

Terms, Definitions & Acronyms

Action plan – A specific series of steps (actions) taken to accomplish a specified goal.

Alberta AIM – Alberta Access, Improvement, Measures is a made in Alberta quality improvement initiative based on the Institute of Health Care Improvement (IHI) Breakthrough Series. Alberta AIM supports family practices, specialty clinics and AHS programs to help them reduce or eliminate wait times and improve office efficiency and patient care. The identification of bottlenecks and reduction of wait times is achieved by predicting and managing patient demands and other strategies chosen by the practice or program through a program of collaborative learning. Measurement is a key component so healthcare providers can understand, change and improve their system performance. <http://www.albertaaim.ca/>



AH – Alberta Health. The ministry sets policy, legislation and standards for the health system in Alberta. The ministry allocates health funding, administers provincial programs and provides strategic direction to AHS in regard to its role in delivering health services throughout Alberta. <http://www.health.alberta.ca/>



AHS – Alberta Health Services. A province-wide, fully integrated health system made up of skilled health professionals who promote wellness and provide healthcare to Albertans. <http://www.albertahealthservices.ca/>



AMA – Alberta Medical Association. The membership organization for physicians practicing within Alberta. The AMA stands as an advocate for its physician members, providing leadership and support for their role in the provision of quality health care. <https://www.albertadoctors.org/>



ASaP – Alberta Screening and Prevention initiative. It is focused on supporting primary care physicians and team members to offer a screening and prevention bundle to all their patients through enhanced opportunistic and planned outreach methods. The focus is on those 1/3 of patients who do not present for screening care. <http://www.topalbertadoctors.org/asap/>

Attachment – Patients that identify with a single primary health care provider for the provision of their primary care.

Care plan – Documented course of care relating to patient care. May also be called a care plan flow sheet.

Change package – An evidence-based set of changes that have been demonstrated to be effective for the improvement of an identified care process.

CPA – Clinical Process Advisor. Consultants with TOP who contribute to the improvement of health services by working with healthcare teams. They:

- promote and support quality improvement initiatives and provide facilitation, consultation and education
- help to identify, plan and implement improvement solutions and further the use of evidence-based medicine
- have knowledge in adult education principles, quality improvement principles and foundations, team development and project management.

Continuity of care – Measures the likelihood that patients see their own provider with whom they have a continuous relationship for their visit. The panel is used to calculate continuity.

EBM – Evidence Based Medicine. The conscientious and judicious use of current best evidence for better health care decision-making for individuals and populations. It has traditionally been implemented through clinical guidelines, protocols and best practices, but recently has also incorporated patient circumstances, preferences and benefits/risks. <http://www.ebm.med.ualberta.ca/ebm.html>

EMR – Electronic Medical Record. A computerized medical record used by an organization that delivers health care, including a hospital, physician's office or clinic.

Health home – Similar to a medical home, but with a different focus. A primary health care home for every Albertan is integral to Alberta's Primary Health Care Strategy. There is no single health home model, and each one could have a somewhat different mix of providers and services that are appropriate for the individuals it serves. However, all health homes will play the same role for their patients. The health home is where people get primary health care services from a team, are connected with other

services, and have their health care journey co-ordinated and managed.

A key feature of the health home is establishing an ongoing relationship with a provider or team. Evidence shows that individuals who are attached to a primary health care provider or team receive more preventive and chronic disease care, make fewer visits to the emergency room, are hospitalized less, and are more satisfied with the care they receive.

** Alberta's Primary Health Care Strategy, Alberta Health, Jan 2014, page 19 "Providing a Health Home".*

HQCA – Health Quality Council of Alberta. An independent organization that gathers and analyzes information and collaborates with AHS, AH, health professions and other stakeholders to translate that knowledge into practical improvements to health service quality and patient safety in the health care system. <http://www.hqca.ca/>

Joint venture – The agreement between non-profit corporations of physicians and the AHS who have collaboratively identified local priorities and developed programs and services; supported operationally and financially through the PCN PMO to better meet local needs.

