

# **Chatham-Kent Health Alliance**

## **Working Terms and Definitions**

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## TERMS and DEFINITIONS

The majority of terms and definitions in this document are from the "*Canadian Health Care Glossary: Terms and Abbreviations*" published by the Canadian Healthcare Association. In addition, definitions and terms have been gathered from the following sources:

- Chatham-Kent Health Alliance (CKHA)
  - Ministry of Health and Long-term Care/Local Health Integration Network (MOHLTC/LHIN)
  - Canadian Institute of Health Information (CIHI)
  - Market Share Analysis prepared by McCartney Consultants Inc.
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**Alliance** - A method of joining two or more organizations. An organization may form an alliance with one or more partners in order to achieve common goals, often faster or at less cost than they could achieve on their own. An alliance is different from a merger or amalgamation in that all partners maintain their own identity. Alliances are often program-specific and time-limited. Chatham-Kent Health Alliance is rather unique in Ontario because of its size (larger than most), that a faith-based partner participates in the model, and the degree of operational integration (100%).

**Alternate Level of Care (ALC) Patients** - Used to describe hospital inpatients who have completed the acute phase of their illness but who continue to occupy an acute care bed while awaiting discharge to, usually, long-term care, residential or other community-based facilities.

**Alternate Payment Plan (APP)/Alternate Funding Agreement (AFA)** - Used interchangeably, these are OMA/MOHLTC payment plan agreements negotiated between physicians and the Ministry for non-fee for service type payments, but paid through and sometimes monitored by the hospital. This remuneration strategy may be based upon fixed or sessional fees, hourly rate or by patient capitation.

**Appropriateness** - Extent to which a particular clinical procedure, treatment, test or service is effective, clearly indicated given the patient's condition, not excessive or inadequate in quantity, and is provided in the setting best suited to the client needs.

**Average Length of Stay (ALOS)** - A common statistic used in healthcare facilities as an indicator of efficiency. Length of stay (LOS) is determined by counting the number of days from admission to separation of a patient. LOS is measured in patient days. ALOS is often compared to ELOS (expected length of stay), the statistical norm reported by hospitals in Canada.

**Average wait time** - Average length of time between receipt of referral and commencement of care or service.

**Bed blocker** - A negative term that refers to a patient in an acute care hospital who no longer requires acute services but who, for any number of reasons, cannot be accommodated in a long-term care facility. They are usually classified as ALC patients.

**Bed capacity** - The total number of beds a healthcare facility can actually physically and safely accommodate. Rated bed capacity is a fixed number and typically exceeds the number of beds that may be staffed and in operation at any point in time. Hospital occupancy rates are calculated using either rated beds or beds staffed and in operation.

**Benchmarking** - Measuring a product or service against excellence found inside or outside the healthcare field as an ongoing process for improvement. Benchmarking is one of many management tools used in an organization's total quality improvement program.

**CACC** – Central Ambulance Communication Centre.

**Canadian Counsel on Health Services Accreditation (CCHSA)** – An independent, non-profit organization and the major national accrediting body for health services organizations across Canada. CCHSA's accreditation program is "one of the few and most effective ways for health services organizations to examine and to improve the quality of their services". Participation in the program is voluntary.

**Canada Health Act** - This federal act spells out the roles and responsibilities of the federal and provincial governments in the delivery and funding of healthcare. This act established the five criteria that provinces and territories must satisfy in order to receive their full share of federal healthcare transfers. The criteria are universality, portability, accessibility, comprehensiveness and public administration. In addition to these criteria, the provinces and territories must also follow regulations contained in the act that require them to provide certain healthcare information and to acknowledge the role of the federal government in healthcare funding. It is the Canada Health Act that bans extra-billing and user fees and provides the legal framework for penalizing provinces that allow them. The Canada Health Act replaces the Hospital Insurance and Diagnostic Services Act and The Medical Care Act.

**Canadian Institute for Health Information (CIHI)** - A federally chartered, independent and not-for-profit organization, incorporated in 1993. CIHI leads activities in the standardization, collection, analysis and dissemination of Canadian health information. CIHI receives, analyzes and shares data with healthcare facilities, ministries of health, health-related organizations and associations, and the private sector.

Through these activities, the institute provides accurate and timely information necessary to establish sound health policy, manage the health system effectively and foster awareness of factors affecting good health.

