Welcome to a new year of *Healthcare Quarterly*. Since 1997 — when Jean Chrétien skated to his second majority government and the Detroit Red Wings flew home with the Stanley Cup — the Longwoods team has been showcasing the latest developments in best practices, policy and innovations in healthcare administration. Here's a snapshot of what you'll find in the first issue of our nineteenth volume.

Brokering Information

The year 1997 also saw the creation of the McGill University Health Centre (MUHC). "Information brokering," Malvina Klag and Marie-Claire Richer explain, was critical to the success of this "dramatic and unprecedented" 18-year endeavour carried out by the MUHC's Transition Support Office (TSO). While learning from the literature on "knowledge brokering," the TSO developed an *information brokerage* "to ensure the right information was available to the relevant stakeholders at the right time." Formal, integrated, centralized, neutral, multifaceted and multilevel: these are among the main characteristics of the information brokerage the authors advise for others planning similar large-scale projects.

Process Improvement

The MUHC's transformation involved a vast number of processes, and fully half of this issue of *Healthcare Quarterly* is devoted to fresh approaches to process improvement. Blayne Welk and his co-authors look at the impact of linking the results of cross-sectional imaging results across hospitals and locations using health-information exchange systems. Examining such a system in Southwestern Ontario, the authors found that the consequent reduction in test repetition enhanced patient safety and hospital/system efficiency.

Inventing ways to improve patient flow in emergency departments (EDs) is a longstanding quest. At Southlake Regional Health Centre in Newmarket, Ontario, the key to process improvement — hinging on the business concepts of value, flow and efficiency — was connecting patients and physicians as soon as possible. To this end, Shawn Whatley, Alexander Leung and Marko Duic explain, Southlake's improvements pivoted on triage, patient inflow and staffing patterns. Lean-driven transformation — eliminating waste and, again, enhancing flow — is another frequent approach in process improvement. At Toronto's Hospital for Sick Children's eye clinic, one of the most persistent issues has been long patient dwell times. Readers will be galvanized by the process improvement team's results in improving this and other related shortcomings. However, the marrow of Agnes Wong et al.'s article concerns the role implicit "mental models" (based on unexamined assumptions) play in creating problems and how, as was the case at SickKids, we can use data and analysis to "build a new mental model" that will aid both patients and staff.

EDs are about flowing patients into the healthcare system, but many experts are also puzzling over how to transition them out to home. Patient-Oriented Discharge Summaries (PODS) are the topic of Shoshana Hahn-Goldberg et al.'s sketch of a project by eight Toronto hospital departments. Customizable for different programs and now freely available online, PODS were co-designed by patients, providers and caregivers, and they contain information patients want at discharge (e.g., medications, appointments). Results are encouraging, with a majority of patients reporting that PODS improved their understanding of their discharge instructions.

Our final process improvement piece returns us to the staff level. Jackie Charko and her colleagues at Halton Healthcare address their use of simulated decentralized patient-care unit prototypes in order to prepare their colleagues for the transition to such a model at a soon-to-be-opened new hospital. Patient-bed numbers, nursing assignments, pod-team station locations, equipment and technology, software licences: these were some of the main factors the team had to grapple with. But the results — including staff confidence and readiness — justified the effort.

Advancing Standards of Care

To what extent does addressing social determinants of health and providing family-centred care require clinicians to deviate from or add to standard care practices? And what are the legal and ethical considerations of doing so? Taking pediatric healthcare as their context, Karen Ho et al. use a case-study approach to unpack several weighty medico-legal tensions and obligations. They also recommend several helpful considerations, including physicians' need to distinguish between parents' consent and the "legal duty of care" they owe to children.

Data Quality

Hospitals are accustomed to being measured. Senior managers at St. Joseph's Health Centre (SJHC) in Toronto, however, were surprised when the Canadian Hospital Reporting Project indicated SJHC had health outcomes poorer than at peer hospitals. This apparent shortcoming, it turned out, had most to do with data quality, analysis and lack of physician involvement in those activities. The two-track data-quality initiative — (1) examining data collection, coding and analysis; and (2) physician case reviews and documentation — undertaken to address the situation led to investments in decision support and health records infrastructure at SJHC, as well as training for staff and physicians on coding and documentation.

High-Performing Healthcare Teams

Teamwork: so much potential, so many challenges. And how can we know whether teams are functioning well? To help answer that question, Kathleen Klaasen and her fellow contributors introduce the development and piloting in Winnipeg of a standardized, evidence-informed program for improving the effectiveness of interprofessional collaborative care teams. Comprising eight indicators, the program proved to be "effective and expedient" for diagnosing team strengths and identifying areas to improve. Interestingly, these positive results were obtained across varying team functions, patient populations and team compositions.

Care in the Community

Our final article presents 10 "practical strategies" for embedding person- and family-centred care (PFCC) in home, community and long-term care organizations. Among the strategies Danielle Bender and Paul Holyoke outline are leadership direction/support, education, enhanced documentation and communication, and the recognition of staff accomplishments. On this last point, one of the paper's most original insights — one that fits neatly with some of the points raised by Klaasen et al. — is that PFCC entails attention not just to the "personhood" of care recipients but also to the human resources that deliver the care itself.

– The Editors

CMHA announces Dr. Patrick Smith as new national CEO

CMHA's National Board of Directors is pleased to announce that Dr. Patrick Smith is CMHA's new national CEO. With a PhD in clinical psychology, he brings considerable experience to this position, having worked in leadership roles in the mental health and addictions sectors for more than 20 years.
Dr. Smith assumes his new role on April 18, 2016.