Improving Patient Care (IPC) Glossary

Current as of December 2011

Action Period: The period of time between learning sessions when teams work on improvement in their home organizations. They are supported by collaborative leaders and faculty, and they are connected to members of other collaborative teams.

Action Period Calls or All Team Calls: Regularly scheduled conference calls during the action period that connect all participating teams with each other, faculty, and collaborative leaders. Content is provided; teams share stories, ideas and tools; results are discussed.

Action Plans: Work plans prepared by participating organizations, to develop and guide tests for change, implementation, and spread, and subsequently define the timeline for the actions.

Advanced Access: A model to reduce delays and wait times in the clinical setting. The core principle of Advanced Access is that patients calling to schedule a clinic visit are offered an appointment the same day. The goal of Advanced Access is to build a system in which patients have the opportunity to see their own provider when they choose. For additional information about Advanced Access see http://www.ihi.org/explore/PrimaryCareAccess/Pages/default.aspx

Aim or Aim statement: A written, measurable, and time sensitive statement of the expected results of an improvement process. An Aim answers the first question in the Model for Improvement, "what are we trying to accomplish?" Improvement requires setting aims. The Aim for IPC II can be found on the *IPC Knowledge Portal.* Tips for setting aims can be found at: http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementTipsforSettingAims.aspx

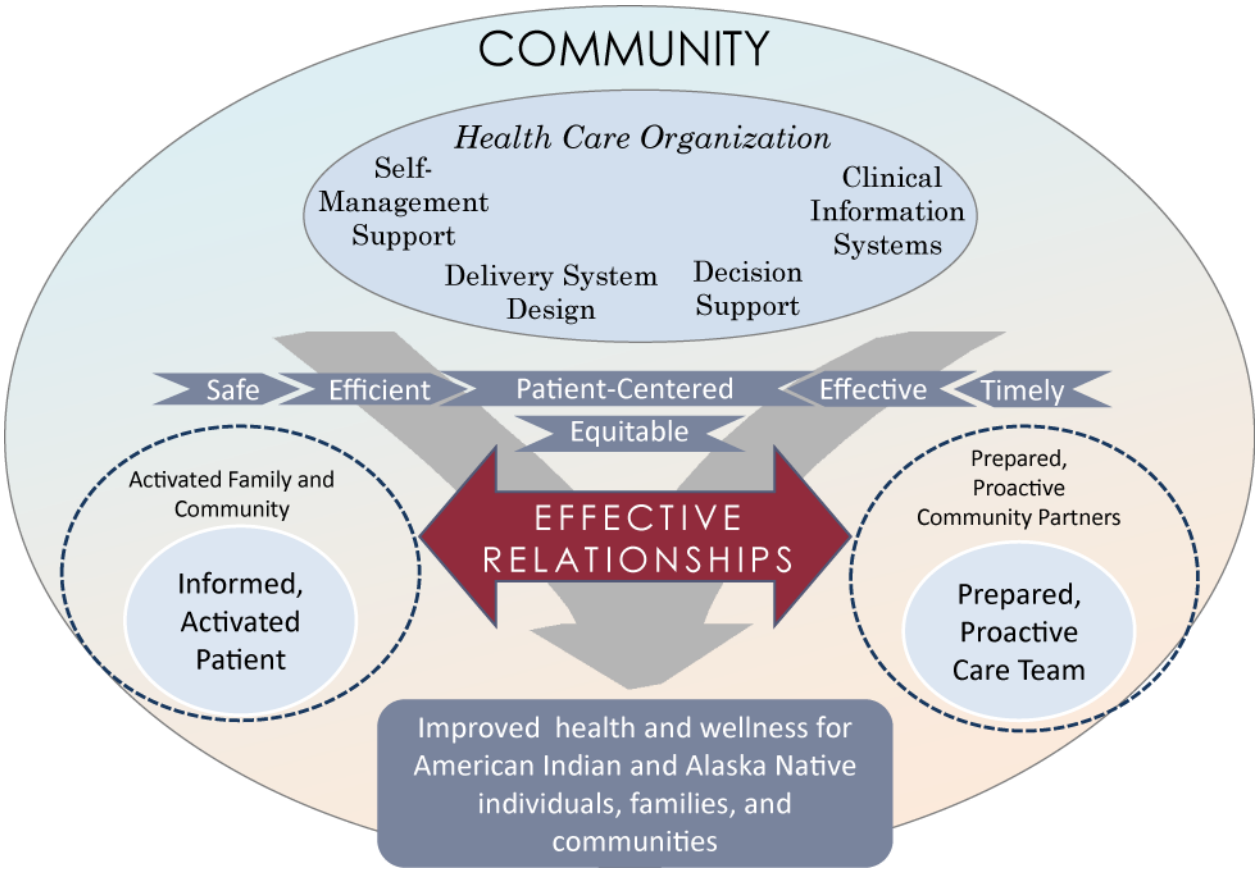
Annotated Run Chart or Time Series: A line chart showing results of improvement efforts plotted over time. The changes made are also noted on the line chart at the time they occur, allowing the viewer to connect changes made with specific results.