**Capacity** - Refers to the number of beds available for use in healthcare facilities.

**Capital budget** - Different from operating budget, a capital budget is determined from various sources and is applied to investments in new buildings, renovations, property, equipment, information technology and other physical assets the organization requires. Like the operating budget, it is also managed in accordance with the values, mission, visions, strategic plan and goals of the organization.

**Case costing** - A method of healthcare accounting in which all direct and indirect costs incurred during an inpatient's stay are attributed to that case. Case costing allows healthcare facilities to determine the actual cost of caring for particular types of cases and to compare their costs to others that treat similar types of patients. Cost per weighted case is the usual indicator (see RIW).

**Case mix group/CMG+** – Every patient treated within a hospital has a disease classification assigned by international convention. Like DRGs (diagnostic related group) in the United States, CMGs use the most recent Canadian classification systems for diseases and related health problems (co-morbid conditions) and related clinical interventions. The CMG+ methodology assigns all discharged patient to major clinical categories (MCCs) and Case Mix Groups (CMGs). This allows hospitals and policy makers to monitor and trend the volume and complexity of cases treated in any given period.

CMG+ methodology is used to create distinct patient groupings that are clinically similar and/or homogenous with respect to hospital resources used. By linking patient groups to resources used in their treatment, CMG+ provides a tool for analyzing resource utilization and costs.

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**Catchment Area** - The geographic area where the majority of patients who receive services from the institution reside. Catchment area is the boundary used to define where the 99% of your current patients reside and can be quite different than one's market share over a broader defined region.

**CCAC - Community Care Access Centre** – A single point of access to the long-term care system, where one phone call provides all the information required for accessing community health and support services or admission to a long-term care facility (nursing home or home for the aged). CCACs combine Care Programs and Placement co-ordination services under one organization.

**CKHA Program Groupings** - Hospital and patient centered activities are usually organized around specialties of medical practice. To structure a market share analysis report and the way data is displayed, CKHA groups patient diagnostics in several different ways. The high level of hospitals grouping used by CKHA programs are medicine, surgery, obstetrics, paediatrics, and psychiatry.

**CKLAG -Chatham-Kent-Lambton Administrators' Group** – Aimed at improving service within the health, education and municipal sectors, sharing equipment, expertise, policies, advice and related resources among member organizations, and conserving resources for the taxpayers of Chatham-Kent and the County of Lambton.

**Clinic** - A specially designed, staffed, and equipped setting where ambulatory care is delivered to scheduled outpatients. Clinics are usually associated with hospitals but may also be provided in a stand-alone facility.

**Cost** - The expense incurred in delivering a product or service. In healthcare, there are many different types of costs including:

**Allowable cost** - Cost, that are reimbursable to an organization by the provincial health ministry.

**Capital cost** - the one-time cost of purchasing equipment or purchasing, renovating or constructing facilities.

**Direct cost** - costs that are attributable to a specific cost centre or patient encounter (e.g. surgical procedure, obstetrical delivery)

**Fixed cost** - a cost that does not vary with the volume of activity (e.g. taxes, parking, heating)

**Indirect costs** - costs that are incurred but are not directly attributable to a cost centre or a patient encounter (e.g. administration, health records)

**Variable costs** - costs that vary in direct proportion to the volume of patient activity (e.g. drugs, linen, medical supplies)

**CPOE (Computerized Physician Order Entry)** – A computer application used by physicians to enter diagnostic and therapeutic orders for a hospitalized patient. The purpose is quick access to local and global knowledge and decision support algorithms.

**Day hospital** - A scheduled array of hospital-based services offered during the day to patients who do not remain in the facility overnight. Day hospital services may be offered for up to ten hours per day, seven days per week. Services may include treatment, rehabilitation, counselling and vocational training.

**Day program** - An inexact term often used interchangeably with day hospital. "Day program" is generally taken to mean a less intensive, less structured service than that at a day hospital. Day programs generally offer fewer allied health professional staff than day hospital programs.

**Day Procedure Group (DPG)** - DPG is a classification system for ambulatory hospital patients focusing on day surgery. DPGs are useful in enabling a healthcare facility to analyze its same day surgery activity for quality management, planning, cost analysis and utilization. The most current list of day procedure groups is published annually by CIHI.

**Efficiency** - Refers to how well resources (inputs) are brought together to achieve results (outcomes), with minimal expenditure. Efficiency differs from effectiveness by introducing cost consideration as measured in money or time. A drug or healthcare service may be very effective but inefficient.