Medical home – Similar to a health home, but with a different focus. A medical home is a vision presented by the CFPC for the future of family practice in Canada. Through a medical home, primary care physicians draw upon the resources of a larger health care team including nurses, pharmacists and other allied health professionals, either on-site or in the extended community as necessary. Primary care physicians, with active participation from patients, coordinate comprehensive health care services to ensure continuity of care.

The medical home *"is where patient-doctor, patient-nurse and other therapeutic relationships are developed and strengthened over time, enabling the best possible health outcomes for each person, the practice population and the community being served,"*

** A Vision for Canada Family Practice: The Patient's Medical Home, CFPC, 2011, page 8 "Definition".*

Current PCNs in Alberta already reflect some of the medical home goals outlined by the CFPC. PCN Evolution will continue to support the development of the home model that works for your community.

Metrics – Metrics focus attention on what is important. It is a measurement standard by which efficiency, performance, progress or quality of a plan,

process or product can be assessed. They can be used in the future to set standards and establish benchmarks.

MDT – Multidisciplinary Health Care Team. A group of health care workers who are members of different disciplines, each providing specific services to the patient.

Outcomes – Specific changes in attitudes, behaviors, knowledge, skills, status, or level of functioning that participants will experience as a result of participation in activities.

Panel - In primary care, panel size is the number of unique patients for whom a provider is responsible for providing care. Panel implies a long-term attachment. A patient can be paneled to more than one service type (e.g. physician clinic and to a PCN that supports that clinic), but ideally to a single provider for each service. Panel is sometimes referred to as "roster".

Patient outreach – Opportunistic and planned strategies used in team-based care to target patients who do not present for screening care.

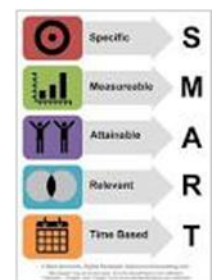
PDSA cycle – Plan Do Study Act cycle.

Provides a framework for developing, testing and implementing changes leading to improvement. This scientific-based model consists of (1) Plan: identify what can be improved and what change is needed; (2) Do: implement the change; (3) Study: measure and analyze the process or outcome; and (4) Act: plan the next change cycle or full implementation.



Performance Indicators –

Sometimes referred to as Key Performance Indicators (KPIs). They are used to identify the most important performance success targets that will add the most value to the organization. A KPI can follow SMART criteria.



Practice facilitator – Plays a key role in implementing clinical change in practices using an improvement methodology. This will include, but is not limited to, assisting practices with understanding their current processes and performance, opportunities for improvement; developing customized work processes for the clinical change; mentoring and coaching clinic staff to implement

new/redesigned processes and spreading the initiative to other practices.

Primary Care – In Alberta, includes clinical services like diagnosis and treatment of non-urgent conditions, chronic disease prevention and management, and mental health and addiction treatment. It is one part of primary health care.

Primary Health Care – Primary health care is a broader concept than primary care, emphasizing prevention and wellness. It recognizes that success in improving people’s health is largely determined by factors in their daily lives, such as lifestyle, housing, relationships, spiritual beliefs, income, and workplace. Primary health care is the first place people go for health care or wellness advice and programs, treatment of a health issue or injury, or to diagnose or manage physical and mental health conditions.

PCN – Primary Care Network. A group of family physicians who work with other health professionals such as nurses, dieticians, social workers, etc. as well as AHS community agencies to coordinate the delivery of primary health services for their patients. Programs and services offered through a PCN can be delivered centrally through one specific location, or decentralized at local physician offices. Each network has the flexibility to develop programs and to provide services in a way that works locally to meet the specific needs of patients within the community.

Primary Care Network Evolution – PCNe
<http://www.pcnpmo.ca/pcnevolution/Pages/default.aspx>

In 2010, the AMA released its *Vision for Primary and Chronic Care* in which it referred to PCN Evolution and recommended the College of Family Physicians of Canada (CFPC) concept of the patient-centred medical care home as a strong starting point.