Backlog: Backlog consists of appointments on the future schedule that have been scheduled in the future due to lack of openings on the current schedule. Working down the backlog recalibrates the system to improve access. For additional information go to http://www.ihi.org/knowledge/Pages/Changes/RecalibratetheSystembyWorkingDowntheBacklog.aspx . For a backlog reduction worksheet, see http://www.ihi.org/knowledge/Pages/Tools/BacklogReductionWorksheet.aspx

Best Practices: A best practice is the belief that there is a technique, method, process, activity, incentive, or reward that is more effective at delivering a particular outcome than any other technique, method, process, etc. The idea is that with proper processes, checks, and testing, a desired outcome can be delivered with fewer problems and unforeseen complications. Best practices can also be defined as the most efficient (least amount of effort) and effective (best results) way of accomplishing a task, based on repeatable procedures that have proven themselves over time for large numbers of people.

IPC Care Model: A refinement of the Chronic Care Model (developed by E. Wagner and associates. See http://www.improvingchroniccare.org for additional information about the Model). The Chronic Care Model was updated by IHS staff to reflect advances in the field of chronic and

preventive care both from the research literature and from the scores of health care systems that implemented the Model in their improvement efforts. The IPC Care Model (show below) reflects those changes as well as the features of high quality care outlines in the "Quality Chasm" report. The IPC Care Model differs from the Chronic Care Model in two important ways: inclusion of the six aims from the Quality Chasm report as criteria for high quality services; and addition of change concepts addressing staff development, cultural competence, care coordination and patient safety.



Champion: An individual in the organization who believes strongly in quality improvement and is willing to work with others to test, implement, and spread changes. Teams need at least one clinical champion. Champions in other disciplines who work on the process are important as well. This champion should have a good working relationship with colleagues and with the day-to-day leader(s) described below, and be interested in driving change in the system.

Change Concept: A general idea for changing a process. Change concepts are usually at a high level of abstraction, but evoke multiple ideas for specific processes. "Simplify," "reduce handoffs," and "consider all parties as part of the same system," are all examples of change concepts.

Change Idea: An actionable, specific idea for changing a process. Change ideas can be tested to determine whether they result in improvements in the local environment. An example of a change idea is, "Simplify process for data entry by having front desk staff enter visit information directly into an electronic registry."

Change Package: A collection of change concepts, key changes, and specific examples of change ideas that serves as a resource for organizations embarking on change within their organization. It includes the key content for the Collaborative, a listing of the essential changes needed to get results, and ideas based on evidence in the literature or from credible expert opinion. The IPC Change Package can be found on the *IPC Knowledge Portal*

Charter: A document to describe and to launch a collaborative, establishing a common vision for the work, including:

- Problem statement, gap, mission statement, and business case for the improvement
- Specific, measureable goals such as improve outcomes, reduce costs
- Expectations for participants, faculty, support structures, etc.

Chronic Care Model (CCM): A model that represents the ideal system of healthcare for people with chronic disease and an approach to re-designing healthcare to mirror that ideal system. Developed by Improving Chronic Illness Care, the model has six components: community resources and policies, healthcare organization, self-management support, decision support, delivery system design, and clinical information systems. For additional information see http://www.improvingchroniccare.org

Clinical Information System (CIS): A comprehensive, integrated information system that is "patient-centered" and includes patient registries, a practice management system, a billing system, an electronic health record, and personal health records. The CIS is one of the components of the Chronic Care Model.

Collaborative: A systematic approach to healthcare quality improvement in which organizations and providers test and measure practice innovations, then share their experiences in an effort to accelerate learning and widespread implementation of best practices. "Everyone teaches, everyone learns."