**Erie St Clair Integrated Supply Chain (ESC iSC)** – With the creation of the LHIN/Ministry of Finance Ontario Buys project, the focus on regional initiatives and consolidation/cooperation across regions has intensified. The goal of the ESC iSC is to improve current supply chain processes by adopting leading practices and promoting regional integration, showing hospitals can work together to make the overall system more efficient

**Estimated Length of Stay (ELOS)** – A predicted length of stay/time a patient will remain in hospital. The ELOS is created by CIHI for each CMG.

**Forward Sortation Area (FSA)** - The forward sortation area is a geographic area identified by the first three digits of a postal code. FSAs are often used to map hospital discharges so information can be graphically displayed on maps related to catchment area and market share calculations.

**Global budget** - A method of healthcare financing in which an organization receives a lump sum of money from a central funding agency to provide services for a given period of time, typically a fiscal year. The funding agency does not specify how the money is to be spent; this role is left to the governing body of the organization with the understanding the core activity (hospital services) are provided and reported upon at year end.

Health budgets in Ontario have been global in nature as are hospital and healthcare facility budgets; however, LHIN-based funding has shifted this traditional approach to "service level agreements" called H-SAAs or Hospital Service Accountability Agreements.

**Governance** - The act of governing in healthcare facilities and regions, as distinct from managing. Corporate governance is the responsibility of the board of directors/governors/trustees, usually volunteers. The principle activities of the governance structure are five-fold: to oversee operations/budgets; approve strategic planning; monitor quality and risk; appoint the CEO and Chief of Staff; and, to manage its governance process through the development of policies and bylaws.

**Great People, Great Place Committee (GP2C)** – A staff-based hospital committee whose purpose is "to engage with the strategic planning direction, *Great People, Great Place*, and enhance a positive environment where employees, physicians, and volunteers live their values, are valued, and because of that quality work exists and is rewarded and recognized".

**HSRC (Health Services Restructuring Commission)** – Mandated in the 1990's to advise the Minister of Health and Long-term Care on opportunities to address inefficiencies, waste and duplication in the health system.

**Health System Improvement Pre-proposal (H-SIP)** – Is a form health service providers complete as an initial step in submitting health system improvement requests to the LHIN for approval. The H-SIP process was developed collectively by Ontario LHINs to facilitate and standardize the way health system improvement requests are submitted. H-SIP is designed to capture the intent and scope of a health system improvement proposal. The purpose of the pre-proposal stage is to allow the LHIN to review and provide feedback on a proposed improvement prior to the health service provider committing resources to develop a detailed business case.

**Horizontal Integration** - In health reform parlance, the regionalization, amalgamation or merger of similar healthcare organizations (e.g. acute care hospitals) in a given jurisdiction for the purpose of improving effectiveness and/or achieving savings.

**Hospital Annual Planning Submission/Hospital Services Accountability Agreement (HAPS/H-SAA)** - The HAPS/HAA process is aimed at helping hospitals identify efficiencies to strengthen their operations and achieve a balanced operating position. It is based on the achievement of performance targets, as well as on negotiation and collaboration to the greatest extent possible.

**Hospital Indicator Tool (HIT)** - Provided on a website that is maintained by the Ministry of Health and Long-term Care to allow comparative analysis of hospital specific areas with peer hospitals of choice. Information is updated and shared on a quarterly basis.

**Hospital Standardized Mortality Ratio (HSMR)** – Compares hospital mortality rate to an overall average rate based on a group of diagnoses that account for 80% of all deaths. The figure is adjusted for age, sex, and length of stay. Observed deaths divided by expected deaths multiplied by 100. A rate greater than 100 suggests the mortality rate is higher than the overall average.

**Hospitalist** - A physician whose clinical practice is predominantly based in a hospital and who is responsible for a patient's care throughout their stay as MRP. A hospitalist can be a general practitioner or internist, and some geriatricians have also assumed this role. The hospitalist acts as the most responsible physician (MRP) for patients who are not being cared for by a specific specialty, for those admitted patients who do not have a family physician (orphan patients) or those admitted patients whose care has been transferred by the usual attending physician. The role includes coordination of consultations with specialists, therapists and discharge planners. Their compensation formulae vary from hospital to hospital.