In January 2013, the minister of health met with representatives from the AMA’s Primary Care Alliance to discuss ways to enhance and evolve PCNs. A new AMA/AH Agreement was signed in May 2013, with a special agreement for primary care. The Primary Medical Care/Primary Care Networks Consultation Agreement committed the parties to develop a framework for PCN Evolution, including consideration of how this evolution would link with the broader provincial primary health care strategy.

Physician clinics are evolving toward the CFPC model for the medical home; and the family physician clinic, supported by the PCN, is becoming a patient’s health

home. It is the hub for providing and coordinating primary care.

The key components of the vision for primary care are:

- physician/health care team patient relationship
- primary care services
- access
- governance and accountability
- supports and enablers.



Participation in PCN Evolution is voluntary for both physicians and patients. Either party is able to terminate the commitment at any time.

Benefits of this relationship include:

- improved health outcomes
- increased continuity of care
- panel management & quality improvement
- lower health system costs
- improved data for health system planning.

PCN PMO – Primary Care Networks Program Management Office. Provides operational and business administrative support services to PCNs, as well as tools and resources to support PCN websites, human resource management, change management, project management, and communications. Primary Care Network Evolution is managed through the PCN PMO. PCN PMO operates in partnership with TOP and the PMP programs.
<http://www.pcnpmo.ca/Pages/default.aspx>

PMP – Practice Management Program, operated through the AMA. PMP provides comprehensive business consulting services to PCNs, Physician Not for Profit Corporations (NPC), Board of Directors and individual physicians/physician clinics on a wide variety of business issues. Focus includes (but not limited to) operations management, human resources, governance, strategic planning, change management and business process improvement. The goal is to enable PCNs and physician members increase their business & operational efficiency to enable the provision of improved clinical services.

PMP endeavours to be a trusted business advisor to physicians and PCNs, enabling them to make informed business decisions. PMP operates in

partnership with TOP and the PCN PMO programs.
<https://www.albertadoctors.org/services/physicians/pmp>

QI – Quality Improvement. A systematic approach to making measureable improvements that lead to better patient outcomes (health), stronger system performance (care) and enhanced professional development (learning).

Registry – Organized by patient, rather than by disease. Data is pulled into a relational database from which reports can be generated that drive daily work by the team members. The registry can generate reports by patient, disease, team, team role, population of focus, alerts (e.g., test is past due), etc. to help teams plan their daily activities.

TOP – Toward Optimized Practice. Helps Alberta physicians and the teams with whom they work implement evidence-based practices to enhance patient care. TOP works with both PCN and non-PCN physicians as well as community-based specialists to implement specific, measurable and evidence-based changes in their practice.



Working together, TOP helps physicians and their health care teams implement clinical practice improvements using evidence-based best clinical guidelines, decision support & quality improvement tools and resources, and support from clinical process advisors. TOP operates in partnership with PMP and the PCN PMO programs.

<http://www.topalbertadoctors.org/home/>

Trilateral Master Agreement – Alberta’s PCNs arose from the 2003 to 2011 trilateral Master Agreement between the Alberta Medical Association (AMA), AH and AHS. Local primary care initiatives were formed in which a group of family physicians (in a not-for-profit corporation) formed a legal agreement with Alberta’s regional health authority (now AHS) to provide a set of primary care services targeted to the local needs of a defined population of patients.

Local primary care initiatives were later rebranded as PCNs. The first PCN “went live” in May 2005.

As of September 2014, there are 42 PCNs operating in Alberta. Over 3,000 family physicians currently practice in PCNs - serving the primary care needs of over 75% of Albertans (as paneled in PCNs in April 2013).

Unattached Patients – Individuals who require and/or desire a family physician for ongoing medical

care, but who currently do not have a therapeutic relationship with one.



Learn more about
PCN Evolution

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