Collaborative Leadership and Faculty: The group of experts on the topic who assist the organization in developing the Collaborative and in teaching and coaching participating teams.

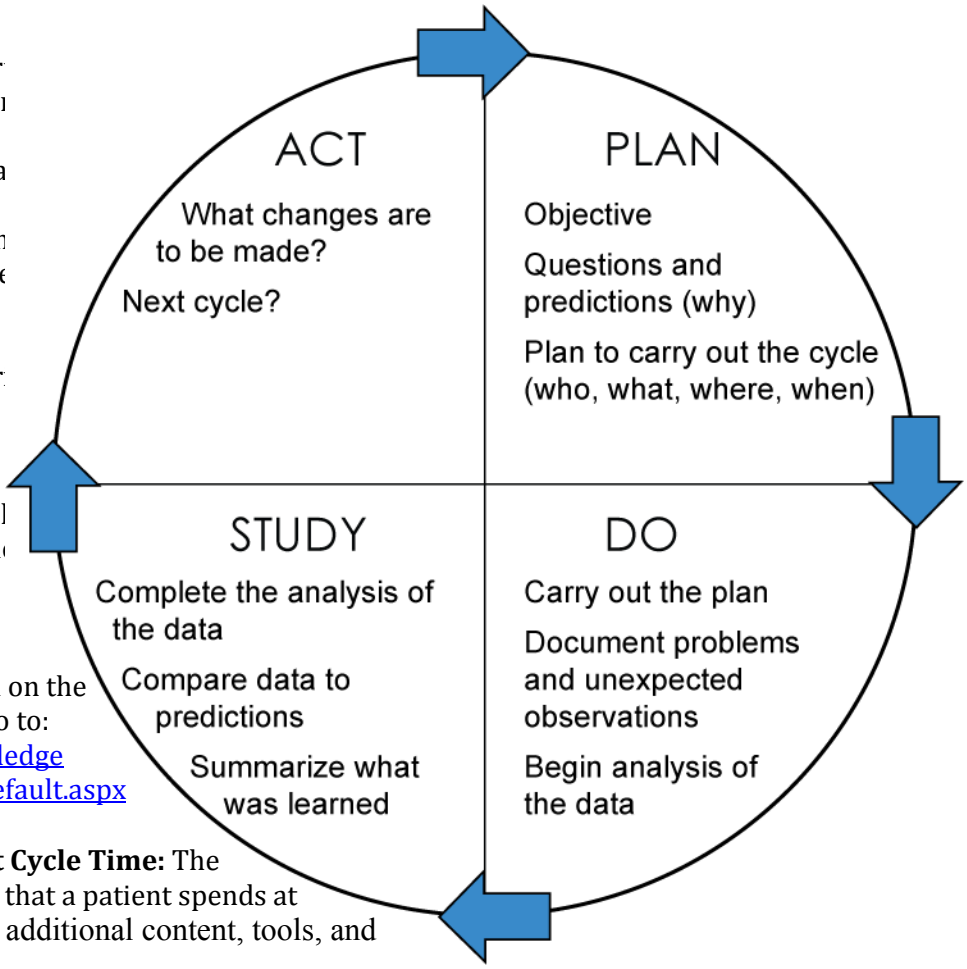
Collaborative Team: All individuals from the participating organizations that drive and participate in the improvement process. A multidisciplinary team that participates in the improvement process in the organization.

Community Health Representative (CHR): a well-trained, community-based, indigenous health care paraprofessional who provides culturally respectful health care, outreach, and health promotion and disease prevention services in tribal or urban communities. http://www.ihs.gov/NonMedicalPrograms/chr/

Core Team Members: Individuals who attend the learning sessions and are accountable to their organizational senior leadership for the work of the collaborative.

Cycle or PDSA cycle: A str
process change. Drawn fro
cycle, this effort includes:

Plan - a specific pla
phase
Do - a time to try th
change and observe
happens
Study - an analysis
the results of the tr
Act - devising next
steps based on the
analysis
This PDSA cycle wil
naturally lead to th
Plan step of a
subsequent cycle



For additional information on the Model for Improvement, go to: http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

Cycle Time or Office Visit Cycle Time: The amount of time in minutes that a patient spends at an office or clinic visit. For additional content, tools, and related changes, see http://www.ihi.org/knowledge/Pages/Measures/OfficeVisitCycleTime.aspx

Data Collection Plan: A specific description of the data to be collected, the interval of data collection, and the subjects from whom the data will be collected. The IPC Data Collection Plan can be located on the *IPC Knowledge Portal*

Day-to-Day Leader: This person manages the team, arranges meetings, assures tests are being completed, and data are collected. The day-to-day leader will be the critical driving component of the team, assuring that tests of change are implemented and overseeing data collection. This individual must understand the details of the system and the potential effects of making change(s) in the system. This person must be able to work effectively with the improvement champion(s) and will often be the "key contact" at the organization (see below).

