Quality Improvement & Innovation Partnership

## GLOSSARY OF TERMS

**Action Group:** Content-specific groups within the Quality Improvement and Innovation Partnership's Learning Community that focus on making changes that lead to an improvement in a specified domain. (see Learning Community). Here are examples of Action Groups.:
**Asthma**
**COPD**
**Diabetes**
**Hypertension**
**Integrated Cancer Screening**
**Office Practice Redesign**

**Action Period:** Time period between learning sessions, where quality improvement work is integrated, tested and reported on.

**Advanced Access:** Within the office practice redesign model, advanced access refers to time allotted in a physician's schedule for same-day appointments.

**Assessment of Chronic Illness Care (ACIC):** The ACIC is an assessment tool used to identify areas of improvement in chronic illness care.

**Breakthrough Series Model:** Developed by the Institute for Healthcare Improvement, the Breakthrough Series Model is the components of the quality improvement work. The Breakthrough Series Model includes the following: topic selection, faculty recruitment, enrollment of participants, learning sessions, action periods, The Model for Improvement (Plan-Do-Study-Act), congress and measurement and evaluation.

**Charter:** Outlines goals, measures and targets of the collaborative/Action Group and the measures to be used to achieve those goals.

**Chronic Disease Prevention Management (CDPM) Framework:** Describes an ideal system of healthcare for chronic conditions. Consisting of six essential components, the framework can also be applied to preventative care.

**Community Health Centre (CHC):** Community Health Centres are non-profit organizations governed by community-elected board members, providing primary healthcare and health promotion to communities across Ontario.

**Congress:** A summative meeting outlining the achievements of teams across all three collaborative learning sessions.

**Cycle Time:** Cycle time is the total amount of time a patient is in the office (from arrival to departure).

**Family Health Team (FHT):** Family Health Teams bring together physicians and interdisciplinary health professionals to provide patients with better access to care, closer to home. Working in a collaborative environment, along with other community-based healthcare organizations, Family Health Teams focus on providing primary healthcare, chronic disease management, disease prevention and health promotion.

**Governance:** The structure of management and/or leadership of an organization.

**Lean Methodology:** A methodology eliminating non-value added steps in a process to improve quality and timely delivery of service.

**Learning Collaborative:** A learning collaborative is way to accelerate improvement in healthcare settings. It brings together quality improvement teams from different practices to learn with and to learn from each other.

**Learning Community:** The QIIP Learning Community is a virtual place for primary healthcare teams to learn, share and innovate with one another in order to improve patient care.

**Learning Session:** The time period within a learning collaborative focused on acquiring quality improvement knowledge and learning methods to incorporate quality improvement in primary healthcare practices.

**Logic Model:** A program planning tool used to outline goals and objectives, implementation methods and outcome measurements.

**Model for Improvement:** A strategy for testing, implementing and spreading practice innovations. The model includes the use of Plan-Do-Study-Act (PDSA) cycles or rapid cycle tests of change to drive improvement.

**Nurse Practitioner-Led Clinic:** Announced in 2007 by the Ontario Ministry of Health and Long-Term Care, Nurse Practitioner-Led Clinics provide a model of care in collaboration with other interdisciplinary healthcare professionals. With a focus on providing primary care, disease prevention, health promotion and self-management, Nurse Practitioner-Led Clinics work alongside community based programs and services.

**Ontario Telemedicine Network (OTN):** A two-way video conferencing system used when two or more parties are in different geographic locations.

**Plan Do Study Act (PDSA) Cycle:** Part of the Breakthrough Series Model, the PDSA cycle is part of the action period between collaborative learning sessions. The PDSA cycles are used for testing and implementing quality improvement changes.

**Process Mapping:** A series of steps that are drawn out to indicate the next item in a process.

**Red Zone Time:** One-on-one time that a patient has with a healthcare provider.

**Spread:** Spreading information, innovation and change amongst healthcare professionals and applying these processes to different chronic illness models of improvement.

**Sustainability:** Maintaining quality improvement methods within the healthcare system.

**Virtual Office:** An online portal where learning collaborative teams can post their QI work.

**Webinar:** A webinar is a web-based seminar where multiple users, in different geographic locations, can access the same interactive web transmission.

**QI Gateway:** A virtual workspace within QIIPs Learning Community. The QI Gateway is a place to access resources and house reports and documentation of best practices, which can be accessed and viewed by all Action Group members. The QI Gateway is also a place to post and share data, cycles of change and discussions.

**Quality Improvement:** "Quality Improvement is an approach to quality that originated in industry and has received increasing attention from the health care system. It is a management philosophy and system which involves management, staff and health professionals in the continuous improvement of work processes to achieve better outcomes of patient/client/resident care. It involves the application of statistical methods and group process tools to reduce waste, duplication and unnecessary complexity in work. The goal of the CQI is to consistently meet or exceed the needs of patients, families, staff, health professionals and the community". (Health Canada, 2000)

**Quality Improvement Coach (formerly known as Practice Facilitators):** Trained in quality improvement methodologies in primary healthcare settings, Quality Improvement coaches assist teams as they test and implement practice changes, track indicator measures and spread quality improvement concepts.

**Quality Improvement and Innovation Partnership (QIIP):** The Quality Improvement and Innovation Partnership (QIIP), formerly the Quality Management Collaborative (QMC), was established and funded by the Ministry of Health and Long-Term Care in January of 2007 to help Family Health Teams and Community Health Centres recruit staff and build teams, implement programs, develop links with community partners, introduce improvements into their practice, and put in place structures required to support these new directions.