of facts and data that provides the basis to identify gaps between actual and desired organizational performance. Analysis often involves the determination of cause-and-effect relationships.

**Aspects of Care/Service:** Key functions, procedures, interventions, treatments, processes, services, or other activities that affect consumers. Aspects of care are prioritized by stakeholders, organizational resources, and/or the importance to consumers. Activities or processes that are identified as high-volume, high-impact, high-risk to the consumer (through omission or commission), high-cost, and/or problem-prone for consumers or service providers.

**Assess:** To measure, appraise, estimate, or judge the characteristics, qualities or attributes of a problem, issue, or condition. Approaches to quality assessment include a standards-based evaluation, case-based review, and statistical profiling. Can also refer to the activities involved in identifying the practices, attitudes, culture, and activities that enhance or hinder the achievement of continuous improvement of quality in the organization.

**Assure:** To make sure and give confidence or trust; to guarantee.

**Audit (Study):** To examine the record of transactions and attest to the excellence of these activities.

**Balanced Scorecard:** Approach used to measure performance: a management system that provides feedback on both internal business processes and external outcomes to continuously improve strategic performance and results. Developed by Robert Kaplan and David Norton, it includes not only financial performance but other elements such as customer value, internal business process, innovation, and employee performance. It is implemented by translating the organization's vision and strategy statements into a comprehensive and quantifiable set of objectives and performance measures, by creating appropriate reward systems, and by collecting and analyzing performance results as they relate to the measures. See also "The Balanced Scorecard" (*Harvard Business Review* 74 [1966]: 86).

**Baseline:** Performance of a current process. Baseline measurements are done to answer the question, "What is the level of quality and where are we today?"

**Benchmark:** This is a quality target that answers the question, "Where should we be?"

**Benchmarking:** Continuous process of comparing service practices with competitors; current status of service/process; a point of reference or standard by which others may be measured and continually improved. Historically benchmark has been used to refer to performance that is regarded as "best in class." The Japanese use the term "dantotsu" to capture this concept. For them, dantotsu means "the best of the best."

**Best practice:** A superior method or innovative practice that contributes to the improved performance of an organization, usually recognized as best by other peer organizations.

**Bottleneck:** Any resources whose capacity is equal to or less than the demand placed on it.

**Brainstorming:** A technique teams use to generate ideas on a particular subject. Each person on the team is asked to think creatively and write down as many ideas as possible. The ideas are not discussed or reviewed until after the brainstorming session.

**Capability:** The total range of inherent variation in a stable process determined by using data from control charts.

**Care:** Actions taken to fulfill responsibility for the positive well-being of persons.

**Cause:** Identified reason for the presence of a defect or problem.

**Change agent:** An individual from within or outside an organization who facilitates change in the organization; might be the initiator of the change effort, but not necessarily.

**Checklist:** Tools for ensuring all important steps and action in an operation have been taken. Checklists contain items important or relevant to an issue or situation. Checklists are often confused with check sheet.

**Check sheet:** A simple data recording device. The check sheet is custom designed by the users, which allows him or her to readily interpret the results. The check sheet is one of the “seven tools of quality”.

**Common causes:** Causes of variation that are inherent in a process over time. They affect every outcome of the process and everyone working in the process.

**Constraint:** Anything that limits a system from achieving higher performance or throughput; also the bottleneck that most severely limits the organization’s ability to achieve higher performance relative to its purposes or goals.

**Consumer:** The external customer to whom a product or services is ultimately delivered; also called end user.

**Continuous Improvement:** An important value statement that endorse the notion that people can continuously improve all processes and activities through the application of systematic techniques. It also embraces the idea that there should be a relentless, ongoing hunt to eliminate sources of inefficiencies, re-work, waste, and not meeting customer needs and expectations. The Japanese use the term “Kaizen” to capture the concept. For them, Kaizen means commitment to excellence and the actual efforts to accomplish ongoing quality improvements. In healthcare, a consumer-centered and -driven quality philosophy and process that relies on each individual in the organization to build quality into every step of service development and delivery.

**Continuous Improvement (CI):** Approach to quality management that builds upon traditional quality assurance methods by emphasizing the organization and systems; focuses on “process” rather than the individual; recognizes both internal and external “customers”; utilizes teams of process owners to develop improvement solutions; promotes the need for objective data to analyze and improve processes. Implies that a process and its service/outcome are never optimized. “If it ain’t broke, make it better.” CI and quality assurance are not synonymous; they enjoy a symbiotic relationship.