**Hot site/Cold site** - A metaphor to describe the relative acuity of clinical sites that may have differing capabilities based on their inherent infrastructure and clinical supports. "Hot site" is staffed and resourced for a full range of clinical services to support emergency services and urgent care. This means that staffing is either on-site 24/7 or immediately available. This does not refer to the ER, per se, but means the ORs, labs, diagnostic imaging, respiratory therapy or other critical supports are readily available and supported by cost effective and sustainable call mechanisms. Chatham-Kent, in many clinical departments and services, does not have the manpower and capital resources to provide 24/7 call groups and technology to two sites—this was at the core to services rationalization in Chatham in the 1990s.

"Cold site" is not staffed for 24/7 emergency procedures and full range of services or on-call mechanisms—rather is an environment of scheduled and lower risk procedures that do not require the full range of 24/7 support services through call mechanisms.

Urgency, access to support services, capacity, and in some cases complexity of care, are the drivers of the "hot site/cold site" differentiation. In both, the case mix handled by the respective programs respects that one site is serviced for higher end/urgent care; the other is not. The reason: the volumes of clinical care and critical mass of health professionals cannot cover/provide call to two sites simultaneously. It also means that the "cold site" has to have mechanisms to assess/triage, communicate and transfer appropriate cases to the "hot site." "Cold sites" can usually handle scheduled clinical care where the "surprise" factor is minimized. This model exists at numerous facilities in Ontario: ranging from Trillium Healthcare (former Mississauga General/Queensway), Lakeridge (with Oshawa General as the hub), Quinte Health, Brant Community, etc. The Ontario stroke strategy is an example of how a "hot site/cold site" model works.

**Indicator** - Performance measurement tool, screen or flag which is used as a guide to monitor, evaluate and improve the quality of client/patient care, support services, governance and management. Indicators relate to processes and results (outcomes). Indicators form the basis of a healthcare facility's quality assurance and improvement program.

**International Classification of Diseases (ICD)** - The World Health Organization (WHO) uses this nomenclature to describe all diseases in common taxonomy. The current version - ICD-10 - assigns identifying codes to all recognized disease groups and procedures. The ICD-10 system and its revisions are used as the basis for health record abstracting and reporting clinical information, and is the basis for any analysis or comparison of clinical performance.

**Joint Policy and Planning Committee (JPPC)** - A partnership organization between the MOHLTC and Ontario's hospitals through the OHA. This partnership has been forged to recommend and facilitate the implementation of hospital reform within the broader context of the healthcare reform agenda in Ontario. Most of its recommendations deal with the policy framework associated with system funding and performance management.

**LEAN/Six-Sigma Healthcare** - LEAN is a "systematic approach to identifying and eliminating waste (non-value added activities) through continuous improvement by flowing the product at the pull of the customer in pursuit of perfection". A LEAN organization is one whose service delivery processes are waste-free. Building a LEAN system is a never ending process and is everyone's responsibility within the organization.

The Six Sigma strategy combines the skill of employees with powerful statistical and consensus-building tools to better identify client needs and virtually eliminate errors and defects.

**Local Health Integration Network (LHIN)** – Is a critical part of the evolution of healthcare in Ontario from a collection of services to a true system that is patient-focused, results-driven, integrated, and sustainable. The Local Health System Integration Act, 2006, places significant decision-making power at the community level and focuses the local health system on the community's needs, improving health results for patients in every part of the province. LHINs will facilitate the effective and efficient integration of healthcare services and make it easier for people to get the best care in the most appropriate setting, when they need it. Ontario has 14 LHINs with varying geographic scale and populations (i.e. Toronto vs. northern Ontario).

**Master Program/Master Plan** – The Master Program is a document that reflects the healthcare facility's present and future role within the community. It outlines current and projected program, staffing, and departmental space requirements based on the demographic data in the healthcare services plan.

A **Master Plan** translates the master program into a physical plan, analyses site use options for alternative development scenarios, and defines the predicted states of development for the facility. The master plan contains a site plan and site utilization diagrams indicating the location of major elements and buildings, entrances and exits, utilities, site services, parking, and obsolete buildings and plant that need renovation or replacement.

**Med 20/20** - A software application used by health records at CKHA to abstract and report upon the types of cases and procedures provided during the course of care at the hospital. This is the source information used to determine the severity of illness, catalogue procedures and interventions to define complexity of care and ultimately reimbursement.