Decision Support (DS): Methods to enable patients and providers to make informed choices about optimal care. This includes the use of evidence from the medical and health services literature, education of providers, and the interactions between specialists and primary care providers.

Delivery System Design (DSD): How care is provided to patients, including the types and roles of the health care team and the types of appointments and follow-up techniques used by the practice to ensure high quality care.

Early Adopter: In the improvement process, the opinion leader within the organization who

brings in new ideas from the outside, tries them, and uses positive results to persuade others in the organization to adopt the successful changes.

Early Majority/Late Majority: The individuals in the organization who will adopt a change only after it is tested by an early adopter (early majority) or after the majority of the organization is already using the change (late majority).

Electronic Health Record (EHR): The Resource and Patient Management System (RPMS) EHR is intended to help providers manage all aspects of patient care electronically, by providing a full range of functions for data retrieval and capture to support patient review upon encounter and for follow-up. By moving most (and eventually all) data retrieval and documentation activities to the electronic environment, patient care activities and access to the record are able to occur simultaneously at multiple locations without dependence on availability of a paper chart. Moreover, point-of-service data entry ensures that the record is always up to date for all users. http://www.ihs.gov/cio/ehr/index.cfm?module=clinicaloverview

Expert Meeting: A panel of 12 to 15 multidisciplinary experts from a variety of organization types with the responsibility to develop the core content for a collaborative and begin to identify faculty to teach and coach participating organizations. It is at this meeting that there is a start to the development of the collaborative goals, change package, and measurement system.

Gantt Chart: A type of bar chart that illustrates a project schedule. Gantt charts illustrate the start and finish dates of the terminal elements and summary elements of a project.

Government Performance and Results Act (GPRA): holds federal agencies accountable for using resources wisely and achieving program results. GPRA requires agencies to develop plans for what they intend to accomplish, measure how well they are doing, make appropriate decisions based on the information they have gathered, and communicate information about their performance to Congress and to the public.

"Green Book": Officially known as "Assessing, Diagnosing, and Treating Your Outpatient Primary Care Practice" and can be found at http://www.clinicalmicrosystem.org A workbook that provides tools and methods that clinical teams can use to improve the quality and value of patient care as well as the work-life of all staff who contribute to patient care. These methods can be adapted to a wide variety of clinical settings, large and small, urban and rural, community-based and academic.

Harvesting Meeting (Knowledge Gathering Session): National leads and Subject Matter Faculty members review results, approaches, challenges, etc. with successful teams to identify the most useful changes and the measures that were most productive. From the information obtained, the charter, change package, and measurement strategy will be reviewed and revised accordingly. These ideas are used to produce written material, create spread materials, and plan the next Collaborative.

iCare: iCare is a Population Management software tool that helps organizations manage the care of their patients. The ability to create multiple panels of patients with common characteristics (e.g., age, diagnosis, community) allows personalization of the way patient data can be viewed. iCare is a Windows-based, client-server graphical user interface (GUI) to the IHS RPMS. It retrieves important patient information from various components of the RPMS database and brings it together under a single, user-friendly interface. http://www.ihs.gov/CIO/CA/icare/

Implementation: Taking a change and making it a permanent part of the system. A change may be tested first and then implemented throughout the organization.

Improvement Advisor: The Improvement Advisor is devoted to helping identify, plan, and execute improvement projects throughout the organization, delivering successful results, and spreading changes throughout the entire system.

Improvement Support Team (IST): A 3-6 member interdisciplinary team whose function is to support improvements in care in the field. Variably consisting of Area, Tribal, and Field staff, the IST serves as the infrastructure for spread and sustainability of improvement in the Indian Health System (IHS, Tribal, and Urban Indian Health programs) and is the backbone of the plan for spread.

