

Last night, President Barack Obama delivered his 2012 State of the Union address. While I know the man has his hands full combating deficits and Republicans, what a difference a year makes: hardly a word crossed his lips about the future of healthcare.

It therefore came as solace to me when this morning I read through the contents of the latest issue of *Healthcare Quarterly*. Here is proof, once again, that we remain blessed with a wealth of intelligent, dedicated people who have not taken their eyes off the healthcare ball.

### Performance Measurement

The first article in this issue steers a perennial topic – performance measurement – in a fresh direction: facility redevelopment. A major building and renovation project is underway at Montreal's McGill University Health Centre (MUHC), and Alain Biron and his co-authors explain how that project's Transition Support Office (TSO) has spearheaded the creation and use of an evaluation framework and measurement tools. The authors assert the presence of causal linkages from measurement to the identification of areas for project-level improvement to the demonstration of the TSO's added value to the MUHC, concluding, "This added value means that patients receive better care." That is a complex set of associations to prove; yet proven, they could have a major impact on facility redevelopment worldwide.

### Quality Improvement

Michael Heenan and his co-authors continue the discussion of performance measurement, albeit on the side of clinical outcomes and patient safety. You might recall reading in *Healthcare Quarterly* 14.4 about how Trillium Health Centre employed big-dot indicators in its board-to-bedside efforts to monitor and stimulate quality improvement. In their piece, Heenan et al. present a similar story about how Credit Valley Hospital (CVH) – actually, soon to merge with Trillium – streamlined its approach to performance measurement. Aligned with the organization's strategy, CVH's Hospital on a Page framework has, the authors claim (again, we need data), been effective in creating a culture of quality and safety as well as communicating key issues to the board, senior managers and clinical programs.

Ronald Lagoe and Shelly Littau provide us with a less rosy view of quality. Like almost everywhere in the United States, cost-containment has emerged as a major priority for hospitals in Syracuse, New York, an area beset by a declining population and expanding numbers of elderly people. Discussing recent patient data, the authors show that as the ranks of "adult medicine" patients have swollen, integration with long-term care and ambulatory care providers has decreased. While greater patient numbers have brought some financial gain, efficiency- and outcomes-related downsides of increased volumes have begun to emerge. I applaud Lagoe and Littau for their finely

woven analysis, and I commend their optimistic outlook on the potential for "integrated healthcare as a community endeavour" as a way to manage these challenges that are not limited to upstate New York (think, for example, of Canada's depopulating rural and northern zones).

### Health Human Resources

Quality is again addressed, but this time in connection to work-life concerns. In his contribution, Jonathan Mitchell takes as his theoretical starting point the causal connection between quality work environments and patient safety as well as care quality. Drawing on Accreditation Canada survey data, Mitchell marshals evidence for "themes" that resonate with several other pieces in this issue; for example, he argues for the need to involve board and senior leadership in bringing about change (see also Heenan et al.) and that "the importance of measurement cannot be overstated in focusing organizational efforts on key priorities" (see also Biron et al., Heenan et al. and Geddes and Gill).

Organization-level quality management requires, E. Lynne Geddes and Caroline Gill contend, appraising personnel performance. Geddes and Gill employed a three-part tool to review the performance of their home-care company's inter-professional therapists against the organization's benchmarks, to review personnel feedback on the tool, to understand the appraisal process better and to identify needed changes to it.

### Primary Care

If primary care is to live up to its full potential, we must solve the vexing problem of access. Jennifer Fournier, Roberta Heale and Lori Rietze focus on "advanced access scheduling," a type of scheduling that is gaining increased attention from primary-care providers, healthcare organizations and governments. Much still remains to be known about the approach (e.g., the impact of patient-to-provider ratios, remuneration strategies, acuity levels). However, Fournier et al. make a strong case that advanced access scheduling can benefit patients, care providers, clerical staff and even the healthcare system itself.

### Leadership

As a final note, I encourage you to enjoy Ken Tremblay's interview with Tom Closson, the recently retired CEO of the Ontario Hospital Association. Tom's wide-ranging views offer a high-level gloss on many of the topics delved into by this issue's essayists. It's never dull and always informative listening to Tom on topics as diverse as organizational capacity, employee engagement, integration through "accountability alignment," performance measurement and monitoring, leadership, medical staff and system funding. One question remains, though: will Tom really be able to gear himself down to work, as he claims, "on a part-time basis"?

*Reggy Leath*