**Continuous Quality Improvement (CQI):** A philosophy and attitude for analyzing capabilities and processes and improving them repeatedly to achieve customer satisfaction.

**Control chart:** A chart with upper and lower control limits on which values of some statistical measure for a series of samples or subgroups are plotted. The chart frequently shows a central line to help detect a trend of plotted values toward either control limit.

**Corrective Action:** A solution meant to reduce or eliminate an identified problem.

**Cost of poor quality (COPQ):** The costs Associated with providing poor quality products or services. There are four categories: internal failure costs (costs associated with defects found before the customer receives the product or services), external failure costs (costs associated with defects found after the customer receives the product or services), appraisal costs (costs incurred to determine the degree of conformance to quality requirements) and prevention costs (costs incurred to keep failure and appraisal costs to a minimum)

**Cost of quality (COQ):** The term Philip Crosby used for cost of poor quality.

**Criteria:** Objective, predetermined elements of health care, the presence, absence, or completeness of which indicates the quality and appropriateness of an aspect of care; substantiated by policies and procedures, rules and regulations, current knowledge, and/or generally accepted standards.

**Critical Path:** Various steps involved in a work process.

**Cross Functional:** A term used to describe a process or an activity that crosses the boundary between functions. A cross functional team consists for individuals from more than one organizational unit or function.

**Culture, organizational:** A common set of values, beliefs, attitude, perceptions, and accepted behaviors shared by individuals within an organization.

**Customer:** Anyone who receives the benefits of an output from another individual, a program, or organization; it is possible to be both a customer of one process and a supplier of another; customers can be internal and external. (Sometimes interchanged with consumer, client, member, patient, etc.)

**Customer-Driven Organization:** Recognition of customer/supplier relationships

**Customer relationship management:** A strategy for learning more about customers' needs and behaviors to develop stronger relationship with them .It brings together information about customers, sales, marketing effectiveness, responsiveness and market trends. It helps businesses use technology and human resources to gain insight into the behavior of customers and the value of those customers.

**Customer satisfaction:** The result of delivering a product or service that meets customer requirements.

**Data:** Refers to raw facts and figures which are collected.

**Data Trend:** General direction of indicator rates over time that may trigger further investigation.

**Decision matrix:** A matrix team use to evaluate problem or possible solutions. For example, a team might draw a matrix to evaluate possible solutions, listing them in the far left vertical column. Next, the team selects criteria to rate possible solutions, writing them across the top row. Then, each possible solution is rated on a scale of 1 to 5 for each criterion, and the rating is recorded in the corresponding grid. Finally, the ratings of all the criteria for each possible solution are added to determine its total score. The total score is then used to help decide which solution deserves the most attention.

**Deployment:** (1) Dispersion, dissemination, broadcasting, or spreading of a communication throughout an organization, downward and laterally. (2) How well a management system (quality, environmental, and so on) is implemented and used throughout the entire organization.

**Deming cycle:** Another term for the plan –do-study-act cycle. Walter Shewhart created it (calling it the plan-do-check-act cycle), but W. Edwards Deming popularized it, calling it plan-do-study-act. Also see “plan-do-check-act cycle”.

**Diagnostic journey and remedial journey:** A two- phase investigation used by teams to solve chronic quality problems. In the first phase, the diagnostic journey, the team journeys from the symptom of a chronic problem to its cause. In the second phase, the remedial journey, the team journeys from the cause to its remedy.

**Driving forces:** Forces that tend to change a situation in desirable way.

**Effectiveness:** State of having produced a decided-upon or desired effect or result.

**Efficiency:** Ratio of the output to the total input in a process. The goal is to use fewer resources, time and so on.

**Electric data interchange (EDI):** The electronic interchange of data from customers to suppliers and from suppliers to customers.

**Employee Involvement (EI):** An organizational practice where-by employees regularly participate in making decisions on how their work areas operate, including suggestion for improvement, planning, goal setting and monitoring performance.

**Empowerment:** A condition in which employees have the authority to make decisions and take action in their work areas without prior approval. For example, an operator can stop a production process if she or he detect a problem, or a customer service representative can send out a replacement product if a customer calls with a problem.