**"Mini-me"** - A metaphor to describe a model where one site (in a multi-site model) is a smaller scale version of a bigger site. This means that the full inventory of services and capabilities is duplicated, but for a smaller volume of patients. Issues with this model include: critical mass for quality, economy or proficiency; requirement of double call coverage and setting up the dynamic that each site is free standing with independent referral patterns. Where there are sufficient cases and manpower, the model is of no real consequence and improves access to care across a geographical region.

However, where volumes are low, the model becomes a "loss leader" for economy and efficiency and is often cited for the potential for lower quality as volumes are insufficient for staff to experience the full range of clinical outcomes to their long term professional growth and skills maintenance. A variation on this theme is the satellite model—where a site houses selected (usually out-patient) components of the larger site. This is how Chatham enjoys dialysis and oncology programs through London Health Sciences and how mental health provides coverage from Chatham to the Wallaceburg site. In each case, the sponsoring program directs the services at the satellite location. When the client condition requires intervention beyond the capabilities of the satellite facility, the client is referred to the lead site.

**Mission** – Gives the overall purpose of an organization. A mission statement explains what the organization does, for whom and the benefit. A vision, on the other hand, describes how the future will look if the organization achieves its mission; it is a statement that describes a picture of the "preferred future".

**MNRH - May Not Require Hospitalization** - Those diagnoses/procedures that have been statistically determined may not require hospitalization and could be moved to the outpatient sector. A CMG is deemed to be MNRH when a certain threshold of Canadian patients has a length of stay of less than one day.

**MRD - Most Responsible Diagnosis** - The one diagnosis which describes/predicts the most significant condition of a patient/resident and the health services/procedures they require.

**MRP - Most Responsible Physician/Provider** - This is the physician most responsible for the care of the patient and/or the longest portion of their length of stay. The MRP may be the admitting physician, the procedural physician or the physician assigned the case. Every patient in the hospital has an MRP.

**MRSA – Methicillin-resistant Staphylococcus aureus** - A strain of the gram-positive bacterial species *Staphylococcus aureus* that is resistant to the antibiotic Methicillin and the related antibiotics oxacillin and nafcillin. (Source: Administrative Resource Manual Policy 5-280)

Carriers and colonized patients act as a reservoir of MRSA that could be spread to other patients who may be at risk of developing a serious infection. Infected patients need to be treated aggressively as the bacteria may become blood borne and life threatening.

**Occupancy** - A measure of the number of beds in a healthcare facility that are in use at a given point in time. Occupancy is determined by taking the midnight census and dividing by the number of beds staffed and in operation and is expressed as a percentage. Occupancy rates are used as a measure of utilization for healthcare facilities.

**One program/Two sites** - To describe that CKHA is organized by clinical programs (medicine, surgery, emergency and community care, women and children, mental health and rehabilitation and long term care). Programs may have in-patient, out-patient, outreach, satellite, screening, patient education and partnership elements based on need, volume of care and resource efficiency.

Some programs may have multiple sites, for example, if CKHA were to sponsor a network of primary care clinics across Chatham-Kent or outreach services for disease screening programs. In some cases, we might consolidate in-patient care (e.g. Paeds); in others, duplicate on both (e.g. medicine).

**Operating Budget** - Indicates the goods and services the organization expects to consume in the budget period, listing both physical quantities and cost figures, and incorporating expense(s), revenue(s) and profit. Expenses include salaries and benefits, supplies, drugs, facility costs and contracted services.

**Outliers** – Cases that exceed trim length of stay. Basically abnormally long lengths of stay, which exceed normal limits.

**Patient-centred care** - A model and philosophy of care that incorporates the preferences of the patient and their families in the delivery of health services. In a patient-centred care model, activities are done *with*, and not *to*, a patient and the focus is on the person and not the medical condition. (Also known as patient-directed care or patient-focused care).

**Patient days** -The total number of days in a given period (e.g., month or fiscal year) during which an inpatient bed was occupied. A bed is considered filled if it is occupied at midnight. Patient days divided by the total number of beds/days available (number of beds x 365 days) give the occupancy rate. The number of patient days for each admission is called the Length of Stay. Total patient days divided by total admissions gives the Average Length of Stay. The total number of patient days is a key indicator of activity in a healthcare facility.

