Healthcare Quarterly at 25

After two years of turmoil, the pandemic seems to be waning. The light at the end of a two-year-long tunnel is getting brighter. Spring is coming – although slowly in some parts of the country. Children are back in school. We are able to socialize and travel again with fewer and fewer restrictions. Tragic events, such as the war in Ukraine and the challenges of climate change notwithstanding, there is a sense of hopefulness in the air.

This season also marks 25 years since the first issue of *Healthcare Quarterly*. Looking back, we can see how the publication – and the health services sector it serves – has matured. And, looking forward, we can envision more progress and innovation in healthcare and *Healthcare Quarterly*, which welcomes new editors-in-chief (more on that later).

In the Beginning

Some readers may remember that the journal began as *Hospital Quarterly* (1997 to 2003). The name seemed appropriate because hospitals were perceived as the dominant players in the health services sector. At that time – the late 1990s – articles from authors across Canada discussed the big issues: benchmarking and performance reports (public access to data?); financing and delivery strategies (the great public versus private debates); regionalization models (one size does not fit all); organizational mergers (some successes and some failures); and, of course, the much ballyhooed Y2K catastrophe.

Over time, the need for health system reform led provinces to focus less on hospitals alone and more on how all sectors and services can work together. Rebranded *Healthcare Quarterly*, the journal attracted and published papers that emphasized evolving priorities such as wait-time strategies, integrated care, electronic medical records and patient safety.

The Guiding Hand of the Editor-in-Chief

For the first 15 years, we had the good fortune of having the late Peggy Leatt serve as the journal's editor-in-chief. Peggy Leatt was chair of the Department of Health Administration at the University of Toronto in Toronto, ON, before moving to a leadership role in the UNC Gillings School of Global Public Health in Chapel Hill, NC. Under her excellent guidance, the journal emerged as a venue for authors to share evidence-based practices with colleagues across the country. It is a model that still serves us well.

Peggy Leatt was succeeded in 2013 by G. Ross Baker at the University of Toronto's Institute of Health Policy, Measurement and Evaluation. Ross Baker is considered Canada's pre-eminent researcher in patient safety and quality improvement. During his tenure, the journal's mandate embraced the country's fledgling quality improvement, health system innovation and patient and family engagement agendas. Submissions continued to reflect the realities of health services with themes that included primary care reform, elder care, models of integration and patient-centred care.

Through the Pandemic

As the health services sector reoriented to face the challenges brought on by the COVID-19 pandemic, the journal's content also refocused on the new reality. Authors across the country were quick to share their practice innovations and approaches to common problems that all jurisdictions were facing. Pandemic-era articles explored topics such as leadership and crisis management, supply chain issues, personal protective equipment shortages, equity, governance and virtual care. People's willingness to share their ideas and tactics in spite of the myriad demands on their time was – and is – remarkable.

Where We Are Now

Through 25 years of publishing, two remarkable editors-in-chief and the invaluable contribution of hundreds of authors, *Healthcare Quarterly* has sought to provide readers with evidence-based ideas and innovations to help them make informed decisions and manage effectively. With the support of its community, the journal plays a critical role in sharing thought leadership, contributing to professional and public discourse and demonstrating the power of collaboration.

We are now delighted to welcome our new editors-in-chief Anne Wojtak and Neil Stuart, who will combine their unique knowledge and expertise to help shape the future directions of the journal (see "Welcoming Our New Editors" [Hart 2022] for more information). We look forward to continuing to provide a platform for exchange and collaboration while also exploring new ideas and direction, such as the critical importance of the social determinants of health, integration of population health concepts into healthcare delivery and system integration.

We thank all our readers for their sustained support and commit to continue to earn your audience over the decades to come.

In This Issue

The evolution of healthcare and *Healthcare Quarterly* described earlier depicts discrete developments proceeding pretty much in lockstep. But as the articles in this issue reveal, all evolutions are not equal. Legislation often lags well behind healthcare realities and requirements, taking time to catch up to new imperatives, attitudes and norms. What governors choose to focus on may miss the mark for which they aim. Competencies favoured in leadership programs may be poorly matched to the tasks required for the job.

Still, innovative experiments in areas such as procurement and the use of artificial intelligence are increasingly in evidence. The complexity and diversity of healthcare issues make it extremely difficult to determine the right weight to apply to competing priorities and to recalibrate over time. And if putting the right primary care model (or models) in place were so easy, the work-in-progress would not be so prolonged.

Tackling the mammoth job of launching a cross-training program to prepare nurses to support a besieged intensive care unit (ICU) during the COVID-19 pandemic – and revising it, all in mere weeks – shows the capacity (and courage) to respond in real time. One of the columns in this issue details some of the burden that the country's healthcare workforce has shouldered throughout the pandemic – and very likely will continue to carry long after the pandemic.