**Evaluate:** To determine the outcome achieved by an activity (or activities) designed to attain a valued objective; to assess quality and/or appropriateness of care, service continuity, resources, based on measurement against criteria, or pre-established levels of performance (thresholds, benchmarks).

**Evaluation Study:** Systematic, in-depth appraisal of care accomplished by utilizing predetermined structure, process, or outcome criteria and a wide variety of data collection techniques, such as interviewing, observation, reviewing consumer records, and performing consumer satisfaction surveys.

**Ensure:** To secure or guarantee; to make sure or certain. Relates to a direct action on the part of a service provider.

**Facilitator:** Expert serving as a process guide, teacher, and consultant in connecting the work to the knowledge necessary for improvement.

**Failure mode effect analysis (FMEA):** A systematized group of activities to recognize and evaluate the potential failure of a product or process and its effects, identify actions that could eliminate or reduce the occurrence of the potential failure and document the process.

**Feedback:** A term from general systems theory generally defined as information about the outputs or behavior of a system that is sent back into the system to affect succeeding outputs.

**Fishbone diagram:** See “cause and effect diagram”.

**Five ways:** A technique for discovering the root causes of a problem and showing the relationship of causes by repeatedly asking the question, “why?”

**Flow kaizen:** Radical improvement, usually applied only once within a value stream.

**Focus group:** A group, usually of eight to 10 people, that is invited to discuss an existing or planned product, service or process.

**Focus-PDCA:** Strategy that helps build knowledge of a process, customer, and small-scale improvement, using the scientific method. Acronym meaning: **F**ind a process to improve, **O**rganize a team that knows the process, **C**larify current knowledge of the process, **U**nderstand sources of process variation, **S**elect the process improvement, **P**lan the improvement, **D**ata collection and analysis, **C**heck and study the results, **A**ct to hold the gain and to improve the process.

**Force field analysis:** A technique for analyzing what aids or hinders an organization in reaching an objective. An arrow pointing to an objective is drawn down the middle of a piece of paper. The factors that will aid the objective’s achievement, called the driving forces, are listed on the left side of the arrow. The factors that will hinder its achievement, called the restraining forces, are listed on the right side of the arrow.

**Follow-up:** Deliberate action taken to ensure the continuing resolution of a problem (issue).

**Fourteen Points:** W. Edwards Deming’s 14 management practices to help companies increase their quality and productivity: (1) create constancy of purpose for improving products and services; (2) adopt the new philosophy; (3) cease dependence on inspection to achieve quality; (4) end the practice of awarding business on price alone; instead, minimize total cost by working with a single supplier; (5) improve constantly and forever every process for planning, production, and service; (6) institute training on the job; (7) adopt and institute leadership; (8) drive out fear; (9) break down barriers between staff areas; (10) eliminate numerical quotas for the workforce and numerical goals for management; (12) remove barriers that rob people of pride of workmanship, and eliminate the annual rating or merit system; (13) institute a vigorous program of education and self-improvement for everyone; and (14) put everybody in the company to work to accomplish the transformation.

**Function (Key):** Goal-directed inter-related series of processes believed to have a significant effect on the probability of desired patient outcomes. High-risk function exposes consumers/providers to a greater chance of adverse occurrences if not performed effectively and/or appropriately; or services that are inherently risky due to consumer characteristics or newness

of service. High volume function performed frequently or affecting large numbers of consumers/providers. A problem-prone function that historically has created problems for the consumer, organization and/or provider.

**Gatekeeper:** A timekeeper; in team meetings, a designated individual who helps monitor the team's use of allocated time.

**Goal:** The desired end toward which activities are directed.

**Guidelines:** Descriptive tools that are standardized specifications for care developed by a formal process that incorporates the best scientific evidence with expert opinion; usually pertains to practitioner practice for a "typical" consumer in a "typical" situation. Accepted synonyms: clinical standard, parameter, protocol.

**Histogram:** A graphic summary of variation in a set of data. The pictorial nature of a histogram lets people see patterns that are difficult to detect in a simple table of numbers. One of the "seven tools of quality".

**Hoshin planning:** Breakthrough planning. Japanese strategic planning process in which a company develops up to four vision statements that indicate where the company should be in the next five years. Company goals and work plans are developed based on the vision statement. Periodic submitted audits are then conducted to monitor progress.