**PCOP - Post Construction Operating Plan** – Before any significant capital project is approved by the MOHLTC the hospital must file and be approved for a PCOP. The PCOP provides estimates of the funding adjustments required by hospitals upon completion of each capital project/phase can be developed. Under the PCOP process the determination of necessary funding adjustments is based on: expected changes in patient service volumes (increments in existing patient services and planned new patient services); and, new operating costs directly altered by the capital project.

**PDST – Planning Decision Support Tool** – A tool used to assist in the analysis and review of program-related projects and to assess hospital operation performance against provincial targets, average and benchmark performance levels in key categories of hospital activity.

**Primary care** – First along a continuum of care (primary, secondary, tertiary, quaternary), primary care consists of basic curative care (including simple diagnostic and treatment, and referral of complex cases to a higher level), preventative care and essential health education, usually provided at the point of initial entry into the healthcare system.

**Program Cluster Groupings** - This grouping methodology was developed by the MOHLTC to cluster patient diagnostic data (CMG data) into medical sub-groupings of patients enabling more detailed analyses by hospital program. Program cluster groupings were developed by the MOHLTC to compare performance data among Ontario hospitals.

**Program Management** - An organizational design model. In healthcare, program management refers to an organization design structured around medical programs (e.g., paediatrics, orthopaedics) as opposed to functional areas (e.g. nursing, allied health, hotel services). Health care programs stem from the corporate mission and are designed around patient needs. The focus is on patient outcomes and the decentralized decision making is driven by information. Organizations with program management delegate decision making to teams of managers who have full responsibility and accountability for programs.

**Qualifying Day Surgery** - The term qualifying day surgery was developed to identify those day surgery cases treated within a hospital that were correctly coded by the health record department and the MOHLTC could include in the cost per weighted case methodology.

**Quality, Risk and Patient Safety Council (QRPSC)** - Ensures a systematic approach is taken to continuous quality performance improvement, risk management and patient safety across the organization. This Council, with representation for the ten Accreditation Teams, the Chief Nursing Executive/Chief Health Professions Officer, Chief Information Officer, Vice President and Chief Human Resources, Infection Control and Pharmacy, is responsible for:

- Ensuring timely implementation of required processes to meet the objectives of the CCHSA's "5 Areas of Patient Safety"
- Overseeing the completion of HIROC Risk Modules
- Providing direction, and overseeing the completion of CCHSA standards and ensuring CCHSA recommendations are responded to
- Identifying organization-wide quality, risk and patient safety related indicators
- Communicating information relevant to quality, risk and patient safety concerns, process improvements, etc.
- Overseeing change management and performance improvement processes

*(Source: QRPS Council Terms of Reference)*

**Quality of care** - The degree to which the care delivered to a patient or an entire population meets that patient's or population's needs and, as well complies with established standards of care.

**QUEST for e-Care** - is a collaborative information technology initiative developed by CKHA, Windsor Regional Hospital (WRH) and Consolidated Health Information Systems (CHIS). QUEST is an acronym for Quality, Utilization, Efficiency, Safety and Technology (highlighting anticipated benefits of information technology) and e-Care is a system of care incorporating electronic tools such as bedside devices, document management and data storage/retrieval. These applications include Horizon Expert Orders (Computerized Physician Order Entry), Meds Manager (Pharmacy system), Surgical Manager (OR system), PACS (Picture Archival Communication System) in Diagnostic Imaging, among many others. These systems and applications incorporate research and specific best practice guidelines in CKHA' IT strategy as well as those within the LHIN.

**Referral Area** - The geographic area from which a secondary, tertiary or quaternary health care facility draws its patients. In some situations, the referral area is mandated by government. In others, it is based on physician practice patterns. The referral area for a healthcare facility may be different for each medical specialty.

**Resource Intensity Weights (RIWs)** – An indicator representing the relative resources used by a patient. Specifically, RIWs are relative values that describe the expected resource consumption of an average patient within a CMG. For example, the RIW for a cholecystectomy (gall bladder removal) is about 1.00 while that of a total hip replacement approach 3.00 and a heart transplant is even a greater multiple.

**Rural health** - A defined scope of healthcare services focused on delivering primary health services across a non-urban geographic region. For example, general practitioners, screening programs, mobile diagnostic services. Usually sponsored by a hospital or clinic.

**Satellite** - A healthcare service that is provided away from the main department. Common satellite services include dialysis centres, pharmacy and laboratory. A satellite places the service closer to the delivery of patient care while achieving benefits of central coordination, improving communication, decreasing turnaround and improving overall patient care.

