"Technology, information and evidence are calling on all of us to keep pace with change, both the capabilities we're developing in our staff and the people we're serving." That comment, by Bridgepoint Active Healthcare CEO Marian Walsh (in a conversation with Ken Tremblay), could serve as a guide to much of this edition of Healthcare Quarterly.

Keeping pace with change is, for example, woven throughout the report on the 11 Health Care in Canada (HCIC) surveys of providers and public stakeholders that, from1998 to 2014, have revealed a "universal sense of quality in our health system" coexisting with concerns over issues such as wait times, difficulties in transitioning from hospital to home care and the need to improve patient-centred care. Joanna Nemis-White and her colleagues also address the surprising finding that HCIC members—which include major national organizations, such as the Canadian Cancer Society and the Canadian Nurses Association—were not perceived "as key players with a responsibility to improve healthcare provision and policy." That, as the authors note, has led to HCIC partners now emphasizing the consortium's strategic communications and knowledge translation activities.

Focus on Emergency Departments

Timely access to care is perhaps never more top of mind than in overcrowded emergency departments (EDs). In their contribution to the debate, Dean Yergens et al. highlight findings from a survey they conducted of nine medical assessment units (MAUs)—short-stay units intended to relieve pressure on EDs—across the country. Focusing on MAUs' structures and processes, the authors documented their "heterogeneous" characteristics, staffing models and quality indicators, as well as perceptions by physicians and administrators (more positive than negative). A different light is cast on ED overcrowding by Glen Bandiera and his colleagues at Toronto's St. Michael's Hospital, once had the worst ED wait times in Ontario for admitted patients. While much has been written over the years on specific structural innovations (such as MAUs), these authors instead address St. Michael's "corporate approach" to patient flow throughout their hospital as a way to improve ED flow. The steps taken and results obtained are inspiring.

Mental Health

Another kind of patient movement—of chronic psychiatric patients into the community—is, however, failing (i.e., preventing patient-centred care), Jessica Spagnolo argues, because of organizational and systemic barriers: a lack of integration among mental health programs and the persistence of prejudice surrounding mental illness. One of Spagnolo's key messages is that for "deinstitutionalization" to succeed, changes in both domains must occur simultaneously.

Learning Organizations

Ongoing staff learning—as Marian Walsh's comment suggests—is critical for quality patient care. In British Columbia (BC), Island Health's evidence-based learning and performance support (L&PS) approach is helping clinical staff keep up with their competency requirements. Conrad Gottfredson et al. pinpoint the main challenge in this as the "volume of information that rapidly evolves in any given year." Island Health therefore implemented a four-step L&PS approach that entails identifying needed knowledge, differentiating among tasks/skills, reviewing participants' roles and the creation of tools and resources plans. A key to success has been "the involvement of subject matter experts throughout the analysis process," and they outline further work needed to evaluate and improve the L&PS approach.

Quality Improvement

Our next article is interesting to read in the wake of the earlier one by Bandiera et al., as it too takes an organization-wide approach; in this case, to improve "care efficiency and quality." Davina Lau and her colleagues explain the work of the Effective and Efficient Utilization Committee (EEUC) at Toronto's Mount Sinai Hospital. Predicated on cross-departmental collaboration, the EEUC engages clinicians and front-line administrators in all initiatives. Among the main ingredients that have brought about an impressive set of outcomes (e.g., reduced wait times, better patient experience) have been a "grassroots" team-based approach, timely data and dedicated project management.

Change Management

"Never let a good crisis go to waste." Winston Churchill's sage insight prefaces our next article, which recounts the impact of a massive flood (caused by a burst pipe) at Hamilton's St. Joseph's Healthcare that led to the immediate shuttering of the ED and cancellation of hundreds of surgeries. As Tina Dhanoa et al. explain, essential to managing this crisis were cooperation among regional partners and excellent communication. Most intriguing of all were the "new normal" innovations that arose directly from managing this crisis, including efficiencies in booking surgeries, establishment of a Medical Consult Unit to facilitate faster transit through the ED and a new "functional design" of the ED to improve patient flow and treatment. Also focusing on St. Joseph's, LeeAnne Kidd and Rob Howe document a less feverish form of change management: the operational readiness planning that preceded occupancy of the organization's new 855,000-square-foot facility. This included hiring of a dedicated team, identifying issues affecting all (or many) units as well as "Big Dot" corporate-wide matters, reviewing the hospital's emergency preparedness plan and staff training.

Managing Data

Many people have been eagerly anticipating Part 2 of the story Jeremy Theal and Denis Protti began in a previous issue (www.longwoods.com/content/23780). There, they discussed the development and implementation of a computerized physician order entry (CPOE) system at North York General Hospital. Now, Theal and Protti open a door onto the *eCare* project's nine success factors (e.g., front-line clinician engagement and clinically focused end-user training). The outcomes and benefits arising from *eCare*'s first three phases make for uplifting news: improvements in clinician effectiveness/efficiency, patient safety and care quality.

Volume 17 concludes with a return to BC and e-health technology. While increasing numbers of primary-care physicians are using electronic medical records (EMRs), Carole Rimmer and her co-authors point out that "achieving greater clinical value and healthcare quality" relies on "meaningful" (or "mature") use. Rimmer et al. explain a project by BC's Physician Information Technology Office that followed a "structured approach" involving its own Clinical Value Model; implementation and post-implementation support; and a reassessment period. By the project's end, physicians' meaningful use of EMR had "increased consistently." As the authors point out, meaningful use is a "long-term" undertaking; however, the findings and lessons they share will be valuable for others seeking to bring about similar progress not only for EMR but also many other "digital health solutions."

Check Lists Debate

Readers will also notice two pieces offering differing perspectives on surgical check lists. The first, an opinion piece by Muniak et al. discusses the BC experience in relation to a paper originally published by Urbach et al. in the *New England Journal of Medicine*. In the second piece, ICES Reports, Urbach and his colleagues provide readers with an overview of their research which suggests that check lists are not as useful as originally thought. We welcome readers' thoughts and comments on this issue.

– The Editors