**Improvement:** Positive effect of a process change effort. To make a product or situation better in the sense of usefulness or effectiveness.

**Indicator:** Measures of specific, measurable, objective events, occurrences, facets of care/service delivery, etc. May be *structure* [i.e., a resource such as employees (retention, recruitment, etc.), a policy/procedure, or training/staff development sessions], *process* (i.e., measures an event or activity performed directly or indirectly for consumers), or *outcome* (i.e., consumer quality of life status; functional status of a consumer after care/service delivery) of care measures used to monitor and evaluate the quality and appropriateness of important governance, management, service delivery, operations, and/or support functions that affect consumer outcomes. Key performance indicators are certain aspects of performance that quantitatively show an organization that it is improving the efficiency of its processes and quality of its outputs.

**Information:** Data which has been processed and analyzed in a formal, intelligent way so that the results are directly useful to those involved in the management of a system or process.

**Input:** The combination of directives, prerequisites, and resources needed to execute a process. The state of activities and resources before a process is carried out to produce the outputs delivered to consumers or other customers. Resources (funds, labor, time, equipment, technology etc.) used to produce outputs and outcomes. Inputs to one process are the outputs from preceding processes.

**Juran Trilogy:** Three managerial processes identified by Joseph M. Juran for use in managing for quality: *quality planning*, *quality control*, and *quality improvement*.

**Kaizen:** A Japanese term that means gradual unending improvement by doing little things better and setting and achieving.

**Key performance indicators (KPI):** A statistical measure of how well an organization is doing in a particular area. A KPI could measure a financial company performance or how it is holding up against customer requirements.

**Lean approach/thinking:** Focuses on reducing cycle time and waste using a number of different techniques and tools. For example, value stream mapping and identifying and eliminating "monuments" and non-value-added steps.

**Learning organization:** Organization that has as a policy to continue to learn and to improve its products, services, processes, and outcomes; organization that is continually expanding its capacity to create its future (as defined by Peter Senge). See also *The Fifth Discipline* (New York: Doubleday, 1990).

**Measurement:** The act or process of quantitatively comparing results with requirements.

**Monitoring:** Planned, systematic, and ongoing collection, compilation, and organization of data about an indicator of the quality and/or appropriateness of an important aspect of care/service, and comparison of those data to pre-established level of performance to determine the need for improvement.

**Non-value added:** A term that describe a process step or function that is not required for the direct achievement of process out-put. This step or function is identified and examined for potential elimination. Also see “value added”.

**Objective:** A statement that will assist in the determination if there is movement away or toward the goal. This is a desired, usually quantified, end result that a company, team, or individual wants to achieve within a specified period of time.

**Outcome:** Product or end-result of one or more processes and short- and longer-term results of service provision; the degree to which outputs meet the needs, expectations, and/or requirements of the customer/other stakeholder; the valued results. What is the outcome (i.e., right thing, target, goal, result, standard of care, reputation to be maintained/achieved)?

**Outcomes Evaluation:** a system that evaluates the outcomes of programs using a variety of approaches from research, accounting, and management.

**Outcomes Management:** An evaluation system that measures the accomplishment of program objectives for the purpose of continuous quality improvement. The ultimate use of monitored data in a way that allows individuals and organizations to learn from experience.

**Output: Activities and resources resulting from a process. Products, materials, services or information provided to consumers or other customers from a process. The output of one process can be the input to a succeeding process. Outputs are the immediate products of internal activity: the amount of work done within the organization or by its service providers (units of services provided, number of groups held, or number of calls answered).**

**Pareto chart:** A graphical tool for ranking causes from most significant to least significant. It is based on the Pareto principle, which was first defined by Joseph M. Juran in 1950. The principle, named after 19<sup>th</sup> century economist Alfredo Pareto, suggests most effects come from relatively few causes: that is 80% of the effects come from 20% of the possible causes. One of the “seven tools of quality.”

**Peer Review:** Review of colleagues by colleagues on the quality and efficiency of services ordered and/or performed; focuses on improving practice/service provision.

**Performance:** Refers to the numerical results information obtained from processes, services and products that permit evaluation and comparisons relative to goals, standards, past results, and performance of others.