Institute for Healthcare Improvement (IHI): The IHI is an independent not-for-profit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action. http://www.ihi.org

IPC 1: Improving Patient Care 1. Originally called Innovations in Planned Care, this was the first phase of IPC that began in 2007. It included 14 pilot sites (8 IHS, 5 Tribal, and 1 Urban).

IPC 2: Improving Patient Care 2. The second phase of IPC began in fall of 2008, 25 new sites joined the original 14 to total 39 participating sites (24 IHS, 12 Tribal, and 3 Urban).

IPC 3: Improving Patient Care 3: The third phase of IPC began in January 2011 with 68 sites (add breakdown of I/T/U.

Kaizen (Japanese for "improvement"): A Japanese philosophy that focuses on continuous improvement throughout all aspects of life. When applied to the workplace, Kaizen activities continually improve all functions of a business, from manufacturing to management, and from the Chief Executive Officer (CEO) to the assembly line workers. By improving standardized activities and processes, Kaizen aims to eliminate waste. Kaizen was first implemented in several Japanese businesses during the country's recovery after World War II and has since spread to businesses throughout the world.

Key Changes: The list of essential process changes that will help lead to breakthrough improvement. Key changes for IPC are located in a high leverage, sequenced change grid in the Change Package.

Key Contact: The individual on the organization's team who takes responsibility for communication between the team and Collaborative staff, including reporting monthly and disseminating information to team members. This person is often the Day to Day Leader of the collaborative work at the local site.

Knowledge Management: Knowledge management is the process of gathering information about the spread process as it unfolds in the organization. Once the spread plan has been put into effect, the spread agent plays an important role in monitoring the process and recommending adjustments as needed to ensure that the spread goals are met. The spread agent can use a number of mechanisms to gather information about the spread process including: formal surveys or

questionnaires, talking and listening to participants in a collaborative or pilot, and websites that enable the participants to share their activities and lessons learned about the process.

Leadership Calls: Monthly conference calls for the leadership of the participating organizations. The curriculum for these calls is focused on improving leadership capabilities, developing a systems approach for the leadership of improvement; being transparent with data, improvement strategies, and experiences; testing, implementing, and sharing successful improvements; and quality as a business strategy.
http://www.ihi.org/knowledge/Pages/Tools/IHIFrameworkforLeadershipforImprovement.aspx

Learning Community: A network of organizations whose members work to achieve rapid and continuous improvement. The community should be a source of innovative, breakthrough improvement ideas inspired by others. It should provide the opportunity for peer exchange of ideas and be designed to drive and support the hard work of leading improvement and implementing sustainable change at the front line.

Learning Session: A meeting during which participating organization teams meet with faculty and peers so as to collaborate and to learn key changes in the topic area (including how to implement them), approaches for accelerating improvement, and methods for overcoming obstacles to change. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes.

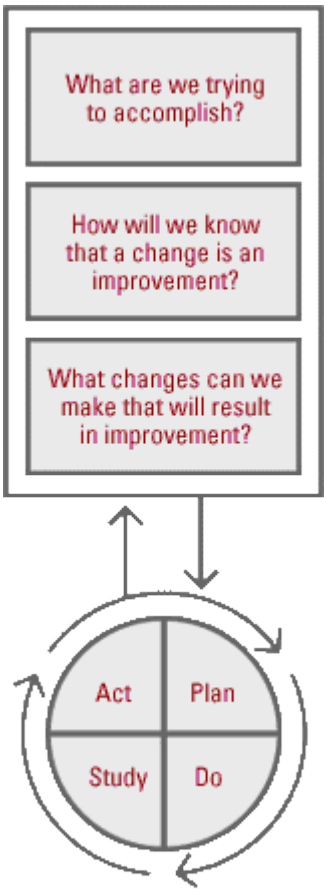
Listserv: An automatic mailing list. When e-mail is addressed to a LISTSERV mailing list, it is automatically broadcast to everyone on the list. The result is similar to a newsgroup or forum except that the messages are transmitted as e-mail and are therefore available only to individuals on the list.

Measure: An indicator of change. Key measures should be focused, clarify the team's aim, and be reportable. A measure is used to track the delivery of proven interventions to patients and to monitor progress over time. A list of all IPC II measures is located on the IPC Knowledge Portal.

Measurement Strategy: Includes the key measures that will be used to track improvement in the Collaborative, definitions of the data elements, and data collection strategies.

