At the time this editorial was being drafted, Team Canada had just completed its best-ever performance in the 2026 FIFA World Cup. This led us to consider the parallels between the worlds of sports and healthcare, with both existing in spaces with high-stakes performance, significant public attention and limited margins for error. In keeping with our *Healthcare Quarterly* focus on healthcare leadership, additional reflections on the sports versus healthcare analogy include the importance of shared purpose over star power, the value of great coaching, the importance of careful planning and preparation and the role of culture in teamwork. As we think about the work to transform healthcare, there are valuable lessons to be learned from within and outside of healthcare. Our *Healthcare Quarterly* editorial team is pleased to continue bringing our readers new and innovative reflections on healthcare leadership and how we "coach" our teams to even higher levels of performance.

In this edition, we continue our theme on integrated care with two new articles on this topic, both featuring the relatively new Ontario Health Team (OHT) models introduced in the province of Ontario. The first article features learnings from the first collaborative accreditation survey process for a multi-governed integrated care network in Southwestern Ontario. The second article addresses the very topical theme of the role of primary care in integrated care. From there, we move to the topic of pharmaceutical research and its connection to health data transformation. This is followed by a different perspective on data, introducing an innovative central command model in Nova Scotia that enables access to real-time patient information to support planning and decision-making. Additional featured topics include ethical decision-making in direct service funding and planetary health. This latter topic is an important and emerging issue for healthcare, and one we would like to draw more attention to. Finally, we wrap up with our quarterly columns from ICES on the learnings from inflammatory bowel disease (IBD) to develop precision public health approaches to multimorbidity (Postill and Benchimol 2026); the Canadian Institute for Health Information's (CIHI's) review of acute care utilization by those with combined mental health and substance use issues (Chen et al. 2026); and Neil Seeman's Quarterly Reflection on the controversy surrounding the expansion of medical assistance in dying (MAiD) in Canada (Seeman 2026). As always, we look forward to hearing from our readers on these topics, as well as suggestions for additional topics for us to explore.

Integrated Care Across Canada

OHTs were introduced in 2019 to advance integrated systems of care across the province by bringing together different health and social care providers to serve a defined population. One OHT, which serves a largely rural region in Southwestern Ontario, made the decision to view accreditation as a system-level integration strategy across 10 partners as opposed to the traditional approach to accreditation within single, distinct organizations. The authors, Lamport Lewis and Partridge (2026), describe the process by which the OHT achieved "accreditation with exemplary standing as an integrated system" through Accreditation Canada. This remarkable achievement comes with some powerful lessons learned about governance, integration, leadership and relationships. The approach demonstrates the potential for leveraging the accreditation process to advance integrated care.

In a second article featuring OHTs and integrated care, Ng et al. (2026) describe the introduction of an integrated home-based primary care program for frail homebound seniors. While other examples of integrated home-based primary care exist across the country, this model was purposely designed to embed person-centred care across macro, meso and micro levels of integrated care. The program is achieving high levels of success, including in health outcomes, avoidable hospitalizations and patient and provider experience. As our population ages, it is valuable to share the lessons learned from such leading examples for improving team-based care in the home.

Advancing Canadian Research and Development

Mullie and Chuck (2026) suggest that the life sciences, particularly the patented pharmaceutical industry, offers a significant opportunity to boost research and development spending in Canada, thereby stimulating lagging economic productivity. However, historic approaches of enhanced patent protection and tax incentives have not proved particularly effective. In their article, Mullie and Chuck (2026) describe how both the US and the European Union have leveraged healthcare data sharing and linkage to facilitate secondary use in support of pharmaceutical research and development. They go on to argue that Canada, with universal healthcare, could provide an ideal environment for secondary data usage as all individuals in the population are included in the collective data. They go on to argue that the policy and legislative changes needed to enable data linkage and sharing would be well worth it in terms of economic benefits.

Innovations in Care

We constantly hear that healthcare in Canada "is in a state of crisis." In crisis situations, command centres are commonly used to coordinate responses. It is therefore surprising that until now, no major jurisdiction has thought of using a coordination centre to address acute care issues. In the article by Muenster et al. (2026), the conceptualization, implementation, operation and sustainability of a centralized care coordination

centre for the province of Nova Scotia has been described. Early outcomes are impressive and, in keeping with the metaphorical nautical terminology used to describe success factors in this article, could serve as a beacon for the rest of Canada's provinces and territories.

Healthcare Ethics

As our systems grapple with the complexity of balancing fiscal accountability and standardization with increased flexibility and patient choice, one potential solution is the use of direct service funding models. In 2019, Ontario introduced a revamped program to support individuals with autism that features a shift to direct service funding for children and youth; however, the funding model presents several challenges, including potential inequities across recipients, differences in access and discrepancies between families' choices and clinical recommendations. Bianchi et al. (2026) examine the benefits and challenges of this program through the lens of one service organization and how leaders and staff are responding to the ethical complexities that have arisen. The ethical principles and decision-making framework described in the article are useful tools for other organizations that are walking the fine line between ethics, patient choice and limited funding.

Planetary Health

With increasing pressure on provincial and territorial governments to expand hospital and long-term care capacity, the article by Zahid et al. (2026) poses an intriguing alternative through small home models. These are described as small healthcare facilities serving 6–20 residents in retrofitted or purpose-built house-size buildings. While there are clear benefits in smaller facilities for delivery of more person-centred patient care, the authors add a unique perspective on the model by studying its environmental impact. The researchers assessed and compared factors such as carbon emissions, water consumption and transport. The outcomes make for a unique case study and argument for the value of expanding small home models in healthcare.

Quarterly Columns

In this issue's ICES Report, Postill and Benchimol (2026) note that the current paradigm considers multimorbidity as a homogenous condition. Using ICES data and IBD as an exemplar, the authors demonstrate how various co-morbidities cluster to influence the severity and outcome of IBD uniquely. The authors then describe how integrated, longitudinal data can be used to predict outcomes and inform approaches to individuals with other index chronic conditions and clusters of co-morbidities in a manner that enables a precision public health approach.

Using data from various CIHI sources, Chen et al. (2026) provide objective evidence for the observed association between substance use and mental illness as a driver for acute care utilization. Results are broken down geographically and demographically, identifying higher risk groups. As the authors state, these data will be useful to focus resources and efforts on those individuals and circumstances where there is repeated acute care utilization, reflecting gaps in continuity, access to community-based care and integration across services.

This issue's Quarterly Reflection by Neil Seeman (2026) is both thoughtful and thought-provoking. Based on the book *Thank God I Failed: A Lawyer's Suicide Attempt and the Case Against Trying* by Orlando Da Silva (Da Silva 2026), Seeman addresses the current discussion of adding mental illness to the criteria for medical assistance in dying (MAiD). Two main issues are highlighted: the capacity of someone with mental illness to objectively choose MAiD and the slippery slope of defaulting to MAiD for people with mental illness and other severe chronic conditions rather than providing the system supports that might enable them to live in a state of improved well-being. As a cautionary tale, this column challenges Canadians to think carefully about our "romance" with MAiD.

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