Patient safety

An intriguing case study on Section 51 of British Columbia's *Evidence Act* (1996) suggests that what you do not know can hurt you. Robson et al. (2022) argue persuasively that despite the good intentions behind extending legal privilege to quality and safety reviews – eschewing naming and blaming in preventable patient harm incidents to encourage learning – the law shields providers, suppresses the truth and teachable moments and, most importantly and unfortunately, hinders healing, especially for people belonging to vulnerable groups who experience disproportionately high levels of harm. The authors call for legislative amendments critical to providing trauma-informed care and restoring trust in the system.

Governance issues

Continuing to probe the workings, wisdom and impact of hospital boards, Hooper (2022) analyzes the relationship between the amount of attention boards pay to quality and finance and the performance outcomes achieved. Using what is described as "the first known quantitative peer-to-peer comparison tool for boards," Hooper (2022: 29) discovered that on average – and regardless of facility type – hospitals are about six times more focused on finance than quality. The study found the payoff to be either nonexistent or negligible, leading the author to suggest that boards should carefully consider the topics they discuss and the time devoted to them.

Promoting innovation

Taylor and Doyle (2022) describe Eastern Health's (EH) foray into "vested contracting," highlighting its history and features, along with associated risks and advantages. EH entered into a long-term contract with a sole-sourced vendor (Compass One Healthcare) in 2020, outsourcing management services for housekeeping, laundry, patient/resident/retail food services and portering. The article, based on interviews with EH executives, directors and the successful vendor, is forthcoming about the challenging demands of the transition – time, training, process and system change and relationship building – but points to greater manager accountability as an early benefit.

Digital health

Shen et al. (2022) have contributed an even-handed and thought-provoking analysis on enabling adolescents' access to their own personal health information (PHI). Readers get a solid briefing on the entwined issues, competing imperatives and disparate rules and rights at play, consent to treatment and expectations of confidentiality, adolescent autonomy, the mature minor doctrine, parental and provider responsibilities and more. The authors provide a clear sense of the legal, ethical, technological and logistical complexities that healthcare organizations are often ill-equipped to manage. There are no standardized approaches or policies on PHI access for minors. Some jurisdictions have no statutes to inform policy making and can only look to federal laws drafted for the private sector. Others set the age of majority at 18, still others at 19. In Quebec, you can access and control your PHI at age 14. Coherent laws and policies on PHI access for adolescents are needed across the country and must reflect the realities of the day. For instance, with virtual care becoming more and more common, denying PHI access to adolescents could negatively affect healthcare utilization and health.

Leadership development

What must healthcare stewards of the future bring to the table? How can graduate leadership programs prepare them for the challenges of the day and decade? Parker et al. (2022) provide

a collective response drawn from interviews with leaders in government, the hospital sector and consulting agencies. Graduate leadership programs must change what they teach and how they train to produce executives with a full complement of competencies that are currently missing or deficient: communication, change management, emotional intelligence and using data and evidence to drive healthcare improvement. To support this, graduate programs should increase experiential learning and dedicate more time to producing better writers and those with a greater understanding of Canadian and global healthcare systems.

Primary care models

As primary care models emerged over the decades, funding structures presented barriers to physician participation in team-based care. Backo-Shannon and Bilton (2022) assert that a new model that they have evaluated has resolved this challenge and provides a range of other benefits. CarePoint Health is an integrated primary care hub in Mississauga, ON, that links family physicians – no matter how they are paid – to team-based care and allows them to access shared resources. A total of 70 affiliated physicians use the centre as an extension of their practices, serving over 100,000 patients and providing access to comprehensive programs and services. The authors say that strong design, team unity and a culture of learning are key assets for CarePoint Health's model. They report that it has produced high satisfaction scores for providers and patients and offers simplified system navigation and coordinated health system planning.

Responding to the COVID-19 pandemic

Within weeks of COVID-19's first wave, the Michael Garron community hospital in Toronto, ON, created, evaluated and revised a program that prepared redeployed nurses to support ICU teams. Reguindin et al. (2022) describe the initial training and education and a second round revised using nurses' feedback to an initial evaluation. The support nurses requested better role clarity, more practice supports and education tailored to each nurse's experience. The authors noted that nurses experienced a pervasive sense of anxiety throughout the learning experience, undertaken at the height of the first wave when few policies or procedures existed. However, they report that the nurses responded positively to the program's reorientation and enhancements, which included another in-class session, more clinical shifts with a level A nurse and simulation training on team-based practice and managing patients' deteriorating conditions.

Quarterly columns

Rosella and Harish (2022) explain how ICES is exploiting its extensive health administration databases to advance machine learning models. As the distance between development and application narrows, they raise important questions about what could be done and what should be done, how and why. Sharing the latest data on COVID-19's impact on the health workforce, authors Tardif et al. (2022) from the Canadian Institute for Health Information highlight changes in roles, virtual care and supply. They report that nearly 6,000 non-practising providers joined the workforce in 2020, but with exposure and infection rates, shortages persist – as do challenges in long-term care and the likelihood that the pandemic will have a long-term and negative impact on the entire workforce.

– The Editors

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