Microsystem: a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, a shared information environment, and produces performance outcomes. Microsystems evolve over time and are (often) embedded in larger organizations. As a type of complex adaptive system, they must: (1) do the work, (2) meet staff needs, and (3) maintain themselves as a clinical unit. Many resources and tools can be found at http://www.clinicalmicrosystem.org

Model for Improvement: Shown on the right, an approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes. For additional information on the Model for Improvement, go to: http://www.ihi.org/knowledge/Pages/HowtoImprove/



Motivational Interviewing: Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Narrative Report: A monthly report submitted to summarize changes that have been tested and/or implemented within participating organizations.

Office Hours: Scheduled conference calls and/or WebEx conferences with multiple participating organizations that are used to address specific topics and or interest areas. These sessions are typically WebEx sessions and attendance is optional.

Organization: the entirety of a health program or system, whether it is composed of a single or multiple sites. Within the IPC, an organization is defined by governance and includes all sites that report to a single CEO and are guided by a single governing body.

Optimized Care Team: A multidisciplinary care team that has each member of the team working most effectively together to maximize the supply of the clinic's services and improve the flow of work and patients. Specific changes that contribute to optimizing the care team might include: staff members working to the highest level of their licensure, training, and competency, cross-training staff to assume different duties as needed, establishing protocols for conditions and processes that can be clearly delineated, limiting interruptions, and meeting regularly.
http://www.ihi.org/knowledge/Pages/Changes/OptimizetheCareTeam.aspx

Patient Centered Care: Care that is truly patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes the patient and their significant other(s) an integral part of the care team who collaborate with health care professionals in making clinical decisions. Patient-centered care puts responsibility for important aspects of self-care and monitoring in patients' hands — along with the tools and support they need to carry out that responsibility. Patient-centered care ensures that transitions between providers, departments, and health care settings are respectful, coordinated, and efficient. When care is patient centered, unneeded and unwanted services can be reduced.
For additional information and ideas: http://www.ihi.org/explore/PFCC/

PDSA or PDSA Cycle: Another name for a cycle (structured trial) of a change, which includes four phases: Plan, Do, Study, and Act. See the definition of "Cycle" above.

Pilot Site: The clinic location for initial focused changes. After implementation and refinement, the process will be spread to additional locations.

Planning Group: A multidisciplinary group of people with expertise in the content of the collaborative who work with the national leads, Improvement Advisor, Director, and IHS Core Group to specify goals, high leverage changes, sequencing, and measures. They serve as faculty, review IPC progress, and participate in listserv discussion and questions.

Prework Period: Pre-Work is the period between the beginning of Pre-Work conference calls and Learning Session 1. During this time, teams have several important tasks to accomplish; including participation in a series of pre-work calls. The material covered and assignments completed relating to these calls is vital to the early success of each participating organization.

Process Change: A specific change in a process in the organization. More focused and detailed than a change concept, a process change describes what specific changes should occur. "Institute a pain management protocol for patients with moderate to severe pain" is an example of a process change.

Process Mapping: An activity that diagrams the steps, decision points, and influencing factors in a workflow process to bring forth a clearer understanding of that process or series of parallel processes.

Project Manager: An individual who tracks the progress, interaction, and tasks of various parties in such a way that reduces the risk of failure, maximizes benefits, and restricts costs of an improvement initiative.

Public Health Nursing (PHN): The practice of promoting & protecting the health of the American Indian/Alaska Native (AI/AN) populations using knowledge from nursing, social and public health sciences. PHN practice is population-focused (individual/family, community, systems) with goals of promoting health and preventing disease and disability through primary, secondary and tertiary prevention interventions.

QILN: Acronym for Quality and Innovation Learning Network. The QILN is open to all programs that have participated in the IPC Collaborative and/or have achieved the fundamental elements of the Indian Health medical home.

RPMS: Acronym for Resource Patient and Management Software. RPMS is an integrated solution for the management of clinical, business practice, and administrative information in healthcare facilities of various sizes. It includes flexible hardware configurations, over 50 software applications. Network communication components combine to provide a comprehensive clinical, financial, and administrative solution. http://www.ihs.gov/RPMS/

Run Chart: A graphic representation of data over time, also known as a "time series graph" or "line graph." This type of data display is particularly effective for process improvement activities.