**Performance Improvement:** Primary result of efforts extended to improve a situation or process; it may be increased output, higher quality, or improved individual learning skills and performance.

**Preventive action:** Action taken to remove or improve a process to prevent potential future occurrences of a nonconformance.

**Problem:** Deviation from an accepted standard of consumer care or best practice.

**Problem solving:** The act of defining a problem; determining the causes of the problem; identifying, prioritizing and selecting alternatives for a solution; and implementing a solution.

**Process:** Series of ordered steps to a desired outcome; an activity that takes inputs, transforms and adds value to them, and then delivers an output to an internal or external customer; activities carried out by service providers in their care/service delivery for consumers (i.e., assessment, treatment planning, discharge planning, test ordering and interpretation, medication administration). Which process (i.e., right way, procedure, practice, method, technique, delivery, standard of performance) will reliably, predictably, and efficiently produce the desired outcome?

**Process Improvement Teams/Problem-Solving Teams:** Usually temporary teams brought together with the specific purpose of solving a problem and/or improving a process.

**Preventive Action:** Action taken to remove or improve a process or to prevent potential future occurrences of a non-conformance.

**Problem Solving:** Act of defining a problem; determining the cause of the problem; identifying, prioritizing, and selecting alternatives for a solution; and implementing a solution. A *six-step* process would include: (1) identify the problem, (2) define the problem, (3) investigate the problem, (4) analyze the problem, (5) solve the problem, and (6) confirm the results.

A *seven-step* process: (1) identify the problem, (2) list possible root causes, (3) search out the most likely root cause, (4) identify potential solutions, (5) select and implement a solution, (6) follow up to evaluate the effect, and (7) standardize the process.

**Quality:** Distinguishing characteristics that determine the value or degree of excellence or met expectation.

**Quality Assessment:** Measurement of the level of quality at some point in time; monitoring, data collection, and making a judgment regarding adequacy with no effort to change or improve. Not synonymous with quality assurance.

**Quality Assurance:** Distinguishing characteristics that determine the value or degree of excellence and the mechanisms to efficiently and effectively monitor and improve consumer care/service delivery provided by competent service providers with appropriate resources. Tends to unveil the fact of flaw, not the cause.

**Quality Characteristics:** Characteristics that are important to the customer, and by which they judge the total quality of the product or service.

**Quality Improvement:** All actions taken throughout the organization to increase the effectiveness and efficiency of activities and processes in order to provide added benefits to both the organization and its customers.

**Quality Initiative:** A formal effort by an organization to improve the quality of its products and services; usually involves top management development of a mission statement and long-term strategy.

**Quality Management:** An overall management function that determines the quality policy, objectives, and responsibilities, and implements them by means such as quality planning, quality control, quality assurance, and quality improvement within the quality system.

**Quality Management System (QMS):** A formalized system that documents the structure, responsibilities and procedures required to achieve effective quality management.

**Quality of Care/Service Delivery:** Degree to which care/services increase the probability of desired consumer outcomes and reduce the probability of undesired outcomes, given the current state of knowledge.

**Quality Policy:** An organization's general statement of its beliefs about quality, how quality will come about and its expected result.

**Quality System:** Organizational structure, responsibilities, procedures, processes, and resources for implementing quality management. The quality system of an organization is designed primarily to satisfy the internal requirements of the organization and not limited to the quality assurance requirements for its customers. The development of a quality system should include (1) a quality statement, (2) a quality manual, (3) quality procedures, and (4) quality work instructions.

**Quality of Working Life:** Refers to the degree to which the organizational culture makes available to employees information, knowledge, authority, responsibility, and rewards to conduct their work effectively and safely.

**Random Cause:** A cause of variation due to chance and not assignable to any factor.

**Risk:** Refers to a potential hazard or quality deficiency associated with a product, services, or process.

**Risk Management:** The controlling of those circumstances/events of care/service delivery that pose a threat to the safety of consumers/workforce/visitors, which simultaneously protects an organization and its financial resources from liability.

**Root Cause Analysis:** Quality tool used to distinguish the source of defects or problems. It is a structured approach that focuses on the decisive or original cause of a problem or condition.