**Secondary healthcare** - Consists of specialized care requiring more sophisticated and complicated diagnosis and treatment than is provided at the primary health care level. Secondary care is typically provided by a specialist (e.g., internal medicine, general surgeon) as opposed to a primary care provider (general practitioner, paediatrician) and usually requires a formal referral except in the case of an emergency. By definition, all patients admitted to hospital are, at minimum, at a secondary level.

**Strategic Planning** - Formalized, ongoing, long-range planning to define and achieve the goals of the organization. The strategic plan responds to seven questions: What are we?; Where are we now?; What is the environment?; Where do we want to go?; How should we get there?; What will our path look like?; How will we measure our progress? The result of strategic planning is a set of organizational goals and objectives that align individual strategies for achieving them. Strategic plans have variable time frames. In stable environments, they may cover five- to seven-year horizons; most hospital plans are in the 3 to 5 range. Strategic plans form the basis of budgets, a framework for any review of organizational performance and timelines for milestone events.

**SWIFT decision-making (Strategic Wise Informed Fast and Timely)** – A term created by the Vice President/Chief Financial Officer to describe our initiative to continuously improve our decision-making and communications processes.

**Tertiary healthcare** - Consists of highly specialized diagnostic and therapeutic services, which can usually only be provided in centres specifically designed, staffed and equipped for this purpose. Trauma, transplant, high end neonatal and intensive care units are examples of tertiary care programs.

**Union** – CKHA has contracts with the following unions:

**CLAC** – Christian Labour Association of Canada (e.g. housekeeping, engineering, dietary, ward clerks, rehab assistants)

**ONA** – Ontario Nurses Association (e.g. RNs, Nurse Practitioners)

**OPSEU Office/Clerical** – Ontario Public Service Employees Union, Office/Clerical (e.g. Program secretaries, registration clerks, accounts receivable clerks)

**OPSEU Paramedical** – Ontario Public Service Employees Union, Paramedical (e.g. Lab technologists, pharmacists, physiotherapists)

**Utilization** - The pattern of usage of health care resources by individuals or groups over a period of time. Healthcare utilization can be reviewed on a personal, institutional, provincial or national basis in order to determine patterns of care for comparative purposes. Utilization review may be conducted on health programs (e.g. cancer care), institutional care (e.g. hospital admissions) or healthcare products (e.g. pharmaceutical usage).

**Values** – Organizational values define those attitudes and behaviours believed to be essential to create the desired culture or internal context for the work of the organization – the work necessary to accomplish the vision and achieve the mission. Clearly defined values provide a code of performance of both individuals and organizations.

**Value-added** - A concept whereby a product or service is enhanced through the addition of features beyond the standard model or consumer expectation. In discussions of processes, if a step in a process is enhanced through the addition of a good or service, then it can be referred to as value-added. In total quality management exercised, individual processes are reviewed to ensure that each step adds value to the product. Those steps that do not are marked for modification or elimination.

**Vertical Integration** - A term used to describe the integration of services across health sectors (e.g., acute care hospitals, home care, long-term care). A vertically integrated health system is expected to improve the continuity of care by removing artificial boundaries between organizations within and across sectors. Vertical integration is often described as a goal of healthcare reform initiatives.

**Vision** – Realistic description of what the organization will become and where the organization will go in the future. Vision represents destinations that are achieved through following prescribed road maps that the organization refers to as strategic directions or strategic plans. A vision statement describes how the future will look if the organization achieves its mission.

**Waiting time** - The time between when a patient books an appointment and when the patient is actually seen by the healthcare professional. Waiting time is often used as a quality indicator and is known to be closely correlated with patient satisfaction. If you need several procedures for your condition, each one can have its own wait time. Most wait times are the duration between the time a course of treatment is decided and when it is performed (e.g. orthopaedic surgeon and patient deciding to schedule a hip procedure and the actual date of surgery).

**Weighted case** - A patient encounter or case that has been statistically manipulated in order to account for the amount of healthcare resources that were theoretically consumed during the course of treatment. The use of a weighted case gives healthcare facilities the ability to compare the cost of treating certain types of patient across their organization with other facilities. Increasingly, provincial governments are using weighted cases as a basis for determining the appropriate amount of funding for a healthcare facility.