Sampling Plan: A specific description of the data to be collected, the interval of data collection, and the subjects from whom the data will be collected. It emphasizes the importance of gathering samples of data and how to obtain "just enough" information.

Special Diabetes Program for Indians (SDPI): The SDPI is a Congressionally established grant program that provides funding for diabetes treatment and prevention services at 399 IHS, Tribal,

and Urban Indian health programs The SDPI grant programs use proven, evidence-based, and community-driven diabetes treatment and prevention strategies that address each stage of the disease. Find more information at:
http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=programsSDPI

Self-Management Support (SMS): The care and encouragement provided to people with chronic conditions to help them understand their central role in managing their illness, make informed decisions about care, and engage in healthy behaviors.
http://www.ihi.org/knowledge/Pages/Changes/SetandDocumentSelfManagementGoalsCollaboratively withPatients.aspx

Service Population: A broad operational definition of population, meant to capture all of those who might reasonably be expected to use the services of a given organization. This definition of population is different than the several other operational definitions for population currently in use in the Indian Health System. For the purposes of IPC, *service population* is defined as: all persons who have 1 visit within the past 3 years anywhere in the organization.

Site: An organization may have one or more sites of care, i.e. satellite clinics. As part of IPC, organizations develop a plan for spread to each of their sites.

Small Multiples: Small multiples are sets of thumbnail sized graphics on a single page that represent aspects of a single phenomenon. Small multiples are used to display comparative data from IPC.

Sponsor: The executive in the organization who supports the team and controls all the resources employed in the processes to be changed. The Sponsor or Senior Leader works to connect the team's Aim to the organization's mission, provides resources for the team, removes barriers to the team's progress, and promotes the spread of work of the team to other sites, providers, and conditions.

Spread: The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application comes from the literature on Diffusion of Innovation (Everett Rogers, 1995).

Storyboard: The board that displays information about a team and its progress and that is displayed at learning sessions to help create an environment conducive to sharing and learning from the experiences of others.

Technical Expert: The team member in the organization who has a strong understanding of the process to be improved and changes to be made. A technical expert may also provide expertise in process improvement, data collection and analysis, and team function.

Test: A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement, and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

Transparency: Sharing performance data in an effort to make organizations more accountable and promote improvement.

Virtual Training/Learning: A process to create and provide access to learning when the source of information and the learners are separated by time and distance, or both; the process of creating an educational experience of equal qualitative value for the learner to best suit their needs when a face to face meeting is not possible. Web conferencing is most commonly used to conduct live meetings or presentations via the Internet. In a web conference, each participant/team sits at his or her computer and is connected to other participants via the internet.

Virtual Environment: The types of available technologies used in the virtual environment are divided into two groups: synchronous and asynchronous. Synchronous technology is a mode of online delivery where all participants are "present" at the same time. (Examples include: telephone, videoconferencing, web conferencing). Asynchronous technology is a mode of online delivery where participants access course materials on their own schedule and participants are not required to be together at the same time. (Examples include audiocassette, e-mail, printed materials, Extranet, etc.)

Frequently Used Acronyms

Some acronyms are hyperlinked to a definition within the full document.

Acronym	Meaning	Link
AP	Action Period	
CCM	Chronic Care Model	http://www.improvingchroniccare.org
CHR	Community Health Representative	http://www.ihs.gov/NonMedicalPrograms/chr/
CIS	Clinical Information System	
CM	Care Model	http://www.improvingchroniccare.org
DS	Decision Support	
DSD	Delivery System Design	
EHR	Electronic Health Record	
EMR	Electronic Medical Record	
GPRA	Government Performance Results Act	
HP/DP	Health Promotion and Disease Prevention	http://www.ihs.gov/NonMedicalPrograms/HPDP/
IA	Improvement Advisor	
IHI	Institute for Healthcare Improvement	http://www.ihi.org
IHS	Indian Health Service	http://www.ihs.gov
IPC	Improving Patient Care	
IST	Improvement Support Team	
I/T/U	IHS, Tribal, and Urban	
LS	Learning Session	
MFI	Model for Improvement	
MI	Motivational Interviewing	
PCC	Patient Centered Care	
PDSA	Plan, Do, Study, Act	
PHN	Public Health Nurse	
QILN	Quality and Innovation Learning Network	
RPMS	Resource Patient and Management Software	
SDPI	Special Diabetes Program for Indians	http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=programsSDPI
SMS	Self Management Support	http://www.ihi.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/