**Run Chart:** A chart showing a line connecting numerous data points collected from a process running over time.

**Scatter diagram:** A graphical technique to analyze the relationship between two variables. Two sets of data are plotted on a graph, with the y-axis being used for the variable to be predicted and the x-axis being used for the variable to make the

prediction. The graph will show possible relationship (although two variables might appear to be related, they might not be; those who know most about the variables must make that evaluation). One of the “seven tools of quality”.

**Scorecard:** An evaluation device, usually in the form of a questionnaire, that specifies the criteria customers will use to rate your business performance in satisfying customers requirements.

**Seven tools of quality:** Tools that helps organizations understand their process to improve them. The tools are the causes and effect diagram, check sheet, control chart, flowchart, histogram, Pareto chart and scatter diagram (see individual entries)

**Silo** (as in “functional silo”): Organization where cross-functional collaboration and cooperation is minimal and the functional “silos” tend to work toward their own goals to the detriment of the organization as a whole. See stovepipe.

**Stakeholders:** Individuals and organizations that have an investment or interest in the success or actions taken by an organization. Stakeholders include customers, managers, employees, partners, regulators, competitors, partners, suppliers, the community, etc.

**Standard:** Any established measure of extent, quantity, quality, or value; an agreed upon or expected level of performance or excellence.

**Statistical Thinking:** Data driven method for decision-making and benchmarking, based primarily on an understanding of process variation.

**Strategic Planning:** The process an organization uses to envision its future and develop the appropriate strategies, goals, objectives and action plan.

**Structures:** Resources assembled to deliver care/provide service; the inputs. Includes staff credentials, staff organization, training/staff development, financial resources, policy/procedures, characteristics of buildings, etc.

**Supplier:** This is any person or organization that provides input into a process. A supplier always has a customer; can be internal or external.

**System:** Collection of processes that work in concert to produce a desired outcome; comprised of input, throughput, output, feedback.

**Team, Quality Improvement:** Individuals (cross-department/facility/function/service) knowledgeable about a particular aspect of care or service and commissioned to improve a process.

**Threshold:** Predetermined single intervention/event or pre-established level of performance for staff, a process, or organization related to a specific indicator. Attainment or non-attainment triggers a review of why the threshold was not reached or crossed. Target (goal) is more often used in quality improvement cultures.

**Throughput:** The volume of output generated by a resource in a specific period of time. The rate the system performance or the velocity of work performed by a system. Throughput counts the units of consumer or other customer value produced in a given time. Throughput is the rate at which the system produces "goal units."

**Total Quality:** An organization’s collaboration to design and operate a seamless value adding system which incorporates quality control, customer service, process improvement, supplier relationships, and good relationships with the community in which it operates.

**Total Quality Management:** Term initially coined by the Naval Air Systems Command to describe its Japanese-style management approach to quality improvement. Since then, TQM has taken on many meanings. Simply put, it is a management approach to long-term success through customer satisfaction. TQM is based on the participation of all members of an organization in improving processes, products, services, and the culture in which they work. The methods for implementing this approach are found in the teachings of such quality leaders as Philip B. Crosby, W. Edwards Deming, Armand V. Feigenbaum, Kaoru Ishikawa, and Joseph M. Juran.

**Utilization Management:** Formal, prospective, concurrent, or retrospective critical examination of necessity, efficiency, and appropriateness of use (over-, under-, or optimum use of resources and services). Can include review of appropriateness of admissions, length of stay, discharge practices, and services provided.

**Value:** This is a judgment about quality that relates to conformance, utility, customer satisfaction, and price.

**Value Added:** Parts of the process that add worth from the perspective of the external customer.

**Variation:** Anything that causes a process to deviate from acceptable standards. Sources of variation in consumer care/service delivery processes can include methods (treatments/interventions), people, management, and supplies.

**Vital few, Useful many:** A term of Joseph M. Juran used to describe the Pareto principle, which he first defined in 1950. (The principle was used much earlier in economics and inventory control methods.) The principle suggests most effects come from relatively few causes; that is 80% of the effects come from 20% of the possible causes. The 20% of the possible causes are referred to as the “vital few,” the remaining causes are referred as the “useful many.” When Juran first defined this principle, he referred to the remaining causes as the “trivial many”, but realizing that no problems are trivial in quality assurance, he changed it to “useful many”.

**Voice of the Customer:** The expressed requirements and expectations of customers relative to products or services, as documented and disseminated to the providing organization’s members.